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WRCAC ISSUE BRIEF

Western Regional
CHILDREN'S ADVOCACY CENTER

Expanding In-Person Mental Health Services Within a Children's Advocacy Center as the Pandemic Recedes

The emergence of the COVID-19 pandemic disrupted the ways that children's advocacy centers (CACs) respond to child maltreatment. Requirements for social distancing along with stay-at-home orders starting in the spring of 2020 forced many CACs to pivot their mental health services to telemental health (TMH) with little ability to prepare. The changes in the delivery of mental health services in the past year have been dramatic -- recently released data from the National Children's Alliance Member Census show that nearly three-quarters (71.2%) of CACs currently offer telemental health services, and of those, nearly all (94.6%) launched them as a result of the pandemic. The sudden rise of TMH cannot be viewed simply as a passing trend to meet the needs of the moment – the NCA data further show that nearly two-thirds (64.7%) of the CACs that launched TMH services during the pandemic plan to sustain them. The evidence is clear -- TMH offers benefits around accessibility, convenience and effectiveness that extend its value well beyond the pandemic. A hybrid model of care that includes both in-person service delivery and TMH has gained broad acceptance and will continue to emerge as the common strategy for CACs to connect children and families with evidence-supported mental health services.

As vaccination rates increase and new case counts diminish, cities and states have relaxed or eliminated restrictions as recommended by the Centers for Disease Control and Prevention (CDC). As this continues, CACs are faced with decisions about how, when and to what extent to return to in-person mental health services (or to more fully return if in-person services have been sustained to some extent throughout the pandemic),

while also weighing the advantages of continued use of TMH for select children and families, independent of the prevalence of COVID-19.

This issue brief carefully examines how to navigate the myriad of issues affecting decision-making regarding the return to more in-person treatment and recommends items for CACs to consider when providing in-person mental health care as part of their service continuum.

First Things First – Understand the Landscape

The section below provides a few things for CACs to consider first when determining when, and to what extent, to proceed with in-person mental health treatment:

Review current state and local restrictions that apply to in-person services. Regulations differ across the country in terms of what level of in-person gatherings are allowed and what safety precautions are required. The CDC offers comprehensive information at cdc.gov for how to maintain a safe workplace during COVID-19 and continues to update their guidance as the circumstance of the pandemic change. State and local public health departments offer tailored information that may apply to your jurisdiction. It is essential for CACs to stay informed about the local conditions and restrictions, and make plans accordingly within that context.

Assess the real and perceived risks to clinical staff. Providing trauma treatment is stressful in the best of times. Adding anxiety about a contagious virus only amplifies the secondary traumatic stress of the work. The psychological safety of staff can be enhanced by including staff members in planning and decision making. Policies and procedures that include a clear set of protocols that protects physical safety can provide comfort to those who may be apprehensive about a return to face-to-face services. One might find it useful to involve staff in gathering information from other CACs and local mental health providers to help inform CAC decision making as to when and how to provide in-person services.

Assess the risks to the CAC. When contemplating changes in service delivery format, the CAC may benefit from a conversation with their liability insurance carrier regarding risk management issues and to clarify limitations to the existing policy and determine if there is a need for additional coverage.

Preparation is Key – Develop Thoughtful Organizational Strategies

Once a decision is made to expand in-person service delivery, there are actions that a CAC can take to ensure the comfort and safety of clients, staff and multi-disciplinary team partners and to ease the transition:

Create a comprehensive plan to reduce the risk of COVID-19 transmission. This plan may include changes in center check-in and screening protocols, client physical health requirements, use of masks or other protective equipment while in the center, changes in center space usage and how a positive diagnosis will be addressed in the center. The American Medical Association (AMA) provides check-in protocols that help meet established standards. The CDC offers cleaning tips and the Occupational Safety and Health Administration (OSHA) has detailed information on screening guidelines and sanitizing protocols to undertake on a routine basis.

Re-tool informed consent documents to reflect risk of transmission of COVID-19, benefits of in-person care, and what protocols are in place to address risk.

The American Psychological Association has a customizable informed consent template. The National Association of Social Workers also has resources regarding TMH and returning to in-person care.

Provide transparent and accessible information to clients. Make intake forms and other documents available online to make it easier for clients to access services safely, timely and efficiently. Clients are likely experiencing a range of emotions, from relief that they will have face-to-face contact, to concern around cleanliness and safety. Offering clear and easily accessible materials beforehand can ease apprehension and is an efficient way to gather necessary information while also limiting the time spent in office completing paperwork.

Communicate well and often to keep clients, staff, MDT members and key stakeholders adequately informed. Clear and timely communications builds psychological safety of the child, family, MDT partners, CAC staff, and community stakeholders who come to the center. The center may find it useful to create a simple

'return to center' flyer to share the safety protocols that have been put in place. The CAC can post them on the CAC website, on social media, visibly in the center and with MDT partners, community stakeholders and clients when scheduling appointments.

Prioritize staff training on new practices. Training will provide staff with clarity and help them feel better equipped to handle any situation that may arise. Create an informed strategy to address what to do if a caregiver or client doesn't adhere to procedures set up to protect everyone and make sure that all staff knows what to do if the situation arises.

Client-Centered Care

Determine which children will benefit most from in-person treatment. Each child and family's needs and situation are unique and should be considered individually when deciding the best treatment course of action. Clinicians may find that some children respond best to face-to-face contact, while other children and family are responsive, and may even prefer TMH and are doing well with that service delivery method. Some CACs may wish to use a hybrid model of care where both TMH and face-to-face contact are used, even within a single case, depending on the circumstances, the phase of treatment (i.e. starting in-office for assessment and the initial treatment visit and then switching to tale-delivery), and any emergent situations that may arise. If the following situations exist, that may suggest the need to prioritize in-person treatment for the child:

- Imminent safety concerns exist for the child which can't be addressed through TMH and require direct contact
- The child is not engaging with treatment effectively in the virtual environment
- The caregiver has mental health and/or substance abuse issues that interfere with effective TMH service delivery
- The child is deteriorating using TMH and in need of safety planning and stabilization

A team of clinicians, trainers and researchers, who spearheaded efforts pre-pandemic to integrate TMH into a CAC setting, have developed a **"Telehealth Guidance Document"** to guide clinicians through a series of questions and considerations in determining what mode of treatment is best suited for CAC children and families.

Click here to view the document.

The American Psychological Association has also published helpful resources in determining the appropriateness of in-person care.

Engage the child and family in decision-making. Determining when and how to conduct in-person services is a difficult decision to make. Each case is unique to the individual client and caregiver needs and desires. Planning *with* the family and not *for* the family promotes informed and solution-focused care. Being open and transparent will promote trust between the CAC clinician and clients. Engaging the family in a purposeful decision-making process about how, when and where services are provided demonstrates respect and competence.

What is the comfort level of the client and their family for sessions in a center environment? We know that client receptivity to and ability to effectively engage through TMH may be challenging for some individuals. Discuss with the family any reservations they have about face-to-face contact and address their concerns proactively. Is staying strictly with TMH the right course of treatment? TMH offers many benefits to providing mental health services, but it may not be for everyone all of the time. Regardless of where the treatment is provided, the ultimate goal is to enhance the child and family's health and well-being through effective, evidence-supported care that is conducive to their needs.

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