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Telemental Health Services for Reaching Rural Victims of Crime: Phase 2

Final Report

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Glossary

Anxiety: A mental condition indicated by excessive worry or concern about real or perceived threats; common amongst those who have experienced multiple, profound, or chronic traumatic events.

Bidirectional feedback: A system or framework in which information flows both ways; in the context of this project, this refers to the repeated exchange between providers, patients, and researchers to ensure that all stakeholders are involved and have a voice.

Electronic health records: An electronic/digital version of a patient's health care history that is maintained and kept confidential by the provider; El Futuro's records include a variety of information about patient characteristics and service utilization and can be deidentified for use in an evaluation.

Evaluability assessment: A systematic process to determine whether a program is able to be evaluated; for this project, this stage was intended to assess if TeleFuturo could be evaluated with people who had experienced different types of crimes.

Evidence-based: A concept or strategy that implements knowledge gained from the existing research; this is something that can change over time to reflect the most recent research.

Evidence-informed: A concept or strategy that can be enriched by previous research but is not limited to it; this can blend knowledge from research, practice, and people experiencing the practice.

Fidelity: A concept referring to the degree to which a program is delivered as intended by the researchers or developers; importantly, not all components of a program are necessarily required to be adopted or carried out to meet standards of fidelity.

HIPAA: Health Insurance Portability and Accountability Act. A federal law that regulates the use and disclosure of protected health information by providers; in telehealth, this involves using encrypted teleconferencing platforms to protect patient privacy.

Hybrid model: A mix of treatment modalities; in this project, that includes those who received a mix of both telehealth and in-person services.

Mixed methods: A research approach that involves collecting and analyzing both quantitative and qualitative data to understand a problem or process.

Process evaluation: A type of research methodology used to determine how a program is implemented; this can help researchers see *how* a program outcome comes about.

Rural: Any area located outside of urban settings; populations in these areas can face limited access to mental health resources. In the context of this project, we classify these areas as containing as less than 500 people per square mile.

Stigma: An instance wherein someone is viewed in a negative or discriminatory way—by themselves or by others—because of a specific trait or characteristic; in this project, this typically refers to negative viewpoints in response to someone seeking mental help.

Targeted Telehealth: TeleFuturo treatment modality involving Focused Acceptance Commitment Therapy via telehealth.

Telemental health: A form of healthcare that is carried out remotely via technology; TeleFuturo is an example of this, intended to support people in rural areas who have been victims of crime.

Transdiagnostic: An approach applied across a variation of diagnoses; in this project, it involves considering therapeutic components that are found across different types of interventions and applying them to victims who have experienced different types of crimes.

Trauma: A lasting emotional response that results from a distressing or disturbing experience, which can be interpersonal (e.g., physical abuse/assault, sexual abuse/assault, and emotional abuse) or non-interpersonal (refugee trauma and mass violence, community violence, and medical or accidental trauma).

Executive Summary

Executive Summary

This executive summary provides an overview of a Phase 2 process evaluation that examined technology based telemental health services for victims of crime (VOCs). The project involved a rigorous process evaluation of TeleFuturo—a comprehensive outpatient approach to working with rural VOCs, particularly those who identify as Hispanic/Latinx. The study focused on identifying critical therapeutic components of TeleFuturo. In addition, this study included a pilot study that assessed feasibility of capturing outcome, fidelity, and cost measures. This Phase 2 evaluation contributes to the existing literature on telehealth interventions for VOCs and provides recommendations for a Phase 3 rigorous evaluation.

The process evaluation of TeleFuturo used a mixed-methods approach, combining quantitative and qualitative data collection methods that took a strong community-based participatory approach, weaving inputs from partners throughout this phase. This allowed the capture of important inputs from providers and clients about barriers and facilitators when implementing evidence-based or evidence-informed interventions using technology-based platforms (either hybrid or full telehealth). For the pilot study, study participants consisted of VOCs who received telehealth mental health services and inputs from experienced providers and site leadership. Outcome measures included improvements in transdiagnostic mental health symptoms, functioning, and satisfaction with the telehealth services. Fidelity measures assessed the adherence of service providers to capturing the key components of therapeutic change while considering the intricacies of working with heterogeneous VOCs. Cost measures were evaluated to determine the feasibility of capturing cost data for different service models (full telehealth, hybrid) Relative costs were compared.

Results indicated several factors important to consider when working with clients who are VOCs living in rural areas. When evaluating critical intervention components, provider, client, and other contextual variables should be considered when determining the type of intervention modality (full telehealth, hybrid, or in person) and the specific evidence-based intervention components employed. These are all critical factors to ensure high-level quality and clinical competence. The pilot study also yielded promising results. The outcomes demonstrated clinically meaningful improvements over time in mental health symptoms among VOCs who received telehealth services. Participants reported high levels of satisfaction with the convenience and accessibility of telehealth interventions. The fidelity assessment revealed important components needed for appropriately capturing fidelity in contexts with complex diagnostic presentations and complex treatment delivery. This resulted in high adherence to the established protocols, indicating the consistent delivery of services in ways that prioritized the safety and privacy of clients. Cost analysis demonstrated hybrid and telehealth services were less expensive than traditional in-person mental health services.

This Phase 2 process evaluation contributes to the existing literature on telehealth mental health services for VOCs in several ways. First, it adds to the growing body of evidence supporting the effectiveness of telehealth interventions in improving mental health outcomes for crime victims.

Second, it highlights the importance of broad fidelity assessment in ensuring the consistent delivery of telehealth services. Finally, this study provides valuable insights into the cost considerations of telehealth interventions, which can inform decision-making and resource allocation. The success of the TeleFuturo technology-based approaches for engaging and providing quality mental health interventions for VOCs residing in rural areas is evident through its ability to recruit a diverse range of VOCs in rural settings that are priority for the National Institute of Justice, capture data for a comprehensive and rigorous evaluation, and advance the understanding of complex victim needs. Moreover, the organizations' and local partners' commitment to dissemination through publications, presentations, conferences, and local provider outreach and training ensures that this study's impact extends beyond the immediate participants, fostering collaboration and promoting the widespread adoption of effective mental health interventions for rural VOCs.

Chapter 1: Background



1. Background

In the past 15 years, considerable progress has been made in developing interventions and treatments for mental health problems experienced by victims of crime (VOCs; McGrath & Johnson, 2022). Despite this progress, VOCs face many access barriers, one of which is the time, costs, and other burdens associated with in-person services. Since the onset of the COVID-19 pandemic, providers have leveraged advancements in technology to provide telehealth to individuals as a supplement or alternative to in-person treatment. This use of telehealth has been shown to improve outcomes for individuals in general and within specific populations (Sinkler et al., 2022). When working in rural settings, specific attention to ubiquitous barriers and solutions to challenges is key for uptake and better outcomes. In this report, the RTI International team describes our Phase 2 Process Evaluation of TeleFuturo—a comprehensive outpatient approach to working with rural VOCs, particularly those who identify as Hispanic/Latinx. This project was part of a phased approach that included a Phase 1 Formative Evaluation (2018-ZD-CX-0001). In particular, we describe activities specific to conducting a rigorous process evaluation of TeleFuturo programming for reaching rural VOCs, including activities around development of fidelity, outcome, and cost measures based on this process evaluation. We additionally describe our bidirectional collaboration with key partners to update the Implementation Guide. Results of the pilot study using fidelity, outcome, and cost measures are discussed. We conclude with recommendations, considerations, and proposed dissemination activities for a Phase 3 evaluation.

1.1 TeleFuturo Foundation – Phase 1: Formative Evaluation

This Phase 2 study builds upon foundational work completed in Phase 1's Programs and Services for Victims of Crime Phased Evaluation Research (2018-ZD-CX-0001), which included the development of a logic model to guide telehealth programming, an evaluability assessment of existing telehealth services, and a pilot test of initial implementation. This pilot test additionally captured necessary components needed for future fidelity assessment of these telehealth services as part of a potential four-phase evaluation.

In Phase 1, the formative evaluation focused on TeleFuturo, a hybrid approach of service delivery by El Futuro (EF), a community-based organization in Durham, North Carolina. Building on a solid foundation of trust it has established in the community, EF's hybrid model of telemental health services combines methods of telehealth and in-person treatment with an array of service components, including psychotherapy, psychiatric services, and case management for a range of VOCs. As part of this work, we completed an evaluability assessment, defined an initial logic model, and began to capture important components needed to be able to evaluate this type of programming for VOCs. Results showed that TeleFuturo could be evaluated with people who had experienced different types of crimes and sought mental health services because of negative sequelae. In addition, important components of many evidence-based approaches were possible using technology-based platforms like Zoom. Finally, it was feasible to monitor client outcomes using brief scales like the Depression, Anxiety

and Stress Scales. These initial findings of feasibility and acceptability were the foundation for a rigorous Phase 2 Process Evaluation (Saavedra et al., 2022a).

1.2 Background Literature

Staggering rates of victimization continue to be a major problem in the United States. From 2020 to 2021, violent victimization rates increased from 19.0 to 24.5 victimizations per 1,000 persons in urban areas and were still considered problematic in rural areas (Thompson & Tapp, 2023). A considerable number of individuals who experienced violent victimizations reported needing mental health services (Fortuna et al., 2020; Freeman et al., 2020). For many areas, access to mental health treatment services continues to be challenging, particularly in rural areas (Bellanti et al., 2022; deRoos-Cassini et al., 2019; Myers, 2019). Telehealth services can increase reach by mitigating barriers such as lack of transportation, inflexible work schedules, and lack of childcare—all which impact patients at risk for health disparities. Throughout the COVID-19 public health emergency (which was characterized early on by lengthy stay-at-home orders), the use of telehealth modalities to deliver care has increased rapidly. Video-teleconferencing has shown some promise for mental health and substance use problems but still may not reach the most under-resourced individuals. Often, availability of appropriate mental health and substance use services is limited, particularly in rural settings. A recent review found that older or minoritized persons, men, those with lower incomes or educational attainment, and persons living in rural settings or for whom English was not their first language were less likely to engage in remote outpatient consults. Research also shows when offering individuals a choice, older and non-White persons prefer telephone over video consultation (Jones et al., 2022).

1.2.1 Unique Mental Health Service Needs of Rural Victims of Crime

Mental health provision for rural VOCs requires unique considerations relative to their urban and suburban counterparts. These considerations include the potential for limited availability of and access to services, lack of transportation, heightened stigma and privacy concerns, unique cultural considerations, and heightened provisions to ensure safety. Common malleable barriers include the following:

- Limited access to services
- Heightened stigma
- Privacy concerns
- Cultural considerations
- Provisions to ensure safety
- Lack of transportation
- Limited resources and prevalent economic disparities

Rural areas often have limited mental health resources, including a scarcity of mental health professionals, specialized trauma services, or support groups. Accessibility and availability of services are a significant challenge for rural victims, requiring creative solutions even when providing telehealth or mobile services. In addition, there may be a higher level of stigma

attached to seeking help for mental health issues in rural communities because of close-knit communities and concerns about confidentiality. Victims may fear being judged or ostracized by their community, making it essential for mental health professionals to create a safe and confidential environment. Finally, many rural communities face economic challenges, including higher rates of poverty and limited access to resources. These factors should be considered carefully because they influence the quality of mental health services and the overall well-being of victims. Mental health professionals and advocates can help increase the quality of services when there is awareness of these economic disparities and work toward providing accessible and affordable services. When developing mental health service programming for rural VOCs, putting these unique albeit ubiquitous challenges are critical for the implementation and recovery supports needed for rural victims to promote their overall well-being and safety.

1.2.2 Role of the COVID-19 Pandemic for Telemental Health Uptake

Nationwide, the COVID-19 pandemic accelerated the adoption of broad telehealth service implementation. This rapid scaleup provides specific benefits for specialized services for VOCs in rural settings (Nagata, 2020). One positive aspect is that more clinicians/providers can use telehealth modalities than before the pandemic. The same is true for individuals receiving mental health services. This is important, because pre-pandemic, clinician capacity and access to reliable technology for quality sessions was one of the biggest barriers (Benavides-Vaellos et al., 2013; Hilty et al., 2008). Another important barrier lifted is reimbursement for services (Mishkind et al., 2021; Sklar et al., 2021).

Pre-Pandemic Reimbursement Barriers. Before the COVID-19 Emergency Reimbursement flexibilities were in place, one major barrier that dissuaded many providers from engaging in telehealth was related to low reimbursement rates. Many mental health services were often reimbursed at lower rates than other medical treatments. This disparity in reimbursement created a disparity in quality evidence-based approaches via telehealth for mental health providers, making it challenging for them to sustain their practices and provide quality care. In addition, pre-pandemic reimbursement for telehealth meant complex billing and documentation requirements. Providers in Phase 1 reported mental health services often involved intricate billing and documentation processes (Saavedra et al., 2023a). Providers reported having to navigate various telehealth-specific codes, modifiers, and regulations, which could be time-consuming and lead to administrative burdens. Relatedly, insurance companies sometimes had inconsistent or ambiguous coverage policies for mental health services. Providers also had to spend additional time and effort navigating these policies to ensure their services were eligible for reimbursement, leading to potential delays or denials. In relation to working with VOCs, another barrier is limited coverage for certain therapies or treatments. Some insurance plans had restrictions on coverage for certain types of therapies or treatments, such as couples therapy, family therapy, or alternative treatments like art therapy or yoga therapy. This limited the options available to providers and their ability to offer comprehensive care. Mental health providers often experienced delays in receiving reimbursement for their services, which can impact their ability to sustain their practices or invest in additional capacity, especially smaller practices.

Notably, the COVID-19 pandemic brought about changes in reimbursement policies and expanded access to telehealth services, which have ameliorated many of these challenges for mental health providers. Despite this uptake, barriers remain for telehealth mental health service provisions for VOCs, particularly rural areas. Below, we describe continued challenges in service provision (heterogeneity of VOCs, need for transdiagnostic options and other more general telehealth service challenges like technology) to introduce our focus in the process evaluation.

1.2.3 Heterogeneity of Needs and Experiences of VOCs

People who have experienced traumatic crimes are heterogeneous and their individual post-crime experiences are different. As such, reactions and mental health needs are also different. Unfortunately, the research literature is limited in how these important considerations and implementation factors influence treatment outcomes for VOCs presenting with a range of mental health problems.

Current literature shows several types of interventions with a technology/telehealth focus are available for VOCs in general. However, there is a limited focus on the broader range of mental health problems experienced by multiple types of victims. Most research either focuses on certain victim types (e.g., individuals who experience interpersonal violence) or outcome studies of specific treatment interventions.

There is a need for transdiagnostic options for individuals who have experienced a range of specific crimes.

As stated by Barth et al., “One of the greatest challenges... is being competent to work effectively with myriad of problems and issues faced by clients.” (Barth et al., 2012, p. 115). The Common Elements and Common Factors approach from the field of social work is based on the framework that there are certain critical elements that contribute to effective outcomes across various therapeutic interventions. These common elements are building blocks for successful mental health service delivery when working with a range of clients/patients. Key non-specific therapeutic ingredients include therapeutic alliance; client empowerment; cultural sensitivity; evidence-informed, goal-oriented focus; and flexibility and adaptability. Therapeutic alliance, which is focused on the quality of the relationship between the provider and the client, is essential. A strong therapeutic alliance based on trust, empathy, and collaboration creates a safe space for the client to explore their concerns. Client empowerment is focused on promoting the client's autonomy, self-determination, and empowerment. Providers aim to enhance the client's strengths, skills, and resources, enabling them to make informed choices and take control of their situations and their lives. Cultural sensitivity and humility are centered on recognizing and valuing the diverse cultural backgrounds, beliefs, and values of clients and are crucial. Providers strive to offer culturally sensitive and responsive interventions that respect and honor individual differences. This also includes a goal-oriented focus; providers work collaboratively with clients to identify and establish clear, realistic, and achievable goals. These goals guide the intervention process and

Key non-specific therapeutic ingredients include therapeutic alliance; client empowerment; cultural sensitivity; evidence-informed, goal-oriented focus; and flexibility and adaptability.

provide a sense of direction for both the provider and the client. Incorporating research evidence and best practices into mental health interventions is also important, and so providers continuously update their knowledge and skills to ensure they are providing interventions that are evidence-based and effective. This includes flexibility and adaptability. The Common Elements and Common Factors approach acknowledges that each client is unique, and there is no “one-size-fits-all” approach. Providers should be allowed to be flexible and adaptable in tailoring interventions to meet the specific needs and preferences of each client. These key drivers are critical for clinical and victim-centered competence and should be the foundation for fidelity approaches.

1.2.4 Implications for Telehealth Implementation and Capturing Fidelity

Capturing fidelity for interventions focused on services for transdiagnostic presentation and victims exposed to different types of crime requires an examination of common evidence-informed therapeutic components that can be captured across interventions and for different victims who experienced different types of crimes. Researchers have discussed the importance of flexibility within fidelity to ensure specific issues with which the person presents are prioritized (Cassiello-Robbins et al., 2021; Cassiello-Robbins et al., 2022). Similarly, it is critical to gain provider perspectives on implementing interventions using technology, relative to in-person therapy (Sklar et al., 2021). In addition, there are challenges in telehealth implementation that require further attention in Phase 2:

- Connectivity issues connecting patient and provider
- Restricted window to complete brief intervention
- Restricted window to complete patient monitoring and outcome measures
- Challenges recording sessions and sharing for review

These are several of the issues that were focused on in this **Phase 2 Process Evaluation**.

1.3 Purpose and Contributions of This Phase 2 Study

The process evaluation is focused on further assessing the implementation of the TeleFuturo for rural VOCs and addressing modifications in outcome instruments to ensure they are (1) feasibly collected in various telehealth spaces (full telehealth, hybrid) and (2) sensitive to capturing change. Based on information gleaned, refinement and revisions will inform the revised Implementation Guide and Logic Model. Moreover, goals of the process evaluation, such as cost and fidelity development, will inform the infrastructure of TeleFuturo, including EF and service provision partners to confirm readiness to capture these elements. These are all necessary steps to put us in position to execute subsequent phases of this Initiative. The process evaluation was guided by four primary goals:

1. Investigate the provider and patient experience with the implementation of the TeleFuturo guide.
2. Examine mechanisms of change and how contextual factors influence implementation.

3. Revise the Implementation Guide, creating associated fidelity measures that capture mechanisms of impact.
4. Pilot the Implementation Guide with fidelity, outcome, and cost measures.

The process evaluation used a concurrent sequential design to understand the context of successful TeleFuturo implementation before thoroughly testing the feasibility of fidelity, outcome, and cost measures for a Phase 3 randomized control trial. For these four primary goals, the following research questions were the focus.

1.3.2 Research Questions: Process Evaluation

1. What barriers to and facilitators of implementation of TeleFuturo for VOCs have been identified in communities after the COVID-19 pandemic?
2. What are key activities and resources needed for implementing and maintaining TeleFuturo programming?
3. What are TeleFuturo’s measurable outputs after implementing the program?

1.3.3 Develop TeleFuturo Fidelity, Outcome, and Cost Measures

1. What are the components of each TeleFuturo service required to align with fidelity to evidence-based practice (Adherence)? How will the skills and capacity of the provider to effectively implement TeleFuturo be measured (Competence)?
2. How do patients respond to TeleFuturo (Responsiveness)? How many sessions are patients likely to attend?
3. How will desired effectiveness outcomes including symptom improvement be measured with VOCs in TeleFuturo?
4. What TeleFuturo implementation costs and revenue sources and amounts are needed to assess model dissemination, cost-effectiveness, and sustainability (including economic viability)?

1.3.4 Pilot of Fidelity, Outcome, and Cost Measures and Implementation Guide

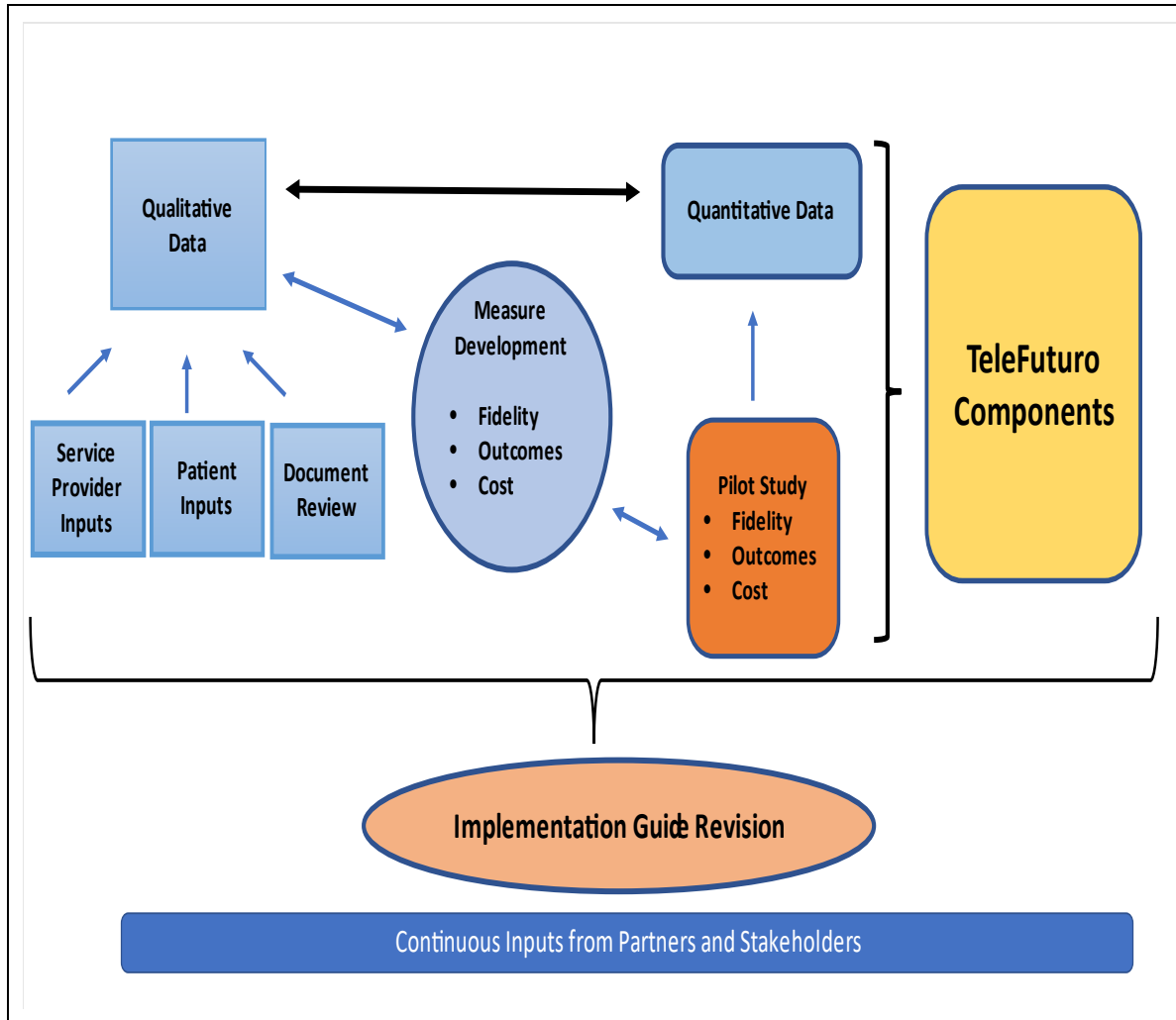
1. During implementation of each TeleFuturo component, what are the barriers to and facilitators of maintaining fidelity to the Implementation Guide?
2. Are outcome measures feasibly collected by providers from VOCs through TeleFuturo services?
3. What costs and revenues for TeleFuturo are available or able to be collected systematically?

Phase 2 Goals

- 1) Investigate the provider and patient experience with the implementation of the TeleFuturo guide.
- 2) Examine mechanisms of change and how contextual factors influence implementation.

For the process evaluation, we pivoted to a concurrent mixed-methods design. This was mainly because the pandemic was still in place at the start of the project, and understanding the changing landscape of telehealth would be better suited by asking quantitative and qualitative questions concurrently. As shown in Exhibit 1, the concurrent sequential mixed-methods research design gathers qualitative and quantitative data independently but with similar research focus. Both are later used to inform TeleFuturo Components. In the next chapter, we describe the methodology employed.

Exhibit 1. Convergent Mixed-Methods Design



Chapter 2

Methodology



2. Methodology

In this section, we describe the methodology used to capture information for the first two Phase 2 goals, which informed subsequent project activities. For this evaluation, we included inputs from providers and clients. First, we describe initial intake procedures and the data collected for each VOC client at baseline. This is followed by goal-specific data collection and analysis.

The VOC client sample consisted of individuals who presented to EF, a community-based mental health treatment center in North Carolina that provides bilingual and culturally informed behavioral health treatment for underserved Spanish-speaking individuals and families. This organization serves over 1,700 patients per year, the majority of whom are first- and second-generation immigrants, many living in rural settings. Consistently more than 95% of patients fall below 200% of the federal poverty level, and 60% self-identify as VOCs. EF partners with the partner sites at the North Carolina Farmworker Health Program and the Office of Rural Health.

The sample also included provider, leadership, and key staff perspectives. These are all described below.

2.1 Traumatic Crime Exposure

Many patients present with multiple, profound, or chronic traumatic events—or some combination of these—related to poverty and migration, most often including depressive and anxiety disorders. Patients are asked at intake about their preferred language (Spanish or English) and can complete assessment and treatment in their preferred language. All assessors and providers are fully bilingual in Spanish and English, and all instruments are available in both languages. Because our study is focused on VOCs, we included individuals who reported experiencing exposure to a crime that was considered traumatic. Trauma was identified using a trauma assessment dataset. These items were collected as part of initial intake interview. We identified a patient as having trauma if they had eligible trauma record(s) in the dataset. For the Phase 2 report, relevant types of traumas were categorized within thematically similar groups, which were verified from clinical perspectives as well. Once each type of violence was categorized within one of the six categories, counts of trauma types were calculated. Counting the number of different types of traumas reported within each category for each client allowed for a better understanding of the complexity of their cases. Traumas that were considered within the physical abuse/assault category included assault, physical abuse, intimate partner, domestic violence, teen dating victimization, and elder abuse/neglect. Sexual traumas included sexual abuse, sexual assault, and child sexual assault materials. Emotional trauma included stalking/harassment, bullying (verbal and cyber), neglect, emotional abuse. Refugee trauma and mass violence included human trafficking, mass violence/violence in home country, and terrorism. Community trauma included arson, burglary, hate crime, robbery, survivor of homicide, kidnapping, and identity theft. Last, medical trauma and accidental trauma included DUI/DWI crash survivor and vehicular victimization. Additionally, traumas within each of the categories were identified as either interpersonal or non-interpersonal, and two variables were created to count the total number of traumas clients experienced that were interpersonal and

non-interpersonal. Interpersonal traumas included physical abuse/assault, sexual abuse/assault, and emotional abuse. Non-interpersonal traumas included refugee trauma and mass violence, community violence, and medical or accidental trauma.

2.2 Goal 1. Conduct a Rigorous Process Evaluation of TeleFuturo

2.2.1 Process Evaluation Participants

Process evaluation data capture about TeleFuturo intervention delivery and components from two main sources: Telemental health service providers and patient representatives.

EF Telemental Health Service Providers. We selected providers from EF who primarily work with VOCs providing a range of mental health and related services. These include psychologists, psychiatrists, clinical social workers, and counselors all trained in TeleFuturo delivery. All providers had at least 6 months of experience working in a telehealth setting and at least 2 years of experience providing mental health services for VOCs. Moreover, all providers were fluent in both Spanish and English. We included this time frame to ensure we captured clinical and technological therapeutic components needed to provide quality services.

Patient Representatives. As part of the victim-centered approach, we made sure to systematically incorporate expertise that patients bring to this process and the value of incorporating their voice. As with our data collection for providers, we used a systematic approach to collect and incorporate patient input to better inform service delivery but also how we conceptualize outcome variables. Participants for the in-depth interviews were randomly selected and had participated in either the targeted treatment or hybrid options.

2.2.2 In-Depth Interviews: Provider and Patient/Client Perspectives

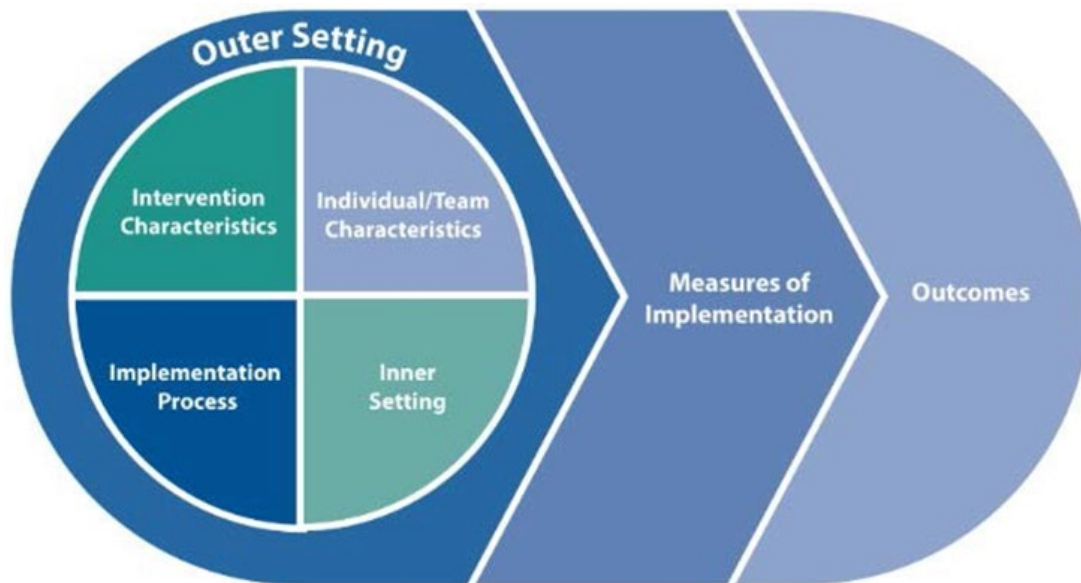
As part our community-led participatory approach, we conducted initial unstructured discussions with EF clinical leadership to review process evaluation goals and critical components to be included in the interview guides. We had initial discussions with the clinical director, supervisors, and other clinicians. We also included initial discussions with reporting and accounting staff to capture changes in billing that might have occurred between Phase 1 and 2 because of ongoing changes related to the COVID-19 pandemic to ensure the impacts on providers was captured and considered, if relevant. From this information and based on our proposed evaluation questions, we developed a semi-structured discussion guide (Appendix A) to support in-depth interviews to ensure coverage of our key evaluation questions. The guide was customized to each specific stakeholder.

We held similar discussions with clients and patient representatives in both in-depth interviews and brief surveys (Appendix B). Our focus with the client/ patient perspectives was on their experiences related to TeleFuturo programming they received and components that would improve their experience or the experiences of individuals in a similar situation or with similar experiences. We also included questions related to fidelity.

Additional Interview Content: As part of these key informant interviews, it was important to capture information from providers and patient representatives about aspects related to

implementation that have to do with Intervention and Implementation Characteristics and other internal EF processes. We used the adapted Consolidated Framework (Exhibit 2) to help us consider important constructs and processes to discuss in the interviews and observe these constructs as part of implementation to ensure they are included in measures of fidelity, outcome, and cost. We used this framework to also inform our co-construction of the TeleFuturo Conceptual Model.

Exhibit 2. Adapted Consolidated Framework for Implementing EF's TeleFuturo Program



We conducted nine provider and staff key informant interviews. Each was conducted via Zoom. Each interview included a lead facilitator and a note-taker as well as the provider key informant. Interviews lasted about 1 hour. All providers were given the questions ahead of time. To ensure the accuracy of our notes, we requested permission from provider participants to record the Zoom call. We took a similar approach for the patient representative key informant interviews. We conducted 15 patient/client (i.e., “client”) interviews. Content for client interviews was focused on the quality of the therapy using technology, understanding individual barriers for getting to and staying in therapy, components that were critical for success in therapy and overall satisfaction. As part of the interviews, we also gathered data via documents review about important components related to provider/client alliance and fidelity options for client information. We conducted an additional 85 brief interviews with this information (Appendix B and C).

2.2.3 Community-Based Participatory Approach Used for Process Evaluation

We used a community-based participatory approach throughout our data capture process to gain iterative *bidirectional feedback* from providers and patients to researchers about important components for teletherapy, including barriers and desired outcomes; this involves actively

involving all stakeholders in the process (Knightbridge et al., 2006; van der Velde et al., 2009). We had monthly meetings with our partners at EF, which included key stakeholders. The EF team met regularly with additional staff not at our meetings to share information provided by key stakeholders involved in teletherapy, which included other providers but also ancillary staff and quarterly, board members, and other community representatives.

As part of this approach, our goal was to gain information for the process evaluation but also to continue to build stronger collaborative partnerships to ensure that all voices are heard and valued throughout the process. This is critical to understanding provider and patient needs for optimal therapy process. As part of our design, we incorporated data captured from providers and patients to collectively analyze the data gathered from focus groups or interviews. This allows for a shared understanding of the findings and encourages diverse perspectives to shape the analysis. We also used the feedback received from providers and patients to refine teletherapy programs, policies, and interventions. We continuously sought input from stakeholders at different stages of the process to ensure that their perspectives were incorporated into the development and improvement of TeleFuturo programming, the logic model, and Implementation Guide.

We cannot overstate the importance of continuous engagement. This involved maintaining ongoing communication and engagement with providers, patients, and community representatives. This can be achieved through regular meetings, forums, or virtual platforms where stakeholders can share updates, provide feedback, and contribute to the evolution of teletherapy. By following this community-based participatory approach, our process evaluation ensured the voices and valuable insights from providers and patients were continuously woven into each of the goals, ensuring that teletherapy programs are responsive to their needs, address barriers, and align with desired outcomes.

2.3 Goal 2. Development of Fidelity, Outcome, and Cost Measures

The study's second goal was to establish an analytic approach (design, data, measures, methods) for model/clinical fidelity, patient outcomes and costs.

2.3.1 Fidelity Considerations for Monitoring in Technology Spaces

Based on our in-depth interviews and review of the literature, we considered feasible options to adequately capture fidelity. Exhibit 3 was adapted from the National Institutes of Health Behavior Change Consortium recommendations and guidance for rigorous evaluation of fidelity (e.g., Borelli, 2011). With our EF partners, we considered the feasibility and utility of each of these options for fidelity monitoring. As part of process evaluation, we also asked questions about fidelity and fidelity monitoring. When providers were asked about maintaining fidelity to manuals and guides, nearly all participants emphasized that fidelity must be paired with flexibility to accommodate patients' needs, challenges of virtual appointments, and to incorporate the provider's own experience. One participant noted that achieving full fidelity to any guide is not feasible when working with patients or clients with complex histories who might still be in precarious situations (e.g., domestic violence, labor trafficking). They noted, "*if we*

need to be a hundred percent of fidelity, I don't see myself following that, I honestly don't." Provider participants named challenges to maintaining fidelity that are unique to the telehealth environment and being responsive to VOCs who might still be in active danger. Other challenges included difficulties sharing required documents with patients electronically. There are also more interruptions and distractions with which to contend, which makes it harder to adhere to a manual/guide closely. One participant said, *"Some of the challenges I have noticed when implementing treatment—treatment modalities that are manualized, such as Seeking Safety and [Dialectical Behavior Therapy], et cetera—are that telehealth sessions can be easily interrupted by a phone call... or someone walking into the room."*

Exhibit 3. Considerations for Fidelity Monitoring

Goal	Approach	Strategies	Fidelity Monitoring
Ensure TeleFuturo sessions are congruent with relevant theory and practice	Operationalize treatment to optimally reflect theoretical basis; define variables most relevant to active ingredients of intervention	Hybrid. Use evidence-based behavior change strategies during calls/session	Monthly review of all patient sessions in supervision meetings; Random 50% sessions (~n = 50) complete fidelity checklist from recorded sessions.
		Targeted FACT. Use session-specific content	Both Hybrid and Targeted FACT
Evaluate treatment dose within and across conditions	Evaluate number, frequency, and length of contact, engagement, and treatment strategies	Document and electronic health record (EHR) review	Monthly supervision; Document and EHR review
Plan for implementation setbacks	Address possible setbacks in implementation (treatment provider turnover/dropout)	Train multiple providers to ensure backup in the event of provider unavailability, illness, or turnover	N/A

Note. Adapted from Borelli (2011).

In telehealth mental health settings, capturing fidelity to a program has challenges. Defining fidelity components that are closely tied to the EF Logic Model and the Conceptual Model is challenging for such a heterogeneous group of VOCs. Ensuring services provided are implemented as intended and ensuring clients receive intended benefits while remaining safe and with their privacy ensured is challenging. Below are some challenges and limitations highlighted in the Process Evaluation that were carefully considered when constructing the TeleFuturo Fidelity Instrument. These challenges can vary depending on the specific context and individuals involved. Open communication, flexibility, and a collaborative approach between

the therapist and client can greatly contribute to maintaining fidelity to a program in telehealth mental health settings.

- **Capturing non-verbal cues:** In telehealth, it can be challenging to accurately assess a client's non-verbal cues, such as facial expressions or body language. This can impact the therapist's understanding and interpretation of the client's emotional state. To address this, providers can encourage clients to express themselves verbally and ask clarifying questions when necessary.
- **Technological barriers:** Technical issues, such as low bandwidth and poor internet connection or audio/video quality, may disrupt the therapeutic process and hinder fidelity to a program. It is important for both providers and clients to have access to reliable technology and a stable internet connection, but this is not always possible. Regularly testing equipment and troubleshooting technical issues beforehand can help minimize disruptions. Flexibility is needed in these circumstances for capturing fidelity.
- **Limited environmental control:** In telehealth, providers have limited control over the client's environment. Distractions or interruptions from the client's surroundings can impact the effectiveness of the program. Providers can suggest finding a quiet and private space for the sessions, where clients can feel comfortable and minimize potential interruptions.
- **The need to adapt interventions to keep clients safe:** Some therapeutic interventions may need to be modified or adapted for telehealth delivery. Certain hands-on techniques or activities that are typically used during in-person sessions might not be feasible. Providers can explore creative alternatives, such as using virtual tools, worksheets, or interactive digital platforms to engage clients and maintain fidelity to the TeleFuturo programming.

2.3.2 Outcome Measures

The outcome study relied on patient-level data from both EF's EHR and from patient-reported responses to the DASS-6, the shortened form of the Depression, Anxiety, and Stress Scale. As part of data collection, patients are also asked about satisfaction with services and overall experiences with TeleFuturo. DASS-6 and the satisfaction questionnaire are both conducted by independent EF staff to help minimize socially desirable responses about clients' experience with the therapist and benefits of the intervention. Appendix C includes a list of these instruments, including an English version of the instructions. We first describe Pilot Client characteristics and TeleFuturo services employed to contextualize outcome measures.

Client Characteristics and Services Outcomes

Because Phase 2 is not an experimental trial, a first step in achieving our goals was to define our client population in terms of their background characteristics and the services they received during the Phase 2 period. The goal was to establish an analytic sample that met key study inclusion criteria, was large enough to be representative of the EF's typical patient population who met these criteria, and for whom sufficient data were available for a robust analysis. Data

constraints were both practical (e.g., missing demographic fields in a patient’s EHR) and substantive (e.g., patients who received only one service from EF during our study period).

Pilot Inclusionary Criteria

- Exposure to traumatic event as a VOC
- 18 or older
- Considered a new client during the study period
- Having at least one service encounter after intake with a valid procedure¹

Instrument/Data Source and Measures

EF’s EHRs contained patient characteristics, including demographics and trauma experiences. The files also contained services records for each patient that specified the type of service (or procedure), the date of the encounter, whether it was delivered by telehealth or in person, the length of the service, Current Procedural Terminology (CPT) codes and billing amount when relevant, procedure description and information denoting some provider types and provider location (even if telehealth was the modality).

Service records contained the following patient encounters: counseling, mental health/psych intake-new patient intake, medical intake, EM/CM-new patient, EM/CM-established patient, and various codes for encounters related to specific programs independent of the mainstream treatment services (e.g., a North Carolina–funded Driving Under the Influence/Driving While Impaired program). Service records also contained procedures or activities without the patient present that were not encounters or billable services, e.g., entering case notes on a patient into the EHR or initiating a referral process on behalf of the patient. Services were combined within a patient to produce the primary study measures. These were counts of comparable types of services received (e.g., individual therapy) by a patient during the study period. We calculated overall service counts and counts by modality (i.e., # Counseling Services = # In-person Counseling Services + # Telehealth Counseling Services). See Appendix D for a description of the services and procedures and what encounter group they were assigned to (counseling, mental health/psych intake-new patient intake, medical intake, EM/CM-new patient, EM/CM-established patient).

Study Design–Related Variables

Services records were also used to define several study design–related variables. First, we categorized patients into three services modality groups: those who received *all* services following intake via telehealth (“**telehealth-only**”), *all* in person (“**in person**”), or those with a mix of telehealth and in person (“**hybrid**”).

¹ Not all the procedures a patient had during study period are considered valid, such as being case note (a full list of valid procedures and respective Current Procedural Terminology (CPT) codes, categorization and associated prices can be found in Appendix D).

Second, we used the services data to identify new patients during the data window separately from established patients. Patients were first flagged as “new” if their first encounter in the data window had one of the following CPT codes:

- 90791: Psychiatric Diagnostic Evaluation
- 99201: Office or Other Outpatient Visit, New Patient, 10 minutes
- 99202: Office or Other Outpatient Visit, New Patient, 20 minutes
- 99203: Office or Other Outpatient Visit, New Patient, 30 minutes
- 99204: Office or Other Outpatient Visit, New Patient, 45 minutes
- 99205: Office or Other Outpatient Visit, New Patient, 60 minutes

Second, if the procedure name or description characterized the encounter as “yearly” and this encounter happened in the first month of the data window, then the new patient flag was removed.

Third, patients were excluded if they did not have at least one encounter after their intake visit.

Finally, services records were used to define the amount of time a patient was in treatment during the study period. Patients have varied lengths of treatment duration because of several factors: the timing of their first service in the data window, discharge, attrition, and timing of a last service within the data window. For analyses of counts and similar measures, it is necessary to scale measures using an appropriate exposure or offset variable so that outcomes are comparable across observations. As described below, the duration in treatment variable is used as an offset variable in statistical models of service counts per month. Treatment duration is constructed as the number of days between the last valid service procedure and the first valid service procedure plus 1 day.

Data Collection

EF EHRs were extracted by a data manager at EF producing multiple data files that were linkable via patient identifiers. These were transmitted to RTI by secure FTP. The data system used by EF is Meditab’s Intelligent Medical Software. For the purposes of this report, we focused on clients/patients and their services between July 2021 and November 2022.

DASS-6 for Telehealth

- Shortened form of DASS-21 in both English and Spanish for screening.
- Useful for discriminating between primary anxiety and affective disorders.

- This study is an important step in the validation of a screening tool that could be an efficient way to identify individuals' affective disorders when time restrictions are present.

Statistical Methods

We describe patients and their services outcomes using tabular frequencies (counts), means and percentages overall and stratified by service modality group. We also provide figures showing patterns of service modality utilization over time. We also summarize the pattern by calculating a transition probability matrix. The transition probability matrix displays the likelihood of a

patient to use a telehealth modality for their next encounter depending on whether, their current encounter was via telehealth or in person. No statistical hypothesis testing was conducted.

Client Symptomology Outcomes

Similar to Phase 1, a major challenge that continues to arise is related to measuring outcomes in constrained periods and context of the telehealth modality. The development of reliable brief instruments, like the DASS-21 and DASS-6, allows providers and clients to maximize their in-session time while still capturing psychometrically sound and clinically useful information and are critical for in-person and telehealth service provision.

Outcome Instrument/Data Source and Measures

During Phase 1, using data from EF's larger client population and based upon the DASS-21 (Lovibond & Lovibond, 1995; Lovibond, 1998; Gomez, 2016), we developed the DASS-6 for Telehealth instrument using graded response item response theory. The English and Spanish versions of the DASS-21, which consists of three 7-item self-report scales (depression, anxiety, and stress), have good psychometric properties (good internal consistency, convergent, and discriminant validity) based on classical test theory methods (Bados et al., 2005; McDonald, 1999; Scholten et al., 2017). Results from the DASS-6 instrument indicated minimal loss in reliability in reducing the DASS to six items, with reliability exceeding .85 (Saavedra et al., 2022b).

DASS-6 for Telehealth Items

Anxiety

- Item 4. I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)
- Item 15. I felt I was close to panic

Stress

- Item 8. I felt that I was using a lot of nervous energy
- Item 12. I found it difficult to relax

Depression

- Item 10. I felt that I had nothing to look forward to
- Item 16. I was unable to become enthusiastic about anything

The DASS-6 was useful for distinguishing clients with single disorders (e.g., anxiety alone, depression alone) from those with comorbid disorders. Furthermore, the DASS-6 is an efficient tool for assessing depression, anxiety, and stress in both English and Spanish in telehealth settings. DASS-21 and DASS-6 were used for pilot results with the intention of using the DASS for telehealth (six-item version) in Phase 2 and beyond.

Data Collection

The DASS-6 is administered to clients by clinicians at the first follow-up visit after the intake appointment, then at the 3-month, 6-month, 1-year, and discharge visits. The rating scale is then completed by the clinicians within the Intelligent Medical Software system.

Statistical Methods

We describe change in DASS-6 assessment scores from Time 1 to Time 2 using means and percentages for assessed clients. We also use paired t-tests to determine whether the mean difference between clients' first and second assessments was statistically significant.

Client Satisfaction Outcomes

Client satisfaction with overall treatment and specific components of treatment has been an important measure in Phase 1, Phase 2, and beyond. Although the DASS-6 is useful for capturing clinical symptomology change, it is not the only informative measure of client success. Using the satisfaction survey to collect quantitative and qualitative responses from individuals who received EF services provides invaluable insight about what success means to each respective client.

Instrument/Data Source and Measures

The satisfaction survey asks all individuals who have received EF services in the past 3 months about their overall satisfaction with EF and specific satisfaction regarding cultural appropriateness, respect, and accessibility.

Data Collection

The satisfaction survey is administered to all new clients 3 months after their intake by an independent assessor (not the therapist or person who assists with intake or outcomes assessment) completed over the phone. This assessor is also blind to the treatment received and therapist who provided intervention.

Statistical Methods

We describe patients and reports of satisfaction with services using tabular frequencies (counts) and percentages. No statistical hypothesis testing was conducted.

2.3.3 Cost Measures

The services data described above are a major component of cost estimates. Other data used in the study are unit prices and activity-based costs of EF's telehealth programming (program costs).

Cost Instrument/Data Source and Measures

Unit Costs. Services cost estimation used the same data as described in the services outcomes section above. We identified a unit price (\$) for each type of service/procedure, which is used to convert service quantities into overall service costs (e.g., the cost of a specific type of group therapy). These costs were summed to create overall service costs per patient and also total service costs per patient for sub-groups of similar services (e.g., counseling services).

The economic perspective for the study is that of the provider—in this case, EF. However, the way we have constructed services costs can also support a payer perspective such as Medicaid in future analyses.

For most procedures, we harmonized the unit price by CPT code. We took the EF EHR-provided billed amount with the highest frequency (mode) within that procedure and assigned the value to all the procedures with the same CPT code. When procedures were missing a billed amount, we assigned a price published in the Centers for Medicare & Medicaid Services (CMS) fee schedule (e.g., 35.89 for procedure 90849 “group therapy mult fam grp” for the North Carolina locality, non-facility, 2023). See Appendix D for the list of final unit prices.

Program costs. We also assessed the feasibility of conducting a cost study for EF’s telehealth program. The purpose of a complete program cost study is to estimate the cost of other resources beyond the direct services (e.g., counseling) described above. These program costs represent all the activities that EF is engaged in to improve care for their current patients and for prospective patients in communities that may be underserved or face barriers to treatment. Program cost estimates can be used to inform both program improvement and sustainability (i.e., what financial resources beyond traditional service reimbursement are needed to sustain EF’s program).

The cost measures are the resources and their associated cost for all activities used in the program. Resources include the labor of staff performing the activities and non-labor resources like space, equipment, software, licenses, and other materials.

In conjunction with the process evaluation, the health economics study identified several major health economic components of the program. The first is the telehealth delivery of services itself. Fully embracing the telehealth service modality required some transition costs, but the focus of this implementation cost study is understanding the ongoing operational or sustainment costs of offering the telehealth. These cost components are the cost of specialized telehealth software/licensing, replacement costs (depreciation) of equipment to support telehealth delivery (e.g., headsets and upgraded personal computing devices), and ongoing information technology support for telehealth and its interface with EF’s EHR system and differential billing practices that may evolve over time as reimbursement policies change. The costs of these will be based on staff time spent on the activities and payment amounts recorded in invoices, contract, and other accounting documents.

The second component of EF’s TeleFuturo program is dedicated staff support for non-service delivery activities. EF employs dedicated staff for coordinating appointments and other communication with patients. Although this is related to telehealth service delivery, it is valuable

for all modalities because it improves overall efficiency and engagement with patients and reduces burden on clinical staff. EF also used dedicated staff for community engagement who work to reduce stigma associated with behavioral health problems and treatment seeking.

Data Collection

The same data collection procedures described in the services outcomes section above were used for the service cost estimates. Published unit prices for services were downloaded using CMS' database of Healthcare Common Procedure Coding System (HCPCS) codes (Centers for Medicare & Medicaid Services, 2023).

Data for the activity-based costing exercise designed to estimate EF's telehealth program costs were drawn from document review and ongoing discussions with EF staff. The process for conducting semi-structured interviews was piloted with EF key informants. Key documents and additional administrative data sources were also identified.

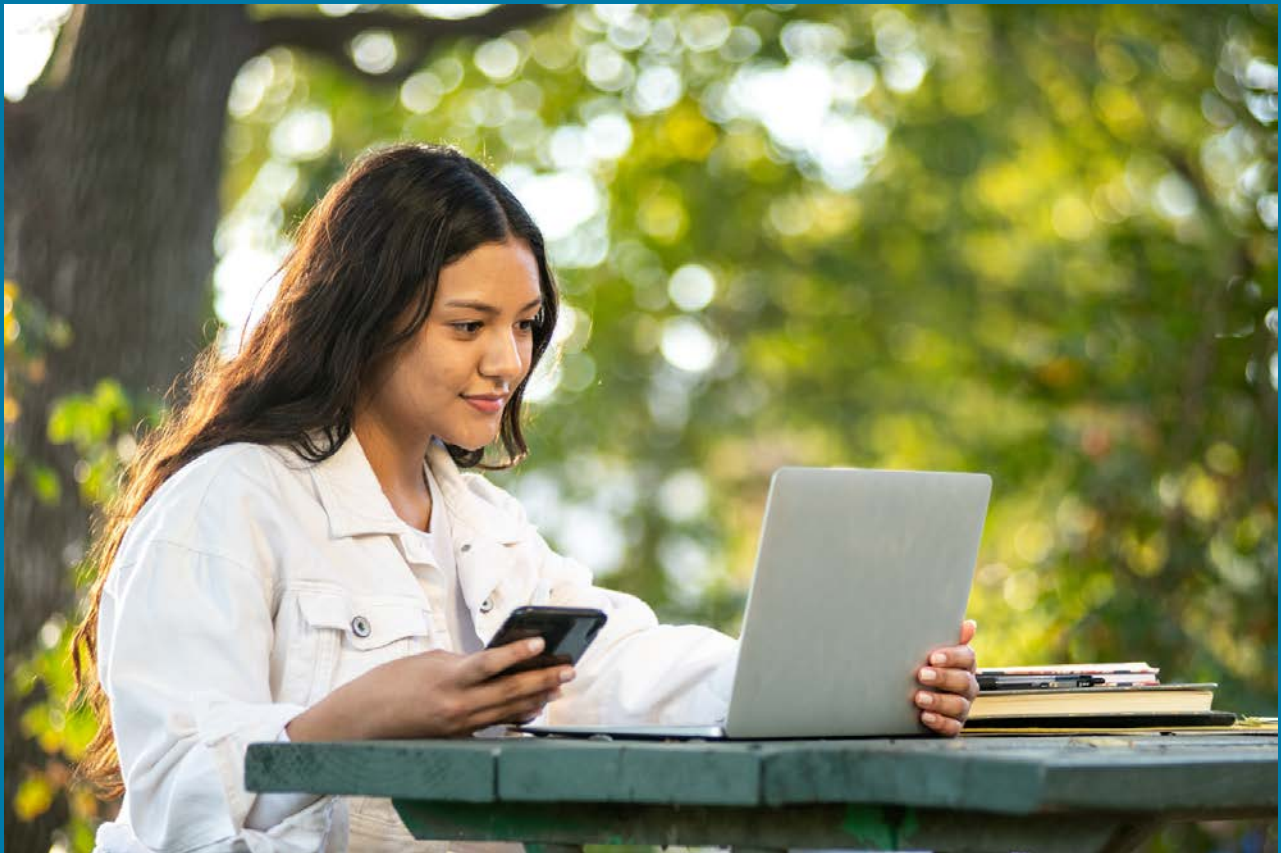
Statistical Methods

We calculate mean monthly service utilization and monthly services costs by services modality groups. These are calculated for counseling services, non-counseling services and all services. Because this is a process evaluation, no statistical hypothesis testing was conducted. Results are presented for all services and for counseling services.

One limitation is that the assignment to the three treatment service modality study groups is based in part on self-selection by the patients. On the one hand, the longer a patient stays in treatment, the more likely it is for the person to have both in-person and telehealth visits. This observation could represent the value of the option of telehealth to patients, which helps them overcome occasional barriers to in-person visits that might have led to disengagement from treatment or missed services. In contrast, there could be a reverse mechanism in which patients who would have remained in treatment longer simply have more opportunities to consume a service by either modality. A partial remedy for this is that our main analysis focuses on patients' monthly average number of services and costs calculated by dividing by their duration in treatment defined above. In addition, the study period ended November 2022, which means patients who started the program later would have shorter treatment duration, which artificially deflated their services costs. Thus, we conducted a sensitivity analysis, which only used patients whose intake visit occurred at least 3 months before the end of the study data window.

Chapter 3

Results



3. Results

3.1 Process Evaluation of TeleFuturo Programming for Rural VOCs

The provider interviews captured information and provider perspectives on facilitators and barriers of delivering telemental health services, recommendations for telemental health use, and feedback on delivering evidence-based interventions with fidelity. Importantly, participants commented on special considerations for clients living in rural areas and those who are VOCs.

3.1.1 General Reactions to Telehealth

Interviews with providers revealed that reactions to telehealth vary among both patients and providers. For some clients, telehealth has been “*a game changer*.” Early barriers once common across providers and patients have become less prominent as both parties have gained experience, familiarity, and comfort with the mode. As noted by many providers, accessibility is a fundamental advantage. Telehealth has increased convenience for patients, resulting in “*an opening of doors*” that has endeared providers once reluctant to adopt the technology. One provider remarked: “*I think the advantage of telehealth, we’re reaching out to people we never, we never have before. We’re reaching out to people who live in small counties with no resources nearby.*” For many clients, telehealth sessions are easier to schedule, and attending therapy virtually eliminates the need to drive to appointments, arrange for childcare, or take large amounts of time away from work. This flexibility has made appointments possible for more clients and at more times of the day. This benefit is particularly important for clients who live in remote areas. “*It’s really easy for them,*” one provider observed. “*They don’t need to drive, they don’t need to stop working, come to the office 1 hour, 90 minutes prior to that.*” Convenience has contributed to increased attendance at group therapy sessions, now offered online. Additionally, providers noted it may be easier to coordinate with remote family members to attend appointments.

Other features of telehealth have likely contributed to its acceptance. Some providers speculated that telehealth might feel safer, emotionally, for some clients. Unlike in-person therapy, telehealth generates a measure of distance and anonymity that a client might welcome. Among providers, telehealth was seen as “*a safe and cost-effective treatment option*” capable of producing results comparable to face-to-face therapy. In the period since the rapid shift to telehealth during the COVID-19 pandemic, providers have gained confidence in delivering therapy online, with all providers reporting feeling either “pretty confident” or “extremely confident” in their ability to deliver therapy virtually.

Despite the identified advantages and growth in the acceptance of telehealth, for some clients, virtual therapy remained less desirable or less feasible. Providers found that some clients were better served in person than with telehealth. One provider commented: “*I wish it was easy to say technology is great and teletherapy is wonderful for everyone; I just really feel like it’s super individualized.*” Contraindications for telehealth listed by providers included the client’s diagnosis, age group (i.e., children and teens), or the type of therapy needed. The ability to use certain activities and therapeutic modalities, like prolonged exposure, is limited in a telehealth

environment. These limitations may differentially affect VOCs because of their experiences of trauma. As one provider related, face-to-face therapy may be helpful for some patients with trauma, due to the dysregulation they commonly experience in response to stress: *“In the room, in the presence of someone, it’s easier to regulate all that than over video.”* One provider perceived telehealth to be an appropriate option for clients who can use the technology, can find a private space, and do not have acute safety concerns. Putting this into numbers, another provider estimated that approximately 85% of clients were able to successfully participate in telehealth, while the other 15% were better suited to in-person visits. Meanwhile, the technology that makes teletherapy convenient for many clients presented a barrier for others. Some clients did not have the technology they needed or had trouble getting comfortable with it. Other clients were wary of the medium, uncertain of the security of the online platform. Some providers presumed that telehealth might feel less warm or engaging for some clients, offering fewer opportunities to connect and build trust with the provider. One provider shared that, with some patients, *“it felt flat or it didn’t, like, the ways of engagement that I’ve utilized before in the room weren’t effective and were hard to replicate.”* They perceived that the loss of personal contact may be particularly salient when working with crime victims. *“Sometimes trauma interferes with our ability to trust, and having less barrier in between us, you know, technology-wise, you might see a turn for more in-person appointments,”* another provider observed and acknowledged *“you might see the opposite, too, you know, if their trust isn’t there and you don’t know, and [a client thinks] ‘I don’t want to put myself in risk, and it’s easier for me to control [the telehealth environment].’”*

3.1.2 Barriers to Using Telehealth

Even when teletherapy is preferred and considered appropriate, providers and clients contend with barriers. Nearly all providers expressed some frustration or concern about the loss of control over the therapeutic environment that accompanies a shift to online therapy. In a telehealth environment there are *“extra factors”* for the therapist to manage, including clients who are regularly distracted during sessions or who take appointments in spaces that are not private. As a result, some clients may be less safe, and others may be less engaged. For VOCs or those with safety concerns, this loss of control over the therapeutic space triggered heightened safety awareness among providers, and, as one provider described, *“an extra layer of making sure [the client] had privacy.”* In group settings, there may be limited ability to enforce the rules of ethical group participation, namely privacy and confidentiality. Providers also noted the potential for a therapist to miss some of the non-verbal cues on which they typically rely during face-to-face sessions. Teens were less likely to turn their cameras on, leading to additional loss of non-verbal information. Although the convenience of telehealth enabled participation in therapy for many clients, one provider noted it also seemed to increase the likelihood of clients missing or canceling appointments.

Providers observed that there are limits of telehealth technology that are both tangible and personal. A few participants described challenges with technology not working as needed, such as video feed freezing during a session. These barriers may be compounded by an inequitable distribution of resources among clients. For clients in rural areas, internet access is more likely

to be unreliable. Key resources, such as Spanish-language social services or substance use counseling, may be limited, and it can be harder for a therapist to know the local resources to which they can refer remote clients. Finding a private space for appointments is more challenging for some clients than others. As a result, some clients choose to forgo or are forced to delay treatment. Even when clients can access a private space, the dissolution of the boundary between therapy and other parts of their life that results from taking appointments at home may present challenges or discomfort. As one provider reflected, *“not everyone wants to have therapy at their house...that artificial differentiation that’s created when you go somewhere to have an appointment doesn’t exist.”*

3.1.3 Solutions to Barriers

Participants also described resources and approaches that facilitate the delivery of telehealth and address some of these challenges. One way that providers try to address barriers such as loss of control over the therapeutic environment and lack of client comfort with technology is to communicate expectations and provide guidance to clients in advance of appointments, especially around the need to have privacy and limit distractions. Providers can also be prepared for technological issues that may occur and communicate these plans, such as switching from video to phone, in advance. To address client concerns about the safety of telehealth or how to use the technology, participants suggested offering training to clients to demonstrate how to navigate the platform they use for sessions and to explain the security features in place. This type of training is currently offered to new telehealth clients by clinic administrators and was praised in interviews. Several participants considered it important to empathize with clients who were wary of telehealth for security reasons or because of uncertainty about its effectiveness. One provider observed that *“sharing my own skepticism toward telehealth and my own change, noticing that [telehealth] was helpful, was a way to kind of decrease that barrier of, like, not being really bought into the technology.”* A few participants recommended offering more flexibility in scheduling telehealth appointments, more understanding when clients have conflicts, sending multiple reminders to prevent missed appointments, and offering the option to attend appointments in person, as needed or preferred. For remote clients, providers noted the importance of having clear policies and protocols for addressing crises, in addition to resource guides specific to the communities where clients live. Telehealth requires a different level of planning, especially for crisis situations. This approach involves balancing client safety and autonomy and ensuring access to the needed resources. As one provider observed, when an in-person client experiences a crisis, *“at least you’re with them in person, you can ask them to stay longer. When they’re in crisis and over the phone they could hang up and then it’s been hard to navigate, like, respecting their choice, but who do you call? Some patients don’t have reliable phone access.”* For this reason, providers recommended collecting emergency contact information for clients with elevated safety concerns, such as VOCs. Supervisors and colleagues continued to represent important sources of support, especially when the need arose to help a remote telehealth client in crisis, in which case the clinic-based outreach workers might assist. General (non-crisis) planning for telehealth sessions can be different than planning for in-person sessions, too. One participant emphasized the

importance of having resources readily accessible during telehealth visits, as the therapist is less able to step away during appointments, and activities like sharing resources with clients are more cumbersome than simply handing over a worksheet.

3.1.4 Resources to Support Telehealth

Interviews also explored the resources needed to facilitate provider delivery of telehealth. As they transition from emergency telehealth use into regular use, participants suggested the need to establish policies and clear expectations around communication with patients, selecting telehealth versus in-person treatment for a patient, and which therapies are suitable for telehealth. One participant suggested that additional training on the online platforms would allow providers to take advantage of the full spectrum of features. Participants also discussed the use of treatment manuals or implementation guides and maintaining fidelity in the telehealth environment. Participants perceived treatment manuals or implementation guides to confer some advantages. Treatment manuals were viewed as useful “roadmaps” or planning tools that can increase the continuity of care via telehealth. Nearly all participants emphasized, however, that fidelity to manuals must be paired with flexibility to accommodate patients’ needs and the challenges of virtual appointments and to incorporate the provider’s own experience. One participant shared that the challenge of adhering strictly to a manual or guide is *“like you don't have room to be useful as a therapist because you follow the treatment manual...there's no room to...apply some personal experience that we understand is really good for this client.”* Another provider described this as a “balancing act,” noting that clinicians have a responsibility to the model they are using but also to apply their own clinical knowledge about the best practices to use in each patient encounter. Several participants suggested that a provider’s level of experience may influence their need for a guide or manual, with more experienced providers benefiting less than newer providers. Newer, less experienced providers were thought to benefit from the additional guidance of a manual while they worked to gain skills and comfort in using various treatments. More experienced providers expressed concerns that rigorous adherence to manuals may interfere with their ability to infuse their personality and clinical experience into sessions. Participants also faced unique challenges to maintaining fidelity in a telehealth environment. As noted above, it can be more difficult to share a manual’s required documents with clients electronically, and there are more interruptions and distractions with which to contend, which makes it harder to closely adhere to a manual or guide. In addition to allowing for flexibility, participants identified some keys to successful treatment manual or Implementation Guide use. These include first establishing a good rapport with a client and ensuring regular training and review of the manual.

3.1.5 Increasing Telehealth Access and Engagement

Finally, providers shared their recommendations for how to effectively engage clients in telehealth and their suggestions for how to make it more accessible for those who need it. Providers recognized the challenge of connecting with clients over video. In addition to typical approaches like commenting on what they are noticing in a client, participants recommended that providers use camera placement, eye contact, and inquiries about the client’s surroundings

to demonstrate their attunement. To prepare, providers might ask themselves, *“how do I be in this frame, you know, and how do I demonstrate my care and concern and my genuine regard for this person who is doing whatever they're doing on their end.”* Participants emphasized the importance of starting slowly, building rapport and comfort, and empathizing with the challenge of opening up on camera. Providers can also make suggestions to help the client create an environment amenable to the session (i.e., minimize disruptions). They should use flexible scheduling, as needed. During the session, providers should take steps to ensure the technology is working and the audio is clear and use fewer moments of quiet than might be employed in an in-person session. For adolescents and teens, providers can use videos, ask about what the client is doing if they appear to be multi-tasking, use interesting features of the platform, like Zoom’s Whiteboard, and encourage the client to turn on their camera, if only momentarily. As is the case with in-person therapy, it is critical to build trust and provide feedback to the client on their improvement.

To increase access to telehealth, participants frequently suggested the need for better connectivity and internet access for clients. Recommendations included establishing tele-booths or distributing Wi-Fi hotspots and offering internet as a utility for North Carolinians. Although implementing such recommendations is typically beyond the scope of individual providers or clinics, these represent areas of need to which providers can bring awareness. On a smaller scale, several participants suggested it was important to raise awareness of EF’s services and to take measures to increase the public’s comfort with telemental health. Participants noted that outreach must continue to be culturally and linguistically appropriate and geographically targeted to reach the organization’s intended audience and continue expanding to areas of greater need.

3.1.6 Patient/Client Interviews.

We interviewed 15 clients selected for participation in either the targeted or hybrid service model. Of the 15 client representatives, 8 were female and 7 male. The majority (n=14) reported being employed either in farming or the hospitality industry; 9 were receiving Tele Futuro targeted treatment, and 6 received the TeleFuturo hybrid service model. All respondents reported currently living in a rural area. Appendix B includes the full list of questions asked in the interviews. For questions regarding the quality of the technology used, most participants (over 98%) stated the quality was very good or excellent for audio, visual, and overall comfort for the sessions. In terms of satisfaction with the time it took to start the session, 53% reported it was very good while 47% rated it as excellent. The item with the most variability and most challenging for client representatives was related to technical interruptions. Some participants (26%) noted their session had so many interruptions their satisfaction was poor or not good. The rest of the client representatives rated these as either good or very good. Many cited this as a critical factor, especially in rural areas where bandwidth may be low or limited. In terms of experiences with therapists, client representatives rated and described their experiences as overwhelmingly positive. Domains of quality related to experiences with therapists included competence explaining and sharing of information in an accessible way, use of knowledge and resources to facilitate therapeutic experience, and respect for their culture and privacy. The

majority of client representatives noted providers led sessions with cultural sensitivity and fostered a powerful therapeutic alliance. Many client representatives noted that engagement was possible and quality was high if they were able to maintain a reliable connection. Preferences for hybrid were related to perceived challenges in bandwidth, and TeleFuturo hybrid models were able to account for this and other scheduling challenges that might have made therapy prohibitive. In terms of capturing meaningful change, clients stated symptom improvement was important but improvements in actual functioning had more value. Functioning around work and family or other relationship factors were consistently reported as most important. In terms of cultural sensitivity of TeleFuturo approaches, most patients noted their experience and the approaches used at EF TeleFuturo would also benefit individuals who are in similar contextual situations including work and other responsibilities. They also noted these approaches are useful to other individuals who identify as Latinx.

3.2 Revision of Implementation Guide

Results from this evaluation complement research findings that treating rural VOCs can present unique challenges because of factors such as limited access to mental health resources, lack of transportation, and cultural differences. However, there are specific strategies and considerations that can help ensure effective treatment for rural VOCs. In Appendix E, we include the updated Implementation Guide named **GUIA TeleFuturo: A Telemental Health Implementation Guide for Providing Mental Health Services to Rural Victims of Crime**. GUIA (which means guide in Spanish) is an acronym focused on Growing Unique Intentional Access to rural VOCs. This guide includes components informed from our phased studies and the literature for researchers or mental health professionals working with rural VOCs. We also included guidelines on components that are in line with the TeleFuturo model to ensure that therapeutic components are victim-centered, client-centered, technology-focused, and culturally relevant. Similarly, we incorporated results from the Process Evaluation inputs from both provider and client inputs to inform the broader TeleFuturo Conceptual Model (see Exhibit 6). Additional information about the TeleFuturo Conceptual Model described below.

3.2.1 Fidelity Approach

Based on our provider in-depth interviews and review of the literature, we considered and tested feasible options to capture fidelity adequately. Exhibit 4 includes components adapted from the National Institutes of Health Behavior Change Consortium recommendations and guidance for rigorous evaluation of fidelity (e.g., Borelli, 2011). We included the final instrument in the revised Implementations Guide (Appendix E). First, it is important to capture technological adherence and competence. This includes questions about the appropriateness of the space and efforts the provider takes to ensure technological and session privacy. Efforts to mitigate technological challenges as possible should also be considered. Second, it is also important to capture broad and flexible clinical competence. This should cover client centered, clinical and cultural competencies. Finally, although not always feasible, it is recommended to include components specific to the evidence-based approach used.

Exhibit 4. TeleFuturo Fidelity Components

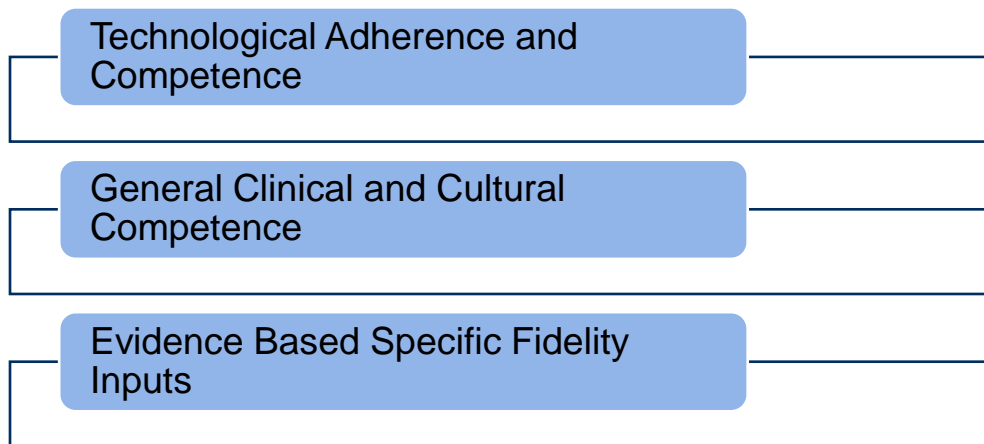
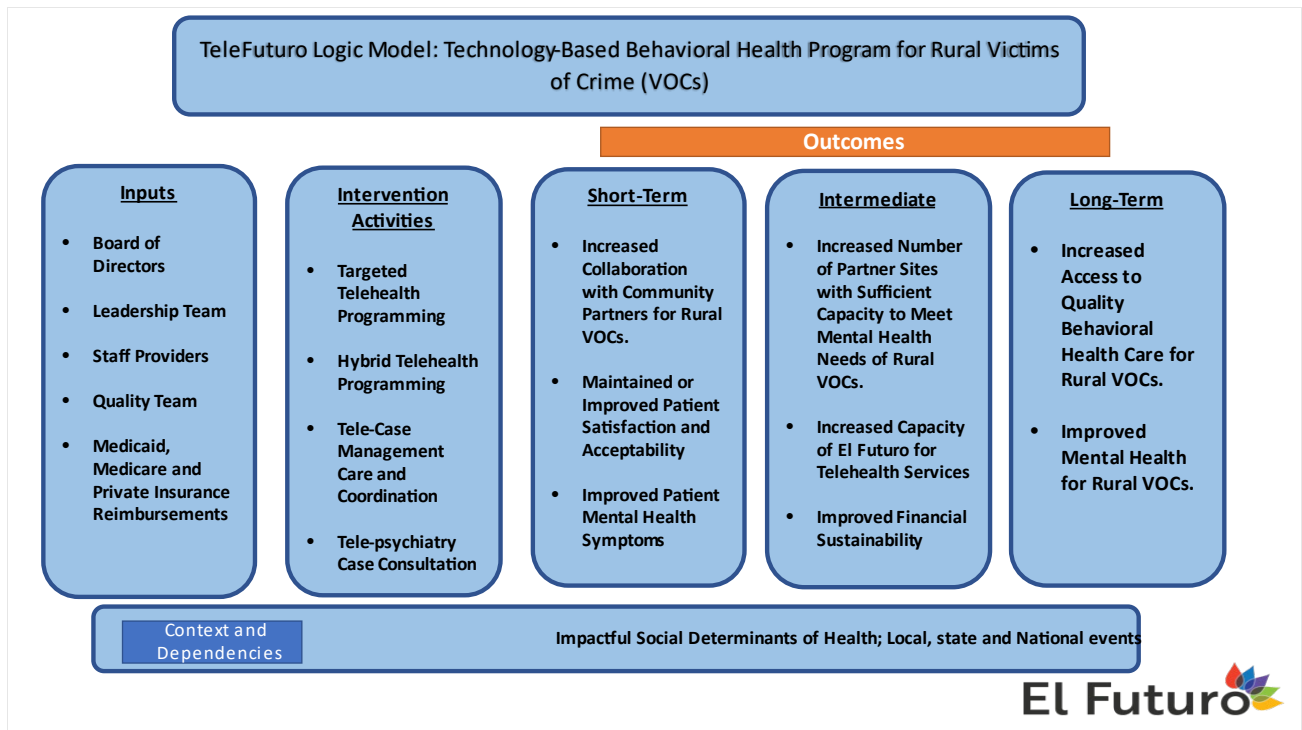


Exhibit 5. EF Telehealth Logic Model

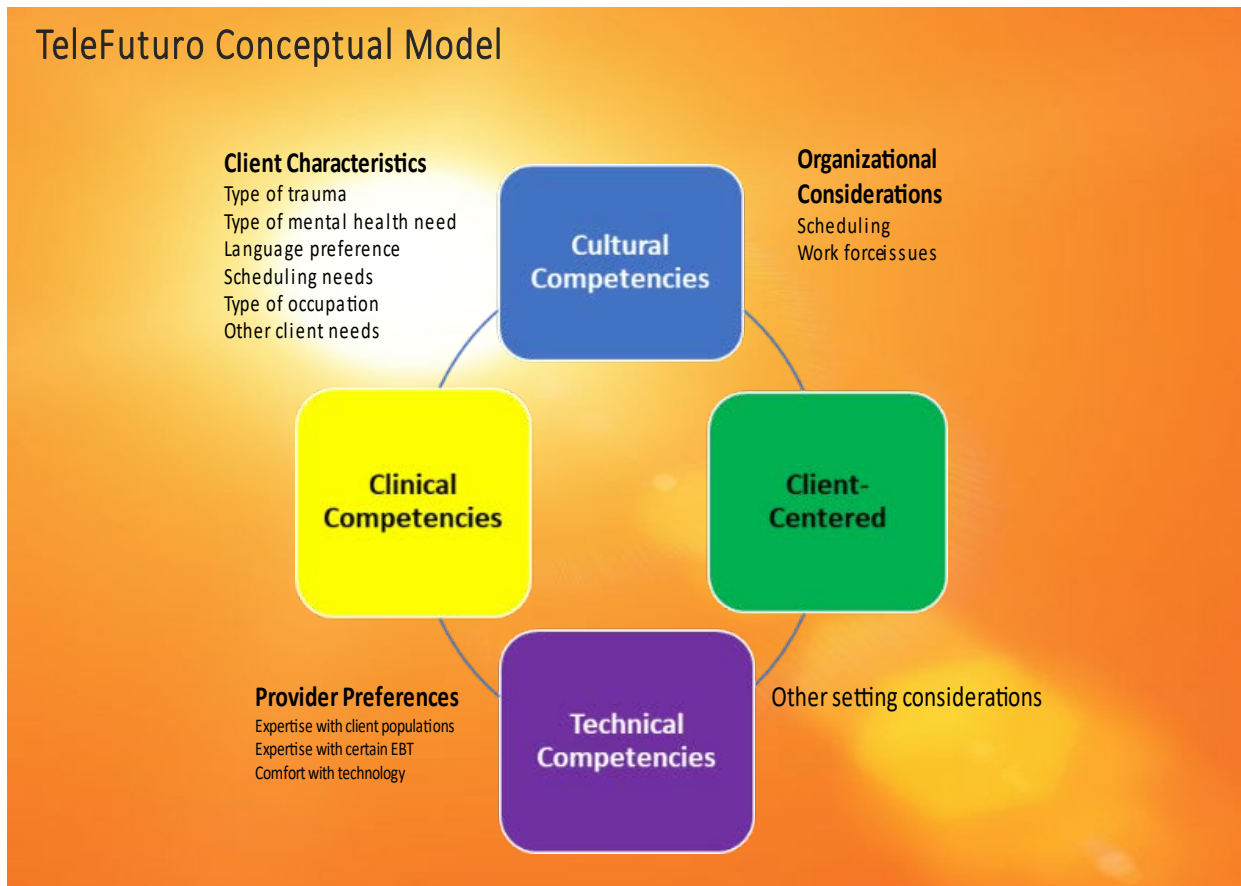


3.2.2 TeleFuturo Conceptual Model

As has been true of mental health interventions for youth and adults for anxiety, depression, and trauma, manualized intervention options have proliferated, with many clinicians in various fields (clinical psychology, social work, mental health counseling) graduating with more extensive training in evidence-informed based approaches. The utility of selecting one intervention for a set of problems has diminished over time given the challenges of selecting the best evidence-based intervention for the client in front of you. As such, researchers have argued for the need

of transdiagnostic approaches to help with guidance of the most appropriate therapeutic approach that also considered client characteristics and provider preferences (Kazdin et al., 1990). Other treatment developers have underscored the importance of bringing in the best features of the manualized evidence-informed/supported treatments into a plan (Weisz & Chorpita, 2012) to best capture the common element/factors to enhance the service provided. This is in line with our finding from our process evaluation of “what works best” with EF clients who are VOCs.

Exhibit 6. TeleFuturo Conceptual Model



3.3 Pilot Study: Fidelity, Outcomes, and Cost

3.3.1 Outcomes

Client Characteristics and Services Outcomes

Client Sample. Clients included in this analysis are adults with endorsement of at least one trauma related to crime victimization, receiving at least one service following an intake visit between July 2021 and November 2022 at EF or an EF site. Since Phase 2 grant funding, 1,098 adult clients with reported trauma who had any mental health service presented to any of the EF sites. Of these, 396 clients agreed to receive mental health services beyond the initial assessment period. This is the primary sample used for the Phase 2 pilot services outcomes and cost analyses. Client-level demographic data were available for a subset of these clients (n = 303), resulting in some missing data, depending on the specific measure. These are annotated in the tables that follow.

Project Success: In addition to results, an important achievement is the usability of EHR data and linkability to clients/patients and services.

Client Demographics. Of the 396 clients, 155 (39%) received hybrid services, 86 (22%) received in-person services, and 155 (39%) received telehealth-only services. Approximately 57% of the clients identified as female, and 19% identified as male, with 24% missing (Exhibit 7).

Exhibit 7. Number of Clients: Sex by Service Group

Sex	Hybrid Services	In-Person Services Only	Telehealth Services Only	Total
Female	81	37	109	227
Male	31	22	23	76
Total	112	59	132	303

Missing = 93

Of the 112 clients who received hybrid services, 16% identified English as their primary language while 84% identified as Spanish; only 8% and 5% identified as primary English speakers among clients within the in-person services only and telehealth-only services, respectively. Exhibit 8 presents the breakdown of primary language spoken across sex.

Exhibit 8. Sex by Primary Language Spoken, n=303

Primary Language	Sex		Total
	Female	Male	
English	25	5	30
Spanish	202	71	273
Total	227	76	303

Note. Missing = 93

Exhibit 9 describes client-reported race and ethnicity. Only 3% of the full sample (n = 303) self-identified as more than one race, with the majority identifying as Hispanic (96%), and the remaining identifying as either Black/African American (n = 1) or White (n = 2). Almost three times as many women (n = 216) as men (n = 74) identified their race as Hispanic. Of the clients self-identifying their ethnicity as Hispanic (n = 299), approximately 43% specified their ethnicities as Hispanic/Latinx, 2% specified Hispanic/Puerto Rican, 5% specified Hispanic/Mexican American, and 50% specified Hispanic, Other. Among clients identifying their race as Hispanic, 37% (n = 107) received hybrid services, while 19% (n = 56) received in-person services, and 44% (n = 127) received telehealth services only.

Exhibit 9. Client Race and Ethnicity

Race	Ethnicity						Total
	American	Hispanic, Mexican American	Hispanic, Other	Hispanic, Puerto Rican	Hispanic/Latino	Non - Hispanic/Latino	
Black/African American	1	0	0	0	0	0	1
Hispanic	0	14	148	7	121	0	290
More than one race	0	2	1	0	6	1	10
White	1	0	0	0	0	1	2
Total	2	16	149	7	127	2	303

Missing = 93

Approximately 223 clients reported their employment status, with 13 clients reporting not being employed in the past 10 years and 70 clients reporting more recent unemployment. Over 60% of the clients reported either part-time or full-time employment (Exhibit 10). Within each treatment group, approximately 62%–67% of clients were employed (Exhibit 11).

Exhibit 10. Employment Status by Sex

Employment Status	Sex		Total
	Female	Male	
Employed, Hours not Specified	1	0	1
Employed, Full-time	47	41	88
Employed, Part-time	37	10	47
Unemployed	58	12	70
Unemployed, Other	10	3	13
Unknown	2	2	4
Total	155	68	223

Missing = 173

Exhibit 11. Employment Status by Treatment Group

	Hybrid Services	In-Person Services Only	Telehealth Services Only
Employed	1	0	0
Employed, Full-time	38	28	22
Employed, Part-time	27	10	10
Unemployed	35	15	20
Unemployed, Other	4	3	6
Unknown	2	1	1
Missing	48	29	96
Total	155	86	155

Exhibit 12 illustrates the highest level of education by sex reported by clients. Of clients receiving hybrid services, 62% reported having at least a 12th-grade or higher level of education (n = 67), compared with 57% of clients receiving telehealth services only (n = 34) and 44% of clients receiving in-person services only (n = 25).

Of the 225 clients self-reporting highest level of education, approximately 195 (86.6%) self-reported Spanish as their primary language. Of all clients, 26% reported completing their GEDs or graduating from 12th grade, and an additional 24% of clients reported completing some college.

Exhibit 12. Education Attainment by Sex

Education	Sex		Total
	Female	Male	
5th Grade or Less	18	5	23
6th–8th Grade	30	11	41
High School – No Diploma	27	8	35
High School Graduate/GED	32	26	58
Some College	42	12	54
Bachelors' Degree or higher	10	4	14
Total	159	66	225

Note. Missing = 171

Client Trauma Exposures. Different types of trauma exposures were captured for clients who presented to EF for mental health services for crime victimization. Individuals were considered trauma-exposed if the specific trauma exposure was in line with the definition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., American Psychiatric Association, 2013; Pai et al., 2017). The DSM-5 definition of trauma requires “actual or threatened death, serious injury, or sexual violence” (p. 271). Stressful events not involving an immediate threat to life or physical injury such as psychosocial stressors (e.g., divorce or job loss) are not considered trauma in this definition (American Psychiatric Association, 2013; Pai et al., 2017). Please refer to the appendices for more detailed tables for each trauma type. As described within the Methodology section, traumas were categorized within thematically similar groups, as well as either interpersonal or non-interpersonal, and these results are described in the following sections. Exhibit 13 shows that across the three treatment groups, physical trauma (65%) and sexual trauma (33%) were the most frequently reported traumatic events. Among the three treatment groups, the hybrid treatment group clients reporting at least one or more of these traumas had the lowest frequencies for both sexual trauma (31%) and physical trauma (61%) compared with clients receiving only in-person services or only telehealth services. The most variance among treatment group endorsements were found for refugee and mass violence, community violence, and medical or accidental trauma. Clients within the in-person treatment group rates reported two to three times higher rates for refugee and mass violence and community violence, whereas they reported four to five times lower rates for medical or accidental trauma compared with the hybrid and telehealth services treatment groups.

Exhibit 13. Crime Trauma Exposure Categories, Counts of Traumas, by Treatment Group

Trauma Type	Counts of Each Type of Trauma	Hybrid Services	In-Person Services Only	Telehealth Services Only	Totals/Percent Across all Treatment Groups by Client
Sexual Trauma	0	107	58	99	264
	1	48	28	56	132
Total Within Group		155	86	155	396
% 1+ Trauma Within Group		31%	33%	36%	33%
Physical Trauma	0	61	27	50	138
	1	80	51	85	216
	2	14	8	19	41
	3	0	0	1	1
Total Within Group		155	86	155	396
% 1+ Trauma Within Group		61%	69%	68%	65%
Emotional Trauma	0	127	76	137	340
	1	26	10	17	53
	2	2	0	1	3
Total Within Group		155	86	155	396
% 1+ Trauma Within Group		18%	12%	12%	14%
Refugee/ Mass Violence Trauma	0	144	67	135	346
	1	11	18	17	46
	2	0	1	3	4
Total Within Group		155	86	155	396
% 1+ Trauma Within Group		7%	22%	13%	13%
Community Violence Trauma	0	138	66	127	331
	1	14	18	24	56
	2	3	2	2	7
	3	0	0	2	2
Total Within Group		155	86	155	396
% 1+ Trauma Within Group		11%	23%	18%	16%
Medical and Accidental Trauma	0	149	85	148	382
	1	6	1	6	13
	2	0	0	1	1
Total Within Group		155	86	155	396
% 1+ Trauma Within Group		4%	1%	5%	4%

In Exhibit 14, we see that differences between treatment groups were minimal for rates of interpersonal trauma; however, among the treatment groups, larger variance was found for

endorsement of non-interpersonal trauma. Across the treatment groups, interpersonal trauma was far more common than non-interpersonal trauma.

Client Service Engagement. Across the treatment groups, clients attended 2–37 service visits (Exhibit 15). A majority of clients, however, attended 2–5 service visits (49%), and 29% attended 6–10 visits. Pertaining to the purpose of client visits, most of the clients (n=353) attended one assessment intake appointment, while the remaining 43 clients had two or three assessment intake visits. In these instances, data suggest clients started treatment, disengaged, and re-engaged in services, necessitating the completion of new assessment intakes. Subsequent to the assessment intake visit, clients attended an average of 5.7 counseling visits. These are important considerations as telehealth intakes can be challenging.

Within treatment groups, hybrid clients, on average, had more visits ($M = 11$) than in-person clients ($M = 6$) and telehealth-only clients ($M = 6$). Twenty-five provider IDs were identified as having served these clients, with the majority ($n = 20$) providing services to clients within all three treatment modality groups.

Exhibit 14. Interpersonal Trauma and Non-Interpersonal Trauma Categories, Counts of Traumas, by Treatment Group

	Count of Each Type of Trauma	Hybrid Services	In-Person Services Only	Telehealth Services Only	Totals/Percent Across all Treatment Groups
Interpersonal Trauma	0	18	15	18	51
	1	93	44	101	238
	2	29	22	27	78
	3	10	3	6	19
	4	5	2	2	9
	5	0	0	1	1
Total Within Group		155	86	155	396
% 1+ Trauma Within Group		88%	83%	88%	87%
Non-Interpersonal Trauma	0	111	50	123	284
	1	32	30	28	90
	2	7	5	3	15
	3	2	1	1	4
	4	2	0	0	2
	5	1	0	0	1
Total Within Group		155	86	155	396
% 1+ Trauma Within Group		28%	42%	21%	28%

Exhibit 15. Service Visits by Treatment Group

Number of Service Visits	Hybrid Services	In-Person Services Only	Telehealth Services Only	Total	Percent
2-5 Visits	40	50	105	195	49%
6-10 Visits	52	28	32	112	28%
11-16 Visits	35	6	9	50	13%
17-25 Visits	17	2	7	26	7%
26+ Visits	11	0	2	13	3%
Total	155	86	155	396	100%

On average, clients engaged in services for 136 days, with some differences found by treatment modality group. On average, clients within the in-person group engaged for fewer days (M days = 95) than clients within the telehealth-only group (M days = 105) and hybrid services group (M days = 190). Differences in length of engagement across treatment modality groups were also found by demographics, with female clients engaging in services an additional 20 days longer than male clients and English primary-speakers engaging in services an additional 77 days compared with their Spanish-speaking counterparts. When examined between treatment modality groups, length of engagement among female and male clients was more similar within the in-person group, with female clients engaging in only an average of 2 more days than male clients. Within the telehealth-only group and the hybrid services group, female clients engaged in services approximately 25 and 41 days, respectively, longer than males.

Except for community violence exposure, clients with more violence exposures did not, on average, have more visits (Exhibit 16). For both interpersonal and non-interpersonal traumas, client visits increased at the second or third count of exposures before decreasing at the highest rate of exposure. For two of the trauma types, we see that as trauma type counts increase, the average amount of time between visits initially decreases, increases, and decreases again.

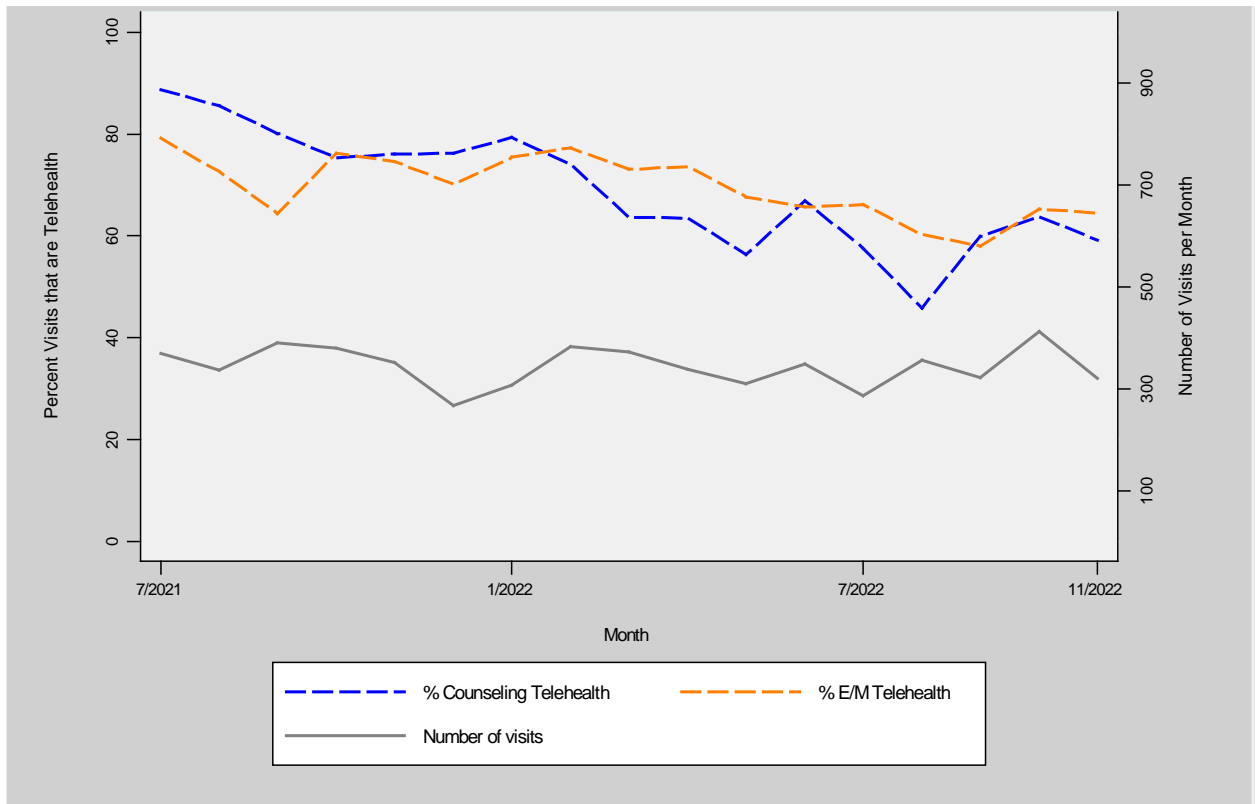
It is possible that clients who have much higher rates of exposure are unable to attend more visits because of circumstances related to their exposures, or there could be evidence of desensitization effects, though these possible explanations were not explored statistically.

Exhibit 16. Service Visits by Trauma Type

Trauma Type	Counts	Number of Visits (Mean)	Treatment Duration in Days (Mean)
Physical Abuse	0	8	137
	1	8	131
	2	9	159
	3	6	299
Sexual Abuse	0	8	127
	1	8	154
Emotional Abuse	0	8	136
	1	7	139
	2	6	69
Refugee and Mass Violence	0	8	135
	1	9	149
	2	7	93
Community Violence	0	8	137
	1	8	134
	2	8	100
	3	13	196
Accidental Trauma	0	8	135
	1	9	163
	2	5	62

Among all (including established clients, N = 486) adult clients with trauma and 2+ services, we found that most of the counseling and assessment visits were telehealth at 88.7% and 79.2%, respectively (Exhibit 17). These percentages steadily decreased over time but remain above 50% over the study period. In Exhibit 18, we present the clients' transition probabilities between the two modalities between any two encounters during the same study data window. Clients were most likely to continue with the same modality from visit to visit (83.1% continue with in-person visits; 87.2% continue with telehealth). For those who do switch modality, they are more likely to go from in person to telehealth (16.9%) than from telehealth to in person (12.8%).

Exhibit 17. Telehealth Counseling and Assessment Visit Trends, Adult VOCs, July 2021–November 2022



Data are from EF electronic health records.

Exhibit 18. In-Person/Telehealth Transition Probability Matrix

Current Visit Modality	Next Visit Modality	
	In-person (%)	Telehealth (%)
In-person	83.1	16.9
Telehealth	12.8	87.2

New and established adult trauma clients with at least two encounters between July 2021 and November 2022 (N = 486). Visits could be for counseling or non-counseling services.

In the cost results section below, we convert these service counts into monthly utilization as context for the cost estimates and to explicitly control for treatment duration as confounder.

Client Symptomology Outcomes

The Depression, Anxiety, and Stress Scale-6 for Telehealth. We received a data extract that included DASS-6 (Saavedra et al., 2022b) assessment data collected August 2017–January 2023, which included 3,286 assessments belonging to 1,935 unique clients. Of these, 913 assessments were administered from February 2021 through December 2022. Clients who had at least two assessments that were both administered in that time frame were included in the

following analysis (N = 162). This time frame allows for reporting parameters consistent with those used in the cost study (though the sample is not an exact match to that from the services data) while accounting for the previous reporting period ending. Many clients included in this sample had more than two assessments, with approximately 20% (n = 33) and 8% (n = 13) having three or four assessments, respectively. The majority (70%) of Time 1 assessments were administered in Spanish (n = 113), and this figure was consistent through the administration of Time 2 assessments (69%).

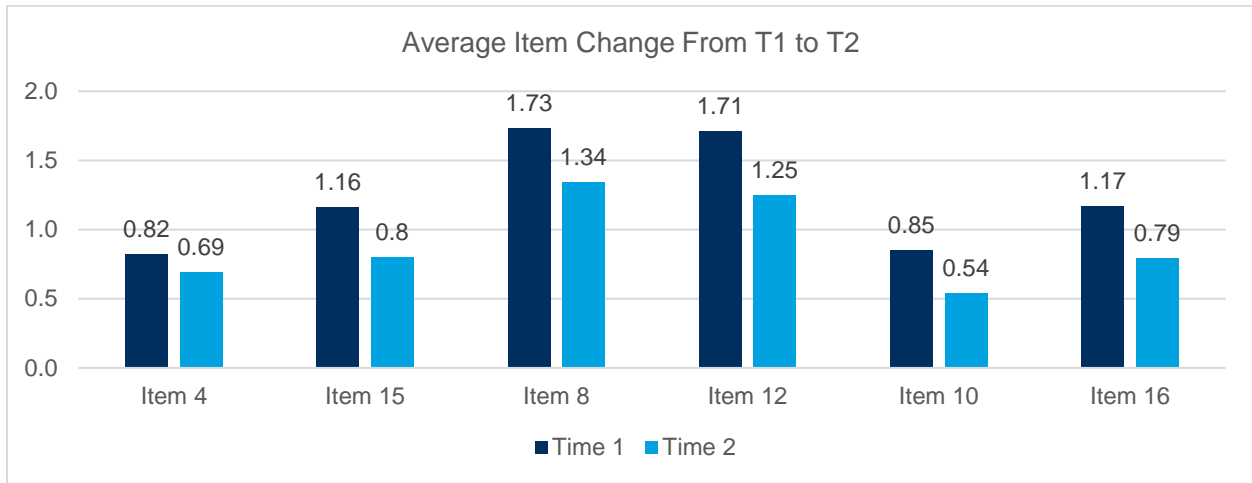
Paired t-tests were used to evaluate the difference in total mean scores from the first DASS-6 assessment to the second DASS-6 assessment. Higher scores reflect more negative functioning. Clients reduced scores from Time 1 ($M = 7.44$) to Time 2 ($M = 5.41$) with an overall average change of 2.032 ($t = 6.55$, $p < .05$). Based on the changes from Time 1 to Time 2, approximately 66% of the clients reported decreased symptoms, 13% reported no change in symptoms, and 21% reported increased symptoms (Exhibit 19). The average number of days between Assessment 1 and Assessment 2 ranged widely across clients. On average, the number of days from the first to second assessment differed by DASS-6 score outcomes, including those that improved (M days = 139.11), remained the same (M days = 103.29), and worsened (M days = 174.70).

Exhibit 19. Overall Changes over Time

DASS Change	Clients (n)	Clients (% of Complete Data)
Improved	103	66%
Remained same	21	13%
Worsened	33	21%
Total excluding incomplete data	157	
Incomplete data	5	
Total	162	

Changes in item-level mean scores were also observed from the first to second administration of the DASS-6, suggesting improvement in symptomology across all three domains (anxiety, stress, and depression; Exhibit 20). Notably, measures of stress, item 8 and 12, represent the highest scores, indicating that clients, on average, may have negative symptomology attributed, at least in part, to chronic non-specific and nervous arousal. The largest decreases in negative symptomology were also seen in measures of stress; item 8 decreased by an average of .39 and item 12 decreased by an average of .46. We see a change in mean scores for anxiety in items 4 and 15, with decreases of .13 and .36, respectively. Finally, depression measures items 10 and 16 also decrease by .31 and .38, respectively.

Exhibit 20. Average Item Change, Time 1 to Time 2



Client Satisfaction Outcomes

The Client Satisfaction Survey. Overall average satisfaction is reported by month and year from June 2021 through March 2023 (see Exhibit 22). Data were not collected for 2 months because of COVID-19–related closure. Satisfaction with specific aspects of EF programming by year for 2021, 2022, and the first 2 months of 2023 are also illustrated in Exhibit 21.

Exhibit 21. Client Satisfaction, 2021–2023



With the exception of service accessibility, clients have consistently reported very high satisfaction from 2021 to 2023. Reports of affordability and connecting with EF via telephone calls, rates of satisfaction decreased slightly from 2021 to 2022 but then increased in 2023. As evident from Exhibits 21 and 22, the majority of clients rated high levels of satisfaction. As part of the process, we wanted to look at the individual items and time trends for the individual items. Across all three years, clients rated the experiences high. More variability was noted in items related to scheduling and cost of services.

Exhibit 22. Client Satisfaction

Date Range	Clients (N)	Satisfaction Rate (%)
June 2021	7	100.00
July 2021	7	100.00
August 2021	0	NA
September 2021	1	100.00
October 2021	12	97.22
November 2021	2	91.67
December 2021	5	100.00
January 2022	9	92.59
February 2022	9	86.11
March 2022	9	79.63
May 2022	10	92.78
June 2022	0	NA
July 2022	16	91.32
August 2022	33	97.47
September 2022	23	98.55
October 2022	12	98.61
November 2022	77	95.02
December 2022	44	98.86
January 2023	28	90.28
February 2023	23	96.38
March 2023	18	98.04

Therapeutic Alliance. In addition to capturing client satisfaction, we were interested in capturing therapeutic alliance, particularly for the targeted service model (full telehealth). There are concerns from the broad telemental health literature related to possible challenges making important therapeutic connections between client and providers using telehealth modalities. Results indicated that 92% of participants reported high levels of comfort speaking with their therapist; 99% of participants reported high ratings of feeling respected by their therapist; 87% of participants reported high ratings of feeling understood by their therapist about what they wanted to work on together; and 92% reported high ratings of hope their situation would improve working with this therapist. The remaining 8% who did not report high ratings cited not needing or wanting to continue with therapy.

Cost Results*Services Cost Results*

Among new adult VOC clients at EF (between July 2021–November 2022), hybrid clients had the longest treatment duration (6.2 months; Exhibit 23). In-person and telehealth-only clients

averaged a little more than half the treatment duration of hybrid clients, 3.1 and 3.4 months, respectively. The average count of all services per month of was similar across the three groups, averaging 2.2 to 2.5. Also similar across groups were counseling visits at 1.5 or 1.6 per month and thus accounting for the majority of all monthly services. Monthly overall service costs were lowest for hybrid clients (\$344), approximately \$100 less than for the other two service modality groups. However, hybrid clients' monthly counseling cost (\$178) was closer that of telehealth-only clients' cost (\$156) than to in-person clients (\$216).

Exhibit 23. Healthcare Service Utilization and Costs per Month per Adult EF VOCs (New clients July 2021–November 2022)

		All New Clients (N = 396)		
		Hybrid	In Person	Tele
N		155	86	155
Duration in treatment (months)		6.2	3.1	3.4
# All Services (Monthly)	# All Services (Monthly)	2.2	2.4	2.5
Cost of All Services (Monthly)	Cost of All Services (Monthly)	344	469	443
Weighted Average Service Unit Cost	Weighted Average Service Unit Cost	156	195	177
# Counseling Services (Monthly)	# Counseling Services (Monthly)	1.6	1.6	1.5
Counseling cost (Monthly)	Counseling cost (Monthly)	178	216	156
Weighted Average Counseling Unit Cost	Weighted Average Counseling Unit Cost	111	135	104

All services included counseling and non-counseling services (e.g., assessments/emergency medical services). Any new client during the full observation period is included.

Counseling service costs reflected different proportions of overall services costs depending on which service modality group. Counseling was approximately half of overall service cost for hybrid clients, less than half for the other two groups. This is in contrast to the count proportions in which counseling was more than half of the services. Relatedly, the weighted average per unit service costs (per month) vary across the three groups (e.g., \$111 for counseling services among hybrid clients versus \$135 for in-person only).

Program Cost Results

From process data collection and discussions with key informants, we identified core activities and related resources used by EF that would need to be quantified to estimate programmatic costs. Based on these, we worked with EF key informants to identify data sources and methods of data collection. We identified *financial documentation* that would be feasible for EF to provide, which contained data on expenditures for materials, telehealth and non-telehealth equipment (e.g., white noise machines for privacy outside counseling rooms), software licenses, and space costs. Staff are clinical service providers, administrators/supervisors, a dedicated program coordinator and scheduler, and community engagement/outreach specialists. Estimating the

costs for these staff requires administrative data/documentation on the timing of hires and each individuals' full-time equivalent or average hours worked in a typical period. These data are typically available in mature organizations, and their availability and amount of detail were confirmed with EF.

Estimating staff costs also requires information on how staff spend their time. Clinical providers' time is spent on direct service delivery (i.e., billable service units), tasks specific to service delivery to clients but that occur outside of the client encounter (e.g., case notes, clinical consultation with supervisors), and other administrative and training tasks. One hypothesis for EF's telehealth program is whether providers' time is used more efficiently (e.g., reduced number of no-show appointments). From services data, we know the numbers and lengths of different services provided and also the frequency of related tasks like completing case notes. The remainder of time spent by clinical providers can be calculated by comparing the service delivery time to their total full-time equivalent time working. For other staff, we also need to estimate how much time they spend on different activities and how those relate to efficiency, costs and program outcomes.

To produce these estimates, we successfully piloted a framework in which semi-structured interviews are used to collect data on typical time spent on different activities. This approach was found to be feasible and acceptable to EF, with staff scheduling for the interviews being the only challenge. In addition, we have laid out the framework for triangulation (corroboration) of estimates using data from these interviews, services data, and administrative data.

Chapter 4 Discussion



4. Discussion

This report describes results from Phase 2: Telemental Health for Reaching Rural VOCs (2020-V3-GX-0073). The TeleFuturo telehealth program developed at EF by clinicians and partners is focused on bringing technological options for reaching individuals who are VOCs, experienced trauma, and sought mental health services. The program had a strong focus on engaging individuals and providing quality evidence based mental health interventions to meet them where they are. Several results are highlighted below that illustrate how TeleFuturo programming has evolved through these phased approaches with the COVID-19 pandemic as a backdrop. We highlight success on various fronts. First, the program has been able to effectively recruit a range of participants from diverse backgrounds who have experienced traumatic crimes (men and women, a range of ages and types of exposure to crimes). This achievement is a testament to the program's accessibility and appeal, which has encouraged victims to seek the support they need. As part of this process, our partners at EF have demonstrated their commitment to capturing necessary data for a rigorous evaluation. By collecting and analyzing comprehensive data related to the participants' mental health outcomes and intervention effectiveness, the program ensures that its services are evidence based and continuously improving. This critical buy-in at the organizational and provider levels and commitment to a rigorous evaluation not only enhances the credibility of the TeleFuturo program but also contributes to the advancement of knowledge regarding the complex needs of individuals who have experienced traumatic crimes. Often, programs and treatments are evaluated in university settings, which is important for initial evidence but whose results do not necessarily extend to community-based settings.

Our study also took a **strong community-based participatory approach**. Thus, as part of process evaluation, we continuously weaved in inputs from our partners throughout this phase (and Phase 1). This allowed us to capture important inputs from providers and clients about the barriers and facilitators when implementing evidence-based or evidence-informed interventions using technology-based platforms (either hybrid or full telehealth). One important finding is even as COVID-19 era restrictions are lifted, telehealth continues to be a popular option for clients; however, as one provider shared, requests for in-person appointments are increasing as COVID-19-related restrictions are lifted. In general, reactions to telehealth were mixed. These mixed reactions from providers and clients point to a need to increase understanding about for whom and under what circumstances telehealth may be appropriate than in-person therapy. Providers noted this was a more nuanced question, with client needs and contextual issues informing selection of which approach was preferred for the VOCs and their situation where they can be able to benefit from mental health services. These findings point to the importance of also considering provider perspectives and inputs in decisions about whether in-person, hybrid, or telehealth options are used in addition to client considerations.

The success of the telehealth program is also reflected in its ability to attend to its participants' diverse needs. By using a telehealth approach, the program can reach individuals in remote areas or those who may face logistic barriers to accessing in-person mental health

interventions. This inclusivity ensures that even the most vulnerable VOCs can receive the support they require, thereby addressing a crucial gap in mental health services.

4.1 Process Evaluation Findings

Provider Interviews. Results from provider interviews highlighted benefits of technology-based approaches now widely noted in the literature. Providers also noted important barriers to consider. Nearly all providers expressed some frustration or concern about the loss of control over the therapeutic environment that accompanies a shift to online therapy. In a telehealth environment there are “extra factors” for the therapist to manage, including clients who are regularly distracted during sessions or who take appointments in spaces that are not private. As a result, some clients may be less safe whereas others may be less engaged. For VOCs or those with safety concerns, this loss of control over the therapeutic space triggered heightened safety awareness among providers, and, as one provider described, “an extra layer of making sure [the client] had privacy.” They also observed both tangible and personal limits of telehealth technology. This emphasized the importance of considering hybrid and in-person options when possible. For clients in rural areas, internet access is more likely to be unreliable. Key resources, such as Spanish-language social services or substance use counseling, may be limited, and it can be harder for a therapist to know the local resources to which they can refer remote clients. Providers noted there are several factors that are important to consider when working with clients who are VOCs. Thus, when considering critical intervention components, provider, client, and other contextual variables should be considered when determining the type of intervention modality (full telehealth, hybrid, or in person) as well as the specific evidence-based intervention components employed. These are all critical factors to ensure high level of quality and clinical competence.

Patient/Client Interviews. Overall, clients consistently reported high levels of satisfaction in multiple domains. Results from Phase 2 Client interviews indicated technology-based telehealth services that made up TeleFuturo (whether full Telehealth or Hybrid) has been met with an overwhelmingly positive response from clients. The use of digital platforms has enabled relatively unproblematic and convenient access to mental health services and options for a range of individuals who experienced trauma after exposure to crimes. Clients reported generally positive integration of technology (mostly video) in their sessions, reporting enhanced communication, and a sense of personal connection with their TeleFuturo providers. Despite occasional challenges with low bandwidth, clients have shown remarkable adaptability to use of the technology because it provides options not available for in-person sessions. Moreover, clients noted providers led sessions with cultural sensitivity as this fostered a powerful therapeutic alliance with the majority of participants reporting high levels on all domains of alliance captured. The ability to connect with providers who understand their cultural background and experiences has elevated their comfort and trust, contributing significantly to their positive outcomes. The flexibility offered by telehealth, allowing clients to schedule appointments at their convenience and maintain privacy, has addressed common barriers in seeking therapy—especially for VOCs. This flexibility has been particularly beneficial for those juggling multiple responsibilities or those in remote locations, making therapy more accessible

than ever before for rural clients. In terms of capturing meaningful change, clients emphasized need to improve functioning above symptom improvement, particularly related to functioning related to work and family or other relationship factors. Most patients noted their experience and the approaches used at EF TeleFuturo would also benefit individuals who are in similar contextual situations including work and other responsibilities. They also noted these approaches are useful to other individuals who identify as Latinx.

4.2 Outcome Findings

Many conclusions can be drawn from the evaluation and analysis of EF outcome measures. First, despite their limitations related to being a community-based provider, our findings suggest that EF has the infrastructure in place to collect and document meaningful outcome data, which has been useful in documenting the accessibility and efficacy of their services for clients who are VOC. This includes client satisfaction data, EHR service data, and change in clinical symptomology using the DASS-6 measure but also clinical information to capture diagnoses, therapeutic alliance, and client satisfaction.

Client satisfaction data was especially useful for contextualizing the other service and change in symptomology outcome data. Being culturally appropriate and sensitive and respectful in all staffing interactions, affordability, and accessibility were important elements that influenced clients' satisfaction. Client responses to these elements were consistently high, so much so that we observed a ceiling effect that makes measuring improvement for EF difficult. Given EF's heavy emphasis on engagement strategies, especially for their Latinx community in North Carolina, it is of no surprise that client reports of satisfaction, specifically pertaining to perceived respect and cultural sensitivity, were so high. For this population, provision of "individualized" treatment services means meeting the clients where they are—as individuals within the context of their culture—which is often overlooked in traditional treatment services. In other words, EF providers consider the experiences, needs, and goals of their clients as unique but also as aspects that are influenced by social and cultural norms and stigmas. Therapeutic best practices such as approaching treatment from a strengths-based perspective, developing appropriate boundaries and trust, using appropriate language and terminology, and being receptive to client feedback are implemented by EF providers using a culturally sensitive lens. For example, EF aims to approach their clients with an awareness of how mental health stigma may be especially harmful to their client because of their culture or background and to focus on the value of "bienestar emocional," or emotional well-being. Using appropriate language and terminology is also essential for developing mutual understanding, rapport, and respect. In addition to being mindful of the client's literacy and finding balance in using diagnostic or clinical jargon, EF providers also communicate with the clients in the preferred language. According to open-ended responses from the satisfaction surveys, using preferred language not only improved client comprehension of therapy but also communicated to the client that what they had to say was important and of value.

EF's EHRs provided important information regarding client demographics and received services. Examination of the EHR data revealed potentially differential patterns of engagement

among clients receiving treatment in different modalities, including hybrid, in person only, and telehealth only. While approximately 68% of clients within the telehealth-only group attended the expected range- between 2 and 5 appointments, clients within the hybrid services group attended a wider range of visits including 2-5 visits (26%), 6-10 visits (34%), 11-16 visits (23%), and 17–25 visits (11%) and on average, engaged in treatment for longer than clients within the in-person and telehealth-only groups. Furthermore, we found that service providers engaged clients using different modalities, suggesting efforts made to tailor and individualize client treatment.

A related limitation of the data is the inability to link clients across some of the data sources. This includes linking client demographic and engagement data with outcome data. Although thinking through and implementing easier ways for their data manager to link client demographic and engagement data with DASS-6 data would be more straightforward from a process standpoint, linking client demographic and engagement data with satisfaction data proves more difficult. One of the main strengths of the satisfaction data is that the survey is administered by an independent assessor, thus allowing for less bias in response. This also allows individuals to feel more comfortable disclosing feedback. For Phase 2, these were also anonymous to ensure to clients their individual information would not get back to providers. This is possible with this organization but was not in line with approach for Phase 2 Process Evaluation as EF leadership and advisors were concerned questions about satisfaction and alliance would be biased by strong social desirability. For a Phase 3 application it will be necessary to link to client outcomes.

4.3 Cost Findings

Results showed post-pandemic telehealth usage patterns over time trended slightly downward, but telehealth remained a prominent service delivery modality. The Phase 2 pilot sample showed the telehealth-only group was the largest. The hybrid group used the most services during the observation period and was in treatment longer. However, their average count of monthly services were similar to or less than those of the other two groups. This highlights several positive features of flexibility in modality. First, hybrid is consistent with longer treatment retention. Second, hybrid options do not increase monthly utilization or associated costs. Third, there is no suggestion that the ratio of counseling to non-counseling service utilization differs for hybrid clients. In other words, being hybrid (or telehealth-only) does not lead to a relative decrease in counseling or relative increase in the use of non-counseling services. Finally, the unit costs within the services mix for hybrid clients was consistent with that of other groups; hybrid clients did not use more expensive types of services.

The potential significance of these findings is that from the perspective of a payer (e.g., Medicaid), reimbursing for telehealth services does not appear to increase monthly utilization or monthly costs. However, only looking at monthly costs is an incomplete analysis for informing telehealth financing policies. First, our results also showed the hybrid clients had more months of treatment than in-person only or telehealth-only modalities. This fact could imply larger overall payments for services. As a check on this possibility, we found that the number of clients served

by EF and the total number of services provided each month did not change over time. One possible explanation is that for every non-hybrid client who stops treatment after 3 months, a new client takes their place. Under this scenario, the longer treatment duration for hybrid clients does not equate to an increase in total service utilization but instead could be the same amount of total service utilization with less client turnover. Second, our cost estimates reflect reimbursement for EF's services. In the current study, we do not observe other healthcare utilization, including emergency department visits and inpatient stays. If the longer treatment duration for hybrid clients is associated with better health outcomes, then a payer might see an overall reduction in healthcare costs for hybrid clients. These are key questions to be examined in the Phase 3 study.

The cost results are also significant from the perspective of EF. Although the value of healthcare resources in this study are denoted as "costs," they represent revenue to EF, maintaining their ability to continue providing services. First, the similarities of service utilization and cost results for the three service modality groups suggest that offering telehealth modalities does not change the EF's revenue stream. Second, the longer treatment duration for hybrid clients can be beneficial to EF because they are not incurring unnecessary costs from client turnover (e.g., labor spent on new assessments, billing paperwork and initial case notes) and no-show appointments. By using their staff more efficiently, EF can better sustain and expand their programs and improve quality.

A secondary result of this study was the establishment of the feasibility of conducting a full cost analysis of EF's program. Estimating the costs of additional specialized staff, equipment, and other resources will provide a more holistic assessment of the value and sustainability of EF's overall program. Taken together, these findings are a critical milestone for fully analyzing the economic viability of EF's program and informing program improvements and future directions.

Finally, the cost analyses conducted for this phase have limitations that should be considered. As noted elsewhere, clients self-select into their service delivery modality group. Next, the longer treatment duration of hybrid clients may not reflect a causal influence of telehealth availability but instead could simply mean that committed clients had more opportunities for which telehealth was needed to continue receiving services. This is expected for a process evaluation. As described below, potential analyses for Phase 3 will be designed to reduce the confounding present in the pilot study.

4.4 Impact/Artifacts

The impact of the program extends beyond its immediate clients served. Through its commitment to disseminating its findings and successes, the program actively contributes to the field's understanding of mental health interventions for VOCs. Sharing our approaches and findings through publications, presentations, and conferences serve as platforms for sharing valuable insights, best practices, and innovative strategies developed through the telehealth program. By disseminating this knowledge, the program fosters collaboration and encourages other researchers and practitioners to implement similar initiatives, ultimately expanding the reach of quality mental health interventions for VOCs. During the project time, the RTI Team

and EF partners presented at national conferences and local meetings. These two symposia and two poster presentations were presented at the Annual Convention of the Association for Behavioral and Cognitive Therapies (2022, 2023). In North Carolina, we were invited to share our results at the Latinx Advocacy Team & Interdisciplinary Network for COVID-19 (LATIN-19). LATIN-19 is a multi-sector group in North Carolina that brings representation from academic institutions in the state, healthcare systems, public health departments, public school systems, community-based organizations, government, faith communities, and others. LATIN-19 was established by clinicians at Duke University to address health disparities within the Latina community because of the COVID-19 pandemic. The team also presented on telehealth considerations when working with VOCs in rural areas. Finally, the team recently published an article entitled: Provider Perspectives on Delivering Telemental Health Services in Rural North Carolina in the *Journal of Rural Mental Health*. Additional dissemination products are also in preparation.

4.5 Community-Level Dissemination: La Mesita

At a local level, EF continuously disseminates to providers across the state. EF leaders proactively ensure that its impact is felt across the state. By disseminating its findings and practices to local providers through its extensive La Mesita network (<https://elfuturo-nc.org/learning-cohort-dando-la-bienvenida/>), EF promotes collaboration and knowledge-sharing within the local mental health ecosystem. This dissemination of information equips local providers with the necessary tools and insights to better serve their communities, ultimately amplifying the program's impact and ensuring that VOCs throughout the state have access to quality mental health interventions.

4.6 Implications for Future Research: Looking Toward Phase 3

One of the largest successes from Phases 1 (2018-ZD-CX-0001) and 2 (2020-V3-GX-0073) is the infrastructure EF has been able to build, refine, and capture victim-centered, provider and service variables that allow for more sophisticated quasi-experimental designs using state-of-the-art approaches to better capture causal inferences. Understanding what works for whom in mental health interventions goes beyond the realm of randomized controlled trials (RCTs). While RCTs provide valuable information on the efficacy of interventions, they often fail to capture the broader factors that influence engagement and optimal outcomes. In the past decade, and particularly post Covid-19 Pandemic, there has been an accumulation of sufficient data on the efficacy of mental health interventions in general and for VOCs. However, to truly understand the nuances of these interventions it is important to delve deeper into factors that contribute to client and provider engagement, adherence, and quality. Factors such as individual preference, cultural context, therapeutic alliance, and treatment adherence play crucial roles in determining the effectiveness of interventions. By acknowledging and researching these broader factors, we can ensure that mental health services are tailored to meet the unique needs and circumstances of individuals, ultimately leading to more successful outcomes.

Several options for this study or for future research are highlighted below. Quasi-experimental designs specifically offer a valuable approach for assessing service model efficacy that

considers client and provider characteristics we have studied in this phased approach. By incorporating these factors, researchers gain a better understanding of how these interventions are working in real-world settings and under what contexts. State-of-the-art designs are available (Cook et al., 2020; Diener et al., 2022; Saavedra et al., 2023b) that are powerful alternatives to randomized control trials. Methodologically, studies can use advanced propensity score weighting, which relies on a detailed assessment/survey of the needs and value for telehealth services, ideally conducted by research staff, knocks out a major portion of unobservable factors that threaten internal validity of estimated telehealth effect.

Other cost considerations that can feasibly be collected with current EF infrastructure to allow for a more sophisticated cost analysis to accompany a rigorous outcome evaluation. Options include collecting information on other healthcare utilization to understand the potential cost savings of telehealth/hybrid models with survey or self-reporting instruments, linking Medicaid claims data/NC's database. In-depth cost analysis of EF's telehealth and hybrid service delivery models understand efficiencies and financial sustainability.

Conclusions and Future Directions

The success of the TeleFuturo technology-based approaches for engaging and providing quality mental health interventions for VOCs residing in rural areas is evident through its ability to recruit a diverse range of VOCs in rural settings that are priority for National Institute of Justice, capture data for a comprehensive and rigorous evaluation, and advance the understanding of complex victim needs. Much of their success is driven by the foundational formative work carried out in Phase 1 (Saavedra et al., 2022b). Moreover, the organization and local partner's commitment to dissemination through publications, presentations, conferences, and local provider outreach ensures that its impact extends beyond the immediate participants, fostering collaboration and promoting the widespread adoption of effective mental health interventions for VOCs.

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Appendices

Appendix A: Provider Interviews

Phase 2 Process Evaluation of TeleFuturo at El Futuro Provider Interview Questions

Background Provider Information Questions

1. Thanks again for taking the time to speak with us today. Just to start, would you please introduce yourself and tell us about how you use telehealth (mental health treatment, case management, psychiatric care, special populations)?
 - a. How many years have you been practicing?
 - b. How long have you been using telehealth?
 - i. How long did it take you to get comfortable using telehealth?
 - c. How comfortable are you delivering clinical services through telehealth? Would you say,

 __not at all confident __a little confident

 __pretty confident __extremely confident
 - d. What populations do you typically serve using telehealth?
 - i. Have the populations served changed since introducing the use of telehealth? If so, how?
 - ii. What are the primary mental health problems or disorder service needs of your patients?
 - e. What has your experience been like providing telehealth?
2. In your opinion and from your experience, what are some key activities and resources needed for implementing and maintaining TeleFuturo programming?
3. I have additional questions related to telehealth.
 - a. What telehealth-specific activities and/or documentation is required for billing?
 - i. How is documentation different from face-to-face service provision?
 - b. How do you currently capture patients' improvement during telehealth treatment? Do you ever give your patients feedback on their improvement that you capture in this way?
 - c. What has your experience been like capturing improvement after telehealth for patients in rural populations (relative to urban, suburban), specifically?
4. What barriers, if any, do you see/have you observed or encountered using telehealth for mental health treatment when working with rural victims of crime, particularly during the COVID-19 pandemic?
5. What strategies/solutions have been used to overcome those barriers? Please consider a wide range of potential barriers, such as your personal attitudes toward telehealth, organizational support for delivering telehealth, issues that come up when technology isn't working well, legal concerns about delivering telehealth, and reimbursement or other financial concerns.

6. What are your thoughts on differences between face-to-face and telehealth services for mental health treatment with victims of crime, particularly after the pandemic?
7. Capturing quality of telehealth and client satisfaction is sometimes challenging. We shared with you the Telehealth Usability Questionnaire. How do you feel about these questions for capturing the quality and client satisfaction of your telehealth sessions?
 - a. When thinking about quality and client satisfaction, are there other questions we should ask?
8. Let's talk about the use of treatment manuals or implementation guides. Thinking about before working at EF and while working at EF, have you ever delivered an intervention using a treatment manual or implementation guide?
9. Let's talk a little about **fidelity**. Fidelity means adhering or sticking to the guidelines provided in the manual/guide with your patient/client. If you had to deliver telehealth as part of your work with EF and follow a treatment manual or implementation guide, what are the some of the facilitators and some of the challenges of maintaining fidelity to an implementation guide?
10. Let's talk a little about **clinical competence**. Clinical competence has to do with the extent to which a therapist/provider has the knowledge and skills required to deliver a treatment to the standard needed for it to achieve its expected effects. Sometimes having to follow a manual or implementation guide can be restrictive in implementing what you know to be best clinically for that client (particularly if it deviates from the manual). If you had to deliver telehealth at EF and follow a treatment manual or implementation guide, are there any strategies you would use to help maintain your clinical competence?
11. Let's talk about keeping our patients **engaged** in treatment. This is not always easy to do. What are some strategies you use to engage patients via telehealth? What are some successes and some challenges that you have experienced in keeping patients engaged?

Wrap up and Future Directions

12. When thinking of the future of tele-mental health service delivery among victims of crime living in rural areas, are there any things you think would need to be changed to improve service delivery? If so, what would you change?

Is there anything else you think we should know about the use of tele-mental health and related services with victims of crime that live in rural areas that we have not asked about today?

Appendix B: Client Interviews

Phone Call Script (use as a guide- include these points)

Hello, I am [add name] from RTI International and I work with El Futuro on a study/project funded by the National Institute of Justice to evaluate El Futuro's telehealth programming. El Futuro let us know you agreed to participate in a brief survey related to your experiences. We are interested in your honest opinions about ways we can improve telehealth services at El Futuro. For your time we will provide you with a \$30 gift card. Is it possible that we schedule the interview there a better time for you?

~~~~~

### Interview Guide for Patients who Received TeleFuturo

Thank you for participation in this interview. We would like to know more about your experience with the services that you received at El Futuro. I work at RTI International and we work with El Futuro to evaluate their telehealth services for a study funded by the National Institutes of Justice.

The interview will take between 15 and 20 minutes. We would like to know what your experience was and your opinions on how we can improve TeleFuturo services. We will refer to any services you received at El Futuro via telehealth as TeleFuturo; the provider you worked with will be referred to as your therapist. Also, for the interview TeleFuturo can include video calls or calls that were audio only which means only used voice and no video.

We would like your opinion and anything you mention will not be shared with El Futuro and it will not impact the services you receive now or in the future at El Futuro. One of the best ways to improve our services is to attend to suggestions patients provide based on their experiences and/or insights. Many times negative comments or critiques are really helpful for making improvements. We will keep all your responses private and your name or experiences will never be associated with any recommendations or comments. All of the information we receive from these interviews will be shared to El Futuro in aggregate form only. For your time, we will provide you with a \$30 gift card. After we complete the interview we can give you additional information on how to obtain it. Do you have any questions?

Let's begin.

#### I. Initial Questions

First, I would like to know what kind of services you received at El Futuro?

Are you currently working? If so what is the type of work you are in?

Do you live in a rural area?

1. Did you receive telehealth services? Specifically did you receive services using video or phone call or a combination?

These questions have to do with your experience with TeleFuturo. [use rating scale for questions 1-6].

Please tell me if your experience was

**POOR (0)    NOT GOOD (1)    VERY GOOD(2)    EXCELLENT (3)**

2. How was the audio quality of the equipment used?
3. How was the visual quality of the equipment used?
4. Did you feel comfortable using this telehealth system?
5. How much time did it take for the session to begin?
6. Did it take too much time to get an appointment?
7. Was the session interrupted for a technical reason? (open ended)

Okay now I would like to know a little more about the services you received. Remember all of the information that you are sharing will be kept private. This information is for us to better understand experiences patients have with telehealth at El Futuro. [use rating scale for questions 8-13].

## **II. Experiences with Therapist**

Please tell me if your experience with your therapist was

**POOR (0)    NOT GOOD (1)    VERY GOOD(2)    EXCELLENT (3)**

8. My therapist explained information well about the services I was going to receive. This experience was...
9. My therapist explained the types of services that could help me. This experience was...
10. My therapist took their time, knowledge, and resources to help me with problems I shared. This experience was...
11. My therapist treated me with respect, was courteous, sensitive to my experiences and was friendly. This experience was...
12. My therapist respected my privacy. This experience was...
13. My therapist answered all the questions I had related to equipment for telehealth. This experience was...
14. Your overall treatment experience using telehealth was...[open question]
15. Thinking about everything we discussed, would you say your El Futuro therapist and staff understand the experiences the Latinx community?
16. The services provided at El Futuro are the most appropriate for the Latinx community.
17. Would you use these services again if you needed them in the future?
18. Do you prefer the sessions in person, or telehealth, or combination?



19. [If telehealth} Why do you prefer telehealth services?

- a. I am too busy
- b. The flexibility offered
- c. Telehealth is easier for childcare
- d. Added privacy
- e. Other reasons

### III. Patient Perspectives on Meaningful Change

Let's talk some about your goals and the outcomes you want and/or need when you receive mental health services in places similar to El Futuro.

1. From your perspective, what areas of improvement are important to you?
  - a. Improvement in symptoms
  - b. Improvement in daily activities
  - c. Improvement in work or school related obligations and experience
  - d. Improvement in personal relationships including family, friends, and romantic partners
  - e. Other types of improvements important to you?
2. Which of these is most important to you?
3. From your perspective, what represents an ideal or optimal result or outcome from therapy?
4. Thank you. Would you say your perspective on ideal or optimal outcomes and areas for improvement are similar to individuals like you? For example?
  - a. Similar for other individuals who identify as Latinx/Latino/a or Hispanic?
  - b. Similar to people who identify as \_\_\_\_\_(include gender identified)?
  - c. Similar to individuals in a similar line of work [prompt for farmworker, essential worker, hospitality or other similar line of work they mentioned above]?

## Appendix C: Outcome Measures: DASS-6 and Satisfaction Questionnaire

### DASS-6 for Telehealth Items

#### Anxiety

- I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion) (Item 4 from DASS-21)
- I felt I was close to panic (Item 15 from DASS-21)

#### Stress

- I felt that I was using a lot of nervous energy (Item 8 from DASS-21)
- I found it difficult to relax (Item 12 from DASS-21)

#### Depression

- I felt that I had nothing to look forward to (Item 10 from DASS-21)
- I was unable to become enthusiastic about anything (Item 16 from DASS-21)

### Client Satisfaction Survey

We appreciate your additional insights on your experience with TeleFuturo.

I felt comfortable sharing and speaking with my therapist

I felt respected.

My therapist understood well what I wanted to work on, through therapy and her/his advice.

I have hope that my situation will improve working with my therapist and following her/his advice.

The 4-point scale options are: 0=not at all; 1=a little bit; 2= agree; 3= strongly agree.

### Therapeutic Alliance (Targeted Telehealth)

I felt comfortable sharing and speaking with my therapist.

I felt respected.

My therapist understood well what I want to work on, through therapy and her/his advice.

I have hope that my situation will improve working with my therapist and following her/his advice.

## Appendix D: Service Encounters

### Procedures, Codes, Categorizations, and Prices

| EHR Procedure Name                     | CPT Code | Bill Amount | Service Type             |
|----------------------------------------|----------|-------------|--------------------------|
| 90832 - psychotherapy 30 min           | 90832    | \$75.00     | Counseling               |
| teletherapy 90832                      | 90832    | \$75.00     | Counseling               |
| tele intern 90832                      | 90832    | \$75.00     | Counseling               |
| tele intern 90834                      | 90834    | \$112.50    | Counseling               |
| 90834 - psychotherapy 45 min           | 90834    | \$112.50    | Counseling               |
| teletherapy 90834                      | 90834    | \$112.50    | Counseling               |
| 90837 - psychotherapy 60 min           | 90837    | \$150.00    | Counseling               |
| teletherapy 90837                      | 90837    | \$150.00    | Counseling               |
| intern 90837                           | 90837    | \$150.00    | Counseling               |
| tele intern 90837                      | 90837    | \$150.00    | Counseling               |
| teletherapy 90846                      | 90846    | \$150.00    | Counseling               |
| teletherapy 90847                      | 90847    | \$150.00    | Counseling               |
| telehealth group therapy               | 90853    | \$26.15     | Counseling               |
| 90853 - group psychotherapy            | 90853    | \$26.15     | Counseling               |
| 98967 -- therapy phone visit 11-20 min | 98967    | \$90.00     | Counseling               |
| 98968 -- therapy phone visit 21-30 min | 98968    | \$90.00     | Counseling               |
| 99441 -- md phone visit 5-10 min       | 99441    | \$100.00    | Counseling               |
| 99442 -- md phone visit 11-20 min      | 99442    | \$100.00    | Counseling               |
| 99443 -- md phone visit 21-30 min      | 99443    | \$100.00    | Counseling               |
| 90791-intake non-medical               | 90791    | \$300.00    | Psych Intake-new patient |
| intern 90791                           | 90791    | \$300.00    | Psych Intake-new patient |
| teletherapy 90791                      | 90791    | \$300.00    | Psych Intake-new patient |
| tele intern 90791                      | 90791    | \$300.00    | Psych Intake-new patient |
| teletherapy yearly 90791               | 90791    | \$300.00    | Psych Intake-new patient |
| yearly 90791                           | 90791    | \$300.00    | Psych Intake-new patient |
| 99204md - e & m moderate, new          | 99204    | \$225.00    | Psych Intake-new patient |
| telepsychiatry 99204                   | 99204    | \$225.00    | Psych Intake-new patient |
| 99205md - e & m high, new patient      | 99205    | \$240.00    | Psych Intake-new patient |
| 99205 child intake                     | 99205    | \$240.00    | Psych Intake-new patient |
| telepsychiatry yearly 90792            | 90792    | \$300.00    | Medical                  |
| telepsychiatry 90792                   | 90792    | \$300.00    | Medical                  |
| 90792 - intake medical                 | 90792    | \$300.00    | Medical                  |

Telemental Health Services for Reaching Rural Victims of Crime: Phase 2

| EHR Procedure Name        | CPT Code | Bill Amount | Service Type            |
|---------------------------|----------|-------------|-------------------------|
| telepsychiatry 99213      | 99213    | \$125.00    | E&M-established patient |
| 99214md - e&m mod., est   | 99214    | \$150.00    | E&M-established patient |
| telepsychiatry 99214      | 99214    | \$150.00    | E&M-established patient |
| 99215md - e & m high, est | 99215    | \$150.00    | E&M-established patient |
| sub use evaluation        |          | \$100.00    | miscellaneous           |
| engagement                |          | —           | miscellaneous           |
| dwi intake                |          | \$20.00     | miscellaneous           |
| tele dwi discharge visit  |          | \$20.00     | miscellaneous           |
| tele dwi group            |          | \$40.00     | miscellaneous           |
| tele intern engagement    |          | —           | miscellaneous           |
| tele dwi assessment       |          | \$110.75    | miscellaneous           |
| teleconexiones intake     |          | —           | miscellaneous           |
| tele dwi intake           |          | \$20.00     | miscellaneous           |
| conexiones intake         |          | —           | miscellaneous           |

Note. CPT = *Current Procedural Terminology*.

## **Appendix E: Implementation Guide**



**GUIA TeleFuturo: A Telemental Health  
Implementation Guide for Providing Mental  
Health Services to Rural Victims of Crime**

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# 1. Introduction

This implementation guide (which will be referred to as the GUIA [the Spanish word for “guide”] throughout this document) is designed to assist mental health professionals, organizations, and service providers in implementing telemental health service programs to address the multifaceted mental health needs of rural victims of crime. Several of the guidelines and recommendations provided in the GUIA may also be useful for hybrid and in-person modes of treatment/service delivery and to the provision of treatment/services to people living in urban areas. However, many of the recommendations are specifically tailored to overcome or alleviate the challenges of delivering treatment/services via telehealth to people residing in rural communities (e.g., those with low Internet bandwidth or limited transportation options).

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**This implementation guide (GUIA) provides a synthesis of components and best practices from evidence-informed approaches; inputs from clinicians in the field, El Futuro providers, staff, and leadership; and guidance from the Phase 2 process evaluation for working with rural victims of crime.**

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## How is telehealth different from in person?

Often telehealth is thought of as a type of therapy, though it is actually an alternative mode for delivering treatment. As is pointed out throughout the sections of the GUIA, there are some additional considerations to attend to when delivering care via telemental health (TMH). Providers, administrative staff, and technical staff could all benefit from additional information and targeted training around considerations relevant to TMH. All staff should have some training on the use of the equipment, basic technical troubleshooting, the design and maintenance of an optimal setting for TMH delivery, and how to handle emergencies. It is recommended that all providers demonstrate competency with the equipment.

Section 2 of the GUIA provides some background information about the importance of TMH to meeting the treatment needs of victims of crimes residing in rural areas. Section 3 provides practical steps that can be taken to ensure that ethical, legal, and effectiveness standards are met in implementing a TMH program like TeleFuturo. Practical clinical considerations that could form the framework for further provider training in delivering TMH care are discussed in Section 4 of the GUIA. Section 4 also includes treatment components that are evidence-informed or recommended in the

“It is important to note that telemental health is not a type of therapy but rather a mechanism to deliver mental health services by those presumably already sufficiently trained in the type of service (e.g., an intervention, diagnostic interview, family counseling) they are delivering”.

Kramer, Mishkind, Ayers & Boyd  
DoD Telemental Health Guidebook  
Second Edition, 2013

literature. Section 5 provides guidance on implementing telemental health interventions specifically tailored to the needs of rural crime victims, establishing effective partnerships, coordinating with ancillary services, and ensuring effective and accessible support. Section 6 covers guidance on client/patient assessment and monitoring; and Sections 7-9 provide additional resources on licensure and certification requirements for treating clients/patients outside of the provider’s home state, and for managing providers’ self-care. The voices of TeleFuturo providers offer guidance and suggestions throughout the GUIA.

## 2. Background

Rural populations often face unique challenges, including limited access to mental health resources. By utilizing telemental health, we can bridge the gap and provide crucial support to people in rural areas who have been affected by crime. In the past 15 years, considerable progress has been made in the development of interventions and treatment for mental health problems experienced by victims of crime, including modalities that have a telehealth option.

Since the onset of the COVID-19 pandemic, options for telehealth in general have been made more widely available. Many of these options have research support, albeit limited support to date. Providing mental health services for rural victims of crime can present unique challenges, including limited access to mental health resources, lack of transportation, and potential cultural differences. Many studies of these interventions do not include sufficient representation of individuals living in rural areas and thus information about the efficacy and effectiveness of these interventions is limited. However, there are specific strategies and considerations that can help ensure effective treatment for rural victims of crime. In this GUIA, we include guidelines and resources gleaned from the available research and from the EI Futuro phased intervention evaluation.

### VOICES OF TELEFUTURO PROVIDERS

*“I think that the accessibility of services and the opening of doors has really endeared me to virtual services.”*

### 3. Ethical Guidelines and Best Practices for Implementing a Telehealth Program

Implementing a telehealth program such as TeleFuturo presents a number of challenges to both program administrators and practitioners. This section of the GUIA provides information and resources for anticipating, understanding, and overcoming many of the most common challenges in a way that protects the privacy and confidentiality of patients/clients.

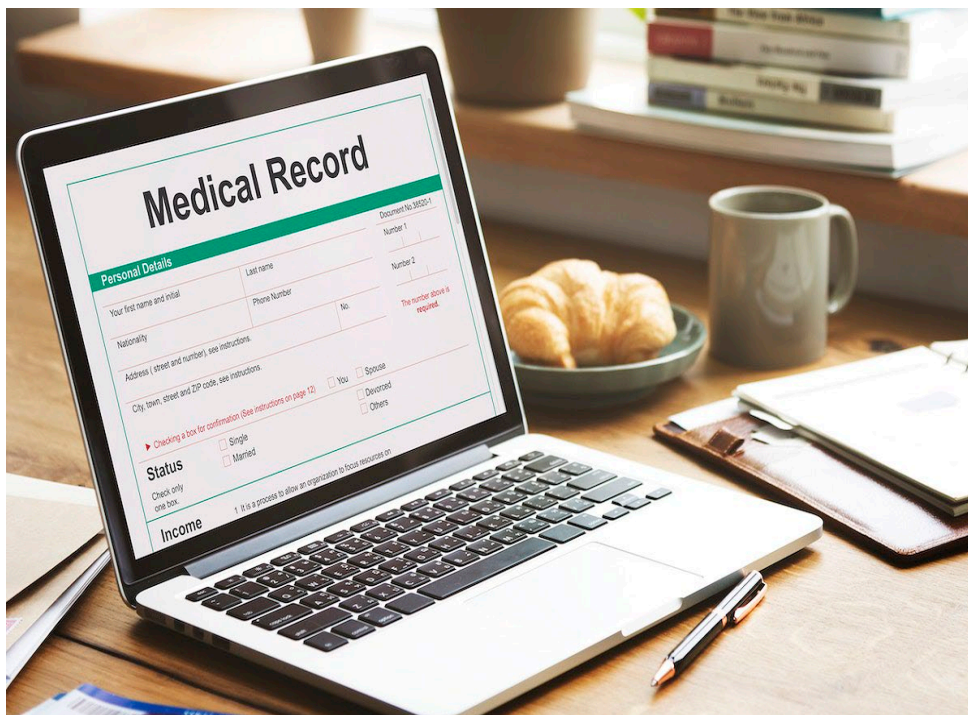
#### Resources for Program Administrators

##### Assessing Technology Infrastructure

Before implementing a telemental health intervention program, it is essential to assess the technology infrastructure available in the service region. Consider factors such as internet connectivity, telephone services, and access to devices like smartphones, computers, or tablets. Identify potential limitations and explore alternative solutions, such as satellite-based internet or mobile hotspot devices, to ensure reliable and uninterrupted communication. Ask potential patients/clients as well. They are more likely to know what kind of connection they have and when it can be spotty or unreliable.

#### VOICES OF TELEFUTURO PROVIDERS

*“I’ve discussed plans with clients with not so good connectivity around connecting at least the audio via phone and then having the video over Zoom or just going to phone completely if we need to, and that’s been effective.”*



## Establishing Confidential and Secure Communication

Maintaining confidentiality and ensuring secure communication channels are vital to establishing trust and confidentiality with all patients/clients but especially with rural crime victims.

- Utilize encrypted teleconferencing platforms or secure messaging systems that comply with HIPAA regulations.
- Inform mental health providers and clients about privacy measures, consent processes, and the importance of safeguarding personal information during telemental health sessions.

### VOICES OF TELEFUTURO PROVIDERS

*"Sometimes you see people concerned over privacy and confidentiality...I know that with Zoom you have a way to use it that is HIPAA compliant, but some clients don't understand those terminology".*

## Other Legal and Ethical Considerations

- ❖ Familiarize yourself with local, state, and federal laws governing the provision of telemental health services.
- ❖ Comply with ethical guidelines and standards set by professional organizations such as the American Psychological Association or the National Association of Social Workers.
- ❖ Ensure that all client/patient information is protected and secure, adhering to all Health Insurance Portability and Accountability Act (HIPAA) regulations.

## Resources for Understanding Legal Considerations

The **Health Insurance Portability and Accountability Act (HIPAA)** provides rules for health care providers and health insurance companies about who can have access to health information. Providing care via telehealth requires the practitioner to understand the rules as they apply to care provided over the phone or computer. Specifics about these rules can be found at the following link: [HIPAA](#).

A second line of protection for patients'/clients' rights that may be operationalized differently within the context of telehealth (as compared with in-person care) is **informed consent**. The following link provides guidance around obtaining informed consent for telebehavioral health visits: [Informed Consent](#).

## Resources for Mental Health Practitioners

Recent improvements of existing technology and development of new technologies have provided new ways to connect with and provide services to new and existing clients/patients. These new opportunities for service provision also present new challenges to providing a treatment or intervention environment in which patients/clients and practitioners feel comfortable as well as protecting privacy and confidentiality. This section of the GUIA provides information and resources that may be helpful to practitioners in adapting and helping their patients/clients to acclimate to treatment delivered via telehealth.

### Gaining Trust

Introducing patients/clients to telehealth is an important step toward gaining their trust that telemental health visits are a safe space for receiving care. The following link provides several resources that help practitioners in introducing telehealth to their patients/clients: [Gaining Trust](#).

These next resources provide information for practitioners about how to inform their clients/patients about how to safeguard their own privacy, navigate technological challenges, and adopt specialized therapeutic techniques and privacy protocols required for telehealth delivery of services to victims of crime.

### VOICES OF TELEFUTURO PROVIDERS

*" I think you try to just help someone know I'm attuned to what's going on in your space. So if you see somebody walk by and be like, "Oh, yes, like who is that?" or "What's going on?" or "I see you, you know, I see your painting in the background, that's beautiful, like tell me about that," or, you know, you're just trying to demonstrate that we are in this together."*

## Technological Skills

Whereas some of the privacy protections that are needed for telemental health care are the same as face-to-face care (e.g., limiting who can overhear spoken conversations, and keeping written records with confidential data secured in a safe space), other privacy protections require more technological knowledge/skills. The following link provides a list of best technological practices for privacy in a telehealth context: [Technological Privacy Practices for Practitioners](#).

## Privacy Protocols

This link provides a few practical tips for precautions practitioners can take to educate and empower their patients/clients to protect their own privacy and confidentiality: [Privacy Protocols](#).

This next link is one you may want to share with your clients/patients to help them understand steps they can take to maintain privacy of their telemental health care: [Technological Privacy Practices for Patients](#).

This additional link provides guidance for practitioners who are treating patients/clients with limited English proficiency: [Protecting Privacy for Patients with Limited English Proficiency](#).

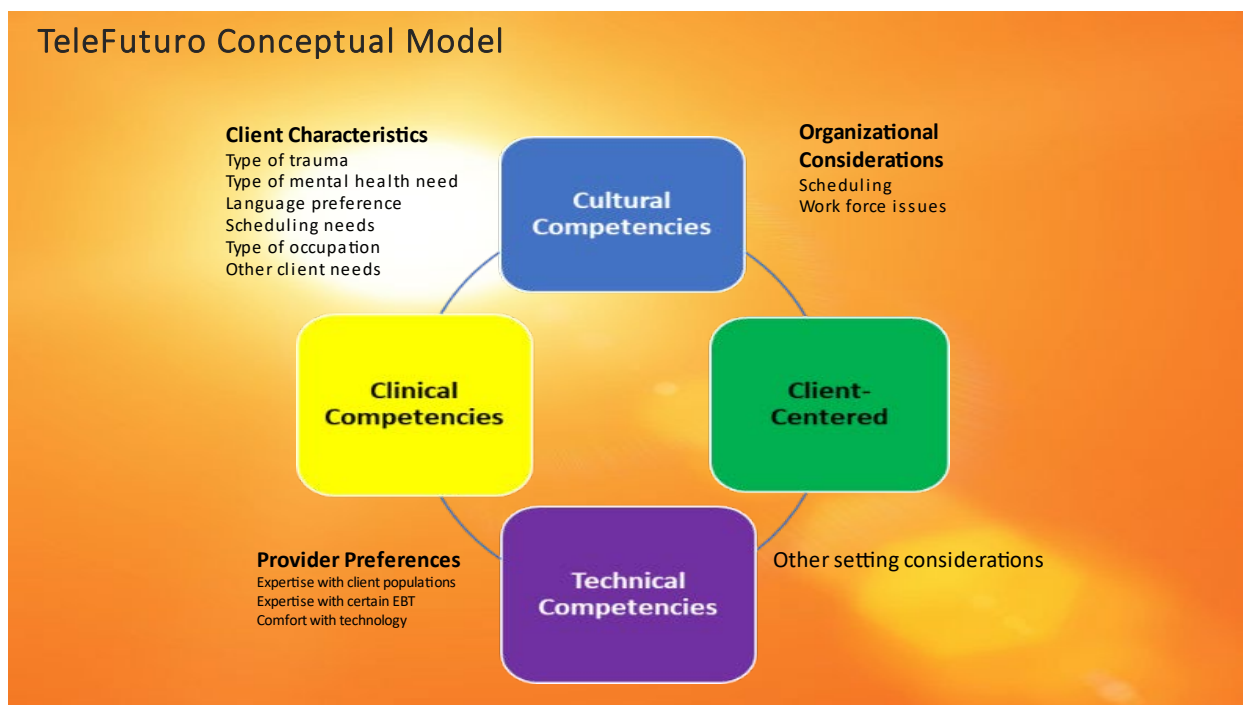
## VOICES OF TELEFUTURO PROVIDERS

*"I make sure, first of all, they're comfortable with that technology, get used to that, and also let them know that I'm in a private location and the session is not being recorded, I will not be sharing any information with anybody...I remind them that it's very challenging to speak to a stranger three, four hours away on a camera, so they may not feel comfortable doing that at the beginning, and I understand their anxiety from that and so I try to put them at ease."*

## Therapeutic Techniques in a Virtual Environment

The delivery of behavioral health care via telehealth presents several challenges to delivering therapeutic techniques that are typically delivered in face-to-face encounters. The following list includes cognitive behavioral therapies (CBT) that can be effectively delivered via telehealth in a private manner, and thus overcome or alleviate these challenges: [CBT for Telehealth](#). The article found at this link provides tips for adapting therapeutic techniques for delivery via telehealth: [Adapting Therapeutic Techniques for Telehealth](#).

## 4. The TeleFuturo Conceptual Model



### Key Components

At its core, the TeleFuturo conceptual model considers the key components needed to provide effective mental health services: clinical competencies, being client centered, cultural competencies, and technical competencies. In addition, the client context,

provider preferences, and other organizational/setting considerations should be included.

*“One of the greatest challenges.... Is being competent to work effectively with myriad of problems and issues faced by clients.”* (p. 115; Barth et al., 2012). The Common Elements and Common Factors approach in social work is based on the framework that there are certain critical elements that contribute to effective outcomes across various therapeutic interventions. These common elements and common factors are considered building blocks for successful mental health service delivery when working with a range of clients/patients. This is a useful framework when thinking about ingredients in the EI Futuro Telemental Health Model.

Key, non-specific therapeutic ingredients include:

- **Therapeutic alliance**, which is focused on the quality of the relationship between the provider and the client, is essential. A strong therapeutic alliance based on trust, empathy, and collaboration creates a safe space for the client to explore their concerns.
- **Client empowerment** is focused on promoting the client's autonomy, self-determination, and empowerment. Providers aim to enhance the client's strengths, skills, and resources, enabling them to make informed choices and take control of their situations and their lives.
- **Cultural sensitivity and humility** is centered on recognizing and valuing the diverse cultural backgrounds, beliefs, and values of clients is crucial. Providers strive to provide culturally sensitive and responsive interventions that respect and honor individual differences.
- **Evidence informed, goal-oriented focus** creates a space in which providers work collaboratively with clients to identify and establish clear, realistic, and achievable goals. These goals guide the intervention process and provide a sense of direction for both the social worker and the client. Other aspects of

## VOICES OF TELEFUTURO PROVIDERS

*Do you share with clients what their progress has been?*

*Definitely. That's a strategy that we use to empower the client. Because the client is coming in, and [we say] 'We're not going to fix your life problems, we're not here to fix your life, we're not here to get rid of the trauma. What we're doing here is that you're going to learn the skills necessary to live with that trauma, to live with that, with that experience that you had, and you're going to be able to manage it in order to still have a functional life.'"*

*"When they are making progress I can say, 'Look, four weeks ago you say you were dealing with this and this is your score, and now look, you have made significant improvement,'"*



evidence-informed practice: Incorporating research evidence and best practices into social work interventions is important.

**Flexibility and adaptability** calls upon providers to continuously update their knowledge and skills to ensure they are providing interventions that are evidence-based and effective. The common factors approach acknowledges that each client is unique, and there is no "one-size-fits-all" approach. Providers should be allowed to be flexible and adaptable in tailoring interventions to meet the specific needs and preferences of each client. They can adapt telemental health targeted or hybrid interventions to meet the unique needs of rural crime victims using evidence-informed practices. Consider incorporating a variety of modalities, such as videoconferencing, phone calls, to accommodate individuals with varying technological capabilities. Flexibility in scheduling appointments can also be beneficial, considering the limited availability of mental health services in rural areas. Information about needs and capacity for technology-based services should be assessed at intake. This can be done in an interview or custom survey format. Considerations for building capacity for individuals with more challenging schedules is recommended.

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### *VOICES OF TELEFUTURO PROVIDERS*

“As a clinician you do have a responsibility to the model that you’re using but you also have the knowledge, the clinical knowledge, about what best practice could look like in a particular encounter.”

### **Evidence-Based Interventions**

The key components of the TeleFuturo model can be utilized as part of a treatment plan that includes different types of therapeutic approaches such as cognitive behavior therapy and behavioral activation. **Table 1** describes several therapeutic approaches that are commonly used in El Futuro, enumerates the disorders/behaviors for which the approach has been shown to be effective, and documents research findings concerning effectiveness of the therapeutic approach when delivered via telehealth.

**Table 1. Evidence-Based Approaches Implemented at El Futuro with Evidence for VOCs and Telehealth**

| Treatment Approach                      | Brief Description of Treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Clinical Indications with Strong Research Support <sup>1</sup>                                                                                                                          | Evidence Base for Delivery to Adults via Telehealth                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Acceptance and Commitment Therapy (ACT) | ACT is based on relational frame theory and emphasizes how attempts to avoid or control unwanted internal experiences (thoughts, memories, emotions, or sensations) result in psychological distress and functioning difficulties. Therapists use metaphors, mindfulness exercises, and behavioral exercises to address the six “pillars” of ACT: acceptance, cognitive defusion, being present, self as context, valued living, and committed action. ACT typically involves weekly individual sessions. | Chronic pain<br><br>Research has generated <i>modest</i> support for ACT’s effectiveness in treating depression, obsessive-compulsive disorder, mixed anxiety disorders, and psychosis. | In the only noninferiority trial comparing in-person and telehealth delivery of ACT for chronic pain, Herbert and colleagues (2017) found that telehealth produced significant reductions in pain interference and other outcomes in a veteran sample that were comparable to in-person delivery (except for sleep quality and activity level); however, the telehealth group had relatively higher dropout.<br><br>Additional empirical research is needed. |
| Focused ACT (FACT)                      | FACT is a brief version of ACT that aims to elicit radical, immediate behavioral change, developed under the assumption that patients are only able and/or willing to attend approximately 4 therapy sessions prior to terminating care. Therapists focus on enhancing patients’ present moment awareness, openness to private experiences, and engagement with valued life activities. FACT typically involves 1-6 weekly individual sessions.                                                           | FACT’s empirically supported treatment status has not yet been determined.                                                                                                              | No evaluations of FACT delivered via telehealth have been published to date. Future empirical research is needed. Evidence for similar                                                                                                                                                                                                                                                                                                                       |

| Treatment Approach               | Brief Description of Treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Clinical Indications with Strong Research Support <sup>1</sup>                                                                                                                                                                                                                                                                              | Evidence Base for Delivery to Adults via Telehealth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Cognitive Behavior Therapy (CBT) | CBT is both a specific approach and an “umbrella term” for other specific therapies grounded in cognitive and behavioral principles. Therapists conceptualize a patient’s presenting problem(s) within the patient’s historical factors, culture and environment, thinking patterns, and behavioral patterns, with a focus on how those patterns are reinforced or punished over time and influence mental health and functioning. CBT typically involves 16 to 20 weekly, 60- to 90-minute sessions delivered in either individual or group format. | Anxiety disorders (agoraphobia, generalized anxiety disorder, panic disorder, and social anxiety disorder)<br>Attention deficit hyperactivity disorder<br>Binge eating disorder<br>Bulimia nervosa<br>Depression<br>Insomnia<br>Irritable bowel syndrome<br>Obsessive-compulsive disorder<br>Posttraumatic stress disorder<br>Schizophrenia | <p>Substantial research has tested the effectiveness of CBT delivered via telehealth, even prior to the COVID-19 pandemic.</p> <p>A review by Thomas and colleagues (2021) found that in addition to noninferiority findings supporting telehealth delivery of trauma-focused treatments and behavioral activation (discussed below in this table), there is some evidence supporting delivering CBT via telehealth to treat anxiety disorders, obsessive-compulsive disorder, and bulimia nervosa.</p> <p>A systematic review by Vallury and colleagues (2015) found that computerized CBT was equally effective for rural and urban patients with depression or anxiety.</p> |
| Behavioral Activation (BA)       | BA is a type of CBT that emphasizes the links between a patient’s behavior and mood (thinking patterns, such as rumination, are considered a mental behavior). Some forms of BA treatment explicitly emphasize the importance of values. Treatment involves helping the patient understand the link between their avoidance and approach behaviors and their negative and positive mood, respectively. BA typically involves 12 to 16 weekly, 60-minute sessions delivered in either individual or group format.                                     | Depression                                                                                                                                                                                                                                                                                                                                  | <p>Trombello and colleagues (2017) found that BA delivered via telehealth to a primary care sample of primarily Spanish-speaking Latinos/as was feasible and effective.</p> <p>Egede and colleagues (2015) found that BA delivered via telehealth to veteran older adults was noninferior to in-person delivery of BA.</p>                                                                                                                                                                                                                                                                                                                                                     |

| Treatment Approach                        | Brief Description of Treatment                                                                                                                                                                                                                                                                                                                                                                                                                  | Clinical Indications with Strong Research Support <sup>1</sup> | Evidence Base for Delivery to Adults via Telehealth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Cognitive Processing Therapy (CPT)</p> | <p>CPT is a type of CBT used to treat posttraumatic stress disorder. CPT emphasizes the impact of trauma on a patient's thinking patterns and how those thinking patterns can interfere with mental health and functioning. Therapists help patients to identify and challenge their unhelpful trauma-related thinking patterns. CPT typically involves 12 to 16 weekly, 60-minute sessions delivered in either individual or group format.</p> | <p>Posttraumatic stress disorder</p>                           | <p>Hassija &amp; Gray (2011) found that CPT and PE delivered via videoconferencing to patients at rural domestic violence and rape crisis centers was effective and satisfactory to patients.</p> <p>Morland and colleagues (2014) found that CPT delivered via video-teleconferencing was noninferior to in-person CPT delivered to a sample of rural, ethnically diverse male combat veterans.</p> <p>Moreland and colleagues (2015) found that CPT delivered via video-teleconferencing was noninferior to in-person CPT delivered to a sample of ethnically diverse female civilians and veterans.</p> <p>Moring and colleagues (2020) have discussed practical considerations for delivering CPT via telehealth during the COVID-19 pandemic.</p> |

| Treatment Approach                     | Brief Description of Treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Clinical Indications with Strong Research Support <sup>1</sup> | Evidence Base for Delivery to Adults via Telehealth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Prolonged Exposure Therapy (PE)</p> | <p>PE is a type of CBT used to treat posttraumatic stress disorder. PE emphasizes how avoidance of trauma-related memories, thoughts, situations, and other stimuli prevent emotional processing and safety learning essential for recovery from trauma. Therapists help patients identify safe-yet-avoided internal and external stimuli, which patients systematically confront via imaginal and in-vivo exposures. PE typically involves 12-16 weekly, individual, 60-minute sessions.</p> | <p>Posttraumatic stress disorder</p>                           | <p>Hassija &amp; Gray (2011) found that CPT and PE delivered via videoconferencing to patients at rural domestic violence and rape crisis centers was effective and satisfactory to patients.</p> <p>Acierno and colleagues (2017) found that PE delivered to veterans via home-based telehealth was noninferior to in-person PE.</p> <p>Morland and colleagues (2020) found that variable-length PE was effective when delivered to veterans via home-based telehealth, office-based telehealth, and in-office in-person, but that patient dropout rates were higher in both telehealth groups compared to the in-office in-person group.</p> |

| Treatment Approach               | Brief Description of Treatment                                                                                                                                                                                                                                                                                                                                                                                                                               | Clinical Indications with Strong Research Support <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                        | Evidence Base for Delivery to Adults via Telehealth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Unified Protocol (the UP)</p> | <p>The UP is a type of CBT used to treat anxiety, depressive, and related disorders. It is a “transdiagnostic” treatment in that it targets shared mechanisms of these disorders (i.e., avoidant responses to unwanted or aversive emotions) via eight cognitive and behavioral strategy modules. Motivational interviewing and acceptance-based elements are also incorporated. The UP typically involves 12-16 weekly, individual, 60-minute sessions.</p> | <p>The UP’s empirically supported treatment status has not yet been determined. However, multiple studies have provided evidence that the UP is effective for people with anxiety disorders (agoraphobia, generalized anxiety disorder, panic disorder, and social anxiety disorder) and depression. Emerging research also suggests that the UP may also address symptoms of alcohol use disorder, posttraumatic stress disorder, eating disorders that co-occur with anxiety and/or depression.</p> | <p>No evaluations of the UP delivered via telehealth had been published prior to the COVID-19 pandemic.</p> <p>In the only published trial of the UP delivered via telehealth, Meyer and colleagues (2022) found that the UP culturally adapted for firefighters was associated with improvements in symptoms of depression, anxiety, posttraumatic stress disorder, and hazardous alcohol use, as well as improvements in quality of life in an uncontrolled pilot study.</p> <p>Cassiello-Robbins and colleagues (2021) reviewed general issues (e.g., logistical challenges) and treatment module-specific considerations for delivering the UP via telehealth during the pandemic. Many of these recommendations may apply to telehealth delivery in general (i.e., not only during the pandemic).</p> <p>Additional empirical research is needed.</p> |

| Treatment Approach                                                                                                                                                                                                                                        | Brief Description of Treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Clinical Indications with Strong Research Support <sup>1</sup>                                                                                                                                | Evidence Base for Delivery to Adults via Telehealth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Dialectical Behavior Therapy (DBT)                                                                                                                                                                                                                        | DBT is a treatment for people with borderline personality disorder. Therapists conceptualize a patient's distress and self-harming behaviors according to a biosocial model of emotion dysregulation, whereby these experiences are thought to result from emotional sensitivity combined with an invalidating environment, in the absence of more effective, adaptive coping strategies. DBT is multi-modal in that patients receive 60-minute weekly individual therapy sessions, 2.5-hour weekly skills-focused group therapy sessions, and as-needed coaching calls over a 1-year period. DBT therapists also participate in weekly consultation meetings to maximize treatment fidelity/effectiveness and minimize therapist burnout. | Borderline personality disorder<br><br>Emerging research suggests that DBT may also address suicidal behaviors, non-suicidal self-injury, and complex posttraumatic stress disorder symptoms. | No evaluations of DBT delivered via telehealth had been published prior to the COVID-19 pandemic. However, some studies surveying DBT therapists ( <a href="#">Landes et al., 2022</a> ) and patients receiving DBT ( <a href="#">Dunn et al., 2022</a> ) have recently been published, and other experts have discussed the potential challenges, solutions, and advantages of delivering DBT via telehealth ( <a href="#">Hyland et al., 2022</a> ), as well as “lessons learned” ( <a href="#">Zalewski et al., 2021</a> ). Additional empirical research in needed. |
| <sup>1</sup> According to empirically supported treatment statuses summarized by the Society of Clinical Psychology, Division 12 of the American Psychological Association ( <a href="https://div12.org/treatments/">https://div12.org/treatments/</a> ). |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

## 5. Telehealth Methods and Hybrid Models

### Telemental Health Interventions for Working with Rural Victims of Crime

Working with rural victims of crime presents unique challenges due to the geographical distance, limited access to mental health services, and the potential stigma associated with seeking help in close-knit communities. Telemental health interventions offer a promising solution by leveraging technology to bridge the gap between mental health providers and rural crime victims. This section is designed to provide guidance on implementing telemental health interventions specifically tailored to the needs of rural crime victims, establishing effective partnerships, coordinating with ancillary services, and ensuring effective and accessible support.





## **Building Trust and Cultural Sensitivity: Partnering with *Nuestra Comunidad* (Our Community)**

Rural communities often have strong cultural values and close-knit relationships. Mental health providers should be aware of and sensitive to cultural nuances, ensuring interventions align with rural victims' beliefs, values, and practices. Building trust is crucial, as rural crime victims may be reluctant to seek help due to concerns about privacy or stigma. Engaging local community leaders, organizations, or advocates can help establish trust and provide referrals to victims.

### **Collaborating with Local Partners**

Rural areas often have limited mental health resources, so it is essential to collaborate with other community resources such as victim services organizations, churches, and community centers. This can help provide additional support to victims of crime and ensure they have access to the resources they need. Collaboration with local resources and organizations is vital to provide comprehensive support to rural crime victims. Establish partnerships with local law enforcement agencies, victim service providers, community-based organizations, and healthcare facilities to identify. This collaboration can facilitate referrals, enhance access to necessary resources, and ensure a coordinated response to victims' needs.

### **Partner with *Nuestra Comunidad* (Our Community)**

Collaboration with local resources and organizations is vital to provide comprehensive support to rural crime victims. Establish partnerships with local law enforcement agencies, victim service providers, community-based organizations, and healthcare facilities to identify trends in the community (e.g., times of year when specific services are less available or in greater demand). This collaboration can facilitate referrals, enhance access to necessary resources, and ensure a coordinated response to victims' needs.

### **Non-Therapeutic Components: Key ingredients in “*Calor Humano*” (Human Warmth)**

It is essential to establish trust and rapport with rural victims of crime. Building a relationship based on respect and understanding can help create a safe and supportive environment for treatment.

As stated previously, it is important to develop a culturally sensitive approach: Rural areas often have distinct cultural norms and beliefs that must be considered when

#### **VOICES OF TELEFUTURO PROVIDERS**

“We need to treat them as the client, as the participant, but also as a friend, and make sure that they gain trust in us, be empathic with them about their problems.”

providing treatment. Being aware of and sensitive to these cultural differences can help tailor treatment to the individual's needs.

**Psychoeducation and Wellness Resources.** Many rural victims of crime may not be familiar with the mental health resources available to them. Providing education and resources on available services and treatment options can help them make informed decisions about their mental health.

**Incorporate trauma-informed care:** Trauma-informed care approaches recognize the impact of trauma on individuals and provide a supportive and empowering environment for healing. Incorporating trauma-informed care into treatment can help rural victims of crime feel safe and supported throughout the treatment process.

Working with diverse groups of individuals who experienced crime and live in rural areas presents unique challenges. These non-specific therapeutic factors that include building trusting relationships, being culturally sensitive, utilizing telehealth technology, collaborating with community resources, addressing transportation barriers, providing education and resources, and incorporating trauma-informed care, mental health professionals can help rural victims of crime achieve positive treatment outcomes.

## 6. Other Resources

### Licensing: Professional Licensure Reciprocity and Portability

Scope of practice varies across behavioral health disciplines (e.g., psychology, clinical social work, counseling) and by state. Most states typically restrict practitioners from providing treatment to a client/patient unless the practitioner is licensed in the state in which the client/patient is located when treatment is received. As clients/patients and practitioners become increasingly mobile and have greater access to technologies such as video conferencing that facilitate making connections from remote locations, challenges of scope of practice may arise. It is the practitioner's responsibility to ensure that she/he is properly credentialed to treat their clients.

Ongoing efforts at the national and state levels have been underway to develop and implement interstate licensure/certification reciprocity and portability compacts that facilitate multistate licensure or certification for psychologists, social workers, counselors, nurses, physicians, and peer support workers. A **licensure reciprocity compact** is a legal contract between two or more states or territories that enables practitioners meeting mutually agreed upon criteria to practice in each other's state or territory. A **licensure portability agreement** is an agreement between states or territories that allows practitioners to transfer a license from one state or territory to another.

This guide provides information about licensure reciprocity and portability compacts that can be utilized by behavioral health practitioners in North Carolina, by discipline.

#### **Counselors**

The American Counseling Association (ACA) and National Center for Interstate Compacts (NCIC) of the Council of State Governments have developed and are in the process of implementing an interstate compact for licensure portability, the Interstate Compact for Counselor Licensure. As of December 22, 2023, North Carolina is one of 31 states that will be participating in the compact. Information about the compact and how to apply for compact privileges are available at this link: [Interstate Compact for Counselor Licensure](#).

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### ***Marriage and Family Therapists (MFTs)***

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The American Association of Marriage and Family Therapists released a model of MFT licensure portability in 2019. This model is intended to promote full licensure portability, allowing providers who have a full and unrestricted license in one state to be issued a full and unrestricted license in another state if they meet certain uniform requirements. Information about licensure requirements and the requirements for licensure portability are available at this link: [MFT Licensure and Licensure Portability Requirements](#)

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### ***Nurses***

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The State Boards of Nursing has adopted the Nurse Licensure Compact (NLC), which allows nurses residing in participating states and territories to treat patients residing in another participating state either in-person or via telehealth without having to apply for licensure in the patient's state. As of December 22, 2023, North Carolina is one of 41 states and jurisdictions participating in the NLC. Information about the compact and how to apply for compact privileges are available at this link: [Nurse Licensure Compact](#)

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### ***Psychologists***

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The Psychology Interjurisdictional Compact (PSYPACT) is an interstate compact that facilitates the provision of psychological treatment across state boundaries. PSYPACT has been enacted in 33 states, including North Carolina. Information about the compact and how to apply for compact authorization is available at this link: [PSYPACT](#)

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## **Physicians**

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The Interstate Medical Licensure Compact (IMLC) is a voluntary expedited pathway to multistate practice for physicians. The IMLC is administered by the Interstate Medical Licensure Commission and provides a streamlined process for multistate licensure by sharing information between state medical boards about physicians who are licensed in their state. Compact legislation for the IMLC has been introduced in the North Carolina General Assembly; as of December 22, 2023, the legislation has not been signed into law. Information about the IMLC and updates about whether North Carolina is participating in the compact can be found at this link: [Interstate Medical Licensure Compact](#)

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## **Social Workers**

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The Association of Social Work Boards has released the language of a draft Social Work Licensing Compact, as developed by the Council of State Governments. This draft is currently under review as of December 22, 2023. Information about how to get licensed to practice in another state is available at this link: [Association of Social Work Boards](#).

## **7. Other Ancillary Services**

**Telepsychiatry** for victims of crime refers to the delivery of psychiatric services remotely using telecommunications technology. It involves providing assessment, diagnosis, and treatment to victims of crime who may be unable to access in-person mental health services due to various barriers such as geographical distance, mobility limitations, or fear of retraumatization. Telepsychiatry allows victims to receive timely and professional mental health support from licensed psychiatrists or mental health professionals through videoconferencing or other secure digital platforms.

**Technology-based Case Management** for serving victims of crime involves similar use of technology-based approaches to reach individuals and to facilitate and enhance the provision of case management services to individuals who have experienced crime. Broadly, it encompasses the use of technology to streamline communication, coordinate services, and provide ongoing support to victims throughout the entire case management process. This can include providing important warm hand offs with secure online platforms for important case management activities such as: scheduling appointments, sharing relevant documents, tracking progress, and facilitating communication between the victim, case managers, and other relevant stakeholders.

**Technology-based Case Consultation** for serving the mental health needs of victims of crime involves connecting with network of providers and experts remotely to enhance the provision of mental health services to victims. It involves seeking expert advice, guidance, or supervision through technological/digital means to address complex cases, obtain specialized knowledge, or ensure the provision of evidence-based practices. This can be done through videoconferencing, online forums, or secure messaging systems, allowing mental health professionals to collaborate and consult with experts in real-time, even if they are geographically separated. This approach aims to improve the quality and effectiveness of mental health services provided to victims of crime.

When engaging **in technology-based case consultation** with other professionals, such as primary care physicians or local communities of clients, it is important to follow certain guidelines to ensure effective collaboration and communication. Many are similar to what is provided above for mental health service provision:

- ❖ Establish clear communication channels: Determine the secure and reliable digital platforms or tools that will be used for case consultation. Ensure that all parties involved have access and are comfortable using the chosen technology.
- ❖ Prioritize your client's privacy and confidentiality of the client's information. Similar to mental health service provision, *but especially when using technology-based platforms*, ensure that the digital platforms used for consultation are secure and comply with relevant data protection regulations.
- ❖ Clearly define roles and responsibilities: Establish clear roles and responsibilities for each professional involved in the consultation process. Clearly communicate expectations, timelines, and the scope of the consultation.
- ❖ Provide all necessary and relevant information to the consulting professional to ensure a comprehensive understanding of the client's situation. This may include sharing assessment reports, treatment plans, and any other relevant documents securely.
- ❖ Respect professional boundaries: Maintain professional boundaries and adhere to ethical guidelines during the consultation process. Avoid disclosing personal or sensitive information unrelated to the consultation.
- ❖ Engage in active listening and respectful communication during the consultation. Allow all parties to express their opinions, concerns, and recommendations. Foster a collaborative and supportive environment.
- ❖ Document and share consultation outcomes which includes recommendations or decisions made that might require followup. Share this information with the client and involved professionals as appropriate, ensuring that everyone is kept informed and on the same page.

- ❖ Follow up on the progress of the client's case after the consultation and evaluate the effectiveness of the consultation process. Make any necessary adjustments or further consultations as required.
- ❖ Stay informed about the latest advancements and best practices in technology-based case consultation. Continuously educate yourself and your team to ensure you are providing the best possible care and support to clients.

## 8. Clinician Wellness Guide

### Taking Care of You: Provider Well Being.

Providing mental health services for individuals who have experienced trauma or are victims of crime can take a toll on providers.

#### Vicarious Trauma

When therapists engage in telehealth, they are often exposed to traumatic stories and experiences of their clients through video or audio communication, which can lead to a vicarious experience of the trauma. Some therapists may find it more challenging to establish a sense of connection and empathetic presence with clients through remote means, making it difficult to provide the same level of emotional support as in face-to-face sessions. The absence of non-verbal cues and the physical distance can contribute to a sense of disconnection and hinder the therapist's ability to fully understand and process their clients' trauma.

Vicarious trauma, also known as secondary trauma or compassion fatigue, is a psychological and emotional response that can affect therapists and other healthcare professionals who provide care and support to individuals who have experienced trauma. While the concept of vicarious trauma is not exclusive to telehealth, the specific challenges and dynamics of telehealth can exacerbate its effects.

As part of this GUIA we include some key factors to look out for that are known to contribute to vicarious trauma for providers in the context of telehealth:

**Exposure to graphic or distressing content:** Therapists may encounter graphic details of traumatic events during telehealth sessions, which can be emotionally overwhelming. The inability to physically distance oneself from the traumatic content can make it harder to process and detach from the experience.

**Limited self-care opportunities:** Telehealth sessions often come with tighter schedules and reduced transition time between clients. This can limit therapists' opportunities for self-care activities such as debriefing, relaxation exercises, or engaging in personal hobbies, which are essential for managing stress and maintaining mental well-being.

Schedule time on your calendar in 1, 5 and 20 minute increments. Do what you can with the little in between time you have.

**Absence of professional support:** In traditional face-to-face settings, therapists often have colleagues nearby or access to immediate consultation or supervision for challenging cases. In telehealth, the physical isolation may make it more difficult to seek support or debrief with peers or supervisors, leaving therapists feeling unsupported or alone in processing their experiences.

**Emotional exhaustion and blurred boundaries:** Telehealth may blur the boundaries between work and personal life for therapists. They might find it challenging to create a clear separation between their professional responsibilities and personal space, leading to emotional exhaustion and difficulty in replenishing their emotional reserves.

To mitigate the impact of vicarious trauma in telehealth, providers can implement various strategies:

- ❖ **Self-care practices:** Prioritize self-care activities, such as engaging in hobbies, practicing mindfulness, exercising, and maintaining a healthy work-life balance. Regularly scheduling breaks and creating physical and emotional boundaries between work and personal life is essential.
- ❖ **Peer support and consultation:** Seek out opportunities for professional support and consultation. Engage in peer supervision, join online communities or forums for therapists, or participate in virtual support groups. These avenues can provide a space for therapists to share experiences, gain insights, and receive validation.
- ❖ **Ongoing education and training:** Continuously educate yourself on trauma-informed care, self-care practices, and resilience-building techniques. Stay updated on the latest research and therapeutic approaches to effectively support clients and prevent vicarious trauma.
- ❖ **Regular supervision:** If possible, engage in regular supervision sessions with a trusted supervisor or mentor who can provide guidance, support, and help process challenging cases.
- ❖ **Practice self-monitoring- it increases self-awareness:** Pay attention to your emotional well-being and be aware of any signs of vicarious trauma. This includes increased emotional reactivity, intrusive thoughts, persistent sadness, or difficulty disconnecting from work-related stress. Identifying these signs early can prompt you to seek support and take appropriate steps to address them.

*"I have three different supervisors who I meet with: one weekly, one bi-weekly, and one monthly... So there's a lot of support around me, and even though it's telehealth, there's always going to be someone who I can reach out in case of a crisis or emergency." -Telefuturo provider*

Mental health practitioners play a vital role in providing professional care and wellbeing support for their clients. Such work with clients who have experienced trauma, if left



unchecked, can result in the professional entering a state of “vicarious trauma” and can affect their self-efficacy or perceived ability to provide services to clients (Sartor 2016). A study in 2021 showed between 40% and 85% of helping professionals have developed vicarious trauma, compassion fatigue, and/or high rates of traumatic symptoms (Mathieu, 2012). It is important for professionals to seek the help they need. Paradoxically however, it seems practitioners often avoid seeking the help they offer to others (Putnik et al., 2011).

It is also common for practitioners in this area of expertise to fall into a culture of a “One-Way Caring Model” approach which requires practitioners to “demonstrate empathy, compassion and patience, without the expectation of receiving such in return from their clients” (Skovolt et al. 2001; Poslun and Gall 2019). This line of thinking can lead to a practitioner’s emotions, boundaries, and self-care to be neglected and increase burnout, emotional exhaustion and may potentially decrease effectiveness in providing care.

### **Awareness**

For mental health practitioners, being aware of their wellness involves being active in understanding and looking out for negative signs or symptoms in their mental, emotional or physical well-being. These signs or symptoms may include but are not exclusive or limited to: burnout, vicarious trauma, compassion fatigue, depersonalization, isolation, neglecting self-care or work-life imbalance etc. “Practitioners also have to hold realistic expectations about the nature of the work they do and an understanding of how to assess the effectiveness of such work” (Posluns et al. 2020). Through making themselves aware of their role, personal and professional expectations and the potential stressors in their career, it allows practitioners to take a proactive and preventative efforts to ensure that any stressors that may affect their personal wellbeing are mitigated.

According to a National Institute of Health study in 2012, across several studies in the early 2000s, it appeared that 21-67% of mental health workers experienced high levels of burnout. (Morse et al 2012). It is crucial for practitioners to be proactive and prioritize their own wellbeing to ensure they can continue to provide quality care and maintain awareness, a balanced life and work relationship, and a support network for themselves. This wellness guide aims to offer practical strategies and self-care

practices from existing literature tailored towards mental health providers but can also be adjusted and applied to practitioners working in other service provider spaces as well. At the end of the wellness guide, a list of additional resources are provided for practitioners to consider when building their own wellness plan.

### ***Establishing Self-Care Rituals***

“Self-care involves self-reflection and action in terms of knowing one’s needs and making a conscious effort to seek out resources that will foster health and well-being” (Poslun and Gall 2019). Establishing and maintaining self-care rituals for mental health care practitioners are vital to their own wellness. These rituals enable them to recharge their own mental and emotional batteries in their demanding and emotionally charged work. Though what works in self-care rituals may vary from person to person, literature in the mental health field suggest self-care various strategies that focus on maintaining emotional, mental, and physical wellness. Considerable strategies are:

- Physical: This includes maintaining an adequate sleep schedule, eating a healthy balanced diet, regular physical activity and establishing a schedule for relaxation and rest ([SAMHSA’s self-care tool kit](#)).
- Emotional and Mental: Emotional wellness includes how to manage and express ones’ emotions that may arise from information or experiences. Where as, mental wellness focuses on how well the mind processes and understands information or experiences. Practicing mindfulness by taking time for oneself daily, incorporating a daily breathing exercise or meditation, or taking a mindfulness training. Experts in the field identified mindfulness as a “way to enhance clinician awareness, acceptance of limitations and clarify self in relation to others” (Harrison and Westwood [2009](#)).

The purpose of establishing self-care rituals is to use them ritually, meaning professionals must practice them as needed or on a daily or weekly basis to prevent potential negative symptoms in their well-being. Self-care also involves maintaining a healthy balance between work and personal activities, which is discussed further below.

It is important to note that not every mental health practitioner experiences or needs are the same and what works may vary. Practitioners should consider adding or adjusting their wellness plan to what works best for them. By doing this, practitioners can better support and empower themselves, and in turn, their clients on their journey of healing.

## 9. TIPS at a Glance

EL Futuro Guide to Assessing Victim Client Needs

### Provider Level

- a. Conduct a comprehensive needs assessment to identify the mental health needs of clients who are rural crime victims.
- b. Collaborate with local law enforcement agencies, community organizations, and victim support organizations to gather relevant data.
- c. Analyze the availability and accessibility of mental health services in the target rural areas.



### Legal and Ethical Considerations

- a. Familiarize yourself with local, state, and federal laws governing the provision of telemental health services.
- b. Comply with ethical guidelines and standards set by professional organizations such as the American Psychological Association or the National Association of Social Workers.
- c. Ensure that all patient information is protected and secure, adhering to HIPAA regulations.

### Technological Infrastructure

Assess the availability and reliability of internet connectivity in the target rural areas.

### Establishing and Maintaining Partnerships

- Collaborate with local victim support organizations, law enforcement agencies, and community centers to build partnerships and identify potential referral sources.
- Establish partnerships with telecommunication providers or telehealth platforms to facilitate the delivery of telemental health services.
- Create a network of local, state and national mental health professionals who are willing to provide services remotely.
- Provide training and technical support to mental health professionals and clients to ensure smooth implementation.

## **Outreach and Continued Education: La Mesita y Nuestra Comunidad**

- Develop outreach programs to raise awareness about telemental and other mental health services among rural crime victims and community members.
- Conduct educational sessions to inform potential clients about the benefits, limitations, and confidentiality aspects of telemental and face to face health.
- Collaborate with local organizations to disseminate information through community events, flyers, or social media platforms.
- Train mental health professionals on telemental health best practices, including clinical assessment, therapy techniques, and crisis management.
- Provide ongoing support and supervision for mental health professionals delivering remote services.
- Foster a supportive environment for mental health professionals to address any challenges or concerns related to telemental health service provision.

## **Monitoring**

- EI Futuro has continuous individual patient monitoring to help providers assess the effectiveness and impact of broader clients which is especially helpful for working with rural crime victims.
- In addition to capturing outcome measures such as the DASS-6, collect feedback from clients, other EI Futuro mental health professionals, and when relevant partnering organizations to identify areas of improvement.
- Utilize outcome measures and surveys to evaluate the effectiveness of telemental including targeted and hybrid interventions.

## **Continuous Improvement**

- Regularly review and update the telemental health implementation plan based on feedback, evaluation results, and emerging best practices.
- Stay updated on advancements in technology, regulations, and guidelines related to telemental health.
- Seek input from stakeholders to ensure the ongoing relevance and effectiveness of the program.

Guidelines and suggestions offered in this implementation guide were informed by the research literature, inputs from several EI Futuro providers since 2019 and ongoing inputs from stakeholders and partners.

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## Appendix F. Phase 2 Fidelity Form



### El Futuro TeleFuturo Fidelity Checklist

|                                                              |              |
|--------------------------------------------------------------|--------------|
| <b>Clinician ID#</b>                                         | <b>Date:</b> |
| <b>Patient ID#</b>                                           | <b>Site:</b> |
| <b>Session ID#</b>                                           |              |
| <b>TELEFUTURO Type: ___Hybrid ___Targeted ___Psychiatric</b> |              |

Instructions for use: For the following section, complete the scoring for the section complete the scoring for the TELEFUTURO session you are reviewing (regardless of type).

#### **Technological Adherence and Competence**

1. The clinician/therapist selected an appropriate location where it is suitable to make the telehealth session (e.g. private, away from excess noise).
2. Clinician/Therapist checks that there is sufficient lighting (can have lamp moved behind the subject to reduce shadows or glare).
4. Clinician/Therapist checks that the camera is in focus and the patient agrees that volume is easily heard.
5. Clinician/Therapist ensures patient privacy throughout the session.
6. Clinician/Therapists followed TeleFuturo Trouble Shooting Policy for TeleFuturo services.

#### **General Clinical Competence (Hybrid or Targeted)**

Please rate clinician/therapist's overall competence (for this session only): \_\_\_\_\_

5. Clinician/Therapist's handling of this intervention was very effective – sufficient in frequency, timing good, very competently delivered. Principles of evidence based approach used were followed. Patient's privacy and safety were prioritized.
4. Clinician/Therapist's handling of this intervention was effective enough given the patient's presentation – sufficient in frequency (neither way too many times nor way too few), and sufficiently competent. Principles of evidence based approach used were mostly followed. Patient's privacy and safety were ensured as possible.
3. Clinician/Therapist's handling of this intervention was mixed – done well enough in one or more instances, but either overdone (too many times) or not done enough (too few) or not done very well at another time when needed (note: if done well enough when needed, but not so well in a situation in which it was not required, give the therapist a rating of "effective" – think of it as good enough given what was needed). Principles of evidence based approach at times difficult to follow. Patient's privacy and safety need improvement and attention.
2. Clinician/Therapist's handling of this intervention was ineffective – needs some improvement: either needs to do this a little better (more competently) or more frequently (or both); therapist clearly tried to do this, it was needed, but either the timing, frequency or quality of the intervention needed to be better in this session; however, there was some foundation of this intervention present to work on and improve. Patient's privacy and safety need improvement and attention.

1. Clinician/Therapist’s handling of this intervention was very ineffective – needs significant improvement, either to learn this intervention from the beginning (it was not close to competent in this session) or to understand the timing of the intervention much differently (timing was off enough to make the intervention ineffective or even counter-productive); Patient’s privacy and safety need serious improvement and attention.

0. Intervention strategy not needed and not delivered in this session

| Telehealth Fidelity Overall Scores                                                                                                                                                                       | Additional Notes |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| <p data-bbox="318 562 675 596"><u>Technological Competence</u></p> <p data-bbox="724 562 932 630"><u>General Clinical Competence</u></p> <p data-bbox="318 856 587 890"><u>EBT Specific Fidelity</u></p> |                  |