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Teletherapy Use in Children's Advocacy Centers: An Effective Solution Amidst the Covid-19 Pandemic

Camille T. Traczek
Gettysburg College

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Keywords

Children's Advocacy Center, Covid-19, Teletherapy, Telehealth

Disciplines

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Camille Traczek
Department of Public Policy, Gettysburg College
Professor Douds
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Abstract

The Covid-19 pandemic has affected people's lives in unprecedented ways. Concerns about social distancing have resulted in the cancellation of therapy and doctor's appointments, leaving those with serious mental health issues without treatment. The need for social distancing amidst the pandemic has particularly affected children seeking treatment from Children's Advocacy Centers (CACs), many of whom have witnessed or experienced abuse. In order to treat children who cannot physically go to a center, many CACs have begun using teletherapy, which is the use of interactive, synchronous technology to provide counselling services. The Adams County Children's Advocacy Center in Gettysburg, Pennsylvania has found teletherapy to be a highly effective method of aiding children during the pandemic and plans on continuing the use of teletherapy services for families who encounter barriers to in-person treatment. Ultimately, the use of telehealth to deliver therapy services has become imperative in the face of the Covid-19 pandemic, and has been effectively utilized in Children's Advocacy Centers, including the Adams County Children's Advocacy Center.

Teletherapy Use in Children's Advocacy Centers: An Effective Solution Amidst the Covid-19 Pandemic

The Covid-19 pandemic has affected people's lives in unprecedented ways. Fear of spreading the coronavirus has triggered government stay-at-home orders, forcing people to remain in their homes except in need of emergency assistance or groceries. Because of this, people have had to find ways to have health consultations and therapy sessions without risking their health by going in person. This is especially imperative for children seeking mental health treatment for trauma, which could be worsened by the stress of the pandemic and the need to quarantine. Children's Advocacy Centers (CACs) primarily provide care to children who have experienced or witnessed sexual or physical abuse, and provide imperative assistance and mental health support as children go through the investigation process. In order to continue providing mental health services during quarantine as well as to children who face barriers preventing them from physically going to a center, CACs have begun utilizing teletherapy. Teletherapy, also referred to as telepsychotherapy or telemental health, is a division of telehealth involving the use of interactive, synchronous technologies such as videoconferencing to deliver psychotherapy to patients (Stewart et al. 2020). As part of my experience as a remote intern for the Adams County Children's Advocacy Center (ACCAC), I conducted research and interviewed the executive director about the use of teletherapy in the ACCAC. Ultimately, The Covid-19 pandemic has made the use of telehealth to deliver health and therapy services imperative, and has been greatly utilized in Children's Advocacy Centers, including the Adams County Children's Advocacy Center.

Telehealth and Teletherapy

Although telehealth has been studied in medicine for years, it has only been considered a feasible treatment option within the past few years. An increase in efficient communications, IT technology, improved diagnostics, and skyrocketing healthcare costs for an ageing population have made telehealth more common (Hunter, 2015). Doctors began experimenting with telehealth in 1975, when a study was done on doctor-patient consultations done via closed circuit computer and television (Hunter, 2015). The study found that telehealth increased consultation lengths by 25%, but notably decreased the number of hospital referrals (Hunter, 2015). Telehealth was most valuable in remote areas where people felt isolated, but the high cost of closed-circuit TVs prevented telehealth from being more popular (Hunter, 2015). The improvement of broadband communication services and normalization of mobile devices have greatly increased interest in and feasibility of telehealth, with pilot programs demonstrating that telehealth has great cost-saving potential (Hunter, 2015). The coronavirus pandemic has further normalized the use of video conferencing as a method of meeting with doctors and therapists, with the Office for Civil Rights going so far as to wave penalties for noncompliance with the Health Insurance Portability Act of 1996 (HIPAA) in terms of telehealth use during the pandemic (Office for Civil Rights, 2020).

Teletherapy is a sector of telehealth focused specifically on the use of technology to deliver mental healthcare to patients. It is a relatively low-cost solution that allows providers and patients at different locations to speak to and see each other in real time (Stewart et al. 2020). Since therapy and counselling focus primarily on the use of conversation to diagnose and treat mental illness, there is no need for in-person contact or expensive medical equipment (Stewart et al. 2020). This makes therapy particularly easy to translate into a video conferencing format, for it offers a comparable quantity of therapist contact relative to in-person treatment (Comer et al. 2014). Teletherapy is particular well suited for children and teenagers, who often have extensive

exposure to and comfort with technology due to growing up in the digital age (Stewart et al. 2020). The video format may even benefit therapists in their treatment of children, for it allows them live observation of the settings children live in and how they behave in them (Comer et al. 2014).

Although teletherapy is easier to implement than other practices in the field of medicine, there are still several barriers that mental health professionals must overcome in order to create a telemental health program. Although the use of video conferencing allows therapists to treat patients from miles away, issues of licensing prevent therapists from practicing across state lines (Kramer & Luxton, 2016). Gettysburg College recently ran into this issue after going through the de-densification process, for even though the school could offer virtual counselling to students on campus, licensing issues prevented the school from continuing to provide these services to students who live in certain states. Individual states have the authority to determine licensure requirements for mental health professionals practicing there, and these requirements may differ depending on the state (Kramer & Luxton, 2016). If therapists want to treat a patient in another state, they would have to obtain a license in that state, which could be costly (Kramer & Luxton, 2016). Since teletherapy has become increasingly utilized in the field, professionals have begun proposing solutions to this, including the creation of a specific telemedicine or national license (Kramer & Luxton, 2016). Although this is a major issue in the general field of teletherapy, this is less of a problem for CACs, which serve specific communities.

Additionally, concerns about malpractice liability remain prominent in the field of telepsychotherapy. Teletherapy is a type of service that connects providers to patients, and not a whole new form of treatment. Because of this, the best standards and practices for in-person therapy sessions apply to virtual sessions, though specific teletherapy guidelines are beginning to be established (Kramer & Luxton, 2016). Teletherapy malpractice cases have already been

adjudicated, though those deal primarily with therapists prescribing medication virtually without doing a thorough in-person examination (Kramer & Luxton, 2016). Most states require an in-person examination to be done prior to the prescription of medication over video conferencing, which therapists must be sure to follow (Kramer & Luxton, 2016).

The most prominent concern that patients and providers have about teletherapy is security and privacy. Patient privacy and data security must be compliant with the Health Insurance and Accountability Act of 1996 (HIPAA), which established patient confidentiality laws (Kramer & Luxton, 2016). As therapists look for video conferencing software to use with patients, they must be aware that just because a company says their product is HIPAA compliant does not mean that it is (Kramer & Luxton, 2016). Business agreements with healthcare providers can affect the HIPAA compliancy of software, as well as specific state privacy laws (Kramer & Luxton, 2016). Debate continues over whether commercially available software products such as Skype are HIPAA compliant, though the need for remote therapy services has forced the Department of Health and Human Services to loosen their restraints on video conferencing platforms (OCR, 2020).

Therapists must also communicate with caregivers of children in order to establish emergency procedures. When treatment is being received in a non-clinical setting, it is crucial that counsellors have contact with someone residing in the same space as the patient if possible (Kramer & Luxton, 2016). Should there be an emergency during a session, therapists must be able to contact someone with access to the patient who can provide immediate assistance. Despite the risks and barriers to implementation that exist, teletherapy is generally safe and effective as long as mental health providers use clear risk management strategies.

Telemental health is largely effective, especially for children. Several case studies have presented preliminary evidence that trauma-focused teletherapy reduces symptoms and is feasible (Stewart et al. 2020). Reviews of child telehealth have had good outcomes in both rural and urban settings (Stewart et al. 2020). Lastly, teletherapy has been found to have high rates of diagnostic accuracy and satisfaction of patients and caregivers (Stewart et al. 2020). Overall, teletherapy is an effective method of providing treatment to children, despite the barriers associated with it.

Children's Advocacy Centers

In recent years, Children's Advocacy Centers have begun to explore teletherapy as a solution to issues with providing services to children who are unable to physically go to a center. However, before teletherapy usage in CACs can be explored, it is crucial that one understands the scope of the services CACs provide. Before the creation of CACs, investigations into child abuse were highly disorganized (Elmquist et al. 2015). Since multiple different groups such as law enforcement, children's advocates, and health professionals were involved, multiple investigations were often needed (Elmquist et al. 2015). This risked retraumatization of children who would have to testify about their experiences to multiple different people (Elmquist et al. 2015). Investigations into child abuse require communication between several agencies, and inefficient communication resulted in overlooked and delayed cases (Elmquist et al. 2015).

In response to this, the first Children's Advocacy Center was established in Huntsville, Alabama in 1985 (Elmquist et al. 2015). CACs are community-based, multidisciplinary organizations that aim to improve the response, investigation, and prosecution of child maltreatment in the U.S. (Elmquist et al. 2015). They help children who have witnessed domestic assault, been victims of physical assault, or who are victims of abuse or neglect (Elmquist et al.

2015). The CAC streamlined the investigation process by bringing all of the separate agencies into one, including police, medical professionals, counsellors, and family advocates. Shortly afterwards the need for standardized procedure led to the creation of the National Children's Alliance (NCA), which provides guidelines to accredited CACs (Elmquist et al. 2015). The NCA stresses the need to customize CACs to their surrounding communities, taking into account population size and whether the area is rural or urban (Brandes et al. 2017). Ten standards must be met in order to be an NCA accredited CAC, which gives centers access to extra funding (Brandes et al. 2017). CACs must have a multidisciplinary team consisting of law enforcement, Child Protective Services workers, medical providers, mental health providers, victim advocates, and prosecutors (Brandes et al. 2017). They must also display cultural competency and diversity through the completion of a community assessment at least every three years to determine community demographics, gaps in strategies, and effectiveness of outreach (Brandes et al. 2017). Additionally, CACs must partake in victim advocacy, which can be done by either linking victims with community-based advocates or by employing staff to be victim advocates (Brandes et al. 2017).

To continue, CACs must conduct on-site forensic interviews and medical evaluations (Brandes et al. 2017). Mental health treatment is an important aspect of advocacy centers, and is particularly relevant to the purposes of this paper. Effective therapeutic treatment must be provided to children facing trauma through the use of evidence-based, empirically supported treatments (Brandes et al. 2017). They must be prepared to provide counseling not only to children, but to caregivers and siblings if necessary (Brandes et al. 2017). CACs can elect to have a mental health provider on-site, by referral, or through linkage (Brandes et al. 2017). Most importantly, CACs must be able to provide mental health resources to all child clients regardless of economic situation (Brandes et al. 2017). The ability to administer mental health interventions

to children who have faced trauma is a priority for the NCA, and should be for CACs as well. Lastly, CACs must also conduct case reviews and case tracking, maintain organizational capacity, and ensure a child-focused setting in order to be accredited by the NCA (Brandes et al. 2017).

Teletherapy Use in Children's Advocacy Centers

Teletherapy has been a crucial resource for Children's Advocacy Centers as they try to treat as many children in their communities as possible. Telepsychotherapy greatly improves children's access to treatment, which is imperative considering that mental healthcare disparities are especially pronounced amongst children (Gloff et al. 2015). Additionally, exposure to traumatic events such as physical abuse, sexual abuse, domestic violence, or witnessing violence is a major public health concern, especially for children (Stewart et al. 2020). Many children in need of mental health care do not receive it, do not receive enough of it, or do not receive care that is evidence-based (Stewart et al. 2020). Trauma exposure without treatment increases risk of further mental disorders, including PTSD, depression, anxiety disorders, and substance abuse disorders (Stewart et al. 2020). Because of this, CACs must work to make treatment available to children who need it, regardless of the many barriers that stand in the way of treatment.

Barriers to Treatment

There are many reasons that a child would be unable to physically go to a center in order to receive services, especially if they are receiving treatment from a counselor that requires consistent visits. People in rural areas are particularly susceptible to these issues (Annan, 2008). Job opportunities in rural areas are usually restricted to seasonal, service, and laborer work with low wages, making it particularly important to be able to attend shifts (Annan, 2008). The geography of these areas often requires workers to make long commutes, and low wages mean

that they must work multiple jobs (Annan, 2008). Women in rural areas face particularly limited job prospects, and fear of missing tight work schedules may prevent them from bringing their children to be treated at a CAC (Annan, 2008). Caregivers may not even have a vehicle they can use to transport their child to treatment. 40-45% of rural people live in poverty, and cars are extremely expensive to maintain (Annan, 2008). Additionally, there is often limited access to public transportation in non-urban areas, which further stands in the way of bringing children to CACs. Only half of rural counties nationwide have public transportation (Annan, 2008). Many parents have to choose between working crucial shifts or bringing their children to receive treatment at CACs, with others not even knowing how they will physically get to a center.

Providing mental health treatment to people in rural areas is a priority in the field, and gaps in mental health care are particularly pronounced in these isolated towns. Three quarters of federally designated Mental Health Professional shortage areas are rural in nature (Comer et al. 2014). Unfortunately, geographic workforce gaps in mental health care are typically filled by physicians and pediatricians who lack the training needed to properly treat children (Comer et al. 2014). The further specialization needed to serve children who have experienced sexual violence make improper treatment even more dangerous.

The Covid-19 pandemic has created another barrier to treatment for not just people in the United States, but all over the world. State governments have issued stay-at-home and quarantine orders across the country, forcing people to remain in their homes except when getting groceries or in emergencies. Officials have stressed the importance of slowing the spread of the coronavirus through social distancing, forcing schools to switch to online classes and employers to switch to working from home, if possible. The stress of continuing with day-to-day life in the midst of the pandemic has made it extremely difficult to remain in good mental health, and requirements to remain isolated inside of homes have only exacerbated this (Pfefferbaum &

North, 2020). However, the need for social distancing and self-quarantining means that many people are unable to go to therapy sessions in person, including children receiving treatment at CACs. The Covid-19 pandemic has concerned mental health professionals due to the stress of the uncertainty of the situation as well as unclear orders about staying at home that could worsen existing mental health conditions, demonstrating a clear need for a solution that allows patients to be treated without being physically near their counsellor.

Teletherapy is capable of overcoming all of the previous barriers to treatment, including tight work schedules, lack of access to transportation, and covid-19 social distancing requirements. It entirely eliminates the need for caregivers to take children to CACs, for children could attend their therapy sessions virtually. This also lowers the costs of long-distance travel and the opportunity cost of caregivers missing time at work to bring children to appointments (Stewart et al. 2020). Teletherapy has become commonplace amidst the pandemic, with the Office for Civil Rights at the Department of Health and Human Services announcing the suspension of penalties for noncompliance with HIPAA requirements under the good faith provision of telehealth (OCR, 2020). The OCR announced that covered health providers could use any non-public facing remote communications platform that is easily available to patients in order to ensure that they receive treatment during the pandemic (OCR, 2020). This was done out of the understanding that the provision of mental health services is imperative during an event as emotionally exhausting as a pandemic, and this shift in understanding has made health providers realize the real feasibility of implementing permanent telehealth programs to address other barriers.

Implementation of Teletherapy in CACs

Teletherapy has become increasingly utilized in Children's Advocacy Centers as professionals realized how effective of a solution it is to distance barriers. Since many non-metropolitan communities primarily allocate their mental health funding to adults, CACs fill an essential gap by treating children (Gloff et al. 2015). Prior to the pandemic, two North Dakota CACs developed a telehealth program to provide mental health services to children in an extremely rural area (National Children's Alliance, 2019). They used a Victims of Crime Grant to fund the program, which involved the training of twelve therapists and five advocates in telehealth (NCA, 2019). Twenty iPads and twenty laptops were purchased to give to families without access to the technology needed to conduct sessions through video conferencing (NCA, 2019). Families without internet were given data enabled devices with internet plans paid for by the CACs (NCA, 2019). Additionally, a HIPAA compliant platform was used, and all the necessary forms were adapted into virtual format to easily send to caregivers (NCA, 2019). Besides successfully linking children to CACs that would not have been able to receive treatment if they had to physically go to a center, the implementation of the program also created a strong relationship between the two CACs as they worked to serve their nearby counties (NCA, 2019). This case study demonstrates the feasibility and benefits of implementing teletherapy programs in CACs.

The above case study mentioned some of the logistics that must be figured out in order to successfully create a telehealth program in advocacy centers, though barriers to implementation are a bit more complicated than they were made out to be in the study. First, many rural homes do not have phones, and only 6.1% of rural families have computers (Comer et al. 2014). Those who do have cellphones often struggle to have a clear signal (Comer et al. 2014). Only broadband or Wi-Fi connectivity can maintain the quality of communication needed for live

mental health treatment, for low bandwidth often results in distorted visuals and audio (Comer et al. 2014).

Security is also a major concern of telehealth and teletherapy. All meetings must be secure in order to maintain patients' privacy (Comer et al. 2014). Luckily, there are a series of clear guidelines that can be followed to make therapy sessions as secure as possible. The video conferencing software used should use the Advanced Encryption Standards Algorithm, and meeting attendees should only be able to log in after being invited by the host (Comer et al. 2014). All virtual meetings should be unlisted, meaning that individuals cannot search for the meetings as they occur (Comer et al. 2014). Video conferencing software should not store any meeting content on a network or automatically record any content (Comer et al. 2014). Ultimately, families must understand that the use of technology and the internet for therapy comes with a risk of breach in confidentiality, and they should avoid the use of identifying information during sessions in order to further minimize this risk.

Access to technology is another aspect of implementation that must be addressed in order to create a teletherapy program in a CAC. Computers will need to be provided in both CACs and in the home of the child receiving treatment. Broadband or Wi-Fi must be installed in the homes of children if they do not have it, or loaned devices will have to have data access. All devices to be used during video conferencing sessions must have a webcam, microphone, and speaker, and CACs must be prepared to provide those to the homes of children if needed.

Therapists will have to make some adjustments to their practice as they switch to an online format of therapy. As seen with the North Dakota CACs, therapists should undergo some form of telehealth training so they are best equipped to treat children virtually. They also should consider the parent/guardian situation of the children they treat, for families play a crucial role in

the treatment of children, and that role is even more important when treatment is being done via teletherapy (Gloff et al. 2015). Therapists must be aware of families' culture and community as they treat children who are undergoing treatment from their homes (Gloff et al. 2015). The maintenance of a community-oriented approach remains vital even in a virtual format (Gloff et al. 2015).

Although I was unable to experience the use of telehealth in the Adams County Children's Advocacy Center due to the circumstances of the Covid-19 pandemic, I still had the opportunity to interview the executive director of the ACCAC, Elida Murray, about how she had integrated telehealth and technology into their practices. The ACCAC uses video conferencing to provide essential mental health services to those who otherwise would not be able to receive treatment. Web-based meetings over Zoom and Web-Ex are being used for teletherapy sessions, and child and family advocates use video conferencing to conduct support sessions and mental health evaluations. Technology has also been used to continue operations during the pandemic, with meetings being done over Zoom. Video conferencing was also used to conduct meetings between interns, the executive director of the CAC, and other staff members. Executive director Murray stated that there were no significant barriers to implementation of the teletherapy program, and that families were generally appreciative that services could continue amidst the pandemic. The Pennsylvania Department of Health provided guidelines for the program and for how to bill insurance for teletherapy sessions, though the CAC had no issue with billing since all services are done for free.

In terms of troubleshooting, the ACCAC faced only minor issues with technology. They had to purchase HIPAA compliant WebEx and Zoom, as well as cellphones for staff members. Some internal processes had to be reengineered by staff in order to manage documentation of sessions. The center's art therapist had to adjust her usual approached to therapy for the virtual

format, including ensuring that all children had art supplies for their sessions by mailing supply kits to their homes. The most prominent issue with teletherapy concerned privacy, for some children and teens who were receiving therapy through the CAC did not have a safe space at home to have teletherapy sessions. Unfortunately, children and teenagers who are victims of physical or sexual abuse may live with unsupportive caregivers who refuse to acknowledge that their experiences had even occurred, creating an uncomfortable environment for sessions. Some caregivers may not support therapy and may feel they need to "monitor" sessions, which is a major breach of patient privacy. Finding a safe space for children and teenagers to have teletherapy sessions while in unsupportive home situations was the greatest issue the ACCAC faced while establishing teletherapy.

Ultimately, teletherapy was determined to be a generally effective method of treatment during the pandemic, though it often depended on the child's treatment plan and the extent of their trauma. All cases were discussed by the ACCAC's Mental Health Program Team prior to treatment, and determinations were made as to whether it would be best for children to receive treatment in person, virtually, or through a hybrid model. Some children who were very young or who faced very complex trauma were not good candidates for teletherapy, and would continue to receive in-person treatment at the center. Despite this, children who did receive treatment via teletherapy were reported to have adapted well, and the ACCAC plans on continuing to offer telemental health as an option after the end of the pandemic. For many families, it is a solution to issues with transportation or scheduling that have long been impediments to children's trauma therapy.

Evaluation of Teletherapy in CACs

Based on both my experiences as an intern at the ACCAC and the literature I have read about telehealth, teletherapy is a feasible, efficient, and effective policy concept to utilize in Children's Advocacy Centers. In terms of feasibility, the main barriers to implementation that must be overcome are supplying families with technology, security, and compliance with privacy laws. All of these are easily overcome, especially in the time of the Covid-19 pandemic, when restrictions on telehealth have been eased in order to increase access to mental health services. The North Dakota CACs that were previously mentioned funded their teletherapy program with a Victims of Crime Grant (NCA, 2019). The Office for Victims of Crime provides discretionary funding to national-scope training and technical assistance delivery programs in order to enhance victim service providers (Funding & Awards, 2019). These funds can be used to identify and create new practices, models, and programs in the victim services field (Funding & Awards, 2019). Victims of Crime Grants can be used to fund teletherapy programs and purchase the devices families need to connect children with therapists virtually. Internet connectivity issues can be corrected through the purchase of ethernet cables (Stewart et al. 2020). Supplying technology may appear to be a large barrier, but ultimately there are resources available to minimize costs, and the widespread nature of technology in the twenty first century means that most families already have technology or are at least familiar with it.

Security is another barrier to implementation that can easily be overcome. Meetings can be made secure using Advanced Encryption Standards Algorithms, and a plethora of video conferencing platforms have been pre-approved as HIPAA compliant by the Office for Civil Rights (OCR, 2020). During the Covid-19 pandemic, health providers can use Apple facetime, Facebook Messenger chat, Google Hangouts, Zoom, and Skype without risk of penalty (OCR, 2020). Even though these platforms have been approved for use, all third-party applications come with potential privacy risks. Only public-facing applications are completely banned from

being used for healthcare purposes, including Facebook Live, Tiktok, or Twitch (OCR, 2020). Healthcare providers that want additional privacy measures and plan on continuing their use of telehealth after the pandemic should enter into HIPAA business associate agreements (OCR, 2020). Vendors that are approved and eligible for business associate agreements include Zoom for Healthcare, Skype for Business/Microsoft Teams, and Updox, among others (OCR, 2020). Overall, teletherapy programs are entirely feasible in CACs, for the logistical issues that stand in the way of implementation can be easily overcome.

Next, teletherapy programs are extremely efficient. They eliminate the time families would need to bring their children to CACs. In today's world, where children are generally extremely familiar with how to work technology, there is little to no learning curve while using video conferencing. Internet connection and laptop or tablet installation would only need to be done once, and the enduring nature of modern technology means that devices will last.

Perhaps most importantly, teletherapy programs in CACs are effective. A pilot study of trauma-focused cognitive behavioral therapy delivered to under-served trauma exposed youth though telehealth had promising results (Stewart et al. 2017). Treatment sessions were 45-90 minutes long, and all patients successfully completed all sessions virtually (Stewart et al. 2017). There were few technical problems with equipment other than some pixilation issues that were easily resolved using an ethernet cable (Stewart et al. 2017). Therapists and caregivers had no safety concerns during the study (Stewart et al. 2017). Therapists successfully engaged caregivers through both child and caregiver sessions, with caregivers managing to virtually meet even while on breaks at work (Stewart et al. 2017). All caregivers indicated that they were satisfied with the teletherapy treatment, with 86% indicating that the technology was easy to use (Stewart et al. 2017). Providers also indicated high satisfaction with teletherapy, saying that the virtual sessions were just as good as in-person sessions and that it was easy to build rapport

through telehealth (Stewart et al. 2017). Overall, patients, caregivers, and therapists were all extremely satisfied with the procedure and outcomes of the teletherapy program. Another study done by Stewart et al. found that nine out of ten children treated for trauma via teletherapy completed Trauma-Focused Cognitive-Behavioral therapy using teletherapy (2020). 96.8% of those who finished treatment did not meet diagnostic criteria for trauma-related disorders at posttreatment (Stewart et al. 2020). Even though this study was not done in the context of a CAC, it examined the use of teletherapy in treating children who have experienced trauma (Stewart et al. 2020). Experiencing or witnessing sexual or domestic violence is an extremely traumatic event, and children with these experiences would likely receive some form of trauma-focused treatment. The results of this study are extremely promising in terms of the effectiveness of telemental health programs in CACs.

Conclusion

The need for social distancing and the slowing down of the spread of the coronavirus amidst the Covid-19 pandemic has prevented children from having access to crucial mental health treatment. In order to be able to continue providing services to children without needing them to physically travel to a center, Children's Advocacy Centers have begun to use telehealth to asynchronously host therapy sessions. Although the concept of telehealth is not new, it has become essential in a time when people are working, doing school work, and shopping all from their computers. Teletherapy has proven to be an effective method of overcoming the barriers to treatment that have prevented children from obtaining treatment in rural areas for years, but has now been normalized amidst the pandemic. The widespread nature of technology in the twenty-first century make teletherapy an incredibly feasibly policy option for CACs, especially considering how familiar children are with the use of computers and cell phones today. Additionally, studies of the delivery of trauma-based behavioral therapy using video

conferencing have proven the effectiveness and ease of telemental health. Teletherapy is a safe, effective, and highly feasible way for Children's Advocacy Centers to continue to provide children with the crucial help they need to heal from the trauma they have faced, and will likely continue to be embraced long after the pandemic is over.

References

Annan, S. (2008). Intimate Partner Violence in Rural Environments. Annual Review of Nursing Research, 26(1), 85–113. https://doi.org/10.1891/0739-6686.26.1.85

Brandes, B., Betz, D., Fine, J., Braun, J., Lynn, A., Doggett, C., . . . Williams, N. (2017). *Standards for Accredited Members* (Rep.). Retrieved October 6, 2020, from National Children's Alliance website: https://www.nationalchildrensalliance.org/wp-content/uploads/2015/06/NCA-Standards-for-Accredited-Members-2017.pdf

Comer, J. S., Elkins, M., Chan, P. T., & Jones, D. J. (2014). New Methods of Service Delivery for Children's Mental Health Care. In 956779647 745102556 C. A. Alfano (Author), *Comprehensive evidence-based interventions for children and adolescents* (pp. 55-67). Hoboken, NJ: Wiley.

Elmquist, J., Shorey, R., Febres, J., Zapor, H., Klostermann, K., Schratter, A., & Stuart, G. (2015). A review of Children's Advocacy Centers' (CACs) response to cases of child maltreatment in the United States. Aggression and Violent Behavior, 25, 26–34. https://doi.org/10.1016/j.avb.2015.07.002

Funding & Awards: Office for Victims of Crime. (2019, September 27). Retrieved October 10, 2020, from https://ovc.ojp.gov/funding-and-awards

Gloff, N., LeNoue, S., Novins, D., & Myers, K. (2015). Telemental health for children and adolescents. International Review of Psychiatry: Telepsychiatry, 27(6), 513–524. https://doi.org/10.3109/09540261.2015.1086322

Hunter, P. (2015). Phoning in sick--telehealth in the iPhone age: As mobile devices become ubiquitous, can health care finally be delivered effectively over the Internet? EMBO Reports, 16(10), 1256–1259. https://doi.org/10.15252/embr.201541099

Kramer, G., & Luxton, D. (2016). Telemental Health for Children and Adolescents: An Overview of Legal, Regulatory, and Risk Management Issues. Journal of Child and Adolescent Psychopharmacology, 26(3), 198–203. https://doi.org/10.1089/cap.2015.0018

National Children's Alliance. (2019). *One Voice, Stronger* (Rep.). Retrieved October 6, 2020, from National Children's Alliance website: https://www.nationalchildrensalliance.org/wp-content/uploads/2020/04/AR2019-web.pdf

Office for Civil Rights. (2020, March 30). Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. Retrieved October 10, 2020, from https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Pfefferbaum, B., & North, C. S. (2020). Mental Health and the Covid-19 Pandemic. *New England Journal of Medicine,383*(6), 510-512. Retrieved October 12, 2020, from https://www.nejm.org/doi/full/10.1056/NEJMp2008017

Stewart, R., Orengo-Aguayo, R., Cohen, J., Mannarino, A., & de Arellano, M. (2017). A Pilot Study of Trauma-Focused Cognitive–Behavioral Therapy Delivered via Telehealth

Technology. Child Maltreatment, 22(4), 324–333. https://doi.org/10.1177/1077559517725403

Stewart, R. W., Orengo-Aguayo, R., Young, J., Wallace, M. M., Cohen, J. A., Mannarino, A. P., & De Arellano, M. A. (2020). Feasibility and effectiveness of a telehealth service delivery model for treating childhood posttraumatic stress: A community-based, open pilot trial of trauma-focused cognitive–behavioral therapy. *Journal of Psychotherapy Integration, 30*(2), 274-289. doi:10.1037/int0000225