



The Fast and the Furious: The Rapid Implementation of Tele-mental Health Practices Within a Children's Advocacy Center

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Abstract

We work at a large, urban children's advocacy center (CAC) that provides treatment and services to approximately 2000 children and families each year who have experienced child abuse and other forms of trauma. While the complexity and impact of the COVID-19 pandemic on both physical and mental health are only beginning to be understood, families with histories of abuse and other traumatic experiences are particularly vulnerable to the negative impacts of isolation due to the extended lockdown. When the COVID-19 pandemic was identified as a public health crisis, the team of providers at the CAC pivoted to meet the newly emerging needs of the children and families served. Tele-mental health practices (TMH) were immediately implemented that required a deep understanding of the imminent safety concerns related to conducting TMH when the client may not feel safe at home. Further, while most of the clients referred for services have experienced child abuse and/or other types of trauma, COVID-19 is its own potentially traumatic event that can further exacerbate an individual's lack of safety and vulnerability to trauma. The current paper provides an overview of the rapid implementation of TMH practices within a large, urban CAC setting. We share the specific tele-mental health practices and implementation strategies that were put into place because of COVID-19 and how they align with the Consolidated Framework for Implementation Research, as well as recommendations for how agency leadership can better facilitate the implementation of innovative practices in similar settings.

Keywords Implementation science · Rapid implementation approaches · Tele-mental health · Children's advocacy centers

Introduction

The process of implementing systems change within organizations has been an area of increased interest over the past few decades. This interest, in large part, has emerged from research published in the last 20 years that asserts that it takes approximately 17 years for research to translate into practice (Green et al., 2009; Institute of Medicine, 2001). The field of implementation science emerged to identify ways in which best practices can be translated into practice improvements. Implementation science models have long emphasized the importance of thoughtful change management that includes multiple stages, such as those outlined by Aarons et al. (2011) that include exploration, preparation, implementation, and sustainment (EPIS). Within the

implementation science field, it has been acknowledged that there has been relatively little focus on the rapid, accelerated implementation of interventions necessitated by organizational, systemic, or cultural events such as the COVID-19 pandemic (Proctor et al., 2022).

In March 2020, the State of California issued a stay-at-home order due to the impact of COVID-19 based on recommendations from the Centers for Disease Control and Prevention. Similar stay-at-home orders were put into place around the United States as well as in other countries around the world at around the same time. While the initial hope was that this stay-at-home order would be brief (2–6 weeks), it quickly became clear that COVID-19 was a significant public health emergency that required quick and nimble transformation of business processes that can be sustained over time. For human services industries, such as hospitals, mental health facilities, and others, the management of COVID-19 necessitated a transition that both allowed families to stay home and abide by the stay-at-home order, but also allowed for the provision of necessary physical and

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mental health services. As a result, the traditional face-to-face model of service provision was no longer sufficient and needed to transition into one that relied on the provision of tele-health services.

While there was a robust literature on the benefits of tele-health services prior to COVID-19, predominantly in rural areas, there were only a limited number of human services organizations who had integrated tele-health services into their daily practice (Barnett & Huskamp, 2020; Comer & Myers, 2016). Aside from therapy models built on telephone or virtual delivery, the provision of mental health services via tele-mental health (TMH) was extremely limited. While several benefits of TMH have been identified, such as the capacity to serve clients across multiple locations, the ability to generalize treatment beyond the office setting, and some positive impacts on the client-provider relationship (Shreck et al., 2020), numerous barriers and limitations have been identified preventing it from being integrated into the service array of most community-based organizations. These factors can be organized into three categories: (1) Provider factors, (2) Client factors, and (3) Organizational factors.

Provider factors include challenges related to understanding and interpreting clients' body language during both assessment and treatment sessions (Shreck et al., 2020), resistance to change or alterations from previous practices (Connolly et al., 2020), turnover of providers (James et al., 2021), availability of staff, space, and equipment to conduct TMH (Caver et al., 2020), and general technology issues, including adequate training, comfort, access, trust by providers of the technology itself, "Zoom fatigue," and time to make the culture change (James et al., 2021). Client factors include general distrust and acceptance of the TMH model of service provision, and technology constraints (access to equipment and wi-fi or internet access) (Caver et al., 2020). Organizational factors include creating an entirely new process to schedule appointments and conduct TMH through a HIPAA¹ compliant portal, time to design the overall organizational processes, hesitancy to implement new technology with existing routines, and the importance of creating new processes specifically to address safety concerns (Caver et al., 2020).

While there are significant challenges with the implementation of TMH practices, most, if not all, community mental health agencies in the United States and in several other countries needed to quickly transition to TMH practices to provide necessary services to the children and families who

need them. Given the importance of implementing TMH practices quickly, and without much, if any, preparation, traditional implementation science models of systems or practice change could not be utilized. Instead, organizations needed to shift overnight to accommodate that need.

Child Trauma within the Context of COVID-19

The COVID-19 pandemic has had wide reaching consequences arising from the disease and the public health measures adopted to curtail its spread. Effects such as the loss of family members, fears of contracting the disease, economic insecurity, increased caregiving burden, social isolation, and reduced access to supportive services have been associated with heightened levels of stress, increases in mental health and substance use concerns among both adults and children, and exacerbation of symptoms in individuals with existing mental health or substance use problems (Czeisler et al., 2020; Ettman et al., 2020; Murphy et al., 2021; Nearchou et al., 2020; Panchal et al., 2021; Patrick et al., 2020; Theberath et al., 2022).

Many of the effects associated with the pandemic, including social isolation, economic strain, increased stress, mental health challenges, and reduced access to services, have been linked with risk for child abuse (Pereda & Díaz-Faes, 2020; Peterman et al., 2020). Reviews of studies published early in the pandemic have revealed a variable picture regarding the impact on rates of child abuse (Cappa & Jijon, 2021; Rapp et al., 2021) with results generally showing decreased reports to law enforcement and child welfare, and increased incidence in hospital settings including child abuse related injuries (Cappa & Jijon, 2021; Rapp et al., 2021).

Overview of the Children's Advocacy Center Model

The purpose of the current paper is to highlight the rapid implementation of TMH that occurred within a children's advocacy center (CAC) following the stay-at-home order that was put into place due to COVID-19. We will also offer our retrospective reflections of the applicability of the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009) in implementing organizational changes quickly. While many, if not most, community-based mental health organizations in the United States pivoted to a TMH model of service provision at the onset of the COVID-19 pandemic, a CAC is a specific type of organization designed to facilitate the multidisciplinary response to child abuse. There are more than 939 CACs across the United States (US) that range tremendously in

¹ HIPAA refers to the Health Insurance Portability and Accountability Act, which was a federal law passed in 1996 in the United States that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

size, staffing, and scope, but all are instrumental to addressing child abuse in their communities. The CAC model of service provision originated in the United States and has been replicated around the world in countries such as Australia and the Netherlands. CACs work with their partners to assist in child abuse investigations through the provision of forensic interviews (in which trained individuals interview children about allegations of abuse) and medical exams (conducted by medical professionals with specific training and experience regarding sexual abuse and, often, physical abuse exams). In addition to forensic interviews and medical exams, most CACs provide the family with support through victim advocacy services and offer mental health services onsite or have a collaborative agreement with external mental health agencies or providers to deliver trauma-focused evidence-based mental health treatment. CACs play a pivotal role in coordinating the multidisciplinary team, including members of law enforcement, child welfare services, and the district attorney's office to ensure that child abuse is identified, investigated, and treated using best practices.²

In the United States, the work is governed by the *Standards for Accreditation for Children's Advocacy Centers* (National Children's Alliance, 2017). This document outlines best practices related to the various "standards" that include topics such as the broader multidisciplinary team, medical exams, victim advocacy, and others. A key component of the standards is to ensure that children who present at the CAC have access to quality, evidence-based, trauma-focused treatment practices. Therefore, it is consistent with the standards as well as general best practices to ensure that CAC clients have access to mental health services, regardless of whether they can attend those services in-person. The current paper describes the implementation of TMH practices within one of the United States' largest urban CACs that serves approximately 2000 children and their families annually. Given the unique needs of the population served at a CAC, that includes children who may have been sexually or physically abused by a caregiver or another adult in their life, specific issues regarding client safety and confidentiality need to be considered. While the forensic interviews and medical appointments continued to be held in-person throughout the COVID-19 pandemic, more than 90% of mental health services were transitioned to TMH within the first 30 days of the stay-at-home order to maintain public safety for both the staff members and the clients receiving services. Providers continued to come and work within the office setting, but clients joined sessions remotely.

² See the National Children's Alliance website at <https://www.nationalchildrensalliance.org/> for more information on children's advocacy centers and the CAC model.

A Review of Rapid Implementation for Systems Change

Implementation science researchers have posited that implementation occurs in several phases or steps with multiple levels of influence operating at each phase (e.g., Aarons et al., 2011; Mendel et al., 2008). For instance, the EPIS model, developed for public service systems, outlines four phases of the implementation process, specifically Exploration, Preparation, Implementation, and Sustainment (Aarons et al., 2011; Moullin et al., 2019). Each of these phases includes several steps to support the thoughtful implementation of a practice or change over a period. While this model of implementation is foundational for creating true practice change within service settings, it may not always be feasible in times when practice change needs to occur in quick succession, as each step within these models require multiple actions taken over an extended period. For example, when implementing an evidence-based intervention within a mental health setting, the initial step might include Exploration (within the EPIS model) which can include months of reviewing the emergent needs of the clients served and conducting a review of the existing practices and their available research to determine which would be the best fit. When change must be implemented overnight, a rapid implementation approach would be helpful. Smith et al. (2020) proposed the following theoretical definition of rapid implementation:

Rapid implementation provides the best possible evidence-based practice of a program or intervention to those who need it, with speed and efficiency, by redefining rigour, and adapting both methods (adapting current approaches, procedures, and implementation frameworks), and trial design, to fit research aims and objectives (p. 9).

Concerns about the time-lag for evidence-based practices to be implemented into clinical practice and advances in science, such as in precision medicine, are driving a call for accelerated uptake of interventions (Smith et al., 2020). Proctor et al. (2022) have identified several factors that underscore the need for rapid implementation of innovations. These include health and social crises such as pandemics; the typically reactive nature of health care, social service, and public health systems where adoption of new practices tends to be prioritized in crises such as with the opioid epidemic; and social disparities in care including racial, economic, and geographical inequities. Rapid implementation efforts have drawn on implementation science models, such as the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009), that are flexible and can be tailored to a rapid implementation context (Keith et al., 2017; Smith et al., 2020).

The Consolidated Framework for Implementation Research (CFIR) emphasizes factors influencing implementation at multiple levels (Damschroder et al., 2009). Based on a consolidation of theories and empirical evidence, CFIR includes five domains of factors associated with implementation effectiveness: intervention characteristics (features of the intervention such as complexity or cost), outer setting (aspects of the external environment such as external policies, and patient needs and resources), inner setting (characteristics of the organization involved in implementation such as leadership engagement), characteristics of individuals (characteristics of individuals involved in implementation such as knowledge and beliefs about the intervention), and implementation process (includes the implementation approach and strategies such as planning activities).

Creating Innovation in Teams

In addition to the implementation science models designed to describe the process of implementing a specific practice or systems change, there is a wealth of literature addressing the factors that are needed to create innovation in teams. Specifically, when the innovation involves the implementation of new technology (such as TMH), specific factors need to be in place. Edmondson (1999) focused on the importance of “team psychological safety” that she defines as, “A shared belief held by members of a team that the team is safe for interpersonal risk taking” (p. 354). Further, team psychological safety is associated with learning behavior, and a team’s willingness to engage in innovations, although it doesn’t impact team *effectiveness*. Team effectiveness is enabled by structural features, such as a well-designed team task, appropriate team composition, and a context that ensures the availability of information, resources, and rewards. Specifically related to technology innovation, Edmondson (2003) found several factors designed to support its effective implementation:

- Support from top management regarding the implementation
- Having the resources necessary and flows of communication in place to support implementation
- Previous experience with the team implementing technology together
- Opportunities for coordination and collaboration among team members to manage the difficult aspects of implementation
- Creating a frame regarding the implementation that focuses on the learning aspect of the activity to improve services, vs. a frame focused on averting risk or need to “get ahead.”

Building on this work, Nembhard et al. (2006) highlighted the importance of “leader inclusiveness,” defined as “words and deeds exhibited by leaders that invite and appreciate others’ contributions” (p. 941). This work highlighted the importance of leadership messaging, and in providing recognition and appreciation for staff at all levels, in supporting implementation and innovation efforts. This work occurs within the context of a broader implementation team. Implementation teams play a critical role in making identified changes and usually consist of a select group of individuals designed to provide internal support and structure to the implementation process, ensuring accountability to the work as the selected practice moves through the stages of implementation (Van Dyke, 2015). Taken together, the research suggests that the effective implementation of an innovative practice change entails more than merely rolling out a new practice but, rather, it takes thoughtfulness and skill on the part of the entire team to ensure that the new practice is implemented effectively and sustained over time.

Provider Considerations for Tele-mental Health Implementation within a CAC Setting

Informed by the literature on implementation and innovation, leaders at our CAC (referred to as “agency”) located in a large urban area sought to quickly transition from an in-person model of mental health services to one conducted predominantly through TMH. Given the complexity of the cases seen in the CAC environment, there were several concerns regarding the appropriateness of utilizing TMH within populations exposed to trauma. Sklar et al., (2021a, 2021b) documented some of these concerns in their work, including client’s diminished willingness to process trauma, not being able to see clients face-to-face (even virtually), and provider discomfort in the trauma healing process if they are unable to see the client in person to determine if they are upset, triggered, etc. Despite some of these concerns, our agency made the decision to pivot to TMH to ensure that services could continue to be provided during a time in which there was a stay-at-home order and concerns regarding infection control were dominant. To facilitate the transition to TMH, agency leadership considered the mechanisms that needed to be in place to facilitate this transition and were informed by the broader implementation science literature. Following several conversations with staff, leadership, and executive level leadership, we decided to focus on the following key activities to facilitate the TMH transition: (1) Agency expectations; (2) Providing training and resource sharing; (3) Technology and space considerations; and (4) Creating communication and collaboration opportunities for staff to support one another. Each of these areas will be discussed and their applicability to the related CFIR constructs shared.

Agency Expectations

The first step that needed to be put into place was for agency leadership to set the expectations related to the transition to TMH. Within CFIR, this step is related to the “leadership engagement” construct, which focuses on commitment, involvement, and accountability of leaders within the implementation. It is also connected to the “relative priority” construct, which focuses on individuals’ shared perception of the importance of the implementation within the organization. The agency had been considering implementing TMH on a very limited and selected basis prior to the emergence of the COVID-19 pandemic. In January 2020, agency leadership identified a plan to utilize traditional implementation science approaches to implement TMH, including conducting a small pilot with one “early adopter” (Rogers, 1962) provider with 1–2 identified clients who were already engaged in therapy and technologically proficient to engage in the therapy process. However, due to other organizational demands, the agency decided to postpone the implementation of TMH until the following fiscal year. With the onset of the COVID-19 pandemic in March 2020, it became clear that the transition to TMH needed to be immediate and organizational leadership immediately voiced a commitment to this transition while emphasizing that it was a top priority. The organization quickly began putting in place the infrastructure needed to make the necessary transition.

In general, agency leadership set an expectation that clients would be seen through the provision of TMH, unless various indicators based on both clinical experience and those highlighted in the literature on TMH suggested that in-person services would be recommended. These included situations with significant safety or confidentiality issues, clients who had no access to technology, clients who refused to be seen unless it was in-person, and very young children who could not engage in TMH services. Further, while most of the initial assessment sessions moved to TMH (with a Research Associate often calling and administering standardized assessment measures over the phone), in some cases, it was determined that conducting the first 1–2 sessions in-person would be helpful in terms of engaging families and streamlining the assessment process. The process was refined on an ongoing basis based on both the guidance from the broader organization regarding safety precautions and based on real-life input from working with clients.

Provider Training and Resource Sharing

Another key component that needed to be in place to effectively transition to TMH was training. This component is related to the “access to knowledge and information” construct within CFIR. There were numerous training activities undertaken, ranging from those designed to support staff

with the technical aspects of TMH to trainings focused more on the application of therapy practices within a TMH environment. Both types of training were important to equip staff with the skills to effectively transition to TMH. The technical trainings focused on teaching clinicians how to use the TMH platform, including how to login, how to schedule a session in a HIPAA compliant manner, and how to begin and end a session ensuring that the client could see and hear the provider. The agency leadership team worked with its Information Technology (IT) team to have the trainings conducted multiple times over various days and times so that staff could join at a time that was convenient for them. The trainings were eventually recorded, as well. Although staff did experience challenges in learning the technology quickly, the practical trainings helped to mitigate some of these issues.

The trainings focused on the application of therapy practices and included targeted discussions on how the providers could integrate TMH elements into their existing evidence-based practices repertoire. Examples of these training activities included how to integrate play therapy techniques into the virtual session, strategies to engage clients using the TMH platform, and ways in which providers can provide psychoeducation on trauma and its impact using online games or activities.

In addition to providing specific training activities, agency leadership worked with staff to create the “Telehealth Clinical Resource Center.” This resource center was a central repository of resources that could be accessed by all providers, was organized by topics and age of clients, and included tip sheets, webinars, and other resources that could support the clinicians in this effort. For example, links to existing webinars on using Trauma-Focused Cognitive-Behavioral Therapy via a TMH format, tip sheets on creating safety during the TMH session, and resources related to mindfulness, managing feelings, and coping skills, among others were included. Additionally, agency leadership highlighted a couple of these resources during twice weekly emails that went out to providers. Agency staff found the process of sharing resources with one another and having a shared resources file to be extremely helpful.

Technology and Space Considerations

A third critical component was the technology and space considerations, that are related to both the “cost” and “available resources” constructs within CFIR, which includes the level of resources dedicated for implementation and ongoing operations, such as money, training, education, physical space, and time. Since the transition to TMH occurred very quickly and without precedent within the agency, determining the technology needs for both clients and providers was somewhat challenging. Some of the technology needs

included having a headset and dual monitors to assist with charting during the session. The agency analyzed available spaces to ensure that providers had access to a private office to deliver the sessions to ensure confidentiality. Additional considerations for space include lighting (e.g., is the provider's face clearly visible on the screen without shadowing) and background (e.g., is there anything distracting behind the provider in the video, such as a mirror or artwork?). In addition, the agency explored options for a HIPAA compliant TMH platform in which to hold sessions. As part of a large pediatric hospital, the agency worked closely with its IT department that was overseeing this effort in the broader umbrella organization. The IT department took the lead on identifying the platform and worked with the organization to ensure that all providers had accounts. They provided tip sheets and training worksheets to support the implementation itself. Additional technology needs focused on ensuring that staff members had cameras and headsets linked to their computers to enable them to see and hear clients during sessions. Due to the high need for these supplies once virtual training and work became the norm during the COVID-19 pandemic, retailers quickly started restricting the number of products that could be purchased at the same time and increased prices to accommodate for the demand. Fortunately, the agency was able to determine the technology needs at the outset and quickly match those needs with available resources, enabling the quick procurement of the necessary equipment so that providers could begin to conduct TMH sessions. This included taking advantage of a COVID-19 specific funding opportunity that covered the costs of headsets and webcams for providers. Receipt of personal equipment such as blue light glasses and headphones was valued by staff.

Communication and Collaboration Opportunities

A final area of focus was on effective communication and collaboration opportunities, that can be linked to the “learning climate,” “planning,” and “engaging” constructs of CFIR. The “learning climate” focuses on creating a climate in which both leaders’ and staff members feel psychologically safe to admit their own fallibility and there is time and space for reflective thinking and evaluation. The “planning” focuses on the degree to which the scheme or method of behavior and tasks for implementing the change are developed in advance. The “engaging” construct refers to attracting and involving appropriate individuals in the implementation and use of the intervention through several combined strategies, such as education, social marketing, and role modeling. One of the trademarks of the COVID-19 pandemic was the constantly shifting nature of the information shared regarding the pandemic itself and associated safety practices. For example, initial guidance suggested that

masks were not necessary (to ensure that they were available for essential staff as needed), but that message quickly changed. These everchanging directives deeply impacted the staff as it was hard to navigate so many shifts over such an extended period. Further, while staff at the agency continued to come into the office, they often spent most of their days behind closed doors, not actively communicating with other staff due to infection control concerns. In essence, the “hallway conversation” among peers that often serves as a critical way for staff to connect with one another and share important information, was lost. Therefore, it became critical to create multiple opportunities to share updates on policies and practices and to connect with one another in this new environment. As a result, the following communication strategies were put into place:

- The umbrella organization (a pediatric hospital) initiated weekly COVID-19 virtual town halls open to all staff that provided updates on the status of the pandemic, testing, vaccinations, risk of in-person vs. using tele-health, etc. These town halls supported the “planning” and “components” of CFIR.
- Agency leadership convened weekly virtual meetings that included training opportunities as well as general updates for the providers and a review of lessons learned. These were often accompanied by tip sheets or Frequently Asked Questions (FAQs) for staff. These virtual meetings supported the “learning climate” and “engaging” constructs of CFIR.
- Agency leadership began sending twice weekly emails to staff that included the highlighting of resources that have been developed within the broader field or internally, sharing updates for staff on policies and practices, and addressing any questions or concerns that arose since the previous message. These messages supported the “learning climate”, “planning”, and “engaging” constructs of CFIR.

Due to the changing nature of expectations and requirements, challenges were encountered with providing clear and consistent messaging to staff across clinical programs, for example regarding procedures for obtaining consent and for sending emails to families that met security and confidentiality requirements. Further, improvements could have been made in the communications to families regarding expectations and guidelines as the transition to telehealth occurred.

Family Considerations for Implementing TMH within a CAC Setting

Families had specific needs to consider during the process of implementing TMH practices. These included the development of resources specific for families and providing

Table 1 Expectations for family members engaging in TMH

Area	Expectation
Suitability	TMH is not a suitable modality for everyone. The provider may determine that services may be better offered via in-person care if there are ongoing challenges with technology or accomplishment of treatment goals to ensure that the client is receiving the best care possible
Confidentiality	Due to the sensitive material that is covered in each session, clients are encouraged to be alone in the room (no family or friends), unless otherwise agreed upon with the provider to respect the confidentiality of the treatment process
Video/audio recording	Video/Audio recording of the session is prohibited, unless directed by provider
Public activities	Clients are directed to not engage in TMH while they are driving or in a public area (e.g., public transit, at a restaurant)
Running late	Clients are directed to call the provider if they are running late
Dress	Clients are directed to dress as if they were going to an in-person appointment at the agency
Privacy	Clients are directed to have the session in a private room with minimal distractions: Cellphones should be turned off or on vibrate (unless it is being used for the session). There should not be any texting, e-mailing, using the internet, or engaging in any other activities on the computer during sessions
Pets or people in home	Clients are directed to inform the provider of any pets or people in the home at the time of session
Use of alcohol or drugs	Clients are asked not to attend sessions while under the influence of alcohol or illegal drugs
Devices charged	Clients are reminded to have their devices fully charged prior to the scheduled appointment

families with the necessary supplies and equipment to effectively engage in the TMH process. Agency leadership created multiple written materials designed specifically for families who were engaging the TMH process, including directions on how to join a session virtually, and a list of expectations to prepare for the session since it occurred in an environment distinctly different from the in-office setting. These expectations are highlighted in Table 1.

Despite this guidance, challenges were presented by privacy and safety issues in the home. For example, clients sometimes did not have a private or safe space for telehealth sessions because there were other children around or caregivers with young children were unable to be alone. Difficulties were presented by clients logging in to sessions from other locations such as a vehicle, someone else's home, or a community location.

Supplies and Equipment

In addition to providing resources, several considerations for supplies and equipment needed to be made to ensure that families could engage effectively in TMH. These included ensuring that families had access to the necessary network technology and equipment to engage in sessions as well as confirming that they had adequate supplies or resources. While many mental health organizations provided equipment, such as iPads and network hotspots to families to assist them in engaging in TMH, that was not an option at this agency due to significant challenges with securing laptops to protect confidentiality, ensuring that they were used only for TMH, and providing them with a data plan. However, in the end it did not present a significant problem as smart phones are ubiquitous and most families were able to use their cell phone to access the therapy session (although this was not

ideal), using available wi-fi networks, as needed. In terms of necessary play therapy supplies, the agency received a generous donation from a funder and was able to develop "tele-therapy kits" that were delivered to the homes of several families and included items such as squeaky toys, memory games, family sets of figurines, doctor kits, miniature animal sets, Play-Doh, dolls, and finger puppets. These items were designed to facilitate the engagement process of TMH and give families the resources they needed to fully engage.

However, there were several challenges that arose in this process. Staff were challenged by the engagement of clients and getting them to participate in TMH sessions. Some children were easily distracted or unable to focus and engage for a full session; teens had discomfort in being on video or were doing other things; "Zoom fatigue" resulted in cancellations; and some caregivers did not buy into the process, thus did not ensure their children attended sessions. Further, while the "tele-therapy toolkits" were initially available, they were only available to some families and were not available if families engaged in therapy 6–12 months after the beginning of COVID-19. Clients also had challenges with technology knowledge, including how to use the virtual platform, connecting to their health record for the session, and unencrypting emails. There were technical difficulties such as video freezing and audio not working. Clients often lacked appropriate devices for TMH sessions. For example, some clients only had access to cell phones that made it difficult for them to see the provider or to see what the provider was sharing on their screen. Another factor was families having unstable internet connections or not having the necessary bandwidth leading to choppy TMH sessions or video not being able to be used. An additional barrier was equipment malfunction (e.g., running out of power/charge, device not working). This made engaging with clients challenging.

Table 2 Recommendations for engaging clients in TMH during the referral and intake processes

Area	Recommendation
Technology	Discuss with the client and caregiver if they have the adequate technology to engage in TMH. This includes a computer, webcam, speakers, or a mobile device (such as iPad or phone) that includes capacity for both video and sound
Privacy	Ensure that the child and caregiver have a private space for the assessment that is free from distractions and where they can answer questions freely
Transparency	Validate with the clients that, while the assessment is being conducted via TMH, it is not ideal, and it might be a strange, new process for them. Be realistic about the challenges associated with collecting information in this way. Let them know that there will likely be unforeseen challenges with the technology and to be patient
Safety	As with any intake process, highlight safety and the need to maintain safety throughout the process
Informed consent	Make sure to complete the Informed Consent as soon as possible. Forward a copy of the Informed Consent form to the family prior to the session so they have time to review. During the first intake session, briefly review it and address any questions that may have emerged

The Implementation of Specific Tele-mental Health Processes

While creating the infrastructure was an important part of the process for quickly transitioning to TMH, a key element was providing very specific, step-by-step guidance for providers that outlined how they should do this process. In general, when a process is new, it can be hard to integrate it into current processes without specific guidance on *how* to do the process. Over time, this guidance becomes habit and can be more effectively integrated into daily practice process. The following specific guidance was shared with providers to assist them in effectively transitioning to TMH.

Preparing for the Initial Session

The first couple of sessions of TMH look quite different from traditional office therapy. Some children might be excited to show the provider their room and their house, introduce them to their pet, etc. Others might not want to show themselves on video or be hesitant to share their home and room. The first session or two will be a transition. Rather than viewing this as a departure from the therapeutic process, providers were encouraged to think about this as another way to build engagement and rapport with the client.

Referral and Intake Processes

The agency created several recommendations for providers to consider as they focused on engaging clients in the TMH format, that was often a new process for them. These recommendations are highlighted in Table 2.

Informed Consent: Developing Trust and Rapport

A key part of the assessment process is developing trust and rapport with the child and family so that they feel comfortable engaging in services and completing the assessment

process. The development of trust and rapport begins with the child and family's very first interaction with the agency. Table 3 highlights some strategies to help develop trust and rapport via TMH.

Safety Planning and Crisis Intervention Strategies

Due to the nature of the work that is conducted at the agency as a CAC, clients and caregivers who receive services are potentially at higher risk for safety concerns. These include but are not limited to fear of harm to self or others, risk of intimate partner violence, and heightened risk of child abuse and neglect. While the provision of TMH creates an opportunity to provide services to families who may not be able to access services otherwise, it presents with heightened safety risks. Therefore, it was critical to develop a safety planning policy and procedure that outlined strategies to create safety before, during, and after a TMH session. This is included in Table 4.

Assessment Processes

Another key component of the TMH process is the initial assessment process in which the provider gathers important information about the client and their concerns to develop the treatment plan. The assessment process includes a clinical interview, behavior observations, and the administration of standardized assessment measures (Chadwick Center for Children & Families, 2009). Throughout the clinical interview, the provider typically asks the child and/or caregiver several deeply personal and detailed questions. For the provider, asking these questions remotely can feel somewhat uncomfortable and impersonal. The following strategies can assist with the clinical interview process:

- Pay attention to body language as much as possible given the technology (and its potential limitations).

Table 3 Strategies for providers on developing trust and rapport via TMH

Category	Strategy
Welcome packet	Forward clients a welcome packet that describes information about the center, the services that are provided, etc. so that they can receive as much information about the process as possible in advance
Transparency	Begin the process of engagement by being transparent about how TMH is different than other forms of therapy and this is likely a new experience for both the provider and the client. Share with the client that this is a joint process
Eye contact and body language	Practice appropriate eye contact and body language. Center yourself on the screen and keep your eyes on the camera (vs. the broader screen itself), as the client will experience this as looking at them versus slight away from them
Voice and tone	Ensure that your voice and tone are calm and connected. Over the course of the day conducting TMH sessions, you can get tired, slouch more, and feel the need to speak more loudly, that can hurt your voice. Pay attention and incorporate strategies to help maintain you voice as needed (e.g., lozenges, tea, voice exercises, watching posture)
Introductions	During an initial interaction with the child and family, introduce yourself, and provide information about your background and experience, including how long you have been doing this work, and your qualifications
“Virtual” tour of office space	Create strategies to provide a “virtual” tour of the office so that the client can experience what it would be like to come into the office itself. This may be through photos shared with the client, or you or intake coordinator may take the client on a video “tour” of the space
Tour of client space	Ask the child and/or caregiver to provide a tour of their own physical space – this may be their own room, the overall house, or a unique space that they’d like to share with you
Check-in	At the end of the first session, check-in with the client about the experience. What worked well for them? What was challenging? Do they want to continue with therapy? If so, what can be improved next time?
Homework	Provide some homework before the next session, including journal prompts, research, to keep them engaged in the process

- Expect the process of conducting an assessment via TMH to take longer than a traditional assessment. Break up the assessment as much as possible to avoid fatigue for both the provider and the child/caregiver.

During a face-to-face assessment session, the provider or intake coordinator may provide the client and/or caregiver with the measures and ask them to complete them in the office prior to beginning the sessions. However, this process may need to be adjusted during TMH, as sending the measures to families to complete and send back can be time-consuming, costly, and can create concerns regarding confidentiality of responses, and potential triggering of measure items. Therefore, the following adjustments can be made to the measure administration process:

- If a measure is available online and there is a confidential portal in which the client and/or caregiver can complete the measure privately, that is an option to consider.
- Otherwise, consider administering the measures verbally to the clients via TMH
 - It can be helpful to scan a copy of the measure and share your screen so that the client can see the measure and follow along with the questions. Some companies who sell assessment measures prohibit this, so agencies are encouraged to check-in regarding the

rules and regulations for each of the measures they use.

- If that is not possible or it is difficult to see, create a visual representation of just the scaling and share that document, asking the client/caregiver to provide ratings using the appropriate scaling for the measure.
- As much as possible, provide the client or caregiver with options on how to complete the assessment – do they want to read it quietly and just give responses? Do they want you to read the questions to them and they point to a response on the screen? Try to keep it as engaging and interactive as possible.
- Regardless, the provider is encouraged to have a copy of the measure in front of them that they can fill in and complete the scoring after the session is complete.
- When sharing the results from the standardized measures, it can be helpful to scan any reports that are generated on the scores and share those in much the same way as you would during an in-person session.

Funding, Licensing, and Legal Considerations

Several additional considerations needed to be made for ensuring that key funding sources supported TMH services. Prior to the COVID-19 pandemic, several of the funding

Table 4 Guidance for ensuring safety before, during, and after the TMH session

<p>Preparing for the TMH session with the family</p> <p>Confirm the address in which the therapy will take place (do not rely on the medical record, as the client may be elsewhere during the session or the address in the medical record is not updated)</p> <p>Ask for the phone numbers of TWO individuals in the house. One might be the client's number (if they have their own number) and the second may be a caregiver</p> <p>In advance, discuss with caregivers the space in which the TMH session will be conducted and how to keep it "protected" and maintain client privacy, including from siblings, pets, and others who may come into the room or may overhear the session. This is particularly important within the CAC environment, as there may particularly be concerns about appropriate boundaries and a historical lack of effectively maintaining privacy. If privacy cannot be maintained during the session, explore other options (e.g., a car or other space) in which the session could be conducted safely</p> <p>Determine where caregivers will be during the session and if the client or provider will be able to contact them if needed</p> <p>Determine if the identified space is potentially triggering (i.e., is this where the abuse occurred?). If so, work with the caregiver to identify another space that may be more appropriate</p> <p>If appropriate, and based on the age, developmental stage, and the child's unique situation, the provider is encouraged to have a similar conversation with the child that includes the following elements:</p> <p>–Where will the child be during the session? Is it a "safe" space, free from potential triggers and distractions?</p> <p>–Is there a "safe" word that the client can use in session if they are not feeling safe?</p> <p>For each client, think about the potential safety concerns that may arise, considering the following:</p> <p>–Has this client previously been at high-risk for abuse in the home, harm to self or others?</p> <p>–How stable is the caregiver? Are they able to support the client as needed?</p> <p>If you have an upcoming session with a client or caregiver who is potentially at a higher risk for self-harm, abuse, intimate partner violence, or another concern, let your supervisor and co-workers know about your concerns, the time of the session, and the client's address. They can then be "on alert" as needed if something comes up</p> <p>During the TMH session</p> <p>Practice "Universal Precautions" to reduce the chances of endangering a client if they are being monitored or have been otherwise threatened regarding what they might say during a session</p> <p>For high-risk situations in which the alleged perpetrator is still in the home, assume clients are not alone even if they say they are, and assume there might be abuse even if they have never disclosed it. Consider identifying an alternate location outside the home for TMH sessions</p> <p>It is recommended that all sessions begin with a safety screen. You can let the clients know that you are doing this with everyone. For this screen, do not lead with specific questions about safety or abuse unless the client brings it up</p> <p>Follow the client's lead regarding what they may or may not feel comfortable talking about. If the client indicates there might be some safety concerns, explore with caution, ask if they could say a little more about what they are concerned about or need help with; be prepared to switch subjects at any time</p> <p>Consider screening for depression and anxiety, as appropriate based on initial check-in at the beginning of the session</p> <p>If the client discloses not feeling safe due to imminent risk/threat of abuse towards themselves or others in the home, conduct a more in-depth safety screen. The following questions can serve as a guide:</p> <p>–If you are afraid for your safety, you can call 911 any time. Would you like me to call 911 for you right now?"</p> <p>–If they indicate they are not in immediate danger and can stay on the phone, offer other ways for client to find help when it's a good time for them</p> <p>If the client discloses suicidal/self-harm thoughts, remote safety planning is like that which would be conducted in person</p> <p>Assess each session for suicide risk as well as changes in risk or protective factors and the emotional impact of pandemic on suicide risk</p> <p>After the session</p> <p>Follow-up regarding the safety issues that emerged during the session per normal protocol</p> <p>Document that a Safety Plan for TMH was created with the client in the client's chart</p> <p>Give some time for "grounding" and closure in between sessions</p> <p>Review any issues that may emerge with the team for support as needed</p> <p>Seek out a colleague for support, even if it's just a note that says, "That was a tough session."</p>

sources that supported mental health services in the United States did not fund TMH. One of the first things that agency leadership did was reach out to the various state and federal funding sources to determine if TMH was considered

a covered service. Because the impact of COVID-19 was far-reaching, it resulted in changes to several policies related to TMH. Ultimately, most, if not all, funding sources supported the pivot to TMH services, at least during the acute

phase of the pandemic. It is unclear if, at the time of publication, these short-term changes will apply in the long-term; nevertheless, having broader system financial support for TMH practices played a critical role in the agency effectively implementing the change.

Applicability of the Consolidated Framework for Implementation Research Constructs

Given the extensive and multi-faceted nature of the implementation of TMH within the identified CAC, agency leadership was informed by the components identified in the CFIR model of implementation (Damschroder et al., 2009). Table 5 provides a snapshot of how some of the components identified in CFIR were utilized throughout this implementation process.

Transitioning Back to In-person Sessions

As vaccines became more widely available, discussions within the agency began to shift from a focus on seeing clients via TMH to adopting a thoughtful approach where providers worked with their supervisors to determine which cases would benefit from being seen in-person and those that could remain in TMH. It was determined that the following cases would be prioritized for in-person sessions:

- Clients with imminent safety concerns that cannot be supported through TMH and would benefit from face-to-face contact.
- Young children with significant trauma symptoms and who are not able to effectively engage in therapy services within the virtual environment.
- Caregivers with specific mental health needs that are interfering with treatment within the virtual environment.
- Clients who do not have privacy at home or do not have a safe, private, and confidential space to conduct the session.
- Clients who have been on TMH but would benefit from 1 to 2 in-person sessions for stabilization purposes, such as safety planning.
- Clients who are coming in for their initial or mid-point assessments and completion of consents and other paperwork.

Overall, it was anticipated that approximately 50% of cases and/or sessions would continue via TMH and the other 50% would be in-person. While some clients might only come in for face-to-face sessions, it was expected that some clients would come in for just a couple of sessions and the rest would be conducted via TMH.

Lessons Learned and Recommendations Moving Forward

The focus of the current paper is to highlight the initial implementation efforts of one CAC at the onset of the COVID-19 pandemic. However, it has become clear that TMH will continue far into the future. Therefore, sustaining this work will be pivotal going forward. The following section outlines lessons learned as well as recommendations for sustaining this work successfully over time.

Staff and Client Support

Staff members within the agency were deeply impacted by COVID-19, both personally and professionally. Across the workforce, several shifts occurred to accommodate for COVID-19, that took a significant toll on employee well-being. Sklar et al., (2021a, 2021b) examined service providers from six community mental health centers who implemented evidence-based practices via TMH. They found that burnout was low *only* when work changes were low and job resource levels were high. Alternatively, when work changes were high, burnout was high across several levels of resources. Indeed, staff members at the agency were severely impacted by burnout. Many providers were balancing the impact of COVID-19 on their own family life (children at-home attending school remotely, managing health issues, etc.) in addition to navigating the impact of COVID-19 on their clients, on top of implementing a new TMH practice. As stated previously, the agency made an organizational decision to have providers continue to come into the office and conduct TMH sessions in office. While this decision was made for several organizational reasons (e.g., accommodating those clients who continued to come in-person, lack of resources to set up both a remote and in-office set up, concerns regarding maintaining client confidentiality in home, and creating opportunities for coordination and collaboration among staff members), it was a large dissatisfier for the providers who felt strongly that they should be able to work at home, as that was the practice in many other programs and mental health providers in the community. Given the decision to keep staff in office, it is important to ensure that issues of burnout are consciously addressed by leadership throughout every step in the process through the provision of resources and supports designed to meet provider needs. These include the following:

- **Monthly Check-Ins:** While there were multiple trainings and support for staff at the beginning of the pandemic, these check-ins decreased after the initial burst,

Table 5 The applicability of the consolidated framework for implementation research (CFIR) constructs in the current setting

Construct	Brief description	How applied in current setting
Intervention characteristics		
Intervention source	Perception of Key Stakeholders about whether the intervention is internally or externally developed	The intervention of TMH was widely regarded as a necessary step across CACs and mental health agencies
Relative advantage	Stakeholders' perception of the advantage of implementing the intervention versus an alternative solution	TMH was a clear preference as it minimized risk related to the transmission of COVID-19
Cost	Costs of the intervention and costs associated with implementing the intervention including investment, supply, and opportunity costs	Costs included purchasing of equipment, as well as staff time and resources to implement the change
Outer setting		
Patient needs and resources	The extent to which patient needs, as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization	These largely focused on technology, but also included situational characteristics, such as the availability of a private room
Inner setting		
Structural characteristics	The social architecture, age, maturity, and size of an organization	The agency is a large CAC with a long history of providing mental health services, but no previous experience with TMH
Culture	Norms, values, and basic assumptions of a given organization	A high value was placed on in-person interactions prior to TMH. This changed over time to a more balanced approach
Implementation climate		
Relative priority	The absorption capacity for change, shared receptivity of involved individuals to an intervention, and the extent to which use of that intervention will be rewarded, supported, and expected within their organization	Prior to officially implementing TMH because of the pandemic, there were several discussions as to its benefits but concerns regarding feasibility. With the onset of the pandemic, this quickly changed
Learning climate	Individuals' shared perception of the importance of the implementation within the organization	The implementation of TMH was viewed as a high priority, otherwise the agency would not have been able to continue seeing clients
Leadership engagement		
Access to knowledge and information	A climate in which: a) leaders express their own fallibility and need for team members' assistance and input; b) team members feel that they are essential, valued, and knowledgeable partners in the change process; c) individuals feel psychologically safe to try new methods; and d) there is sufficient time and space for reflective thinking and evaluation	Several attempts were made to facilitate a learning climate, including honest and transparent communication regarding some of the challenges associated with TMH, as well as doing this work within the context of COVID-19. However, more time to plan and set this frame would have likely been helpful
Characteristics of individuals	Commitment, involvement, and accountability of leaders and managers with the implementation	Agency leadership was very committed to this work
Knowledge and beliefs about the intervention	Ease of access to digestible information and knowledge about the intervention and how to incorporate it into work tasks	Several folders were created to facilitate the sharing of information, along with offering training opportunities and peer sharing opportunities
Self-efficacy		
Self-efficacy	Individuals' attitudes toward and value placed on the intervention as well as familiarity with facts, truths, and principles related to the intervention	Due to the nature of the COVID-19 pandemic, most staff supported the transition to TMH. However, there was disagreement on whether providers could conduct this work in the office or within their own homes
	Individual belief in their own capabilities to execute courses of action to achieve implementation goals	Training opportunities and resource sharing was offered to increase staff self-efficacy in the implementation

Table 5 (continued)

Construct	Brief description	How applied in current setting
Other personal attributes	Includes personal traits such as tolerance of ambiguity, intellectual ability, motivation, values, competence, capacity, and learning style	Some staff members embraced this new opportunity, while others expressed great levels of dissatisfaction and frustration throughout the process
Process		
Planning	The degree to which a scheme or method of behavior and tasks for implementing an intervention are developed in advance, and the quality of those schemes or methods	Agency leadership engaged in multiple planning meetings designed to support the implementation of TMH
Engaging	Attracting and involving appropriate individuals in the implementation and use of the intervention through a combined strategy of social marketing, education, role modeling, training, and other similar activities	Several training opportunities and tip sheets were created to provide education and support for providers engaging in TMH
Formally appointed internal implementation leaders	Individuals from within the organization who have been formally appointed with responsibility for implementing an intervention as coordinator, project manager, team leader, or other, similar role	Agency leadership and supervisors were tasked with supporting the implementation within their specific teams. Support was provided through several planning and review meetings regarding the process

leaving staff to feel more isolated as the pandemic continued. Therefore, it would have been helpful to continue monthly meetings and check-in with staff to provide the message that they are important and that they continue to be valued by the organization over time.

- Embed within Existing Staff Support and Organizational Health Initiatives: Several CACs and outpatient mental health organizations have existing initiatives designed to support staff members in doing work related to trauma and child abuse. It is recommended that organizations embed post-pandemic support work into these existing initiatives designed to support staff over the long-term.
- Provide Ongoing Training Opportunities: During the initial phases of the pandemic, there were multiple learning opportunities for staff about transitioning to TMH. However, these quickly dissipated as they became more fluent in providing TMH. Therefore, an opportunity was lost to keep staff connected to one another, allowing them to share new innovations and ideas that they had developed as they were doing this work, as well as presenting updated information from the field to the staff members providing TMH.
- Training New Staff Members on TMH: In 2021, staff turnover increased tremendously across several service sectors, both in the United States and abroad, termed “the Great Resignation.” As a result, there are both mental health providers who are leaving the workforce and providers who are entering the workforce and will be doing this work for the first time. Therefore, it is imperative to ensure that there are training opportunities in place designed to support new staff members, including trainees and interns, in understanding how to do TMH effectively while creating a safe and protected environment for clients.
- Providing Staff and Clients with Necessary Resources: At the beginning of the pandemic, there were several funders who came forward and provided the agency with donations for tele-therapy kits that included supplies for both staff and clients to assist them in effectively engaging in TMH. However, over time, those resources dried up and there were not as many available to clients who are now beginning to engage in TMH. It is recommended that agencies embarking on this work in the future consider ensuring that these types of resources will be widely available over an extended period, rather than only at the beginning.

Addressing Technology Needs

In the implementation of TMH practices, technology is a foundational element. If it is working effectively, is flexible and tailored to the needs of the client and the provider, the TMH session can go very smoothly. However,

if there are challenges with internet connection or gaps in provider or client knowledge of specific technology, then the session can feel burdensome and frustrating for both the client and provider. Therefore, ensuring that the infrastructure is in place to support stable technology efforts is crucial. While the agency described in the present paper was able to maximize the available technology resources, there continued to be challenges in that area. For that reason, agencies are encouraged to consider the following recommendations to better facilitate the use of technology.

- **Technical Assistance for Clients:** During the COVID-19 pandemic, the focus was on minimizing human contact for infection control purposes. However, in general, it may be helpful to create opportunities for technical assistance and/or training opportunities in the home with the client prior to the provision of TMH services. During this session, the provider can assist the client with troubleshooting any foreseen technology needs related to wi-fi access, bandwidth, and other potential challenges.
- **Funding for Technology:** While many of the clients described in the current paper had access to smart phones to participate in TMH sessions, that is far from ideal. If possible, agencies are encouraged to acquire funds (through mechanisms such as technology grants) that would allow for the purchase of iPads for clients to use for sessions or hotspots to enable better internet access. While these are not always possible due to challenges in purchasing data, protecting equipment, and confidentiality on the use of devices, agencies are encouraged to explore the options that might be available to them to better support their clients.
- **Improved Equipment for Staff:** In the current COVID-19 pandemic, the transition to TMH took place quickly around the world with multiple organizations and systems vying for limited resources in terms of equipment such as video cameras, headphones. However, generally, these resources are now more widely available. Organizations are encouraged to thoroughly research all the available options and purchase those that are better quality and likely to sustain over time. The initial investment will reap rewards many times over if the equipment is built to last and adaptable for staff while increasing staff satisfaction.
- **Ongoing Training and Resource Development:** While several resources were developed in the current initiative to help staff learn how to use the equipment, it would have been helpful to have follow-up trainings related to technology and create a Frequently Asked Questions (FAQ) document specifically designed to support staff in troubleshooting technology needs.

Implementation Strategies

Consistent with the CFIR model described previously, several implementation strategies were integrated into the process of rolling out TMH processes with agency providers. These strategies are designed to be flexible and support the rapid implementation of improvements within a variety of settings and contexts. In the spirit of practice improvements and maximizing the CFIR model, the following suggestions may have assisted with ensuring that the implementation better met the needs of staff and families:

- **Go slow to go fast:** Everything occurred in such rapid succession that it was difficult to slow down and ensure that it was working effectively. Upon analysis, it may have been wise to take a pause and insert thoughtful time for planning and bringing staff members up to speed on the process prior to implementation. Taking one week to create tip sheets and roll out training, while providing staff support, would have likely increased self-efficacy and decreased burnout throughout the entire process.
- **Employ the use of “early adopters” or “champions” of this work:** While all staff members understood the importance of pivoting to a TMH model overall, there were many beliefs and opinions as to how it should look. Throughout the implementation process, staff reported feeling like it was happening “to them” versus “with them.” To better support the staff and ensure that their voice was adequately represented, one recommendation is to ensure that there is a staff member on every team who attends the planning meetings and serves as a champion for implementing this work with their colleagues. These individuals may serve as part of an “implementation team” designed to provide internal support and structure to the implementation process (Van Dyke, 2015). This would have enabled more efficient two-way communication and integrated staff feedback towards improvement in real time.
- **Increased and ongoing communication:** While there were several efforts at creating opportunities for open communication with staff, there were several missed opportunities. Due to the highly changing nature of COVID-19 and the requirements associated with it, the messaging seemed to change constantly, making it difficult to provide clear and coherent communication on an ongoing basis. Therefore, transparency about what is happening, what is confusing, and attempts for clarification on an ongoing basis would have been helpful. This, coupled with a feedback loop in which staff can pose questions and ask for clarification, may have decreased some of the staff anxiety associated with the implementation of TMH and increased self-efficacy.

Conclusion

The implementation of TMH practices in response to the COVID-19 pandemic represented a significant cultural and societal event that will be reviewed and analyzed for years to come. As a large, urban CAC located within a healthcare setting, the agency described in this paper was tasked with rapidly implementing TMH while navigating issues related to safety, isolation, confidentiality, and technology. Building on implementation science models such as CFIR, the agency focused on implementation in four key areas: Agency Expectations, Provider Training and Resource Sharing, Technology, and Communication and Collaboration Opportunities. Efforts were made to understand and address both provider and client level needs. CFIR constructs provide a helpful way to understand and approach rapid-cycle implementation approaches. While CFIR provides a helpful way in which to understand the rapid-cycle implementation process that we underwent at our CAC, it is important to note that agency leadership did not intentionally review and implement the necessary changes with CFIR in mind. Like many agency leaders at this time, changes occurred in line with the rapidly changing requirements and concerns that were arising daily. We were generally aware of the implementation science literature prior to COVID-19 and proceeded to make changes based on that understanding, but we did not specifically adhere to any implementation models in this work. This is not uncommon in cases of large emergencies that impact multiple systems and require an immediate response by organizational leaders who do not have the time or bandwidth to review the literature prior to responding. Implementation science researchers are encouraged to identify ways in which the research can be broken down into manageable steps that can be applied easily in emergency circumstances and to share those steps in an easily digestible format.

While there were many successes associated with this work, including the rapid provision of TMH to clients who needed it within a CAC environment, there were some challenges and lessons learned. The primary challenge was supporting providers in doing this work and preventing burnout. Support can take many forms, such as ensuring that providers have the resources available to complete the work effectively. However, it goes beyond resources and includes activities such as ensuring that there is clear communication and expectations, and opportunities for staff to share their frustrations with others and identify problem-solving activities. While these activities occurred at times, it was often for a short-term period and not consistently sustained over time. Recommendations for the future include ensuring that a planning process is built

into the implementation effort, as thoughtful planning can play a key role in preventing frustration in the long-term. Additional recommendations include ongoing, clear, and transparent communication with staff members to provide them with the most updated information. Finally, while the initial focus of the work was on the emergent need, systems need to be put into place that can sustain long-term. Therefore, when implementing any change, agency leadership should consider how this will be sustained over time.

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Declarations

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