Western Regional
CHILDREN'S ADVOCACY CENTER

Telemental Health Network Readiness and Planning Guide for Chapters

January 2024

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The Western Regional Children's Advocacy Center (WRCAC) would like to acknowledge the hard work and generosity of our telemental health pilot project partners including the Washington and Montana State Chapters and the project consultants for sharing their expertise and resources that helped to inform this guide:

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WRCAC is supported by cooperative agreement #15PJDP-22-GK-03062-JJVO awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this publication are those of the author(s) and do not necessarily reflect those of the Department of Justice.

INTRODUCTION

For many children who have experienced the trauma of child abuse, high-quality and effective mental health services may be the key to recovery. The challenge for all Children's Advocacy Centers (CACs), however, is finding and retaining the right professional(s) who have the skills and training to deliver evidence-based trauma treatment over their career. Trauma-trained therapists are those individuals who have been trained on evidence-based trauma-focused treatment modalities and completed consultation groups on how to integrate those modalities into their work. Access to trauma-trained therapists who work with children and adolescents, even in urban areas, can be limited. For rural and frontier CACs, access to onsite or local qualified mental health professionals can be nonexistent.

Telemental health (TMH) services can be a lifeline for clients living in rural and frontier communities. It can also be a way for CACs located in urban and suburban areas to increase capacity to serve clients who may have transportation or other barriers that impact access. Implementing a statewide TMH network at the Chapter level can be a way to address access to trauma-trained therapists and the barriers clients face when smaller CACs or rural/frontier CACs do not have the capacity to do so. Components of a TMH network include: training, technology, a network of trauma-trained therapists, task sharing professionals/paraprofessionals such as victim advocates or child protective services (CPS) workers, network coordination of referrals, and therapist/client matching. These components, and others addressed in this guide, benefit from Chapter-level support and the ability to see things from the state viewpoint. While individual CACs will still need to provide support and connection to referrals, having the Chapter provide leadership for the main areas of support and implementation allows more CACs to take advantage of TMH.

Initially, utilizing TMH to deliver services to CAC clients was met with hesitancy among clinicians and CAC directors who were uncertain about the efficacy of telemental health. In 2020, the COVID-19 pandemic put TMH services in the forefront, allowing many CACs to continue serving clients when they could not be seen face-to-face. The COVID-19 pandemic precipitated rapid changes in service delivery models and clinician understanding of the research supporting TMH. As a result, the number of therapists experienced with telemental health delivery jumped from a handful to thousands almost overnight. This wide experience using telemental health opens a new door to quality mental health for CACs in rural and frontier communities: employing one or more therapists to work directly for the rural CAC while they continue to live remotely (potentially far from the center) and deliver therapy via telemental health.

Developing Statewide TMH Networks

In 2020, the Western Regional Children's Advocacy Center (WRCAC) launched a Statewide Telemental Health Pilot Project, partnering with Children's Advocacy Centers of Washington (CACWA) and the Children's Alliance of Montana (CAM), as well as consultants with telemental health expertise, to establish statewide TMH networks connecting trained CAC-affiliated trauma therapists in one part of the state with children in more rural regions far away using video conferencing.

State Chapters are uniquely positioned to increase access to quality mental health services for CAC clients and provide support to CACs implementing TMH services through the development of statewide TMH networks. This guide incorporates lessons learned from Chapters who have piloted TMH networks in Utah, Washington and Montana and helps Chapter leaders consider factors which indicate the need for, and their capacity to support, the establishment of a TMH network. This readiness guide and corresponding implementation resource toolkit are intended to help "demystify" the process and give Chapter leaders a good sense of the steps involved in making networks happen in their states.

HOW TO USE THIS GUIDE

This guide starts with sharing the benefits for Chapters of establishing statewide TMH networks. It also briefly reviews why Chapters may not want to proceed. There are many things to consider in deciding whether to proceed with planning a telemental health (TMH) network for member Children's Advocacy Centers (CACs) in your state. (*For a better understanding of the types of TMH networks that can be utilized, please refer to Appendix A*)

Next, you will find a series of checklists that ask you to contemplate relevant questions. These questions are centered around areas that are important to consider at the beginning stages of establishing a statewide TMH network. Following each checklist, you'll find information that explores those central components—or readiness focus areas—with a description of what you may want to consider. ***You do not need to answer yes to every item on the checklist in order to undertake this initiative; rather, we have designed the descriptions to help you weigh each area's importance.*** Given the scope and complexity of establishing TMH networks, we recommend Chapters complete the guided reflection section after reviewing the focus area checklists and questions, and consult with WRCAC and/or your regional CAC for assistance prior to moving forward. WRCAC has staff dedicated to the development of TMH networks as well as an online Telemental Health Resource Center dedicated to TMH resources relevant to CACs.

For Chapters that have already begun the process of developing or have established TMH networks in their state, our hope is this guide will support your efforts to strengthen that work. We hope this guide will also inform your decision-making around those implementation points or resources you might consider adding.

PROJECT CONSIDERATIONS

Benefits of Chapters establishing and managing TMH networks

Children's Advocacy Centers (CACs) play a vital role in organizing a community's trauma-informed response to child abuse. As the CAC movement has expanded and evolved, CACs and the National Children's Alliance (NCA) have become far more cognizant of the importance of helping the child victim heal from the emotional trauma inflicted upon them. The NCA Standards for Accreditation have added more specificity related to the need for CACs to provide high quality mental health services. If these standards are implemented meaningfully, a CAC can have confidence they are providing effective mental health services and optimizing the child's potential for a strong recovery.

Implementing the mental health standards in any CAC can be challenging. Even in the most well-resourced urban centers it is difficult to fund, recruit, train, retain, and supervise adequate numbers of qualified mental health providers. In fact, almost all mental health organizations across the nation, of any type, are currently struggling with vacancies and difficulties finding highly qualified providers. The competition for qualified candidates is even greater when seeking skilled child mental health providers, and even further challenged when seeking providers trained in evidence supported trauma treatment models, especially when seeking culturally diverse and/or bilingual providers who reflect the community served.

These challenges affect all CACs seeking to deliver high quality mental health services, but they are especially true for CACs located in rural and frontier regions of the nation where a shortage of any mental health providers is well documented (see CDC's Rural Health Policy Brief: Providing Access to Mental Health Services for Children in Rural Areas) For rural and frontier CACs there are often few, if any, local mental health providers who meet NCA Accreditation Standards.

Even CACs that employ mental health therapists report full caseloads and often must place children on a waiting list in hopes a vacancy will open in one of their staff's caseloads. Those rural and frontier CACs relying on a linkage agreement also face challenges associated with the availability of their affiliated therapists to accept new patients. Many linkage therapists in community agencies or private practice have full caseloads from a variety of referral sources and rarely have open therapy slots awaiting a CAC referral.

As a result of these challenges, CACs sometimes struggle to meet timely mental health needs of the children and families they serve and, as a practical matter, the NCA Mental Health Standard. In fact,

mental health workforce challenges can be one of the reasons CAC's fail to reach accreditation or reaccreditation on their first try. Traditional strategies to improve the situation have limited utility as there simply may not be adequate numbers of qualified professionals living within commuting distance of the CAC to provide sufficient levels of in-office therapy, whether employed or through a linkage agreement.

The most viable alternative may be to establish a state or regional network of qualified therapists utilizing telemental health to serve children referred from CAC's lacking adequate local mental health infrastructure. Several State Chapters have experimented with organizing such a network with promising results.

Chapters already coordinating training in evidenced-based treatments for CAC clinicians and providing technical assistance related to meeting the NCA Mental Health Standard for accreditation are in a strong position to develop a statewide TMH network.

Potential Benefits of a Network:

- Overcomes the hurdle of distance, allowing a child, perhaps living hours away from the treating therapist, to receive state-of the-art, evidence supported trauma therapy from a qualified provider without the burden of travel.
- Provides increased value for rural and frontier regions where the choice is often teletherapy or no therapy (or referral to a provider that does not meet NCA qualifications). In the simplest terms, such a network uses technology to replicate what a well-resourced CAC in a metropolitan area that has adequate number of qualified therapists can do in person, but via the web.
- Helps to increase equitable access so that rural, urban, and suburban located CACs can all provide access to quality therapy services.
- Provides a standardized process for providers to enhance consistency of service provision across the state.
- Allows the Chapter to see gaps in delivery and service needs for a broader state context to better target supports and respond to need.
- Provides support and ways for therapists to share training, professional literature, and practical clinical experience.
- Reduces sense of isolation among providers who work in an environment where they have no local peers to share the emotional burden of the work.
- Helps to address knowledge and skill acquisition
- Improves management of secondary trauma stress, far more powerfully than individual practitioners or isolated CACs acting on their own

Why some Chapters may feel they are not ready to establish and manage TMH networks

Some of the reasons Chapters cite for their decisions in this regard include:

- Uncertainty about this being an appropriate role in which a membership association should engage.
- Other priorities for the Chapter or their membership competing with the needs for TMH services.
- Lack of engagement/interest from centers for TMH
- Lack of consistent support among local member centers for the Chapter to lead this work
- Insufficient funding and/or Chapter staff FTEs to devote to the work.
- Lack of Chapter staff expertise in TMH.
- Lack of need (all centers have adequate mental health workforce locally or the state does not have underserved rural areas).
- Concern about being able to coordinate funding for services.

READINESS FOCUS AREAS

CHAPTER CAPACITY

ITEM	YES	NO	DON'T KNOW
Are the CAC Directors and Chapter Board supportive of the Chapter participating in a telemental health treatment network?			
Does the Chapter have staff with expertise in mental health?			
Does the Chapter have staff capacity to oversee and coordinate the project or interest in expanding staff to do so, if funding can be secured?			
Does the Chapter have relationships or the ability to develop relationships with key stakeholders in the state (child welfare agencies, community mental health, etc.) who will support the network (i.e. connecting with possible providers, understanding reimbursement models, etc.)?			
Has the Chapter assessed broadband coverage (i.e., high-speed cable, DSL, and fiber internet) across the state to identify any gaps in service?			
Does the Chapter have an understanding of the ways CACs can utilize community resources to provide access to TMH? (i.e. schools, churches, libraries, etc.)			

Are the CAC Directors and Chapter Board supportive of the Chapter participating in a telemental health treatment network?

Creating buy-in from your membership and board is important. Understanding what members prioritize in terms of the Chapter's investment of time and money will be an important first step in this process. Identifying concerns and priorities of the membership and other Chapter leaders may help you strategize how to approach this endeavor.

The most obvious essential component of the network is the existence of a clear need and desire for the services of the network. That translates into a set of CACs who have a need for high-quality mental health services for their clients that cannot be met locally or by existing arrangements (*See*

Appendix B for questions to consider when assessing access to CAC mental health services). Successful implementation will require the Chapter and participating CACs accept the efficacy and value of telemental health, adopt new practices, and take on key responsibilities. Saying yes to this project requires buy-in from your staff, membership, and board/governing body.

Does the Chapter staff have expertise in mental health?

While this is not a requirement to establish a mental health network at the Chapter level, having someone on staff or being able to consult with someone with mental health expertise will be extremely helpful in understanding important details from the different licensure requirements in your state to caseload and scheduling of clients.

Can the Chapter commit a staff member or hire a staff member to oversee and coordinate the project?

Chapters are in a great position to support mental health service delivery at an administrative level. However, State Chapter directors are typically very busy with a wide range of demanding projects and competing priorities. Some Chapters have larger staff resources while others operate as a one-person office. While not critical at the first stage of planning, both Washington and Montana found it very helpful to secure state funding during the planning phase for a part time staff person to focus on building and supporting the network. While a mental health background is helpful for this person, it is not required. What is required is intelligence, analytical skills, and an aptitude for project management. There are many tasks to be accomplished as the network takes shape from provider recruitment, training logistics for both therapists and referring CACs, policy development, referrals process creation, state specific treatment finance, and communications with rural MDTs.

For sample job descriptions of these positions, please refer to the Telemental Health Network Implementation Resource Toolkit.

Does the Chapter have relationships with key stakeholders in the state who will support the network? (i.e. child welfare agencies, community mental health, etc.)

Members can be drawn from state specific resources that are knowledgeable about provision of general children's mental health across the state, such as large provider agencies or provider networks, Indian Health Service or other tribal providers, government mental health agencies, or statewide professional organizations. It is wise to be sure partnerships go beyond the existing CAC

community and seek input/connection from the broader mental health field in the state to be sure the Chapter has a broad perspective on the state of service provision and provider workforce issues, as well as reimbursement models and relevant state laws.

One way to engage mental health experts as consultants would be to establish an advisory committee. Such an advisory committee might best be composed of both rural/frontier CACs and any CACs in the state with well-established mental health programs. While the rural CAC directors would be excellent fits for this role, the clinical director or clinical supervisor of the well-developed CAC treatment program would also be an excellent addition. It would be wise to include one or more practicing therapists or others who have served in the recent past as a therapist in the state.

Has the Chapter assessed broadband coverage (i.e., high-speed cable, DSL, and fiber internet) across the state to identify any gaps in service?

Having a good understanding of how people access the internet in your state is an important initial step. Many schools across the nation switched to virtual learning at the height of the pandemic, forcing many rural areas to address the limitations in network coverage in their region. While great progress has been made related to cellular data coverage and internet access in rural areas, "data deserts" still exist in some areas. For a successful TMH network, the state must have the telecommunications infrastructure to support video conferencing at both ends of the network connection. Even if a family has access to the internet, the speed of the connection may not be sufficient to support video platforms such as Zoom. Conversely, some families may only have access to using their cell phones to access the internet and data plans may limit how much data they can use. This is especially true of families in rural/frontier communities. Getting an accurate picture of internet access in your state can be a challenge for many Chapters, but there are internet resources that can help (i.e. https://broadbandmap.fcc.gov/) and many states governments have rural connectivity initiatives underway that can be a resource.

North Dakota, Montana, and Washington utilized a technology company, Blue Moon Technologies (www.bluemoonnd.com) for support in this area. These Chapters reported that having this task contracted out was quite helpful and saved them time and resources better spent elsewhere.

Is the Chapter aware of ways CACs can utilize community resources to provide access to TMH? (i.e. schools, churches, libraries)

Even if families have access to the internet, their homes may not be the best place to access a TMH session. Clients may not have a private place they can talk without interruption or may not feel safe to talk if others can overhear them. Understanding ways a CAC can utilize community resources can address many of those concerns.

During the planning phase the state could also weigh the option of using rural CAC offices as the location for children to come for therapy (as they would if the CAC had a local in-house therapist for in-person sessions) vs. a community location near where the child lives, such a school or library.

NEED FOR TMH NETWORK

ITEM	YES	NO	DON'T KNOW
Have you identified the type of TMH network you would like to implement? *(See Appendix A for types of TMH networks)*			
Has the Chapter identified the main gaps in access to qualified providers in rural, frontier, and other communities within the state?			
Does the Chapter have the capacity to inventory how their CACs are currently meeting the mental health needs of their clients? *(See Appendix B for a sample CAC Capacity Survey)*			
Do you have reason to believe that there are therapists within the state that have the capacity to accept clients from the network?			

Have you identified the type of TMH network you would like to implement?

A state telemental health network can take many forms. There are two basic frameworks in which a State Chapter can create their network; a "Mutual Support Network" and "Hub-and-Spoke" Network. *For a more detailed description, please refer to Appendix A.*

Has the Chapter identified the main gaps in access to qualified providers for rural, frontier, and other communities within the state?

Creating buy-in from centers may involve gathering data related to gaps in service in the areas they serve. Considerations based on our pilot programs include: distance to the CAC (is it a challenge for some families?), language barriers between families and an available qualified provider, waiting periods to initiate services, and if there are clinicians licensed in bordering states (dual-licensed) that can provide services. For CACs who have an onsite therapist or contract with outside therapists and want to establish TMH services, looking at the data related to cancellations/no-shows can also be

useful. Access to daycare, reliable transportation, gas costs, and caregiver availability could be behind reasons clients are not able to attend in person.

Does the Chapter have the capacity to inventory how their CACs are currently meeting the mental health needs of their clients?

Collecting information can take time and resources. It is important to consider if the Chapter has staff capacity to do this. This depends on how many CACs you have in your state and how many mental health providers are already engaged with work at/with CACs. You will want to look both at on-site mental health staff and those employed via linkage agreements. For some Chapters this may be an easy task as mental health services are not well-developed, for others more time may be needed to gather the information. Please refer to the sample CAC Capacity Survey in Appendix B that could be sent to CACs in the state.

Do you have reason to believe that there are therapists within the state that have the capacity to accept clients from the network?

Understanding the level of need among potentially referring CACs is vital but understanding the other side of the equation in the network model is equally critical. Is there a potential pool of trained and skilled therapists who are willing to provide therapy, via tele-delivery, to clients who may live far away? The therapists must also be willing to work as part of a team with distant CACs. In addition, the network therapist must be willing to meet NCA requirements for documentation of their qualifications and continuing professional education. Ideally the pool would be composed of providers already trained in the preferred evidence-supported treatments and if not, a pool of therapists willing to be trained and mentored to reach expertise. The Chapter must aspire to create a pool large enough to keep pace with the anticipated referrals. In Washington and Montana's experience, most therapists who volunteered for the pool had full cases loads and were only able to accept one or two cases at the same time. If this is the case, it means the pool most be large enough to meet demand assuming each participant will only take two to six new network clients a year.

CAC'S MENTAL HEALTH AND ADVOCACY TEAM CAPACITY

ITEM	YES	NO	DON'T KNOW
Are there CACs in the state that already offer telemental health services?			
Have CAC clinicians received any training on tele-delivery of evidence-based treatments (EBTs) for trauma?			
Do CACs in the state generally perceive TMH as an effective and viable treatment options?			

Are there CACs in the state that already offer telemental health services?

Many CACs pivoted to TMH during the pandemic. Some have continued to offer hybrid options, while others may have stopped offering TMH when they resumed in-person services. It will be helpful to understand how many CACs have used or are currently using TMH, even on a limited basis. Knowing what platforms have been used, what they learned from implementation, and any issues with engagement or support for TMH services they experienced will be important if your Chapter wants to establish a sustainable statewide network.

Have CAC clinicians received any training on tele-delivery of evidence-based treatments (EBTs) for trauma?

While most clinicians who serve CAC clients have been trained in EBTs, many of them have not been provided training specific to delivering those EBTs via TMH. Having a sense of who has been given training in TMH delivery will be important in supporting the engagement and comfort-level clinicians have with delivery of services. There are many important adaptations and suggested ways to engage clients when delivering trauma EBTs via TMH. For TF-CBT, the most common EBT that CAC therapists have training in, there are many trainings and resources available via NCA Engage, the Telehealth Outreach Programs at the Medical University of South Carolina (MUSC), and TFCBT.org. If the decision is made to implement a TMH network, it will be important for the Chapter to become

familiar with these resources and ways to connect CACs to them. In North Dakota, Montana, and Washington, the RCAC or State Chapter arranged MUSC tele-delivery training for network therapists.

Do CACs and individual staff in the state generally perceive TMH as an effective and viable treatment options?

Understanding current attitudes and perceptions of TMH at CACs in your state is critical for implementation. This could be accomplished with a short survey of CAC staff that would be supporting TMH referrals. This would include not only directors and supervisors, but the victim advocates who would be connecting families with TMH services. Before training clinicians to provide TMH, centers need to make sure the staff referring clients have a good understanding of the modality. Assessing where centers are in their understanding of TMH delivery will help to determine the level of training needed for staff and providers. This training includes staff at centers who will be the ones referring clients to TMH providers. It is critical that advocates and other staff understand the benefits of TMH so they can explain them to clients. If the center staff are not on board in selling TMH, clients will not be referred.

REGULATIONS AND REIMBURSEMENTS

ITEM	YES	NO	DON'T KNOW
Does the Chapter have an initial plan for how mental health providers will be paid?			
Does the Chapter understand mental health insurance and billing and how it may pertain to TMH?			

Does the Chapter have an initial plan for how mental health providers will be paid?

There are several paths to funding TMH services. Some Chapters may want to consider applying for a grant to initiate services in their state or secure private funds through fundraising efforts. State or VOCA funding may also be a consideration. Both Montana and Washington settled on a simple solution: the therapist bills for the network cases the same way as they bill for all others. In other words, if the therapist or their employer is equipped to do so and the client has insurance, Medicaid, or Victims Compensation, the therapist would bill for their time the same as if they were a local client. On the other hand, if the therapist is supported by a grant that will allow service delivery to network clients, then they proceed as they would for any of their clients served by that grant. This has proved a practical solution for Montana and Washington, but it does little to incentivize participation in the network, as many payers reimburse therapists or their agencies at discouragingly low levels. In a better-funded network, the Chapter could secure funding to create financial incentives such as a monthly stipend for active participation in the network paid on top of any fee-for-service billing. Relatedly, the State Chapter may explore the benefit of seeking a grant to support one or more therapists to be employed or contracted directly by the Chapter or to be located at an existing CAC with a well-regarded trauma treatment program who is dedicated exclusively to serving network referrals remotely.

Does the Chapter understand MH insurance and billing and how it may pertain to TMH?

Understanding the primary and potential funding sources for mental health treatment in the state for both fee-for-service and for grant or contract support of treatment positions is critical for planning. For fee-or-service this often includes Medicaid, private insurance, or Victims Compensation. If the providers are to bill Medicaid, Victims of Crime, or private insurance then it will be important the Chapter understand, in general, the payment rates of potential network providers. Such rates are often set for a typical 50-minute therapy session and vary by provider type, with a PhD level psychologist paid at a higher rate than master's level providers. Understanding the math of this is vital if the Chapter envisions employing or contracting for a therapist directly to support network clients or encouraging a member CAC to do so.

As the National Health Emergency (NHE) associated with the pandemic ends, the Chapter must also determine if the rates paid are the same for teletherapy as they are for in-office sessions. Before COVID, some states and some insurance companies reimbursed providers at a reduced level for therapy provided via video conferencing. With the NHE came an expectation for payment parity between in-person and tele-mental health but that requirement expired with the end of the NHE in May 2023. However, At the time that NHE expired in 2023, the following states had passed "mental health parity laws" requiring equal payment for teletherapy: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Georgia, Kentucky, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, Oklahoma, Oregon, Utah, Rhode Island, Virginia, and Washington, and five more have adopted some more limited parity (see the 2023 Telemental Health Laws & Behavioral Telehealth Regulations). It is important for a Chapter considering a fee-for-service billing model to support their network to determine if their state is among those allowing reduced payment for teletherapy and incorporate that knowledge in their planning.

If a provider seeks fee-for-service reimbursement for individual sessions then they are subject to HIPAA and all its requirements. For teletherapy, after the end of the NHE period, this also means use of a HIPAA compliant video communication platform that ensures confidentiality of the therapeutic communications. As a practical matter and to ensure compliance with state laws and NCA accreditation standards it is recommended that all CACs, whether legally subject to federal HIPAA rules or not, seek to follow HIPAA guidelines in choosing a teletherapy platform and establishing tele-communication links and record keeping between the CAC, the therapists, the clients, and the Chapter.

NEXT STEPS

Evaluating Readiness

It is unlikely any State Chapter will fully be ready to make a decision about establishing a telemental health network without some additional study and consideration. Revisit your readiness checklists. In general, items checked "YES" indicate areas of readiness, and items checked "no" or "don't know" indicate you may have work to do. However, many of the questions are designed to raise awareness about things to take into consideration, and a "no" or "don't know" may just indicate a structural dynamic to be aware of. This list is not intended to be exhaustive – there are many other variables that may weigh into your Chapter's decision about whether or not to establish a TMH network.

Below is a list of questions we encourage you to explore with those who may be involved in helping you make a decision on establishing a telemental health network in your state.

Guided Evaluation Questions

1. **As we reflect on our answers to the readiness checklists, what strengths do we have that will contribute to the success of the network? What will be our areas of challenge?**

   At the outset it would be wise to enlist the support and insights of your Regional Children's Advocacy Center and/or the perspective of the NCA Institute for Better Mental Health Outcomes in the Chapter assessment process.

2. **What other information do we need to make a decision about moving forward with this initiative? Who can we reach out to secure the additional information that is needed for decision making?**

   When it comes to determining the need for such a network the Chapter will want to seek out the opinion of CAC directors in rural and fronter areas to be sure they believe in the efficacy of TMH, perceive a real need for such a TMH network, and are willing to ensure a flow of referrals once the network is in place.

   In some states the Chapter will find state officials in the governor's office or mental or public health departments who are responsible for improving the services and supports in rural areas. Such a person or agency can be an ally in gathering the information the Chapter needs to decide about creating a network.

   The readiness assessment process will also typically include people most familiar with mental health delivery in the state. You may wish to first reach out to the clinical leadership of any CACs in the state who have well established in-house mental health programs. There would also be

value in reaching out to private therapists who have well established linkage agreements with CACs in the state who can serve as informants about mental health delivery in the state and reimbursement models commonly used by private practitioners or community agencies.

The Chapter should also conduct a scan to determine the identity of other potential informants and allies, such as organizations and individuals in the state who are part the of National Child Traumatic Stress Network, certified TF-CBT therapists in the state and state leaders of professional organizations such as NASW, APA, etc. The scan may also seek to identify any existing mental health service providers who market their services statewide or across multiple regions using tele-delivery who can provide meaningful guidance based on their experience and perhaps even become part of the provider network.

3. **Who needs to be involved in the decision about whether or not to move forward with the TMH network?**

   Important constituencies to consider should include your board of directors, rural CAC directors, your full membership, the staff of the Chapter, and entities responsible for allocating funding (legislative bodies, state agencies, etc.).

4. **How will we communicate the decision to our various stakeholders once it has been made?**

   For a telemental health network to succeed in a CAC environment it is important that all key stakeholders are engaged and supportive. To facilitate this, it is important that the Chapter formulate a communication plan at the beginning to keep key players informed about what is being considered from the onset. Key stakeholders include the obvious parties such as the Chapter Board of Directors and the directors of rural CACs but also all member centers and key staff such as victim advocates who will ultimately be making referrals and therapists who may be part of the network, as well as MDT members in participating CACs.

5. **As we reflect on our answers to the readiness checklists, what strengths do we have that will contribute to the success of developing a TMH network? What will be our areas of challenge?**

   It is important to consider all the strengths your Chapter brings to support this process. Some may not be mentioned in this guide and could be valuable assets in addressing the challenges that arise when implementing a TMH network. Additionally, just because there are challenges, does not mean you can't move forward with exploring this endeavor. There are many ways to approach TMH implementation- it is not all-or-nothing and you may decide to start with smaller

steps and work towards the larger ones when you are ready. Some Chapters may decide to pilot the program with only one or two CACs at first, then expand as capacity builds.

6. **What are the next steps to take?**
   Where a Chapter decides to go next will depend on where you are in the process and what challenges you have identified that need to be addressed before moving forward. However, support is available. Technical assistance can be provided by WRCAC and you can contact your Regional CAC as well. If your Chapter is ready to move forward with the implementation process, resources are available through WRCAC's Telemental Health Resource Center and the new T*elemental Health Network Implementation Resource Toolkit for Chapters*.

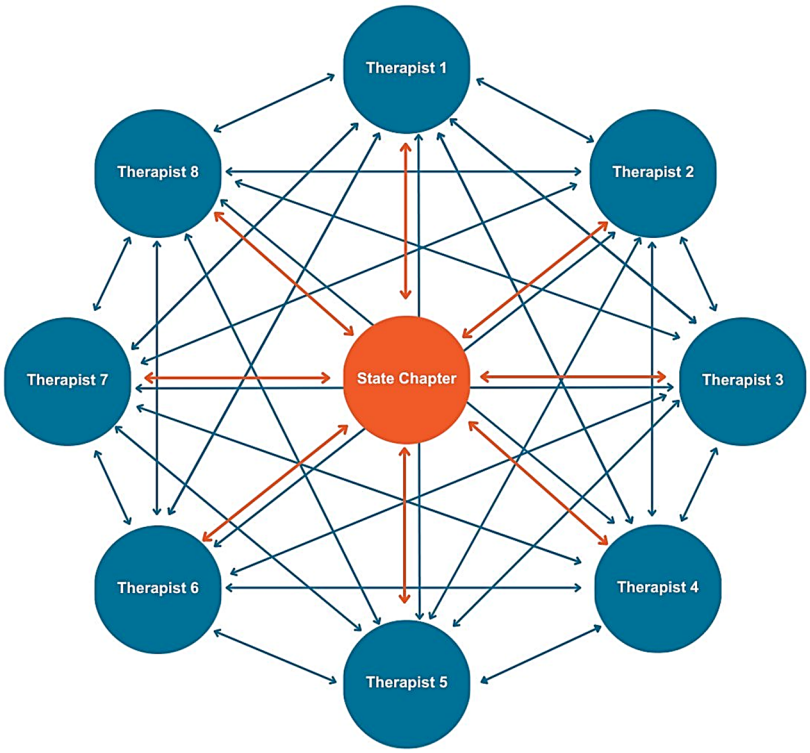
For resources to support the implementation of a telemental health network, please refer to WRCAC's **Telemental Health Network Implementation Resource Toolkit**.

APPENDIX A

Types of Telemental Health Networks

A state telemental health network can take many forms. There are two basic frameworks in which a State Chapter can create their network: a **Mutual Support Network** and a **Hub and Spoke Network**.

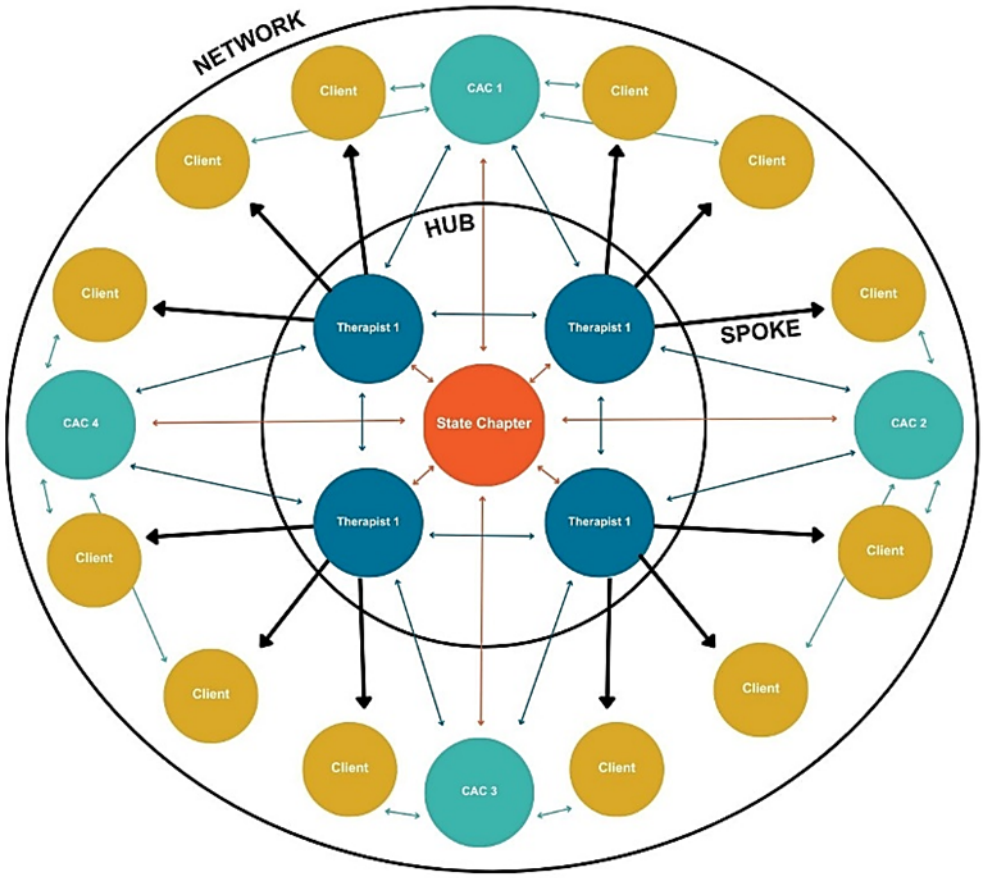
The **Mutual Support Network** is probably most straightforward to set up as it organizes existing assets in a new way. This type of network is best suited for states that have an adequate number of CAC-employed or linked therapists but uneven demand that leave some therapists with long wait lists and others, perhaps many miles away, with available therapy slots.



North Dakota established one of the first such networks linking CAC-employed therapists in a mutual support arrangement. When the therapist at one center has a full caseload and is unable to accept another client, the child could be referred to another therapist in the state with a vacancy, allowing the child to start therapy much faster using telemental health. States that have a number of well-established, qualified linkage therapists could set up a similar network linking children in one CAC to available employed or linkage providers in another center, perhaps hours away. An organized Mutual Support Network can act in concert to help address knowledge and skill acquisition to

continuously improve quality and, at the same time, improve management of secondary traumatic stress, far more powerfully than individual practitioners or isolated CACs acting on their own.

This model has a lot of merit but does not suit the needs of states where rural and frontier CACs lack any employed therapists and too few qualified local linkage providers. In such an environment the network must link treatment expertise from better resourced areas to regions that lack local capacity to meet the needs of traumatized children. This type of model is often referred to as a "**Hub-and-Spoke" Network**. In this network, qualified therapists, often located in larger cities or university towns where more mental health professionals practice, are the "**hub**", and the CACs and children they serve, sometimes hundreds of miles away in the most isolated and often under-resourced regions, are the "**spokes**" reaching out across the state.



This could take the form of one or more well-resourced urban CACs with well-developed treatment programs serving as the hubs and providing telemental health to children referred by distant CACs who lack local capacity.

To succeed however, the centers serving as hubs must have the capacity to accept referrals from afar. This may prove challenging when even the most well-resourced centers have more demand than capacity. This was the reality in Montana and Washington when the Chapter sought to create telemental health networks in 2020. In these states, the Chapters choose to build an expanded hub-and-spoke network that went beyond existing CAC-affiliated therapists. The Chapters recruited providers, some of whom were unknown to their local CAC, who were already trained in an appropriate NCA-approved therapies such as TF-CBT, to join a network organized and facilitated by the State Chapter. Of course, as was the case in Washington and Montana, the Chapter may not find enough existing willing and qualified trauma trained therapists to meet the demand. In this case, the Chapters offered training and consultation in selected evidence-based treatments models approved by NCA to expand the pool of qualified therapists for the network.

While not formally tested yet, at least two other variations of the hub-and-spoke network are worth considering. In one possibility, the State Chapter would secure funds for the employment of one or more network therapists, who would either work through contract with an existing CAC that already has a strong internal trauma treatment program, or for the Chapter directly. These therapists would serve as the "hub" and treatment to children in under-resources regions through telemental health. The other model would be to expand the hub-and-spoke network beyond the state borders to include CACs, other organizational providers, or private practice therapists from other states to serve as the hub. This opens the door to potential candidates widely, but it does present an important challenge: state professional licensing. For this model to work, each therapist residing out of the state must secure a license in the state where the children they serve reside. For example, the State Chapter in Montana might recruit several therapists residing in Los Angeles area to as part of the Montana hub, but those therapists would need to secure an appropriate license to provide therapy through the state of Montana. While this presents a challenge, it is not insurmountable, and it is not all that uncommon for professionals to hold licenses in more than one state.

APPENDIX B

Assessing Access to CAC Mental Health Services

Consider the following questions when assessing access to mental health services provided by CACs in your state. The Sample CAC Capacity Survey below can be sent to CACs in your state to assess the capacity of their mental health teams and determine if they may be a good fit to participate in a TMH network.

For mental health services being conducted at CACs, consider:

- Number and full-time equivalent (FTE) of therapists employed by the CAC
- What evidence-based treatments (EBTs) are CAC therapists qualified to deliver? "Qualified" is defined as completing formal training (not just participating in conference workshop or online course such as TF-CBT Web) and participating in consultation, as required by developers
- Number of CAC therapists formally "certified" in an EBT (and which EBTs)
- Number of children receiving mental health services annually
- Approximate number of children receiving mental health services annually by age category (e.g., 0-5, 6-12, 13+)

For mental health services accessed via linkage agreements, consider:

- Number of linkage agreements with community providers
- Number and FTE of community therapists serving CAC clients through a linkage agreement
- Do community therapists who support the CAC specialize in mental health services for children, or carry a general child and adult caseload?
- Do the community therapists supporting the CAC specialize in trauma treatment, or respond to a wide range of potential mental health challenges?
- What EBTs are community therapists qualified to deliver? "Qualified" is defined as completing formal training (not just participating in a conference workshop or online course such as TF-CBT Web) and participating in consultation, as required by developers
- Number of community therapists formally "certified" in an EBT (and which EBTs)
- Number of CAC children receiving mental health service annually
- Approximate number of CAC children receiving mental health services annually by age category (e.g., 0-5, 6-12, 13+)

Sample CAC Capacity Survey

Children's Advocacy Center Name			
Name of person completing the survey			
Email		**Phone**	
CAC Address			
Counties served by the CAC			

How does your CAC offer mental health services? Check all that apply.	
	In-house therapist(s) employed by the CAC → ***COMPLETE SECTION 1***
	Linkage agreement therapist(s) not employed by the CAC → ***COMPLETE SECTION 2***
	Other → ***COMPLETE SECTION 3***

SECTION 1 – In-House Therapists	
How many FTE therapists does the CAC employ?	
How many clients did your in-house mental health team serve last full fiscal year?	
Do you have enough therapists?	
Do you have problems finding qualified applicants for any mental health therapist vacancy?	
Does your team have the capacity to provide therapy to additional clients from other CACs?	
Does your CAC have a waitlist for therapy?	
If yes, how long is the current estimated wait to initiate therapy?	

How many children/youth are currently on the waiting list?	

	Note: If you offer CFTSI in the short term after interview or exam, answer this question as it relates to the waitlist to start other therapies such as TF-CBT.	
How do the therapists deliver services? Check all that apply.		
	In the office	
	In the home or other community setting (like a school)	
	Telemental health	
What therapies are your therapists trained in? Check all that apply.		
	TF-CBT	
	EMDR	
	PCIT	
	CFTSI	
	AF-CBT	
	PSB-CBT	
	Other _____	
Can any of your therapist deliver services in languages other than English?		
	What languages?	
Do you provide clinical supervision?		
	If yes, who provides clinical supervision?	
	Who employs this clinical supervisor?	
How do you financially support your therapy program? Check all that apply		
	Government Grant	
	Payment by MDT Partner	
	Private Foundation Grant	
	Victims of Crime Compensation Funding	

	Medicaid
	Private Insurance
	Philanthropy/Donor Support
	Other – Please explain:

SECTION 2 – Linkage Agreement Therapists	
How many therapists serve CAC clients via linkage agreements?	
Who are your linkage agreements with? Check all that apply.	
Private practice therapist(s) or a group private practice	
Community mental health agency who employs the therapists	
How many CAC-referred clients did your linkage therapists serve last full fiscal year?	
Do you have enough linkage agreement therapists?	
Do you have problems finding qualified trauma therapists willing to meet NCA accreditation requirements in your area?	
Do any of your linkage therapists have the capacity to provide therapy to additional clients from other CACs outside your area?	
Does your CAC or your linkage therapists have a waitlist for therapy?	
If yes, how long is the current estimated wait to initiate therapy?	
How many children/youth are currently on the waiting list? Note: If you offer CFTSI in the short term after interview or exam, answer this question as it relates to the waitlist to start other therapies such as TF-CBT.	

How do the linkage therapists deliver services? Check all that apply.	
	In the office
	In the home or other community setting (like a school)

	Telemental health
What therapies are your linkage therapists trained in? Check all that apply.	
	TF-CBT
	EMDR
	PCIT
	CFTSI
	AF-CBT
	PSB-CBT
	Other _____
Can any of your linkage therapists deliver services in languages other than English?	
What languages?	
Do your linkage therapists receive trauma specific clinical supervision?	
If yes, who provides clinical supervision?	
How are the linkage therapists paid? Check all that apply.	
	Government Grant
	Payment by MDT Partner
	Private Foundation Grant
	Victims of Crime Compensation Funding
	Medicaid
	Private Insurance
	Philanthropy/Donor Support
	Other – Please explain:

SECTION 3 – Other Arrangements	
If you have another arrangement to meet the mental health needs of your clients and meet NCA Accreditation please describe:	
If the state were to organize a statewide CAC mental health network to provide high quality trauma mental health services remotely to your clients and their families remotely using tele-mental health would your CAC be interested in participating?	
If yes, how many referrals would you estimate your CAC would make on average per month?	
Would you be willing to have your victim advocate trained to support the case identification, referral, and on-going support during treatment?	
Would your therapist(s) (in-house or linkage) be able and willing to consider providing telemental health services to support other CACs?	

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Chadwick Center for Children and Families

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Western Regional
CHILDREN'S ADVOCACY CENTER