Remote delivery of a therapeutic intervention to court-mandated youths of Haitian descent during COVID-19

Louis Herns Marcelin1,2,3 | Toni Cela1,3 | Richard Dembo4 | Michèle Jean-Gilles5 | Bryan Page1 | Danna Demezier1 | Roy Clement1 | Rachel Waldman1

1Department of Anthropology, University of Miami, Coral Gables, Florida, USA  
2Department of Public Health Sciences, University of Miami, Miami, Florida, USA  
3Laboratory on Health, Family and Migration, Interuniversity Institute for Research and Development (INURED), Port-au-Prince, Haiti  
4Department of Criminology, University of South Florida, Tampa, Florida, USA  
5Robert Stempel College of Public Health and Social Work, Florida International University, Miami, Florida, USA

Correspondence  
Louis Herns Marcelin, P.O. Box 248106, University of Miami, Coral Gables, FL 33124-2005, USA.  
Email: LMarcel2@miami.edu

Funding information  
National Institute on Drug Abuse, Grant/Award Number: 1 R34 DA043784-01

Abstract  
The threat generated by the COVID-19 pandemic has triggered sudden institutional changes in an effort to reduce viral spread. Restrictions on group gatherings and in-person engagement have increased the demand for remote service delivery. These restrictions have also affected the delivery of court-mandated interventions. However, much of the literature has focused on populations that voluntarily seek out face-to-face medical care or mental health services, whereas insufficient attention has been paid to telehealth engagement of court-mandated populations. This article draws on data gathered on an NIH/NIDA-funded study intervention implemented with juvenile justice-involved youths of Haitian heritage in Miami-Dade County, Florida, during the COVID-19 public health crisis. We explore the process of obtaining consent, technological access issues, managing privacy, and other challenges associated with remote delivery of family-based therapy to juvenile justice-involved youth. Our aim is to provide some insights for consideration by therapists, healthcare workers, advocates, researchers, and policymakers tasked with finding alternative and safer ways to engage nontraditional populations in health services. The clinical trial registration number is NCT03876171.
The threat generated by the COVID-19 pandemic has triggered sudden institutional changes in an effort to reduce viral spread. Restrictions on large group gatherings and person-to-person engagement have increased the demand for remote delivery forms such as telehealth, telemedicine, teletherapy, and telemental health, using various technological platforms. Much of the emerging literature on the accessibility, use, and effectiveness of remote service delivery, however, focuses on populations that voluntarily seek out medical care or mental health services, with some focus on difficult-to-reach populations such as immigrants, those with limited English proficiency (Barney et al., 2020; Endale et al., 2020; Ortega et al., 2020; Rodriguez et al., 2020), and rural residents (Woodall et al., 2020). Insufficient attention has been paid to remote delivery engagement of court-mandated populations and even less on communities that also traditionally face access barriers to such services, with some exceptions (Batastini et al., 2020). This article aims to fill this void, drawing on data gathered between March and September 2020 by a National Institutes of Health/National Institute on Drug Abuse (NIH/NIDA)-funded clinical trial study.

As health systems and institutions increasingly rely upon telehealth services in response to the public health crisis and, in some cases, under the guise of its accessibility and low costs, we must consider the implications for minority populations that have traditionally lacked access to services, had their requests for services rebuffed, have declined services offered, and/or have been mandated to services. We build on the emergent literature to explore issues such as obtaining consent remotely, accessing technologies, and managing privacy as we delve into the challenges, particularly examining participant engagement associated with remote delivery of family-based therapy to juvenile justice-involved youth.

We begin with a brief overview of the study as conceived and implemented before the COVID-19 pandemic, then we provide a synopsis of remote service delivery from a cross-disciplinary perspective, followed by a discussion of services’ accessibility to underserved populations. Subsequently, we present data collected while providing remote services under a Miami-Dade County-issued stay-at-home order. In our discussion, we elucidate some of the opportunities and challenges posed by the use of remote delivery when working with minority, immigrant populations mandated to service. Our aim is to provide some insights for consideration by researchers, social services advocates, clinicians, healthcare workers, and policymakers tasked with finding alternative, safe ways to engage marginalized groups in services that are delivered remotely.

The Haitian Adolescent and Family Study is a unique NIH/NIDA-funded clinical trial intervention that is testing the safety and efficacy of culturally competent, integrated family and individual-based program, designed to reduce drug use, sexual risk, and delinquency risk for youths of Haitian descent, ages 13–17, in Miami-Dade County, Florida. This pilot study modifies a specific intervention, the Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA; Santisteban et al., 2013), for appropriateness in Miami-Dade County’s Haitian sociocultural contexts. CIFFTA was developed for a Hispanic population and addresses problematic adolescent behaviors such as conduct issues, depressive disorders, failure in school, family disputes, delinquency, violence, substance use, and risky sexual behavior (ibid.). To modify this CIFFTA intervention, we draw from sociocultural data of prior studies, including some implemented by the authors, conducted on families of Haitian descent and
their neighborhoods over the last 30 years (Marcelin, 2005, 2017; Marcelin & Page, 2007; Marcelin et al., 2021; Grenier & Stepick, 2009; Rey & Stepick, 2013) and continuous ethnographic data collected with the families since the inception of this study. We randomize two groups of adolescents into either the CIFFTA model or the Standard of Care (SOC) currently being offered by Miami-Dade County’s Juvenile Service Department (JSD) to adolescents of Haitian descent in their diversionary programs (see Figure 1).

Adolescents are referred to the study by the JSD. After obtaining consent from guardians and assent from the adolescents, our team randomly assigns them to one of the two conditions. We conduct assessments of all parents/guardians and adolescents, and for those referred to the CIFFTA intervention, we develop and implement an intervention plan. The intervention includes individual psychoeducational and family sessions, generally delivered over a 3-month period. Unlike the traditional CIFFTA model, which is delivered in a clinical setting (Santisteban et al., 2013), a unique aspect of this study intervention is that the therapy sessions are delivered in participants’ homes to reduce missed sessions and premature termination. This innovative feature removes an important barrier to sustained participation in the intervention by immigrant families of Haitian heritage. Home delivery requires that, first, after referral and enrollment into the study, the ethnographers, who themselves are of Haitian descent, conduct the baseline assessments and maintain sustained engagement with as many family members of the participants as possible over the lifetime of the project. Observational data, interviews, and social mapping data provide sociocultural understandings for therapists to build rapport with youths and their families. Despite its many challenges, home delivery allows our research team to identify key sociocultural principles that have informed our modification of the CIFFTA model and are being incorporated into core elements of family therapy for this population. A separate ethnographic team conducts observations and interviews with the study participants in their households throughout the study. Following the baseline assessment, follow-up assessments are conducted in intervals of 3, 6, and 12 months after delivery of the intervention. Primary study outcomes include sustained abstinence in substance use, better family functioning, avoidance of sexual risk behaviors, and improvement of conduct disorder. Secondary outcomes include reduced recidivism rates and gang involvement. Ultimately, the study’s multidisciplinary team hopes to identify key sociocultural principles to be integrated in core elements of family therapy tailored for this community in the United States.

FIGURE 1  Clinical trial process
The study was at its 15th month of implementation when the US government declared a Public Health Emergency for the 2019 Novel Coronavirus (COVID-19). Following NIH’s instructions to those conducting NIH-funded clinical trials and human subject studies that were impacted by the declaration (Notice Number: NOT-OD-20-087; Release Date: March 16, 2020) and the University of Miami’s Guidelines for Human Subjects-Related Research Visits during the COVID-19 pandemic, all research activities were immediately suspended. We then developed a new protocol adapted to encompass remote delivery of the intervention. Ideally, the new delivery method would entail using Zoom Telehealth for service provision; however, we understood that certain family constraints (e.g., financial, lack of technological proficiency, limited access to infrastructure, etc.) might make this platform inaccessible to some of our families. To avoid disruption of services, we were prepared to accommodate families that only had telephone or cellular phone access. We subsequently applied for amended IRB approval to transition the intervention from home-based to remote delivery, in whatever form best accommodated our families. The matrix below (Figure 2) describes each component of the trial as it was intended to be implemented and the adjustments we made to continue the trial. It illustrates the challenges faced and how each was addressed.

At the time when we resumed implementation and switched to remote delivery mode, 25 study participants and their parents were already enrolled in the study. Seven new study participants were enrolled during the pandemic. In a few cases with two-parent households, we have been able to engage both parents in sessions either together or separately. In total, 32 study participants (18 male and 14 female youths) were randomized into the two conditions: 18 youths in CIFFTA and 14 in the SOC. The modified CIFFTA intervention is generally delivered over 3 months (12 weekly sessions) but can last as long as 6 months (18 weekly sessions)—depending on the level of risk, with a 1-h-long session facilitated per week. However, for high-risk youths, the intervention may

| Component                  | ARM A: Pre COVID-19                                      | ARM A: Stay-at-Home Order                                      | ARM B: Pre COVID-19                                      | ARM B: Stay-at-Home Order                                      |
|----------------------------|---------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------|
| Consent Process            | Consent process completed within 7 days of referral     | Consent forms adjusted to include remote delivery of intervention and assessments | Consent process completed within 7 days of referral     | Consent forms adjusted to include remote delivery of intervention and assessments |
| Baseline Assessment        | Completed at home with both youth and caregiver within 7 days of consent | Some assessments completed on separate days due to scheduling issues (e.g., youth and caregiver not available at the same time) | Completed at home with both youth and caregiver within 7 days of consent | Some assessments completed on separate days due to scheduling issues (e.g., youth and caregiver not available at the same time) |
| Drug Testing               | Administered during each home-based assessment          | Administered once stay-at-home order lifted in Miami-Dade      | Administered during each home-based assessment          | Administered once stay-at-home order lifted in Miami-Dade      |
| Intervention               | Counseling sessions facilitated at home                 | Counseling sessions facilitated remotely                       | N/A                                                    | N/A                                                    |
| 3-month Assessment         | Completed at home within 10-days of intervention completion | Completed remotely and at times on separate days due to scheduling issues | Completed at home within 10-days of intervention completion | Completed remotely and at times on separate days due to scheduling issues |
| 6-month Assessment         | Completed at home 12-14 weeks after completion           | Completed remotely and at times on separate days due to scheduling | Completed at home 12-14 weeks after completion           | Completed remotely and at times on separate days due to scheduling |
| Booster Session            | Completed at home 12-15 weeks after completion           | Completed remotely 12-15 weeks following intervention completion | N/A                                                    | N/A                                                    |
| 12-month Assessment        | Completed at home 9-10 months after completion           | Completed remotely and at times on separate days due to scheduling | Completed at home 9-11 months after completion           | Completed remotely and at times on separate days due to scheduling |

FIGURE 2 Pre-COVID-19 and during Miami-Dade County stay-at-home order
require up to two 1-h sessions per week. In addition, 1-h-long booster session was delivered to youth participants 6 months after successful completion of the intervention. Youth in the SOC are served by other JSD-authorized agencies and community-based organizations. Similar to CIFFTA, SOC interventions include weekly 1-h sessions over a period of 3-months for low-risk youth. The frequency or length of the intervention may be extended for moderate and high-risk youths. Notably, we are one of only two entities providing family-based therapy to juvenile justice-involved youth of Haitian descent in Miami-Dade County. All SOC interventions provide individual therapy that is focused exclusively on the youth. As part of our study, we regularly interview the therapists providing services to youth participants in the SOC to ascertain progress, persistence, and completion of the intervention. Data reported in this article are limited to the 12 cases that were enrolled in our modified CIFFTA intervention during the pandemic. Of these cases, five began the intervention receiving services at home whereas the remaining seven were enrolled during the pandemic and, thus, exclusively served remotely.

The current restrictions on interpersonal contact have given rise to strategies for electronic contact for various purposes, from remote service delivery to staff meetings. The use of electronic means to deliver the therapeutic intervention represents a "work-around" that remains true to the original intent of the intervention's design: Allowing participants to receive mental health services from the comfort of their own homes. Remote delivery of the intervention is intended to be a short-term response to the county-issued stay-at-home order to allow our youth and their families to continue to receive services during the pandemic. It is not our intention to modify our service delivery method from home-based to remote delivery. Although remote services offer some benefits, we believe that our intervention is best delivered in person and, thus, fully intend to resume home-based services once it is deemed safe for the families and our clinical staff to do so.

3 | REMOTE SERVICE DELIVERY: THE STATE OF THE APPROACH

Providing services remotely has a number of benefits for both clinical staff and clients. Remote services have been proven to increase accessibility by eliminating a number of barriers. Telepsychology has been effective in addressing the challenges clients face in terms of distance and travel, reducing the stigma often associated with seeking services, and helping clients manage competing life obligations (Abrams, 2020; Birk & Radick, 2020; Moreau et al., 2018; Racine et al., 2020). The latter has particular significance in the context of the COVID-19 pandemic, as more than three million migrants are projected to become unemployed in the United States. Many of those fortunate enough to remain employed are essential workers, placing them at greater risk for viral infection, a risk exacerbated by the reality that 20% of migrants are uninsured (Jewers & Orozco, 2020). Similarly, telehealth has been credited with making health care accessible to those who live far from services or have transportation issues, while also addressing shortages in healthcare providers and specialists (Saenz et al., 2019). Teletherapy was also found to be as effective in treating socioemotional issues, via online platforms, as in-person services (Batastini et al., 2020; Burgoyne & Cohn, 2020; Langarizadeh et al., 2017; Saenz et al., 2019). It is also convenient, provides participants with intimate access to physicians without the nuisance of wearing masks (during the pandemic), and resolves service disruptions for those patients who were hospitalized, discharged, and transitioned to outpatient care (Birk & Radick, 2020). Moreover, Burgoyne and Cohn (2020) reported patient satisfaction and flexibility in its use by different populations as additional strengths of teletherapy. These modalities of service also have benefits for providers, such as increased ability to expand their client base, increased profitability, and lower costs, as well as additional potential for future benefits as remote service delivery advances technologically (Langarizadeh et al., 2017; Racine et al., 2020).

Remote delivery using videoconferencing platforms allows providers to maintain some aspects of in-person engagement. For example, videoconferencing allows for providers to use body language and their voices to convey warmth and positivity (Matheson et al., 2020). Further, it may offer some advantages over clinically based services, such as access to the client’s home environment (ibid.). This may present opportunities to connect with families and display genuine curiosity about their lives by discussing home décor that may have cultural or personal significance.
and identifying other interests that clients may have (ibid.). There are, however, drawbacks to remote delivery. For example, when services are filtered through video, it may be difficult to observe nonverbal and visual cues, and some may go unnoticed. The use of smartphones for telehealth poses potential security risks that may lead to Health Insurance Portability and Accountability Act (HIPAA) violations (Smith et al., 2017). Audio-based service delivery does not offer the possibility of observing behaviors or the client’s home environment and requires that providers employ other skills, strategies, and techniques to connect with and engage the client. In both cases, videoconferencing and audio-only delivery models require much more effort on the part of clinicians to observe, capture, and hone-in on some of the key elements of their therapeutic models.

Additional concerns with remote delivery include issues with connectivity, visibility, and sound that may hinder the provider’s ability to properly assess the client’s presentation (Loi & Pring, 2020; Racine et al., 2020), which can ultimately impact client care. In-person interactions facilitate the recognition of certain behaviors or identification of odors that may indicate signs of poor physical or mental health. With remote delivery, providers must rely upon oral communication and develop new skills to assess patient wellbeing in the absence of these cues. In cases where remote services are provided solely using audio technologies, specific gestures and sayings may not translate as well as they do in-person.

As when providing in-person services, remote delivery service providers must be attentive to the larger sociocultural contexts in which their clients operate, particularly when serving minority and immigrant populations. Social identity positions such as ethnicity, gender, sexual orientation, religion, socioeconomic status, and disability status, among others, contribute to shaping the ways in which individuals imagine and organize the world around them and should be taken into account when offering remote service delivery (McCord et al., 2020; Saenz et al., 2019). In Miami-Dade County, engaging members of the Haitian community in services presents unique challenges, often due to migration history and immigrant status, poverty, and sociocultural marginalization (Authors, 2005, 2007, 2017, in press; Gollub et al., 2015; Grenier & Stepick, 2009; McMahon et al., 2016). Further, this community continues to be burdened by the label of HIV carriers that was assigned to them by the Centers for Disease Control and Prevention (CDC). This is a stigma that fomented distrust of government agencies and outside institutions that continues through today (Authors, 2005, 2007, 2017; Sangaramoorthy, 2014). Because of this, providers should attempt to gauge how these factors inform the client’s communication style at the micro and macro levels. However, effective remote communication will involve trial and error, as the provider must constantly adjust how they interpret and convey attitudes and behaviors (Godine & Barnett, 2013). When providing telehealth services, practitioners are encouraged to readjust expectations, pace themselves, and be intentional about the relationship process (Burgoyne & Cohn, 2020). These suggestions may help alleviate some of the stressors experienced by providers while navigating this novel approach.

There are other, equally problematic service delivery issues not exclusive to telehealth: Not having the proper contact information for clients (Batastini et al., 2020); client distraction (Abrams, 2020; Endale et al., 2020); inability to establish rituals to situate and prepare for counseling sessions (Burgoyne & Cohn, 2020; Matheson et al., 2020); Zoom or general fatigue associated with screen gazing (Burgoyne & Cohn, 2020; Loi & Pring, 2020); limited access to providers; as well as life stressors such as caregiver unemployment (Endale et al., 2020). Despite these challenges, the accessibility and cost-effectiveness of telehealth seem likely to make it the future of service delivery that many health and social services and other providers are coming to embrace. Yet, although effectively addressing some issues related to access, remote service delivery is in itself inaccessible to many underserved populations.

3.1 | Remote service delivery and underserved populations

Underserved populations include ethnic minorities, rural residents, low-income families, and those with limited English proficiency (Batastini et al., 2020; Ortega et al., 2020; Rodriguez et al., 2020; Woodall et al., 2020). Despite the many cited benefits to remote delivery, the research is replete with challenges and limitations which may disproportionately impact particular groups in negative ways. Even though telehealth, teletherapy, telepsychology,
or telemedicine resolves some barriers to services, these modalities can further marginalize certain populations such as immigrants, refugees, or the incarcerated, and place them at a disadvantage. One important aspect of this service modality that has been explored is its viability for certain populations. For some, telehealth is not a practical option, and, therefore, clients must be screened to determine whether it is an appropriate service delivery model. Furthermore, providers should offer alternative solutions when remote delivery is not deemed appropriate (Racine et al., 2020). Lack of access to technologies and unfamiliarity with the use of technological equipment and various platforms serve as barriers to remote services for underserved communities (Ortega et al., 2020; Rodriguez et al., 2020). Though access to equipment such as smartphones, tablets, laptops, and desktop computers has certainly increased over the past decade, 21 million Americans have poor, limited access to an internet connection or no access at all (Ortega et al., 2020). Telemedicine requires access to a broadband connection, familiarity with videoconferencing technology, and a technological proficiency which many underserved communities lack, making the service itself inaccessible for those most in need (Woodall et al., 2020). Certain populations are particularly disadvantaged in this regard, including those living in rural areas, the elderly, those with lower levels of education who may be less comfortable with new technologies, as well as those with limited income to invest in equipment or pay monthly service fees. Such access limitations have resulted in disproportionate reliance on audio-only modalities such as landlines or cellular phones that may not have videoconferencing abilities to serve this population (ibid.). However, these new technologies are not only inaccessible to the underserved, in some cases, they also pose significant challenges for providers.

Some providers are uncertain which programs to use or are unable to judge their quality (Abrams, 2020), have questions regarding the functionality of programs (Abrams, 2020; Endale et al., 2020; Langarizadeh et al., 2017; Moreau et al., 2018), or may be unfamiliar with equipment options (Batastini et al., 2020; Moreau et al., 2018). These factors may be exacerbated by a lack of technological literacy or proficiency on the part of providers and/or their patients (Abrams, 2020; Endale et al., 2020; Langarizadeh et al., 2017). For these reasons, it has been recommended that providers have trained staff available to assist with troubleshooting issues as they arise (Moreau et al., 2018); offer additional, guided training and phone support to address technological limitations (Abrams, 2020; Barney et al., 2020); and host educational conversations or informal talks to orient clients to online counseling (Birk & Radick, 2020). What these factors reveal is a need to acknowledge the limitations of remote delivery; it is not accessible for everyone.

In the following section, we detail our implementation of our intervention study. We detail our efforts to prepare our clinical team for remote service delivery, the process by which we obtained consent and ascertained their access to technology, as well as our efforts to structure our intervention and research in the context of the COVID-19 pandemic.

### 3.2 Preparing for the unknown: Remote service delivery and staff training

With no additional resources to train our clinical staff to deliver the CIFFTA model remotely, we relied heavily on our clinical supervision team to train our therapists for this new, unchartered territory. We had to be realistic and acknowledge the barriers to service delivery we might encounter, but we also needed to acknowledge the specific challenges we would face working with court-mandated youth. Along with the clinical supervision team, we developed a written guide for delivering mental health services remotely. The guide was reviewed, discussed, and validated during a 2-h clinical supervision meeting in preparation for remote service delivery. After the first two remote delivery experiences, we reviewed and readjusted the guide with the clinicians paying special attention to key provisions related to the technological and human challenges they faced. We repeated this exercise after subsequent sessions with existing and newly recruited participants. This exercise allowed us to incorporate concrete examples into the therapists’ training, which we have ultimately codified in this article. A unique feature of the guide was its focus on the importance of tending to the mental health needs of the youth, families, and therapists needs as well as its prioritization of, first and foremost, the impact of the global pandemic on our families’ lives.
The therapists have been encouraged to practice self-care and to identify signs of difficulty in coping both in themselves and in families. The idea that therapists must protect their own mental health, though not new, is particularly important during such difficult and unpredictable times. Creating space for therapists to recognize and acknowledge how the pandemic is affecting them is of critical importance, as it has implications for the services they will provide to their families. Once therapists have been encouraged to identify and address their own mental health needs, then they can shift their focus to promoting self-care and identifying any signs of persistent anxiety or depression in youths and their families. Community-based resources have been identified and shared with therapists, including COVID-19 programming in Haitian Creole, testing-site information, unemployment benefits, food banks, and others, which they can, in turn, share with their families.

Therapists have been encouraged to check-in with families to determine how the pandemic was affecting them. As some families had already begun the intervention, certain issues may already have been identified as the focus of the intervention. However, in light of the public health crisis, therapists have been guided in how to engage families on additional topics such as educational disruption, employment disruption, social isolation, and self-protection during the pandemic. Depending on the youth or family’s willingness to share such information with the therapist, and its impact on the family, the intervention plan can be modified to address COVID-19-related impacts on youth (e.g., remote learning challenges, substance use, engagement in risky behaviors, etc.) and family functioning (e.g., conflicts, domestic violence, acculturation, etc.) as well as environmental stressors (e.g., job loss, food insecurity, marital stress, etc.).

Therapists have been encouraged to explain how the public health crisis might impact their JSD cases (e.g., disruptions to services, complications in completing community service, etc.). Finally, therapists have also been trained to develop a plan with the youth and their parents that will help them successfully complete the therapeutic intervention by developing a timeline to ensure that they understand how missed sessions could prolong or lead to unsuccessful termination of the intervention, contracting to modify session length as needed (to 30-min sessions) due to online platform burnout and detailing how to create and maintain privacy and confidentiality (use of space, headphones, etc.) during the intervention.

In addition, therapists have been given a guide to General Mental Health for Families which includes recommendations for coping during the pandemic: Creating a routine, establishing an exercise routine, practicing self-care, identifying a support network and checking-in on them (and allowing them to check in on you), increasing flexibility and self-regulation, countering irrational thoughts with logic, expressing gratitude towards oneself and others, among others.

We have been adapting our intervention to deal with a pandemic which is not yet fully understood. It had begun to take many lives in Washington and New York states; however, its impact on Florida, specifically Miami-Dade County, had yet to be seen. This training was designed to prepare our therapists to deal with the unknown, to be patient and flexible with one’s self and with others while using new media to deliver the intervention. Remote delivery of the CIFFTA intervention was expected to be a short-term solution in response to the pandemic; therefore, the training was not designed to prepare our therapists to deliver the model remotely in the long term.

3.3 | Obtaining consent for participation in remote service delivery

As institutions transitioned from in-person to remote delivery of services during the pandemic, practitioners had an obligation to obtain patient consent to engage in this new service modality, for both new and existing patients (Abrams, 2020). Consent, however, would also now need to be obtained remotely. As during face-to-face interactions, obtaining consent remotely entails explaining the process and procedures related to treatment and determining the technologies patients have access to, are familiar with, and agree to use for the intervention. Identifying an appropriate setting for the consultation or intervention entails a discussion on the intervention’s structure, logistics, roles, and expectations, and beginning the process of rapport building (Matheson et al., 2020).
Nevertheless, certain considerations must be taken into account when working with populations such as the participants of this study. Although the youth (and their parents or caregivers) have agreed to participate in JSD diversion programs, their participation cannot be considered fully voluntary, as they are faced with having their case adjudicated in court if they refuse the intervention. And even after they consent, the element of coercion remains ever-present, as failure to complete the program successfully, or rearrest, will result in their cases being referred to court, which may lead to tougher sanctions.

Despite the coercive nature of the consenting process when working with mandated populations, it is a process that must be undertaken, as families have the right to decline diversion services just as they may refuse to participate in the study. With this in mind, our study team set out to continue the consenting process during the pandemic. The pandemic necessitated a certain level of flexibility that had not existed previously, as some parties were more readily available, due to the Miami-Dade County-issued stay-at-home order and schools’ transition to remote learning, whereas others, such as essential workers, were not. This flexibility introduced new challenges, as consent had to be obtained from both the youth and at least one parent or caregiver. On several occasions, one party’s availability did not correspond with the other’s, compelling therapists to carry out the process separately for youth and adults. In some single-parent households, youths were sent to the other parent for extended visits, separating them from their primary caregiver for a period of time. Other parents and caregivers sent their youth to visit relatives in another city or state, as one therapist explained during clinical supervision:

There was slight difficulty in scheduling the consenting process with 113B... I called [her] caregiver and completed the consenting [process] and [the caregiver] informed me that [she]was unavailable and would be leaving for Orlando the same day to visit with relatives...[The caregiver] willingly shared 113B’s number ... and I was able to complete the consenting process with the youth several days later.

There were also language barriers that made facilitating the consent process with all participating family members at one time quite challenging. During home delivery, our bilingual therapists could discuss the study and the therapeutic intervention and respond to any questions or concerns the youth or parents had while simultaneously translating for and between the two parties, where necessary. Offering services in the patient’s preferred language is acknowledged as one, though not the only, effective strategy to serving diverse populations remotely (Endale et al., 2020). In most cases, youths were more comfortable discussing the process in English, whereas parents and caregivers preferred to receive that information in Creole. As a therapist explained, “The consenting process occurred separately for the youth and his parent since the youth’s preferred language was English and the parent’s was Creole.” This was not uncommon, as most families were contacted on their cellular phones, which would later serve as their preferred modality for remote service delivery, as we explain in the subsequent section. This technology made it logistically challenging to engage both parties at the same time. Though speaker phones might make a group meeting and simultaneous translation possible, to protect family privacy, this was generally discouraged. As this example demonstrates, technological limitations served as a significant barrier to effective service delivery.

3.4 | Access to technology

Most families had access to a cellular phone, but not all members had their own phones or a phone that was in service. In most cases, the cellular phone served as the principal technology used for remote service delivery. Beyond that, in many cases, therapists could only determine if families had access to a desktop, laptop, or tablet if it had been observed prepandemic during home-based service delivery or if they were informed by youths when inquiring about their academic performance: “104B and her family had access to smartphones, laptops, and a
desktop computer, which I observed when I provided services in the home. The family does have internet access. The youth reported that she and her siblings were provided with laptops from the school during the COVID-19 pandemic.

Some youth, however, did not have their own cellular phones. In such cases, services had to be mediated through their parents, whose cellular phones they would use. For example, during the pandemic, 104B’s mother reported that the youth no longer had a cellphone, requiring the youth to use her mother’s cellphone to participate in a booster session. The mother scheduled the appointment on a day that she would be home to accommodate the session. In other cases, when the parent’s cellular phone was not available, some would use an older sibling’s phone, which at times proved disruptive, as this therapist explained: "207A borrowed his brother’s phone to complete his assessments since the father was going out for the day and unavailable. The youth was interrupted more than once by his brother who kept asking how long it would take before he returned the phone.”

Four of the families recruited into this study, at one time or another, did not have cellular phone service. 117A’s mother had her service disconnected during the pandemic. Unable to reach the family, the therapist contacted the youth’s JSD case manager who had to go to the family home to contact them. During a subsequent session, the youth shared with the therapist that his family “had to choose between paying rent or the cellphone bill,” and so their service had been disconnected.

Matheson et al. (2020) not only stress the importance of identifying what technologies clients have access to, but they also argue that practitioners must negotiate what technologies clients are most comfortable with and most willing to use for telehealth. As we learned in our study, although some families had access to smartphones, laptops, or computers with internet access, they were not always willing to use videoconferencing technologies such as Zoom or even WhatsApp or FaceTime. All but one family declined to have sessions video recorded, even for the purpose of clinical oversight, opting to be audio recorded instead. Perhaps their rejection of video-enabled platforms is due to youths’ engagement with the juvenile justice system and mistrust of this institution; however, there may also be other factors, such as immigration status, negative experiences with child protective services, whether past or present, or reluctance to have their homes captured on video. Therefore, allowing clients to select the technology they wish to use is critical if we are to establish a therapeutic alliance between parents and therapists.

### 3.5 Protecting privacy during remote service delivery

Due to the potentially sensitive nature of remote delivery, numerous researchers have cited the importance of promoting safety and confidentiality during service provision (Abrams, 2020; Barney et al., 2020; Burgoyne & Cohn, 2020; Endale et al., 2020; Langarizadeh et al., 2017; Looi & Pring, 2020). They recognize how privacy breaches can easily impact the telehealth or telepsychology process. Incidents such as individuals walking in during counseling sessions (Batastini et al., 2020) were not limited to the home environment but were also observed in the workplace.

In our intervention study, therapists emphasized the importance of maintaining privacy during service delivery. Some youth worked to maintain privacy in a number of ways, including retreating to a private bedroom during sessions. Some could be heard asking others to leave the room to establish privacy, as this therapist explained in the following case:

At the beginning of the intervention, I had to remind 117A that he needed to be in an area that is secluded and private. I do not know the configuration of the home, but it does seem that there is not a lot of personal space. As the sessions progressed, the youth started maintaining his privacy and would remind his siblings to exit his room, which he shares with his siblings, when they interrupted the session.
This youth was referred to the program during the stay-at-home order; as a result, the therapist did not know the configuration of the space as he had not been able to visit the home. Further, as the youth was using audio-based equipment, the therapist could not directly observe where the youth had designated as his therapeutic space. Although therapists could not directly observe whether privacy was maintained, they were able to use their sense of sound to ascertain whether it was. On one occasion during the intervention, an assessor reminded 212B of the need for privacy, particularly when a lot of noise was heard in the background. The assessor determined that the youth had relocated to a quiet area due to a subsequent reduction in background noise. Remaining sensitive to sound became an essential strategy to protecting youth privacy. This was a bit less challenging when therapists were already familiar with the home setting and could inquire about the youth’s location.

There were other strategies employed to maintain privacy. One such strategy was to remain attentive to changes in youth behaviors: “During one session, I noticed that 113B seemed to be more quiet than usual. When I probed about her demeanor, she disclosed that she was using a headset because she was not alone.” Though the headset ensured that others could not hear the therapist’s statements, it may not have created conditions for the youth to speak candidly and self-disclose. This illustrates some of the challenges of providing remote services, particularly to youth who may not have the luxury of a private bedroom. It also requires judgment on the part of the therapist to determine at what point the intervention must be stopped due to a breach of privacy.

One therapist reported that 114A was not afforded complete privacy, as his parents would interrupt sessions from time to time if they overheard something and wished to interject. At one point, as the therapist responded to the youth’s description of his relationship with his sister, his father intervened: “Gen de konvèsasyon wap fè ak 114A, fòk nou ta involve nan yo [There are certain conversations you are having with 114A that we [parents] should be involved in].” This represented a serious breach of privacy, which could indicate that the youth never fully had privacy during the intervention. The therapist continued to emphasize the need for privacy to the parents while acknowledging and validating their authority as parents and their concerns regarding their child. In this situation, cultural sensitivity required that the therapist request privacy for the youth without challenging the parent’s authority. The therapist had to understand how culture shapes belief systems, identity, and family organization, and influences how study participants respond to treatment. By negotiating the two, the therapist was able to maintain a therapeutic alliance with the father and create the possibility for some privacy. Developing an alliance with the parent is critical, as studies conducted with youth referred and mandated to services show a positive relationship between parental engagement in a child’s treatment services and successful outcomes (Dakof et al., 2001; Mauro et al., 2017). Parents and families who are actively involved in treatment services can help reduce youth involvement in the juvenile justice system by monitoring and overseeing their adolescent’s behavior but also by helping create privacy for the youth, as appropriate to allow them to fully benefit from the therapy. Parental monitoring protects against delinquency and risky behavior in adolescents regardless of their cultural backgrounds (Griffin et al., 2000).

There are, however, strategies that can be employed to protect privacy when patients do not have sufficient space or privacy for consultation due to the configuration of the household. The clinician may recommend the use of headphones and a fan or noise-making machine that is placed outside the door to prevent others from listening. Ensuring privacy is vital as it may affect the participant’s level of comfort and willingness to self-disclose. This is a critical component of the therapeutic process, as self-disclosure enables vulnerability and without it, the therapeutic process may be superficial. Abrams (2020) suggests that mental healthcare providers should begin their sessions by making certain that the participant is in a safe and private location, and they should know the participant’s exact address. This is necessary to protect confidentiality but also for the study participant’s safety in case of an emergency.

Whereas in-person sessions typically employ structure and rituals, practitioners have less control over the participant’s environment during remote sessions, making it critical to emphasize and discuss session structure during the consenting process. As Matheson et al. (2020) point out, in a clinical setting, the office is a controlled environment that belongs to and is operated by the provider. This, along with the provider’s physical presence, helps maintain order and reinforce appropriate behaviors during a session. However, when the physical and symbolic space of the office, or intervention setting, is no longer available, the practitioner’s authority may be easily undermined. The lack of space in
certain homes made establishing privacy a challenge for some youth in our study. One of our cases is notable, as the youth lived in a modest home with his mother and eight siblings. When privacy could not be maintained, the therapist would reschedule to stress the sessions’ importance and compel the youth to adhere. In another case, the therapist had to conclude a session midway through when the youth was heard entering a vehicle with her mother. In a third example, a therapist was able to complete two assessment tools before loud music was overheard playing in the background. The assessor also noticed a change in the youth’s tone as he began to provide single-word responses such as “yes” or “no” with no further elaboration or additional remarks. “I suspected there wasn’t privacy anymore, so I asked him if he was still alone and if it was a good time to continue. The youth responded, ‘No.’ I had to reschedule the remaining assessments for the following week.” Although the pandemic may have made it easier for the therapist to reschedule a session, under such conditions, it may be difficult to establish rituals and structure the intervention.

Remote delivery disrupts the typical session structure, as it eliminates rituals such as the physical preparation that compels the patient to transition into a mental space that they associate with their consultation or intervention (Burgoyne & Cohn, 2020; Matheson et al., 2020). Whereas during home-based delivery the therapist can identify and encourage the reconfiguration of a space for a session, remote service can be disruptive if the home space has not been properly set-up by the study participant for those purposes. As a result, remote sessions may feel less structured, which can lead to a shorter attention span, less engagement, and the failure of the participant to properly prepare for the intervention, including establishing and maintaining a level of privacy. In the case of family-based treatment, Matheson et al. (2020) recommend establishing exact start, break, transition, and end times at the beginning of each session and holding participants accountable for their involvement. However, they do acknowledge the potential for inconsistency or a decline in session attendance due to lack of structure in the home setting (ibid.).

As mentioned above, therapists have been working hard to maintain privacy but have had to contend with issues of space that were, in many respects, beyond their control, such as shared bedrooms or, in one particular case, working with parents who did not believe their children were entitled to privacy. Though these situations hindered the maintenance of privacy, even monitoring privacy became much more difficult because the families have been using cellular phones for audio-only service delivery.

3.6 Variations in levels of engagement: From in-person to remote service delivery

The most important strategy employed by therapists to build rapport with families was to be flexible. This required accommodating youth and family members’ schedules and sometimes erratic attention spans: “When working with 207A, I was patient, accommodating and flexible when it came to completing the assessment but it was not an easy experience.” Though therapists tried to remain flexible, remote service delivery was not always the most effective approach:

Remote delivery seemed to make it harder to build rapport with the youth and his mother. Both of them were contacted, via phone and text, and did not always follow up with me. It took me about 3 weeks to complete the baseline assessment. This family was, by far, the most difficult one to build rapport with...I was flexible when it came to scheduling appointment times, rescheduled as needed, offered to break up the sessions so all assessments were not completed at once, and used humor, where appropriate. These strategies showed little success in building rapport with the family. They were disconnected and weren't present during the sessions.

Here, the therapist is trying to adapt and accommodate study participants as the pandemic brought sudden change to institutions, organizations, and communities; however, as the therapist pointed out, extending such accommodations does not always pay off in terms of youth and/or family engagement.

As during face-to-face service delivery, during remote delivery, youth levels of engagement varied. Some youth who began the intervention face-to-face showed the same level of engagement after transitioning to remote
services. For example, one therapist reported that the male participant was difficult to engage during a remote booster session, which was consistent with his engagement levels during the face-to-face intervention. In response, the therapist invited the mother to join the session: "Once the mother was invited into the session, the youth became more engaged and responsive to the therapeutic process. The youth remains engaged in the sessions because his mother actively tries to create a three-way conversation. The youth also stays engaged as a way to monitor what his mother says about him and share his point of view." In another case, engagement declined as the youth transitioned from in-person to remote therapy: "Remote delivery made it easier for 113B to disengage in the process... For example, she did not sound sleepy or groggy in person and often spoke up more during home-based therapy. Many times, during remote delivery, she responded that she did not know and did not elaborate unless I probed her for further information."

Among youth who experienced the entire intervention during the pandemic, some showed positive engagement:

The youth was always available and engaged throughout the intervention. 116A was able to open up about his communication skills and work on improving them. The youth expressed his feelings about the work that was done and how it could be applied to his day-to-day life. 'Yeah...I just keep working on this (communication skills). It can help me a lot... by teaching me patience.

One therapist experienced no challenges in keeping 118A engaged in the therapeutic process. The youth was able to identify his needs, which included improving his communication skills and dealing with social anxiety regarding communicating with and engaging others. While reflecting on his anxiety, he disclosed, "Maybe like, I’m scared of being rejected, unwanted, or denied."

However, this level of engagement was not always evident. Another therapist reflected on a study participant’s demonstrated resistance throughout the intervention:

The youth kept saying that she was not able to hear me over the phone. I wonder if this [was] a form of resistance...the youth has not identified any goals for the intervention and demonstrate[d] low engagement. I am struggling to change 115B's narrative that [the intervention] is a punishment... I wonder if the youth is resistant because the intervention is being done through remote delivery.

Therapists lamented how remote service delivery reinforced avoidant behaviors among those less inclined to engage. In the case of 115B, the therapist speculated that: "...remote delivery seems to have reinforced her avoidant, maladaptive pattern in approaching life issues. She dodges my phone calls, the calls drop out of nowhere, and the sessions end abruptly, sometimes with no clear transition. All of these occurrences have made it difficult to engage the youth well during the counseling intervention." The selection of audio-only technologies for remote service delivery was sometimes thought to be a strategic decision on the part of youth and their families, as the following composite quote suggests:

I do think that some participants choose the phone option as a way to avoid engaging in the therapeutic process. Sometimes, it is due to resources or lack of proficiency in technology but for some, it is purely avoidance. They can disengage if they want, they can do something else while they are speaking to you on the phone... it is convenient because you are not interrupting their life...it is not a priority. For me, counseling is about getting yourself into that space, organizing your space, your time, for a session. I have not seen that with them...There is a disconnect. If you were at their house it would be different. Some have tried to do a session while driving, which is not counseling. They accept the call as part of their day and not necessarily as a [therapeutic] session per se.
This was a serious preoccupation shared by the therapists during weekly clinical supervision meetings, as they lamented the fact that they were not trained to deliver services remotely and that it required more effort on their part: “I received a good foundation but as a therapist, you are trained for in-person therapy. Through remote delivery, you are not able to see the person, pick up on their nonverbal cues, body language, and so on.” Godine and Barnett (2013) suggest that remote delivery requires a disproportionate reliance on oral communication and that practitioners must be sensitive to the possibility of misinterpretation. The overreliance on oral communication was evident as our therapists tried to convey feeling and affect to their participants:

Not seeing the participant places somewhat of a barrier on the therapeutic relationship. In the case of 113B, I had to work hard to smile through the phone and be engaging, entertaining to help continue to strengthen the rapport.

I had to readjust the way I practice. You have to be very mindful of what you say because you are not able to see the physical cues. When you hear silence, you do not know if it’s because they are thinking, if they are distracted, or so on. You are not able to see how they are reacting to you and what you are saying. You do have to work hard to keep the families engaged.

At times, the sessions seem superficial. It is hard to build rapport if you have not seen the person...

Face-to-face sessions are validated through presence, body language, and so on. [I have] had to rely on [my] voice, tone to emphasize certain points as it is not face-to-face. A lot more effort is required for remote delivery.

My approach has changed therapeutically because I am afraid that if I come off too harsh, they are going to create barriers for me to not have access. I have to be very careful with what I say to make sure I get another session. It is easy to have them disengage. I have to be intentional with my word choice.

Whereas the first three quotes express sensitivity to how communications are received in the absence of nonverbal cues, the final quote links communication directly to engagement. For this therapist, effective communication during remote service delivery is critical if the goal is to have the participant return for the next session. However, the burden has not fallen solely on the shoulders of the therapists. These changes in the service delivery model have also required more of our clinical supervisors: “With remote delivery therapy notes, I had to ask [the therapists] explicitly what they are sensing that they cannot physically observe anymore. I am counting a bit more on their instincts as therapists to really help us understand what is going on during remote service delivery.”

Academic institutions, particularly medical schools and health programs in the United States, have only recently begun offering courses in remote delivery in their clinical training programs (AAMC, 2020). Remote delivery requires the development of a different set of skills. One’s instincts are called upon in a different way: “...it takes a lot of energy out of you. I feel tired after a session...You use a lot more energy to make sure that it is a good session...you can sense when someone is over the session, they yawn, and so on.” Perhaps most importantly, therapists reported that remote service delivery has affected their ability to challenge participants during therapeutic sessions: “You do not want to challenge [study participants] too much because you do not want them to disengage and increase their resistance and avoidance in the next session.”

Just as with in-person therapy, to engage youth in a remote intervention, great emphasis must be placed on structuring the intervention. Nevertheless, when considering how we structure a therapeutic intervention with juvenile justice-involved youth, we must bear in mind that consent in such cases may not always be genuine. There is an element of coercion involved, as refusal to participate in the diversion program may result in some form of
sanction. This circumstance suggests that youth, as well as family members, who believe they were wrongly charged or do not see the value of the intervention may search for alternative ways to express their opposition despite consenting to participate. Remote delivery provides ample opportunities for disengagement, therefore, we must acknowledge that challenging participants who volunteer for intervention are not the same as challenging those who are not there by choice. As members of our clinical team expressed, insufficient attention has been paid to the use of this delivery model with court-mandated youth:

We think that the world is moving in a direction to create accessibility...but...the fact that they are court-ordered, that puts a lot of pressure on the therapist knowing that at any time we can lose them if they keep disengaging and being avoidant.

We have to hold ourselves back and not be as challenging as we can. Does remote delivery take into consideration how to work with court-mandated participants who do not want to be engaged in services? There is another level of investment that comes with that. They are only seeing you because they want to complete the program.

Remote delivery resources that are available are not geared towards mandated individuals. COVID-19 has pushed remote delivery towards mandated individuals but there is no acknowledgment of that out there. In that respect, we are on the cutting edge. Accessibility is for those who want it not those who are mandated for it.

The toll of COVID-19 on participant families has been significant. The pandemic has not only expanded the use of remote delivery across diverse populations, including court-mandated groups, but it has also introduced instability and uncertainty into the youths’ lives and even into their therapy options.

4 | DISCUSSION

The COVID-19 pandemic has exacerbated the vulnerability of minority populations in the United States and elsewhere (Bhala et al., 2020; CDC, 2020). As immigrants of Haitian heritage, the families in this study were often already contending with issues such as discrimination, limited healthcare access, precarious employment (e.g., under-employment and overrepresentation as essential workers), low education and income, and poor housing. These structural issues, in addition to "long-standing systemic health and social inequities," place Black families at greater risk for contracting the virus, experiencing severe complications associated with infection, and dying from it (ibid.). When engaging with immigrant families of Haitian heritage, practitioners must remain sensitive to these realities and their implications for families’ physical and mental health.

Before the pandemic, the research team was conscious of the many barriers immigrant families of Haitian descent face in accessing services and seeing them through to completion. The adaption of the CIFFTA model to home-based delivery was partly a preemptive measure to address some of those barriers that have been identified by others, such as distance, transportation issues, the stigma associated with accessing services, and negotiating life’s competing demands (Abrams, 2020; Birk & Radick, 2020; Moreau et al., 2018; Racine et al., 2020). In the current study, we have had to re-train our therapists to deliver the intervention remotely, believing that this would be a short-term adaptation of the model in response to an unprecedented public health crisis. This COVID-19 pandemic was not only a crisis faced by our youth and their families, but one which affected us all. Therefore, re-training not only focused on the new delivery method but greatly emphasized tending to the mental health of our families and therapeutic team.

The delivery of the intervention during the pandemic has required that all families consent to receive services remotely, even those who had consented to participate in the study before our transition away from home-based
therapy. Obtaining consent via telephone introduced new challenges. Whereas before the pandemic, the therapist would schedule a meeting with the family at their home to discuss the study and intervention, during the pandemic they were sometimes forced to meet with each party separately. The elapsed time between consenting processes often delayed the commencement of the intervention. The benefit of obtaining consent from the family at one time is that it allows the therapist to contract with both parties and reach a collective agreement regarding everyone's respective roles. By doing so, parents are able to hold youth accountable while reinforcing the therapist's work. However, we must again acknowledge that when working with mandated populations, consent is not synonymous with voluntary participation. Further, the coercive nature of consent in this situation may translate to lower levels of engagement, as evidenced by some of the youths who participated in this study. Though the element of coercion exists whether we are providing in-person or remote services, remote delivery provides more opportunities for youth, and family members, to disengage.

4.1 Creating the therapeutic space: Cellular phones and therapeutic (dis) engagements

Consistent with Matheson et al.'s (2020) recommendations, families in our study have been offered the option of being videotaped or audio-recorded during the consenting process. Although we explain to families that the purpose of these recordings is to facilitate clinical supervision, the vast majority have consistently declined to be videotaped, opting for audio-recordings. This has been the response, across the board, of families served before and during the pandemic. Though families have not been asked to explain their preference for audiotaped sessions or resistance to being videotaped, we speculate that the potentially intrusive nature of home-based therapy, when compared with clinic-based interventions, may account for this resistance. Further, we must consider how images of their homes, specifically space, or lack thereof, furnishings, tidiness, and so forth, may reveal their socioeconomic status. There may be an element of shame regarding the conditions under which some of the families in this study live. We must also consider how mistrust between minority populations and the juvenile justice system may increase their resistance to having their homes or family members videotaped.

Though some families did not have the requisite infrastructure—smartphones, computers, or a broadband internet connection—to support remote delivery, most did. They often opted, however, for an audio-based intervention using their cellular phones. Some families had to share phones to facilitate the youth's participation in the intervention. A few families experienced phone service disruptions during the intervention, often as an economic consequence of the pandemic. These examples elucidate some of the limitations of remote delivery, calling into question its viability for certain populations. We must also recognize that cellular phone use in remote delivery poses its own challenges that extend beyond potential breaches of HIPAA. As Smith et al. (2017) note, "smartphones provide convenience, portability, and connectivity" (p. 3) facilitating medical consultations from a distance. However, the appropriateness of cellular phones, in general, and smartphones, in particular, for a therapeutic intervention must be questioned, as the function of cellular phone technology is twofold: (1) To increase accessibility, hence its original name—mobile phones and (2) to facilitate multitasking. The latter often serves as an impediment to creating a therapeutic space, in particular for teens, who believe they have become adept at multitasking.

One of the principal tasks of the therapist is to create a safe therapeutic environment that allows the participant to think differently and re-examine their life. Therapists must create conditions for the participant to be vulnerable, yet this requires that they establish a genuine connection. There is a certain level of vulnerability, lowering one's guard and being receptive to the intervention, that is necessary for therapy to be effective. This requires the full presence of all parties. Though cellular phones facilitate connectivity, they allow for simultaneous presence here and there; with a caller/call recipient and whatever other additional activities, the callers might be engaged in. With a cellular phone, we can be in multiple places at the same time yet not fully present in any of
them. Partial presence disrupts the counseling ritual, making it difficult for the therapist to structure the intervention. These superficial connections often mask physical and emotional distance. As evidenced in our study, cellular phones may be strategically used by participants who have little or no motivation to engage in the therapeutic process.

The use of audio-based technologies also prevents direct observation of the home environment, participant behaviors, and nonverbal cues. It compels providers to compensate by employing other skills, strategies, and techniques that will help them connect with and engage the participant. They must now rely upon sound, or silences, to detect mood changes in the participant, distractions in the home environment, or even breaches in privacy. Providers must eliminate distractions on their end as well and encourage clients to do the same. The elimination of distractions serves as a solid platform to facilitate active listening and attending, two important communication skills that providers must master in this platform. Providers must also rely on their intuitive abilities and clinical experience to decipher the level of client engagement during sessions. If the provider senses the client is not engaged, steps can be taken to re-engage them, such as asking direct questions to determine what has changed, using flexibility during the intervention, or employing humor, where appropriate.

As described above, remote, audio-based therapy poses significant challenges to establishing and maintaining privacy. Absent physical presence or video recordings, therapists, at times, have struggled to maintain a private physical space for the delivery of the therapeutic intervention. For youths recruited into the study before the pandemic, therapists were somewhat familiar with their home environment and could envision and, therefore, orient the youth within the space. However, for those youths who experienced the entire intervention remotely, therapists did not have the benefit of visiting the home. This is particularly important when working with low-income families who are more likely to have less physical space, with more people per square footage. The issue of privacy was also exacerbated by a stay-at-home order that forced children and adults alike to remain at home. Some youth played an active role in maintaining privacy during the sessions; however, youth who exhibited lower motivation levels tended not to. Therapists would have to use new skills to detect privacy breaches, such as inquire about background noises or remain sensitive to changes in youths’ behaviors (e.g., lowered voices, brief responses, etc.). And, when a breach in privacy occurred, therapists have had to decide whether it was a momentary breach or if the session should be terminated, which, in a few circumstances, it has been.

Privacy has distinct meanings within sociocultural settings and is afforded differently within groups. In our therapist’s encounter with 114A’s father, who occasionally intervened during his son’s sessions, there was a clear discrepancy between what the therapist understood as a condition for privacy and the father’s understanding of privacy. In most Haitian cultural contexts, children are not afforded the same level of privacy as is expected by therapists; in such contexts, parents believe that they must be able to exercise full control of the environment within which therapists deliver services. Thus, the youth’s privacy, in the case of 114A, had to be negotiated with his parents. It is for this reason that the father interjects, pointing out that the youth’s parents must be included in certain conversations. This is not to say, however, that the parents should be privy to all conversations. Nevertheless, the father’s standpoint has to be factored in by the therapist in a way that would not be necessary in an office visit.

Whereas an outsider may interpret the father’s actions as intrusive and as a breach of, or lack of respect for, the youth’s privacy in a therapeutic intervention, a culturally competent interpretation provides other insights into the father’s behavior. An alternative interpretation suggests that the father was exercising parental monitoring in the context of a therapeutic intervention. The father displayed parental authority by interjecting as he wanted to ensure that the values imparted by the therapist to his son were consistent with the values he, as a parent, has inculcated in his child. Though this level of parental monitoring is not expected and could be considered disruptive during therapeutic intervention, it could also be considered a positive skill that we aim to promote within parents, as it is directly linked to youth engagement in positive behaviors and successful completion of treatment. Further, the father did not show resistance to the treatment process. Instead, he demonstrated high levels of motivation and a willingness to engage.
In this case, the therapist had to negotiate youth individual privacy—a Western cultural value—with Haitian cultural conceptions of parental authority and youth deference to that authority—a Haitian sociocultural value. Advocating for the youth’s privacy, understood as a dominant American value, in this context could be interpreted as a direct challenge to the parents’ authority, possibly undermining the success of the intervention itself. This may have resulted in a power struggle between the therapist’s desire to protect and maintain the youth’s privacy, as learned during his clinical training as a therapist, and the father’s imperative to exercise parental authority by monitoring his son’s treatment, as his cultural system dictates. Cultural responsiveness compelled the therapist to negotiate the youth’s privacy while acknowledging parental authority so as not to undermine the alliance established between the parent and therapist. These cultural factors may affect a client’s desire to seek care or follow through with treatment. As the literature suggests, when working with youth and their caregivers, the latter’s engagement and parental monitoring is critical to the youth’s success in treatment (Dakof et al., 2001; Griffin et al., 2000; Mauro et al., 2017). Although we understand parental monitoring as an exercise that happens outside of the therapeutic context, as this example demonstrates, in a remote environment, it is a skill that must be negotiated within the therapeutic process.

5 | CONCLUSION

The COVID-19 pandemic is a public health crisis of historic proportions that has affected societies around the globe in direct (e.g., infection, loss of life, etc.) and indirect ways (e.g., job loss, educational disruption, domestic violence, family separation, etc.). Public and private institutions from all sectors, including research and academic ones, have dramatically changed their ways of working, opting for remote delivery of services that require the use of various technological platforms. Remote delivery comes with its own challenges and, therefore, requires specific training for its practitioners, particularly for institutions and organizations that plan to permanently transition to this form of service delivery. In this study, we have modified the home-based delivery of our therapeutic services to remote delivery of the intervention; however, this modification has been a temporary response to the stay-at-home order. Our clinical team’s experiences during the pandemic have, most likely, mirrored that of other service providers in that we were, in many ways, reacting to a constantly changing and unpredictable situation. This has resulted in a reevaluation of the effectiveness of the therapeutic modality and the specific skills that it requires of our therapists to properly assess a participant’s well-being and engagement without the possibility of face-to-face interactions.

As such, therapists have had to adapt to an ever-evolving situation by being flexible with families. Though the strategy was to accommodate youth to facilitate engagement, it has also created conditions for those with low motivation to engage in avoidant behaviors that disrupted established rituals. Yet, despite these setbacks, therapists have continued to be flexible, adapt to change, and be emotionally nimble enough to recognize that our families were already vulnerable before and are even more vulnerable during the pandemic. Our expectations for engagement had to be balanced against the reality that many families of Haitian descent do not have the luxury of worrying about the pandemic’s health concerns because as low-income, immigrant families, many are suffering from the pandemic’s economic shocks. Therefore, as we consider how best to engage mandated youth in remote services, we must also consider how the socioeconomic disruptions associated with these uncertain times influence how youth engage in remote interventions.

Providing remote services to underserved populations presents us with challenges while offering opportunities to improve the quality of their lives and communities. Drawing on our discussion of key issues, noted above, we recommend the provision of intervention services be preceded by a site readiness assessment. Key elements of this assessment should include: (1) Access to sufficient technical tools (e.g., PCs, tablets, smartphones, etc.), what technological tools do clients have access to and have they experienced service disruptions of any kind within the past 3–12 months that may deter remote service provision (e.g., poor internet connectivity, cellular phone service disruption, etc.)?; (2) sufficient skills in using these tools; does the client use the technological equipment available to
them and how comfortable are they with its use? Does the client require basic coaching on how to use these tools for service delivery? Will the skills they possess facilitate service delivery (e.g., Do they know how to download applications and create a new account, are they able to use videoconferencing functions, etc.?); (3) private space for participation in intervention services, what is the configuration of their home, do they have access to a private bedroom or office?; and (4) family structure and readiness to engage in therapeutic services (e.g., the presence of key family members to participate in the intervention; no job related, prolonged absences by an important family member), do they have sufficient family support within, or even outside of, the household? We must find ways to help families address any challenges identified by providing equipment and training, helping them structure the home space to ensure privacy during service delivery, and, particularly when working with adolescents, ensuring they have proper family support. This assessment and our responses to it will ensure that vulnerable families are able to take full advantage of remote delivery of services at a time in which they may need it most.

5.1 Study limitations

The data analyzed in this article as well as the recommendations that emerged from the analysis are based on a limited sample size: 12 cases, seven of which were cases enrolled during the pandemic and five that began as a home-based intervention but transitioned to remote delivery. Because we are still collecting data on the process of remote delivery in the restrictive context created by the pandemic, we do not know if more cases would change the dynamics, findings, or recommendations. We plan future analysis of more aggregate cases which we hope will either validate the findings and recommendations or address the inevitable shortcomings of this first-hand analysis of how we confronted the challenges of service disruption posed by the COVID-19 pandemic.

ACKNOWLEDGMENTS

We wish to acknowledge and thank April Mann for her critical review of several iterations of this manuscript. Funding for this study comes from the National Institute on Drug Abuse (NIDA), grant number: 1R34DA043784-01A1. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health or NIDA.

CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1002/jcop.22559.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

REFERENCES

Abrams, Z. (2020). How well is telepsychology working? Monitor on Psychology, 51(5), 46. http://www.apa.org/monitor/2020/07/cover-telepsychology
American Association of Medical Colleges (AAMC). (2020). Curriculum reports: Content documentation in required courses and elective courses. https://www.aamc.org/data-reports.curriculum-reports/interactive-data/content-documentation-required-courses-and-elective-courses
Barney, A., Buckelew, S., Mesheriakova, V., & Raymond-Flesch, M. (2020). The COVID-19 pandemic and rapid implementation of adolescent and young adult telemedicine: Challenges and opportunities for innovation. Journal of Adolescent Health, 67(2), 164–171.
Batastini, A. B., Jones, A. C. T., Lester, M. E., & Davis, R. M. (2020). Initiation of a multidisciplinary telemental health clinic for rural justice-involved populations: Rationale, recommendations, and lessons learned. *Journal of Community Psychology, 48*, 2154–2173. https://doi.org/10.1002/jcop.22424

Bhala, N., Curry, G., Martineau, R. A., Agyeman, C., & Bhopal, R. (2020). Sharpening the global focus on ethnicity and race in the time of COVID-19. *The Lancet, 395*(101238), 1673–1676.

Birk, S., & Radlick, L. (2020). *Behavioral healthcare now and post COVID-19: Integrating telemental health services*. Healthcare Executive. https://healthcareexecutive.org/archives/july-august-2020/behavioral-healthcare-now-and-post-covid-19

Burgoyne, N., & Cohn, A. S. (2020). Lessons from the transition to relational teletherapy during COVID-19. *Family Process, 59*(3), 974–988. https://doi.org/10.1111/famp.12589

Centers for Disease Control and Prevention (CDC). (2020). Coronavirus disease 2019 (COVID-19): Health equity considerations and racial and ethnic minority groups. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2FCoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fracial-ethnic-minorities.html

Dakof, G. A., Tejeda, M., & Liddle, H. A. (2001). Predictors of engagement in adolescent drug abuse treatment. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(3), 274–281.

Endale, T., St. Jean, N., & Birman, D. (2020). COVID-19 and refugee and immigrant youth: A community-based mental health perspective. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(51), S225–S227.

Godine, N., & Barnett, J. E. (2013). The use of telepsychology in clinical practice: Benefits, effectiveness, and issues to consider. *International Journal of Cyber Behavior, Psychology and Learning (IJCBPL), 3*(4), 70–83.

Gollub, E. L., Cyrus, E., Dévieux, J. G., Jean-Gilles, M., Neptune, S., Pelletier, V., Michel, H., Sévère, M., & Pierre, L. (2015). ‘Men don't need to know everything’: A field trial of a discreet, female-initiated, contraceptive barrier method (FemCap™) among Haitian-American women. *Culture, Health & Sexuality, 17*(7), 842–858. https://doi.org/10.1080/13691058.2015.1005672

Grenier, G. J., & Stepick, A. (2009). *Miami now!: Immigration, ethnicity, and social change*. University Press of Florida.

Griffin, K. W., Botvin, G. J., Scheier, L. M., Diaz, T., & Miller, N. L. (2000). Parenting practices as predictors of substance use, delinquency, and aggression among urban minority youth: Moderating effects of family structure and gender. *Psychology of Addictive Behaviors, 14*, 174–184. https://doi.org/10.1037/0893-164X.14.2.174

Jewers, M. M., & Orozco, M. (2020). Migrants, remittances and COVID-19: Remittance behavior and economic and health vulnerability. Inter-American Dialogue.

Langarizadeh, M., Tabatabaei, M. S., Tavakol, K., Naghipour, M., & Moghbeli, F. (2017). Telemental health care, an effective alternative to conventional mental care: A systematic review. *Acta Informatica Medica, 25*(4), 240–246. https://doi.org/10.5455/aim.2017.25.240-246

Looi, J. C. L., & Pring, W. (2020). Private metropolitan telepsychiatry in Australia during Covid-19: Current practice and future developments. *Australasian Psychiatry, 28*(5), 508–510. https://doi.org/10.1177/1039856220930675

Marcelin, L. H. (2005). *Identity, power, and socioracial hierarchies among Haitian immigrants in Miami-Dade, Florida*. In: Dzidzenyo, A., & Oboler, S. *Neither enemies nor friends: Latinos, blacks, afro-latinos/as* (pp. 209–228). New York: Palgrave.

Marcelin, L. H. (2017). Sexual experiences among Haitian American adolescents in Miami Dade. Florida. In: Marcelin, L. H., Cela, T., & Dorvil, H. (Eds.). *Haitian youth in the Americas* (pp. 389–415). Québec, Canada: Presses de l’Université du Québec.

Marcelin, L. H., Dembo, R., Cela, T., Burgos, C., Copeland, M., & Page, B. (2021). Collaboration as process: The Making of a partnership to serve at-risk youths of Haitian descent. *Annals of Anthropological Practice*. https://doi.org/10.1111/napa.12154

Marcelin, L. H., & Page, B. (2007). Rare experiences in Miami. In: Browser, B. P., Quimby, E., & Singer, M. When communities assess their AIDS epidemics: Results of rapid assessment of HIV/AIDS in nine American communities. (177–192). New York: Lexington Books.

Matheson, B. E., Bohon, C., & Lock, J. (2020). Family-based treatment via videoconference: Clinical recommendations for treatment providers during COVID-19 and beyond. *The International Journal of Eating Disorders, 53*(7), 1142–1154.

Mauro, P. M., McCart, M. R., Sheidow, A. J., Naeger, S. E., & Letourneau, E. J. (2017). Parent and youth engagement in court-mandated substance use disorder treatment. *Journal of Child & Adolescent Substance Abuse, 26*(4), 324–331. https://doi.org/10.1080/1067828X.2017.1305935

McCord, C., Bernhard, P., Walsh, M., Rosner, C., & Console, K. (2020). A consolidated model for telepsychology practice. *Journal of Clinical Psychology, 76*(6), 1060–1082.

McMahon, R. T., Stanforth, E. T., Dévieux, J. G., & Jean-Gilles, M. (2016). HIV risk behavior and internalizing/externalizing psychopathology among adolescents in court-ordered treatment. *The American Journal of Drug and Alcohol Abuse, 42*(2), 187–195. https://doi.org/10.3109/00952990.2015.1132719

Moreau, J. L., Cordasco, K. M., Young, A. S., Oishi, S. M., Rose, D. E., Canelo, I., Yano, E. M., Haskell, S. G., & Hamilton, A. B. (2018). The use of telemental health to meet the mental health needs of women using Department of Veterans Affairs Services. *Women’s Health Issues, 28*(2), 181–187. https://doi.org/10.1016/j.whi.2017.12.005
Ortega, G., Rodriguez, J. A., Maurer, L. R., Witt, E. E., Perez, N., Reich, A., & Bates, D. W. (2020). Telemedicine, COVID-19, and disparities: Policy implications. Health Policy Technol, 9(3), 368–371.

Racine, N., Hartwick, C., Collin-Vézina, D., & Madigan, S. (2020). Telemental health for child trauma treatment during and post-COVID-19: Limitations and considerations. Child Abuse & Neglect, 110, 104698. https://doi.org/10.1016/j.chiabu.2020.104698

Rey, T., & Stepick, A. (2013). Crossing the water and keeping the faith. Haitian religion in Miami. New York University Press.

Rodriguez, J. A., Clark, C. R., & Bates, D. W. (2020). Digital health equity as a necessity in the 21st Century Cures Act Era. Journal of the American Medical Association, 323(23), 2381–2382.

Saenz, J. J., Sahu, A., Tarlow, K., & Chang, J. (2019). Telepsychology: Training perspectives. Journal of Clinical Psychology, 76(6), 1101–1107.

Sangaramoorthy, T. (2014). Treating AIDS: Politics of difference, paradox of prevention. Rutgers University Press.

Santisteban, D. A., Mena, M. P., & Abalo, C. (2013). Bridging diversity and family systems: Culturally informed and flexible family-based treatment for Hispanic adolescents. Couple and Family Psychology: Research and Practice, 2(4), 246–263.

Smith, K. A., Zhou, L., & Watzlaf, V. J. M. (2017). User authentication in smartphones for telehealth. International Journal of Telerehabilitation, 9(2), 3–12. https://doi.org/10.5195/ijt.2017.6226

Woodall, T., Ramage, M., Labruyere, J. T., McLean, W., & Tak, C. R. (2020). Telemedicine services during COVID-19: Considerations for medically underserved populations. The Journal of Rural Health, 37, 231–234. https://doi.org/10.1111/jrh.12466

**How to cite this article:** Marcelin, L. H., Cela, T., Dembo, R., Jean-Gilles, M., Page, B., Demezier, D., Clement, R., & Waldman, R. (2021). Remote delivery of a therapeutic intervention to court-mandated youths of Haitian descent during COVID-19. Journal of Community Psychology, 1–21. https://doi.org/10.1002/jcop.22559