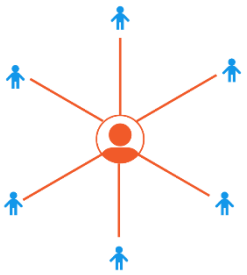
Building a Statewide Telemental Health Network to Support Children Living in Rural Montana

Children's advocacy centers (CACs) are uniquely positioned to support a child's recovery from the psychological and emotional effects associated with trauma. However, not all mental health providers or mental health treatments are equal or equally accessible. Children and youth served by CACs need and deserve access to providers skilled in trauma treatment. The National Children's Alliance's *National Standards of Accreditation* have moved assertively in recent years to require CACs to employ or partner with providers trained in select evidence-based trauma treatment models. Meeting this expectation is challenging even in the most resource-rich communities, but for CACs serving largely rural and even frontier regions (where less than 6 people live per square mile), the challenge can be more daunting. Qualified providers may not be within reasonable driving distance for children and families living far from population centers, or providers may be overwhelmed by referrals and children must wait months to initiate therapy.

Given this context, the Western Regional Children's Advocacy Center (WRCAC) partnered with the Children's Alliance of Montana (CAM) and Children's Advocacy Centers of Washington (CACWA) to pilot efforts to build telemental health networks across their respective states. This issue features important lessons learned along the way in Montana. The vision was to implement a "hub and spoke" model, based on an idea pioneered by the Veterans Administration over 20 years ago to serve Native American veterans with PTSD living in remote regions of the northern plains.[1] Our adaptation of the model envisioned linking a network of trained trauma therapists in urban areas (the "hubs") to children and CACs spread around the state in rural and frontier areas (the "spokes") through telemental health service delivery. A simple concept, but nothing is as easy as it first appears.



WRCAC has supported the state efforts with training and consultation from experts at the Medical University of South Carolina (MUSC), who have conducted and evaluated telemental health delivery of trauma-focused cognitive behavioral therapy (TF-CBT) for several years; CAC professionals in North Dakota, who implemented tele-delivery of TF-CBT with support from MUSC before the pandemic; and Blue Moon Technologies Inc., a technology company who worked with CACs in North Dakota to integrate therapy tools into a virtual environment. WRCAC staff have provided supplemental support

and regular consultation to both states. Additionally, CAM and CACWA have sought and secured funding to add chapter staff dedicated to the project.

The State of Montana has large areas that are sparsely populated, tribal reservations that are vastly under-resourced, and ten satellite and developing CACs that face difficulties in meeting all of the *National Standards of Accreditation*, including the mental health standard. CAM was determined to build a telemental health network to bring high-quality trauma treatment to these rural and frontier regions. To date, CAM has successfully recruited and trained 27 therapists from eleven communities to serve as the initial core of the network, and within weeks of launching the network, the chapter matched 25 children from seven regions, including multiple tribal communities, with remote tele-therapists.

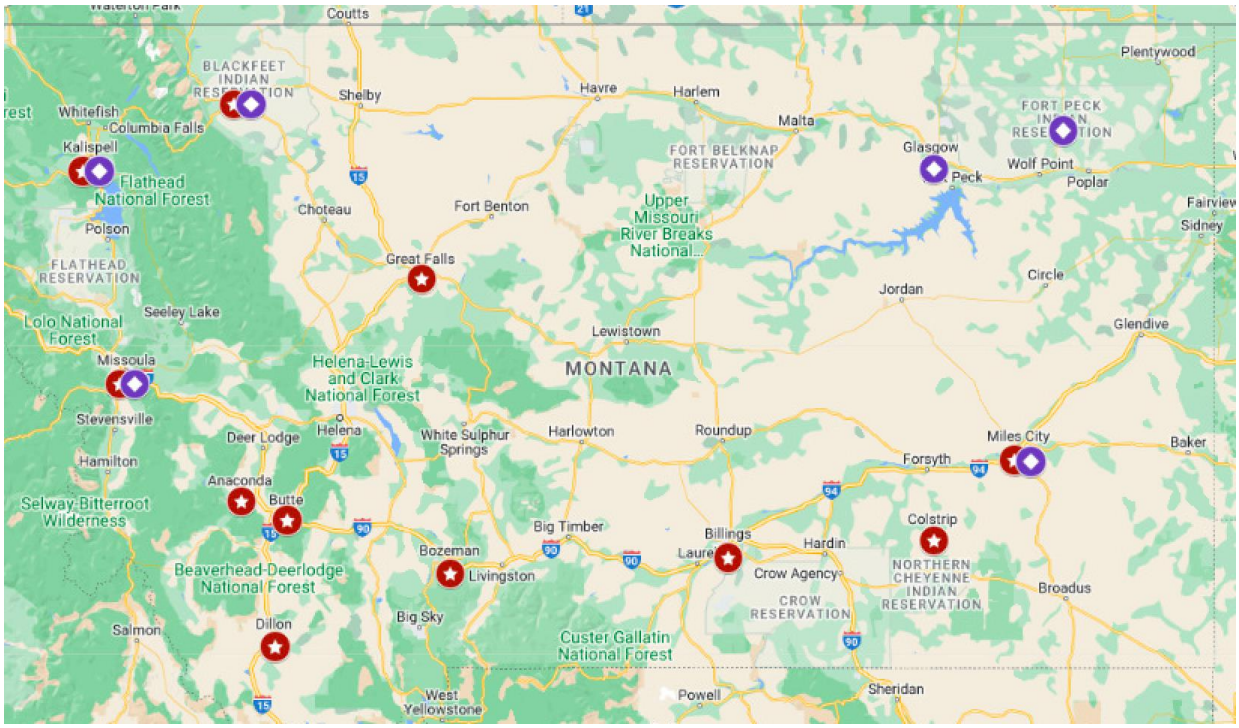


***Figure**: The red stars on the map mark the locations of the therapists participating in the MT TMH network. The purple diamonds mark the locations of the agencies who have referred clients to the network. In many instances, the referent agencies serve multiple counties and/or reservations.*

While the project is still in its infancy, CAM and WRCAC have already learned important lessons that break out into several categories as follows:

Building Broad Support: At the outset, we believed that broad support across the state would be needed to establish the network, but we have discovered these partnerships yield other benefits as well. Montana has fostered a supportive environment for the project and made innumerable new connections that will support not only the tele-mental health network but also the CAC movement in the state. The chapter created a steering committee that now includes representatives of CACs, state

funding agencies, other statewide mental health providers, and the Governor's office, some of whom previously knew little about CACs. Expanding these partnerships has created a larger network for referrals and helped with identifying clinicians who are trauma-trained but not CAC affiliated.

Client Engagement and CAC Staff Buy-In: CAC directors and staff, along with others who will be making referrals, need to be well-informed about the project and convinced the effort will produce positive outcomes for their clients. To facilitate buy-in, specialized training was provided to "brokers" of mental health services, which in Montana includes CAC victim advocates, FBI Victim Specialists serving reservations, tribal victim advocates, and child welfare workers. Brokers not only make referrals to the network, but also play a key role in client engagement by informing families of the value of trauma treatment and the effectiveness of telemental health. These professionals have been essential to promoting the project locally and connecting families with mental health services.

Additionally, the relationship between the paired broker and therapist is critical. They must function as a team. The matched therapist is not likely from the same community as the child victim, may be unfamiliar with the family dynamics and/or the community culture, and must depend on the broker to be their guide. This is even more important when the child is immersed in a distinctive culture, such as that of a tribal community, and the therapist is from another cultural background and unfamiliar with the culture of that specific tribe and the resources of the community. The therapist may also need local knowledge and support to address emergencies where in-person action is needed or to solve problems, such as finding a physically and psychologically safe place for the client to engage in therapy (such as a school or a CAC).

Provider Recruitment: Finding a cadre of trauma-trained therapists has been a challenge. CAM sought experienced trauma therapists who were trained in NCA-approved evidence-based trauma treatments, and who ideally had experience delivering therapy remotely. CAM began by reaching out to therapists who previously attended one of their TF-CBT trainings, and the steering committee helped cast a wider net. Trained therapists who indicated capacity to accept new cases were then offered specialized advanced training in tele-delivery of TF-CBT. To expand the pool of candidates further, CAM offered a new round of TF-CBT training, followed by a second round of training on implementing TF-CBT via telehealth. Going forward, CAM recognizes that as the number of referrals grows, they will need more therapists in the pool, so they are planning to conduct additional recruitment and begin a new training collaborative later this year.

***"One very important thing we have found is that the therapists are very excited to be participating in a project that is innovative and reaching unreachable kids. They are using their expertise to make a difference."* - Brenda George, Executive Director of Children's Alliance of Montana**

Network Building: Building a loosely affiliated group of therapists into a mutually supportive network has only just begun. Contrary to initial expectations that participating therapists would all come from one or two population centers in Montana, they have come from eleven communities, including some rural areas like Miles City and Colstrip (with populations under 10,000). While the trainings and subsequent consultation calls allowed therapists to develop initial relationships with one another and

foster connections across the group, more work will need to be done to shape the group into a true peer support network. CAM envisions monthly peer support calls to further advance network building, and thought is being given to seeking funding for a state clinical coordinator or consultant who can organize and support the group further. CAM is also looking at what other incentives they can provide to clinicians to draw them into the network.

Network Logistics: Montana has developed a simple system to link children in need with available therapists. The referring party, usually a victim advocate, sends a referral form to the CAM project coordinator. The referral has basic information necessary to make a connection including a unique case number assigned by the state's Child and Family Services Division (CFSD). The referral form, however, contains nothing that would violate HIPAA when passing through unencrypted communication channels. CAM then identifies an available and appropriate therapist from the network pool and connects the therapist and referent. From there the therapist reaches out to the family to engage them in the therapeutic relationship.

Technical Challenges: So far, the news on the technical side of the project is good. Borrowing an idea from North Dakota, CAM provides children with "telehealth boxes" that include necessary supplies for remote therapy such as markers, pens, play-dough, a journal, positive affirmation cards, and a feeling SUDS scale. Additionally, WRCAC purchased iPads for CAM to loan to CAC clients who do not have their own device, and Blue Moon has configured the iPads so they can only be used for tele-therapy. However, CAM has found the need for iPads has not been as great as expected. Most children and youth either have access to their own devices or can access devices at school or the CAC where they are completing their telemental health sessions. Likewise, we have not seen widespread problems with internet bandwidth being a limiting factor reaching children remotely, especially when they are accessing tele-sessions outside of their home. However, the project is still young and as it expands into new areas internet access may emerge as an issue.

Project Evaluation: Now that the project is underway and children are engaged in therapy, CAM is planning to gather basic non-identifying information each month on participating clients. Using a simple manual system for now, the goal is to track how many children are receiving therapy, the number of sessions that are occurring, clinical perceptions of progress, and any issues that arise such as technical challenges and no-show rates. CAM is considering going much further and introducing a short psychometrically sound clinical monitoring tool to help guide therapy at the clinician level and provide feedback on clinical progress at the network level, which may become invaluable in seeking support to sustain and grow the network in the years ahead. As the first operational project phase winds down, the chapter will also be reaching out to participating therapists to evaluate their needs, challenges encountered, satisfaction with the process and ways to improve.

Montana (and Washington) have learned the value of "going slow to go fast", which means do your homework, lay a solid foundation, and when the pieces are in place, launch the initiative. Neither state chapter leader has a clinical background, but both have now learned a great deal about mental health and what it takes to organize a functioning statewide telemental health network. Both chapters have

also made new and invaluable connections with the wider statewide mental health and child protection community. Their hard work and that of their steering committees and staff have already paid off, as children who would be languishing far from a trained trauma therapist are now getting the help they need.

Stay tuned for updates and lessons learned from the TMH Pilot Project in Washington!

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[1] Shore, J., Richardson, B., Dailey, N., and Byron, B. (2016). *Telemental Health Clinics for Rural Native American Veterans*. U.S. Department of Veterans Affairs Office of Rural Health Promising Practices, 1(1).

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