



TELEHEALTH AND HYBRID TREATMENT FOR CO-OCCURRING DISORDERS

FREDRICK DOMBROWSKI, PHD

LMHC, CASAC, LPC, LADC, NCC, CCMHC, MAC, ACS, BC-TMH, HS-BCP, ICADC, DCMHS
COUNCIL OF ACCOUNTABILITY COURT JUDGES, ATHENS GEORGIA

OBJECTIVES



Participants will identify client strengths and skills that can make telehealth an appropriate treatment option



Participants will identify how to apply evidence-based practices (specifically CBT and MI) to telehealth



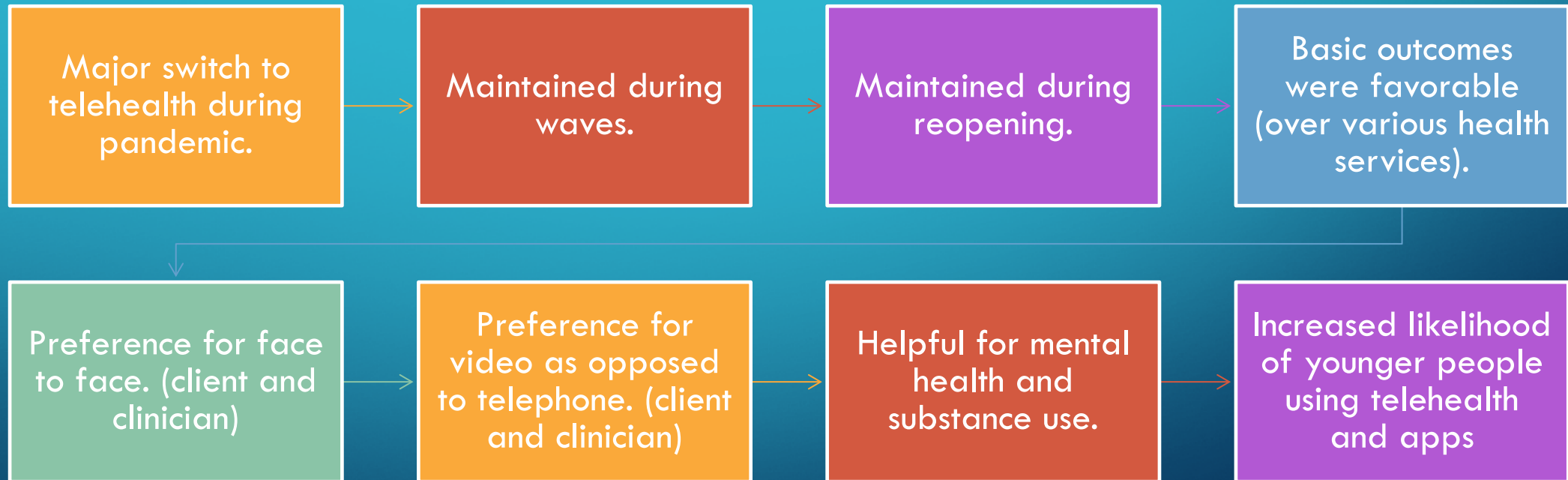
Participants will identify how to navigate potential speed bumps to telehealth treatment



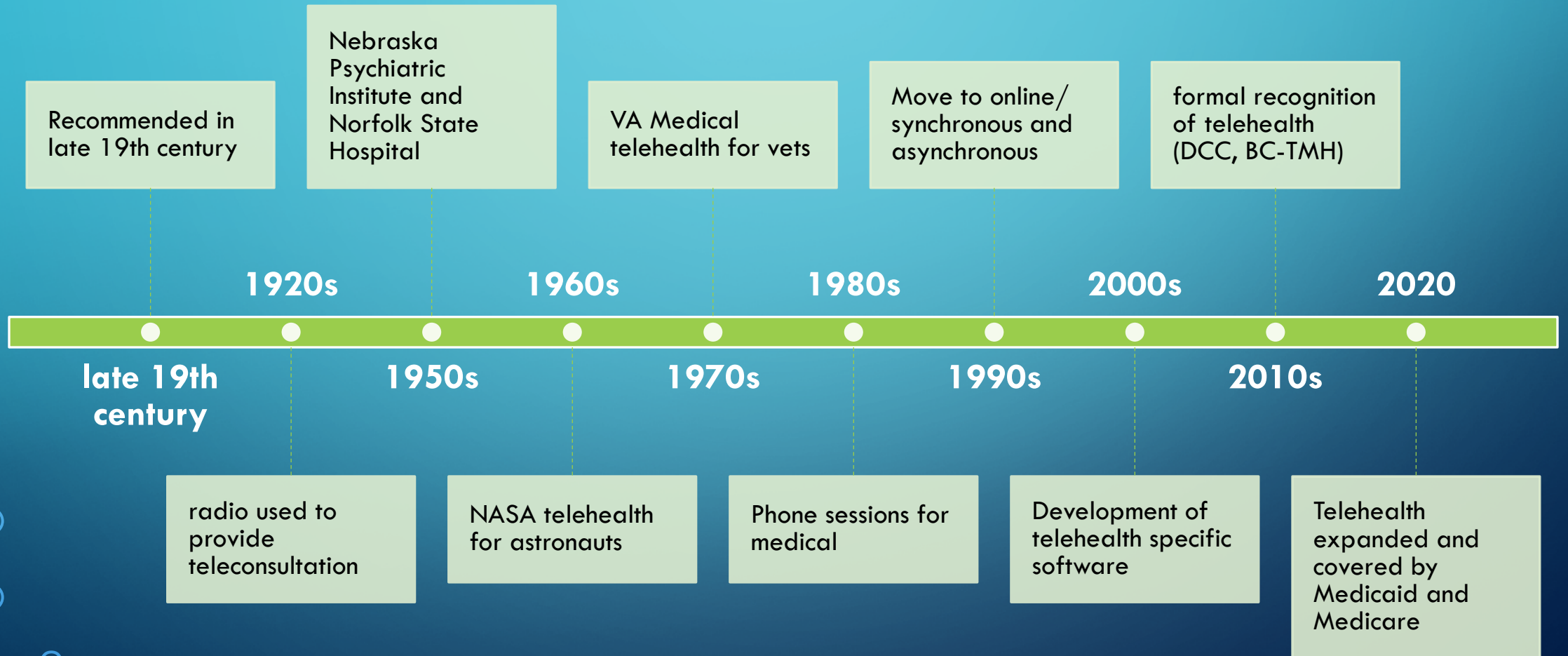
ABOUT ME

- Started working in MH/SU in 1998
- Worked in various settings
- Obtained the Distance Credentialed Counselor Certificate in 2015.
- DCC switched to BC-TMH in 2018 (Cert # is 13)
- COVID 19 increased trainings provided
- Seen numerous ethical problems related to telehealth

RESEARCH



HISTORY OF TELEHEALTH



TECHNOLOGICAL ADVANCES

First Wave Technologies

- Photocopy and fax machines
- Word processing
- Voice mail and answering machines
- Electronic claim submission

Second Wave Technologies

- Computerized test administration, scoring, and interpretation
- Providing clinical services via the telephone

Third Wave Technologies

- Virtual reality treatments of anxiety disorders
- Interactive televideo communication treatments

VALUE OF TELEPHONE TREATMENT

- Homebound patients (e.g., agoraphobia, physical limitations, remote locale, etc.)
- Relative safety and anonymity of telephone interactions
- Ease of contact between appointments and during crises

ASPECTS OF TELEHEALTH

Benefits

Social distancing

No need to travel

Computer or phone

Rural areas lacking specialist

Weather may not disrupt

Accommodates workers/ parents

Drawbacks

Phone/ computer are needed

Internet is needed

Lack sensory information (smell)

Options for dishonesty

Problems with software

Patient may be distracted

IDENTIFYING A GOOD FIT

Not every client will be a good fit for telehealth

May consider drug of choice, severity of symptoms, access to care

Cultural humility and competency must be equally applied

Various factors which impact appropriate fit

Your ability

Clients ability

LEVELS OF CARE

- 0.5 Early intervention for at risk populations: Treatment is educational about risk factors. Relatively quick duration. **GOOD FIT**
- Level 1: Outpatient services. Individual and group therapy. Helps participants maintain functioning while having treatment. **GOOD FIT**
- Level 2: Intensive Outpatient: several groups throughout the week. Partial hospitalization: treatment can be 8 hours a day, five days per week. **POTENTIAL FIT**
- Level 3: Inpatient treatment to obtain initial sobriety and residential treatment for maintenance of initial sobriety. **NOT A GOOD FIT**
- Level 4: Medically managed intense inpatient treatment. **NOT A GOOD FIT**

CLINICAL ASPECTS

- MH and SU treatment can be provided via telehealth.
- Consider level of care based on use and symptoms.
- Traditional outpatient services.
- Threat of harm to self or others requires higher level of care.
- Beginning of decompensation requires higher level of care.
- Individuals living with mild & mod sub use disorders.
- MI and service connection for individuals with severe SUDs.

CASE EXAMPLE

Darnel is a 42 year old African American father of 3 children, recently laid off domiciled with his wife. Darnel has a history of AUD which began in his 20s. Darnel's drinking has increased following his loss of job three months ago. He reports drinking 8 beers per evening. He meets criteria for AUD moderate via the DSM 5. His drinking has caused ongoing difficulties with his wife. He feels disconnected from friends and supports. He has access to the computer, feels comfortable online, and has availability to connect with a counselor.

How is Darnel a good fit?

How can he not be a good fit?

CASE EXAMPLE 2

Tanya is a 27 year old employed white female living with opiate use disorder receiving 60 mg of methadone daily who has not used illicit opiates in several months. Tanya continues to use THC twice per week as she works from home as a graphic designer. She reports that she has no intent to stop using THC although her goal is to become opiate free.

How is she a good fit?

Any concerns about fit?



CASE EXAMPLE 3

- Maurice is a 72 year old white male veteran who meets criteria for opiate use disorder following a work injury several years ago. He is no longer working and lives with his wife. Maurice does not own a computer and reports his belief that his information can't be carefully secured on a computer. Additionally, his work injuries have impacted his hands and his sense of hearing which often causes difficulty when speaking on the phone.



Is he a good fit?



SECURITY FOR MOBILE DEVICES

- Install and enable encryption to protect health information stored or sent by mobile devices.
- Use a password or other user authentication.
- Install and activate wiping and/or remote disabling to erase the data if it is lost or stolen.
- Disable and do not install or use file sharing applications.
- Install and enable a firewall to block unauthorized access.
- There is no such thing as HIPPA-compliant text messaging.

SECURITY FOR MOBILE DEVICES CONT.

- Install and enable security software to protect against malicious applications, viruses, spyware, and malware-based attacks.
- Keep your security software up to date.
- Research mobile applications (apps) before downloading.
- Maintain physical control of your mobile device. Know where it is at all times to limit the risk of unauthorized use.
- Use adequate security to send or receive health information over public Wi-Fi networks.
- Delete all stored health information on your mobile device before discarding it.



CELL PHONE SECURITY

- 20% of providers did not use a password-protected phone despite using it for calls and text messaging with patients (Elhai & Hall, 2016).
- What are the risks of this practice?
- Elhai, J. D., & Hall, B. J. (2016). How secure is mental health providers' electronic patient communication? An empirical investigation. *Professional Psychology: Research and Practice*, 46(6).
<http://doi.org/http://dx.doi.org/10.1037/pro0000054>

DURING PHONE CALLS

Only provide information if signed consent is provided.

Review with clients how to obtain and sign forms.

Verification needed by the patient (DOB, address, birthday).

Your phone call could be recorded by patient.

Be cautious and respectful when discussing pt information.

Your phone records indicate that a call was made.

Do not say anything you wouldn't say face to face.

Landlines are expected to be secured.

MAKING TELEHEALTH EASIER

- Use one platform
- Use appropriate Netiquette
- Have appropriate framing- face to background ratio
- Use appropriate lighting
- Use appropriate background
- Try to avoid phone only sessions when possible

LEGAL CONCERNS

Bound by HIPAA

Devices: computer
(desktop/laptop),
tablet, cellphone

Platform: video,
audio

Cellular service,
internet service

Communication:
email, phone, text,
mail

Storage: cloud,
hardware (e.g.,
jump drive, hard
drive), paper

Payment

APPROPRIATE FRAMING

- Using your personal real life background can have some consequences
- Use appropriate background based on your work
- Ratio of clinician to background
- Your background communicates to the client
- Avoid using personal pictures
- There are options

SETTING UP CLIENTS FOR TELEHEALTH

- Agencies should have a primary worker designed to set this up
- Phone meeting to assist patient with getting and using software
- IT team is representation of team
- Informing in the beginning that not all patients are accepted to telehealth
- Your picture and presentation matters
- Make your online office like a real office

THOUGHTS ABOUT THIS BACKGROUND?



THOUGHTS ABOUT THIS BACKGROUND?



THOUGHTS ABOUT THIS BACKGROUND



MY REAL LIFE BACKGROUND? MAYBE I CAN SMILE!



CHOSEN BACKGROUND

[HTTPS://UNSPLASH.COM/S/COLLECTIONS/ZOOM-BACKGROUND-OFFICE](https://unsplash.com/s/collections/zoom-background-office)



EQUIPMENT

- Desktop computer, microphones, speakers, monitors, cameras, CODEC and other accessories – ITU standards
- Policies and procedures regarding equipment quality control and validity testing.
- Physical security
- Good working condition and replace equipment as necessary
- Disaster planning and backup

LIKE REAL LIFE

Software must be HIPAA compliant.

Software must be double locked.

Easy access to IT support when needed.

All documentation should be done ASAP (before end of day).

Evolution of software.

Poor response to software can leave you and your clients vulnerable.

I AM NOT PROMOTING SOFTWARE HERE ARE SOME OPTIONS

- **Simple Practice:** <https://www.simplepractice.com/camftaffinity/>
- **VSee:** <https://vsee.com>
- **Doxy.me:** <https://www.doxy.me>
- **SecureVideo:** <https://securevideo.com>
- **Thera-link:** <https://www.thera-link.com>
- **CounSol.com:** <https://www.counsol.com>
- **WeCounsel.com:** <http://www.wecounsel.com>
- **Evisit.com:** <https://evisit.com/>

PRACTICING ACROSS STATE LINES

- Generally advise against it
- Clinician must be licensed in both the state of residence and state of service
- Must be aware of local services
- Prepare before accepting a client
- Collaterals, emergency services, hospitals, benefits
- You can still get sued even if client agrees to therapy
- You can still be sued even if the client signs the informed consent

NAADAC ETHICAL REQUIREMENTS

BENEFITS

- (a) reducing geographical barriers
- (b) provision of services to those with physical or psychological disorders
- (c) working with individuals and families who would not take advantage of traditional services.

LIMITATIONS

- (a) concerns about maintaining confidentiality
- (b) challenges associated with developing a therapeutic alliance
- (c) inability to assess nonverbal communication
- (d) determining and resolving practice and licensure jurisdiction concerns
- (e) assessment and provision of emergency services.

NAADAC CODE OF ETHICS

- Provision of HIPAA-compliant services via technology, electronic devices.
- Platforms: land-based and mobile communication devices, fax machines, webcams, computers, laptops, tablets, flash drives, external hard drives, and cloud storage.
- E-therapy and e-supervision platforms: tele-therapy, real-time video-based therapy and services, emails, texting, chatting and instant messaging.
- Providers and clinical supervisors shall be aware of the unique challenges
- Take steps to ensure that the provision of e-therapy and e-supervision is as safe and confidential as possible.

TRAINING

- Professionals must be trained:
 - how to properly use the technology
 - Organization policy
 - HIPAA and security
 - Indications
 - When to cancel and order a FTF
 - Quality control and peer review

BOARD-CERTIFIED-TELEMENTAL HEALTH PROVIDER

- You must be licensed in your state
- Must complete the required in depth training
- Take the exam
- Pay the fee

<https://www.cce-global.org/credentialing/bctmh>

LIVE VIDEO

Synchronous and real time.



Can serve as substitute for FTF



Used for consultation



Can be used for mental health and substance use

STORE AND FORWARD

- Asynchronous
- Not real time
- Secure email
- Transmission of files
- X-rays, medical assessments
- E-consults
- Psychiatrist reviews and signs off on Intake Asmt.



MOBILE HEALTH

- Cell phones
- Tablets
- Targeted text messages for behaviors
- Can be used for physical health
- Mindfulness reminders
- Emergencies broadcast system



LIVE ONLINE SESSIONS

- Camera and microphone additions
- Have a monitor large enough to see patient
- Monitor size 22 to 24 inches
- Cameras on computers may not be high quality
- Helps to confirm mental status exam
- Having tablets encased in protection
- Will have same expectation of provision as FTF sessions (patients must be focused on treatment)

GUIDELINES

- Adhere to same guidelines as you would in person.
- Provider must have opportunities to practice on software
- Must have reliable bandwidth
- Administration must have observable goals and objectives for program.
- Appropriate clinician room set up.
- Lighting, background, soothing colors.

POLICIES AND PROTOCOL

- Consider current protocol
- Adapt to telehealth
- How to provide services
- Obtaining informed consent
- Affirming patient has access to technology
- Have support from administration



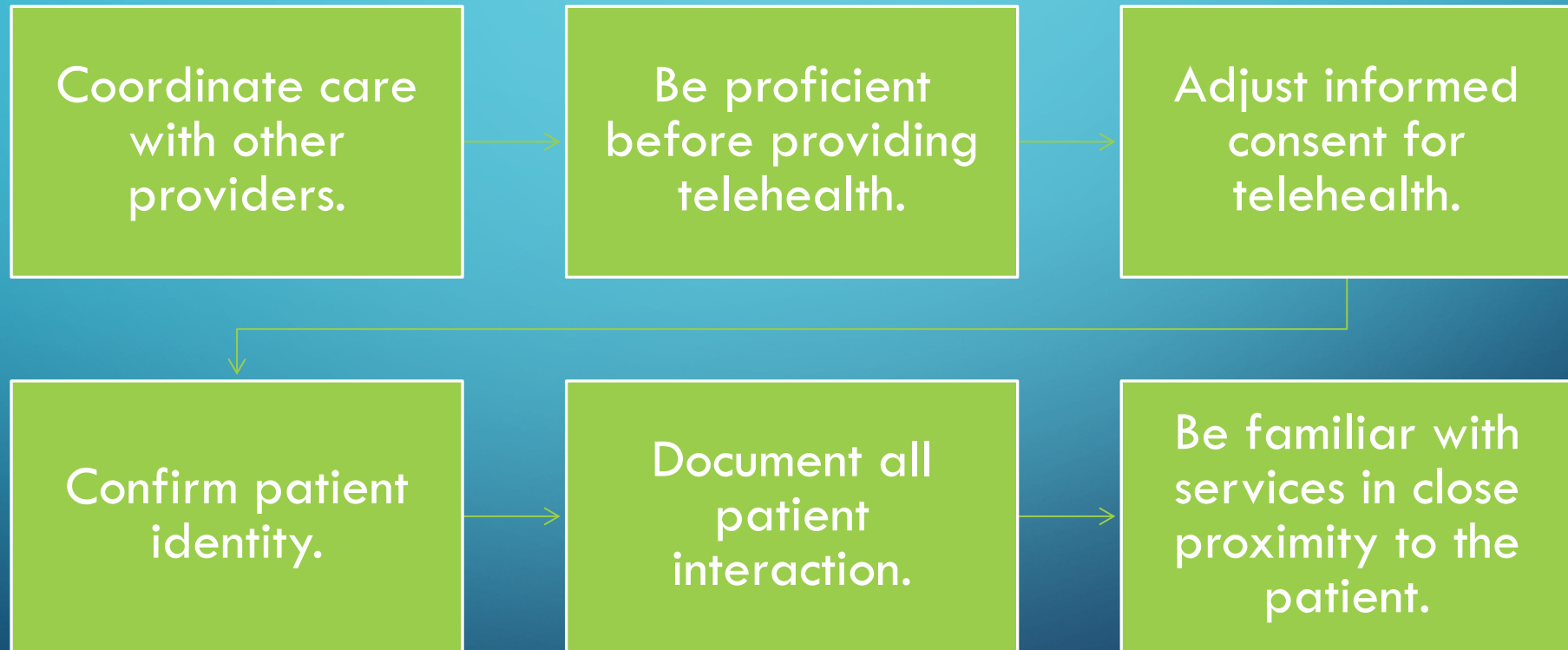
TELEHEALTH MAINTENANCE

- Face to face is not resuming as was prior to the pandemic.
- Telehealth has increased flexibility for specialists.
- Switch to major tele branding.
- Companies developing full guidelines.
- Considerations for state laws, billing, etc.
- Adjust levels of care as needed.
- Telehealth not for everyone all the time.

SETTING UP TELEHEALTH

- Informed consent
- Safety information
- Mandated reporter
- Mental Status Exam (Oriented to time and place)
- Treatment plan

MANDATORY COUNSELOR STEPS





INFORMED CONSENT

- Benefits/ limitations of telehealth must be in informed consent.
- Patient must be aware of these limitations and expectations.
- Counselor can ask patient to repeat this information back.
- Counselor must document reviewed informed consent.
- Patient has right to revoke informed consent.
- Parents/ guardians approve for minors.

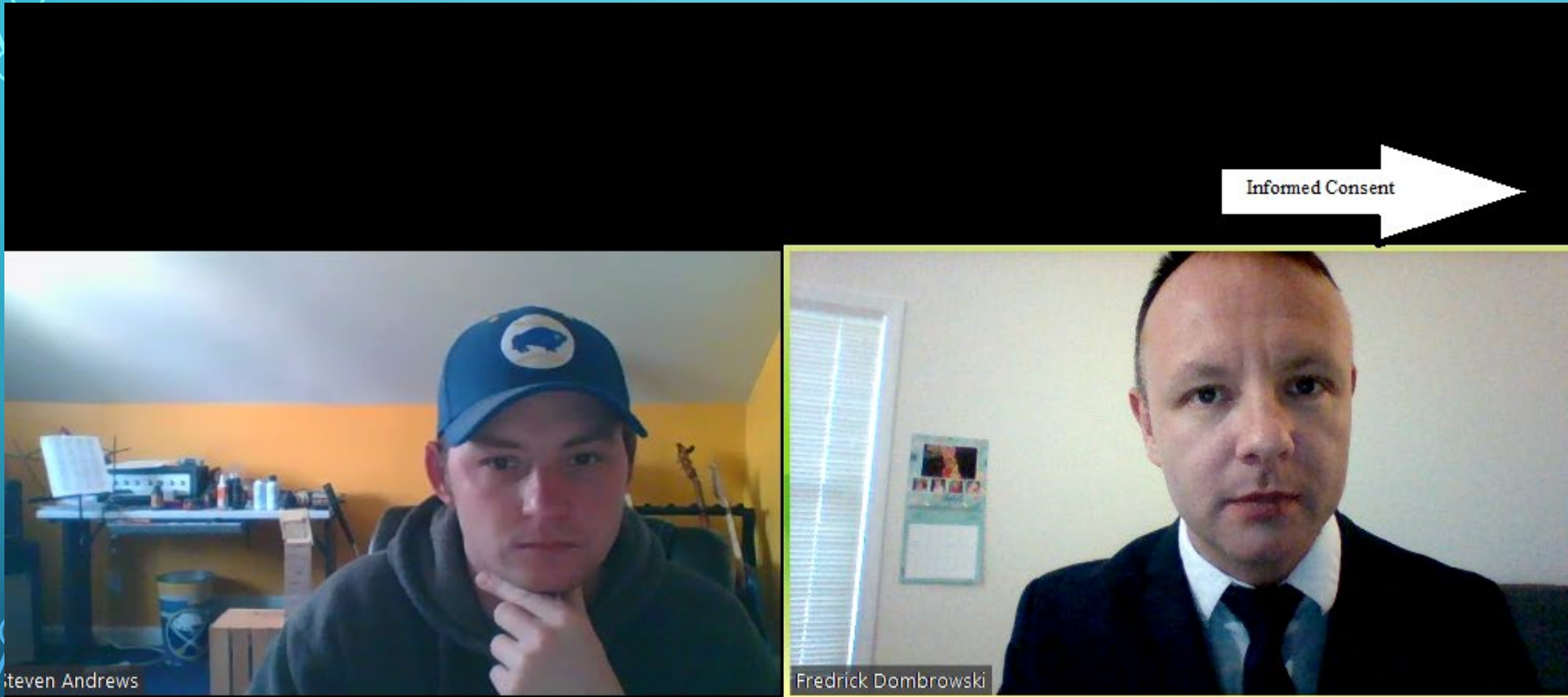
NAADAC EXPECTATIONS FOR INFORMED CONSENT

- contact information of the client, counselor/provider and supervisor;
- e-therapy is not always an appropriate substitute or replacement for face-to-face counseling;
- all of the procedures that apply to delivery of in-person services shall apply to the e-delivery of services;
- duty to warn and mandatory reporting laws that shall apply to all counseling services, including e-therapy;
- confidential and privacy rules and laws, and exceptions to those rules and laws;
- issues related to security and privacy of information, and potential for hacking or other unauthorized viewing;
- access to counseling services and to technology assistance to use e-therapy;
- benefits and limitations of engaging in the use of distance counseling, technology, and/or social media;
- potential misunderstandings due to limited visual and auditory cues;
- potential for confusion often present in e-delivery of services;

NAADAC EXPECTATIONS CONT.

- response time to asynchronous communication (emails, texts, chats, etc.);
- possibility of technology failure and alternate methods of service delivery;
- emergency protocols to follow;
- procedures for when the counselor is not available;
- consideration of time zone differences;
- policy regarding recording of sessions by either party;
- cultural and/or language differences that may affect delivery of services;
- possible denial of insurance benefits; and
- social media policy.

INFORMED CONSENT



your confidentiality, we can't promise that your online session is free from danger by hackers or those with illegal internet access. Do you agree to continue with this session as scheduled?

From Me to [Everyone](#):

Informed Consent: While we are attempting to meet your needs via tele counseling, the same expectations are required as if you were seeing us face to face. We ask that you allow for private time between yourself and your counselor for the session. As this session is through an agency, you are agreeing to the regular reimbursement as requested by the agency and allowed by your insurance. As your counselor, we remain mandated reporters to maintain your safety and the safety of those around you. While we work to maintain your confidentiality, we can't promise that your online session is free from danger by hackers or those with illegal internet access. Do you agree to continue with this session as scheduled?

From [Steven Andrews](#) to [Everyone](#):
yes

To: [Everyone](#) ▾

📎 File

⋮

Type message here...



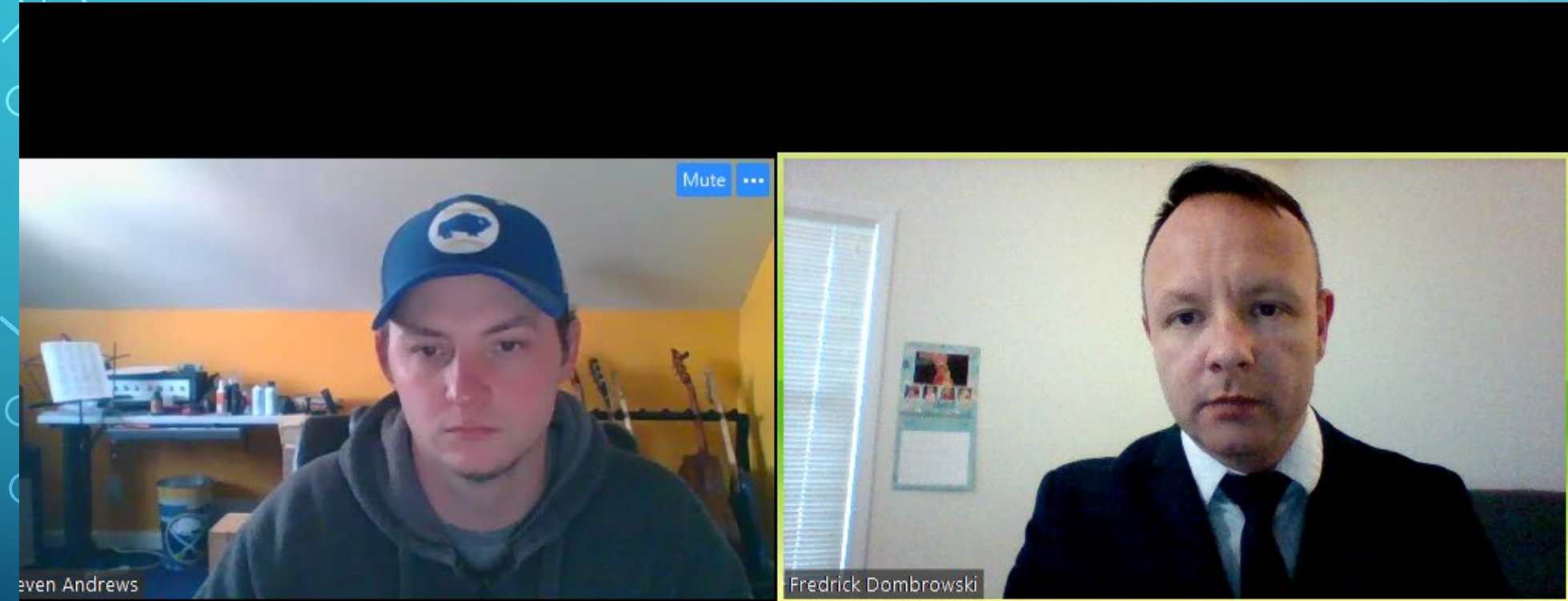
MENTAL STATUS EXAM

- Ask information oriented to time and place.
- Ask for date (month, day, year, and day of the week).
- Three objects for memory: Apple, Table, Penny.
- Ask patient to spell WORLD backwards.
- Ask patient to recall three objects.
- Affect
- Rate of speech
- Observable body movement
- Tangential

VERBAL AND NON-VERBAL CUES

- Addiction professionals shall acknowledge the differences between non-verbal and verbal cues in face-to-face and electronic communication, and how these could influence the counseling/supervision process.
- Providers shall discuss with their client/supervisee how to prevent and address potential misunderstandings arising from the lack of visual cues and voice inflections when communicating electronically.

MENTAL STATUS



Oriented to time and place

time between yourself and your counselor for the session. As this session is through an agency, you are agreeing to the regular reimbursement as requested by the agency and allowed by your insurance. As your counselor, we remain mandated reporters to maintain your safety and the safety of those around you. While we work to maintain your confidentiality, we can't promise that your online session is free from danger by hackers or those with illegal internet access. Do you agree to continue with this session as scheduled?

From Steven Andrews to Everyone:
yes

From Me to Everyone:
What day is it?
What time is it?
What is your wife's name?

From Steven Andrews to Everyone:
Thursday, 6:51, Robyn

To: Everyone

SAFETY INFORMATION

- Local hospitals
- Local Psych ER
- Local substance use tx
- Collateral contact info
- Agreement by client to use services

EMERGENCY SERVICES



From Me to Everyone:
What day is it?
What time is it?
What is your wife's name?

From Steven Andrews to Everyone:
Thursday, 6:51, Robyn

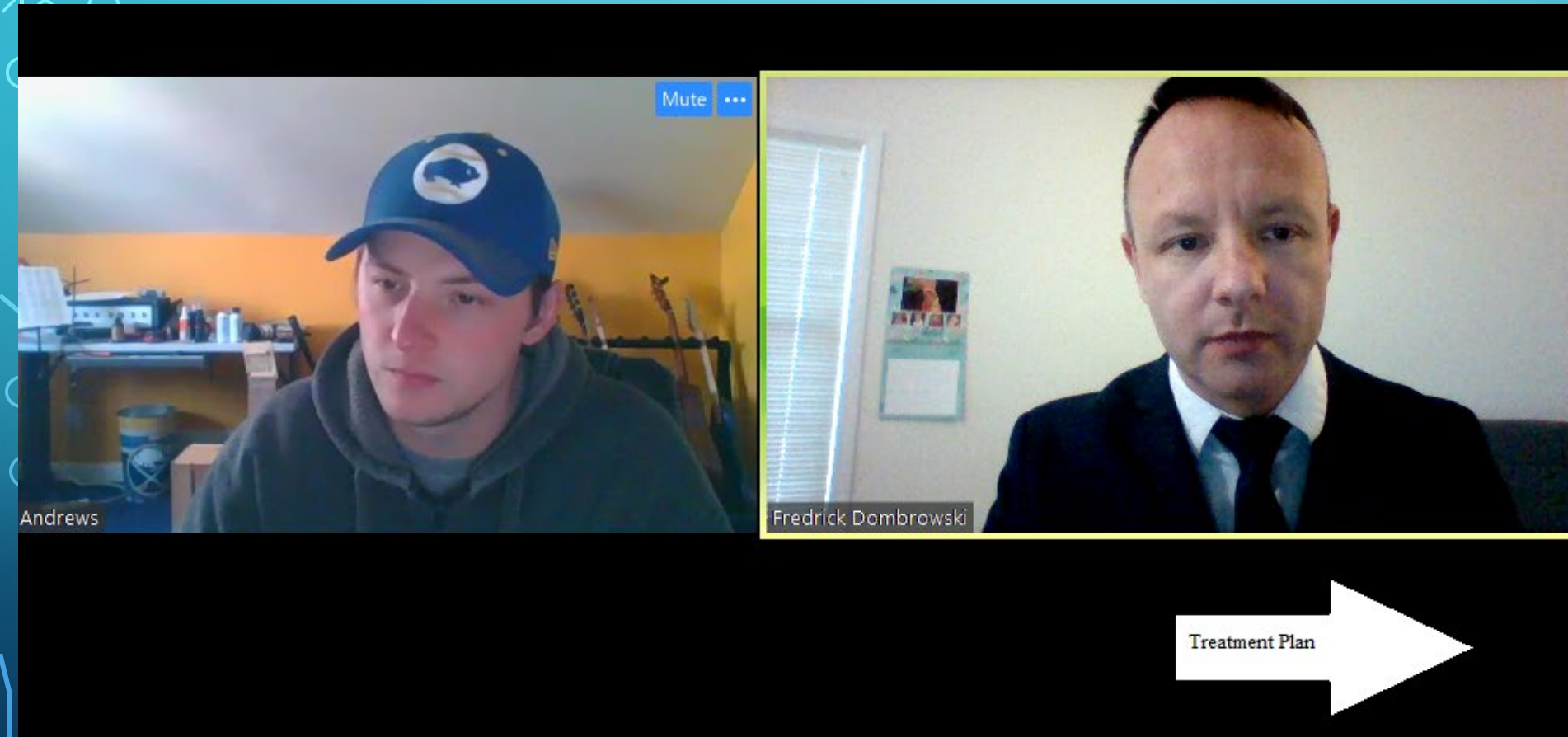
From Me to Everyone:
Crisis Services of Erie County
716-834-3131

Emergency Psychiatric Room
Erie County Medical Center
462 Grider St, Buffalo, NY 14215
(716) 898-3169

Emergency assistance
<http://www.211wny.org/>In an
emergency call 911

From Steven Andrews to Everyone:
ok

TREATMENT PLAN



Erie County Medical Center
462 Grider St, Buffalo, NY 14215
(716) 898-3169

Emergency assistance
<http://www.211wny.org/>In an
emergency call 911

From Steven Andrews to Everyone:
ok

From Me to Everyone:
Treatment plan:

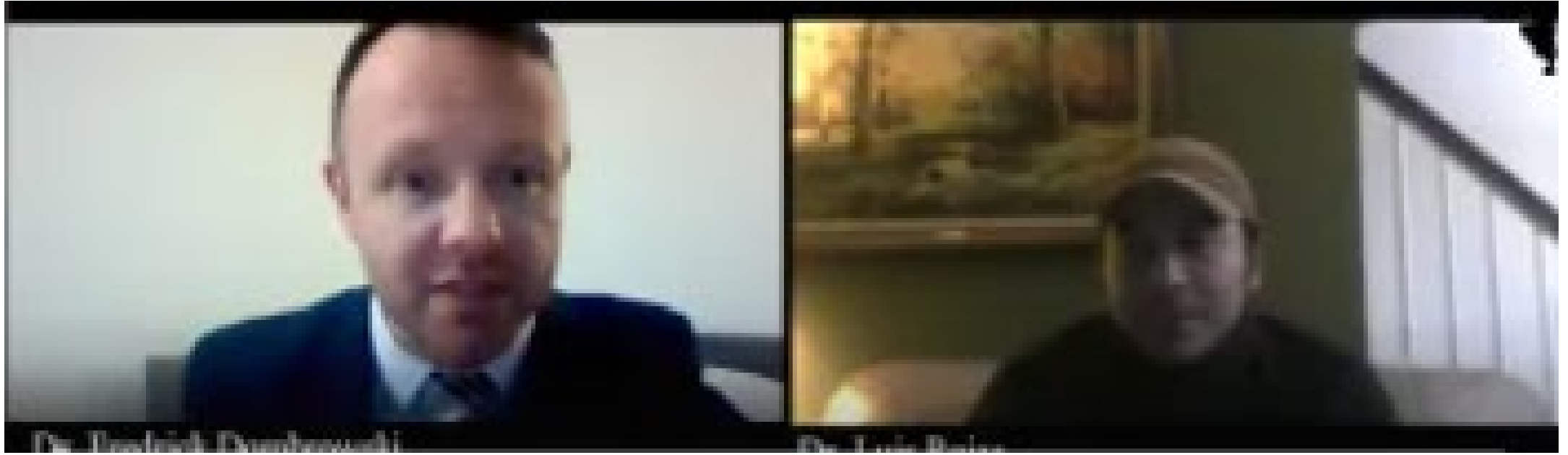
Mental Health Objective:
Steven will improve anxiety as evidenced
by engaging in three mindfulness skills
independently.

Substance Use Objective:
Steven will maintain sobriety as
evidenced by engaging with sober
supports three times per week.



STARTING THE SESSION

- Get client baseline
- Don't try to solve problems
- MI/ Person Centered language
- Expect problems
- Validate client experience
- Consider various problems



PUTTING IT TOGETHER

[HTTPS://YOUTU.BE/OSY7WRP-5AI](https://youtu.be/osy7wrp-5ai)

CONSIDERATIONS FROM INTERACTION

- Affect
- Presentation
- Goals
- Connections
- Amount of time



STEPS TO RESUMING SUBSTANCE USE

- Baseline concerns
- Emotional
- Mental
- Physical
- Consequences

WARNING SIGNS

- Romanticizing past substance use.
- Connection with people, places, and things associated with use.
- Discussions focusing on negative aspects of treatment.
- Disconnect with sober support.
- Missing treatment.
- The individual stops pursuing other recovery activities (work, school, etc.)

STIFLED PARTICIPATION

- Distractions during the session
- Client doing chores
- Child care
- Lack of clinical tools
- Struggles to resolve resumed ambivalence
- Use of technology between services

MAKING THE MOST OF CLINICAL WORK

 Session connection to client goals

 Ongoing use of consistent orientation

 Reflection and commitment to software (make this a part of your sessions).

 Use MI regarding ambivalence towards software

 Validate concerns regarding software limitations



ENHANCED TECHNOLOGY

- Use of apps to assist with skills use
- Technology to connect with sober supports
- Apps to assist with emotions
- Review of apps in session
- Making the most of digital services

MOTIVATIONAL INTERVIEWING APPS

- Precious; MI Skillset
- Re-engages client in change and sustain talk
- MI Skillset for clinicians as well
- Provides use of worksheets transferable to clients
- Can be used in between sessions via mobile app
- Integrative software
- Engages change talk to conceptualize coping strategies



ALCOHOLICS ANONYMOUS APPS

- Helps to connect individuals to meetings
- Can connect to others virtually
- Access to sponsors and supports
- Access to AA literature
- Provides daily affirmations
- Connect to AA events in the client's area
- AA 12 step tool kit; 12 step guide AA

TELECOUNSELING AND MOTIVATIONAL INTERVIEWING



Basic principles of MI can translate to telehealth



Maintain focus on patient goals



Benevolently demanding



Model professionalism



Email, snail mail worksheets beforehand



Work with patient to complete in sessions

8 MOTIVATIONAL INTERVIEWING TASKS

- Overall conceptualization: collaborative and open
- OARS and Unconditional positive regard
- Identify use change talk
- Eliciting and enhancing motivation to change
- Rolling with resistance
- Developing a change plan
- Enhance patient commitment through steps
- Flexibility to meet unique needs (other theories).

BEGINNING STAGES

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy

ROLLING WITH RESISTANCE: MANDATORY

- Reflect the resistant statement
- Reflect the tone
- Reflect what you're hearing
- Acknowledge impasse
- Support choice
- Simple Reflection
- Amplified Reflection
- Double Sided Reflection
- Shifting Focus
- Agreement with a Twist
- Reframing

8 MOTIVATIONAL INTERVIEWING TASKS

- Overall conceptualization: collaborative and open
- OARS and Unconditional positive regard
- Identify use change talk
- Eliciting and enhancing motivation to change
- Rolling with resistance
- Developing a change plan
- Enhance patient commitment through steps
- Flexibility to meet unique needs (other theories).



WALKING THROUGH THE STEPS

- What is the clients desire to change?
- How can they potentially change?
- What are the reasons or benefits of change?
- What is the need to change?
- How can the client commit to any form of change?
- How can we get a client commitment to change?
- What are the steps for change?

CONCEPTUALIZING CHANGE

How do I conceptualize change?

| | |
|--|--|
| What is your D esire to change? | |
| What are some of your A bilities or strengths to help change? | |
| What are some R easons to change? | |
| What is the N eed to change? | |

IDENTIFYING MOTIVATION TO CHANGE

Many people may be forced to get help from family members, work, or justice related agencies. It is important to allow you an opportunity to express yourself and your concerns.

Please Place an "X" in the box that best describes your readiness to change:

| I don't want to change | I'm thinking about change | I don't know if I want to change | I'm kind of ready to change | I'm very motivated to change |
|------------------------|---------------------------|----------------------------------|-----------------------------|------------------------------|
| | | | | |

You may feel that others are making you attend counseling. Let's look at this in more depth

| Who is making you attend? | What do they say the problem is? | What don't they understand? | What is valid about their concerns? |
|---------------------------|----------------------------------|-----------------------------|-------------------------------------|
| | | | |

ELICITING CHANGE WORKSHEET

| How do I feel about substance use? | How has substance use helped? | How has substance use harmed me? | What are my goals? | How can stopping or cutting down substance use help? |
|------------------------------------|-------------------------------|----------------------------------|--------------------|--|
| | | | | |

DEFINING GOALS WORKSHEET

You are the expert on you. Your goals are the driving factor for treatment. Below are some areas in your life that you may have specific goals.



| Substance Use/ Mental Health | Physical Health | Family | Work/ Vocational | Spiritual |
|------------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| What is the specific goal? | What is the specific goal? | What is the specific goal? | What is the specific goal? | What is the specific goal? |
| How to measure progress? | How to measure progress? | How to measure progress? | How to measure progress? | How to measure progress? |
| How do I do this? | How do I do this? | How do I do this? | How do I do this? | How do I do this? |
| Is this important to me? | Is this important to me? | Is this important to me? | Is this important to me? | Is this important to me? |
| When can this be completed? | When can this be completed? | When can this be completed? | When can this be completed? | When can this be completed? |

A LACK OF CHANGE

- A lack of change = Sustain Talk + Discord
- Sustain talk is the patient's arguments against change (desire, reasons, and need to stay the same, inability to change, no commitment to change, not making plans or taking steps toward change)
- Discord is dissonance in the therapeutic relationship (e.g., defending, being adversarial, interrupting, ignoring or being distracted)
- High levels of either sustain talk or discord predict a lack of change. Both are important patient communications and attended to in MI.

CBT

- Use of interactive CBT tools
- Daily thought and mood records
- Co-occurring anxiety and depression
- Access to thought challenging techniques
- Identification of new behaviors
- CBT Companion; CBT Tools for Healthy Living, Shine

TRIGGER RECORD

Trigger Journal

| Day | Trigger | Feelings (1 to 10 intensity) | Thoughts |
|-----------|---------|------------------------------|----------|
| Monday | | | |
| Tuesday | | | |
| Wednesday | | | |
| Thursday | | | |
| Friday | | | |
| Saturday | | | |
| Sunday | | | |

COGNITIVE DISTORTIONS

- **Perfectionism:** all or nothing thinking.
- **Should statements:** arbitrarily setting standards.
- **Overpersonalization:** taking too much responsibility.
- **Selective attention:** focusing only on one aspect.
- **Denial:** Failing to see your own role in a problem.
- **False-permanence:** thinking things are more permanent than they really are.
- **Overgeneralizing:** a single event becomes applied to future events.
- **Catastrophizing:** making things out to be worse than they are.
- **Magical thinking:** everything would be better if...
- **Emotional reasoning:** acting as if emotions are reality.
- **Mind reading:** assuming what others are thinking.
- **Double standard:** being more harsh on yourself than you are to others.
- **Self centeredness:** only seeing your own perspective.
- **Fallacy of fairness:** believing life must be fair.

<https://www.therapistaid.com/worksheets/cognitive-distortions.pdf>

ADJUSTED TRIGGER JOURNAL

Adjusted: Trigger Journal

| Day | Trigger | Thoughts | Feelings 1-10 |
|-----------|---------|----------|---------------|
| Monday | | | |
| Tuesday | | | |
| Wednesday | | | |
| Thursday | | | |
| Friday | | | |
| Saturday | | | |
| Sunday | | | |

What common cognitive distortions did I experience?

THOUGHT CHALLENGING

| What thought am I thinking? | What Cognitive Distortion am I thinking? | What are some questions I can ask my thoughts? | What are my new thoughts? |
|-----------------------------|--|--|---------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

PUTTING IT ALL TOGETHER

- Previous worksheets must be consecutive.
 1. Trigger Journal
 2. Thought Challenging
 3. Behavioral Identification
 4. Thought Challenging and New Behaviors – Final Worksheet

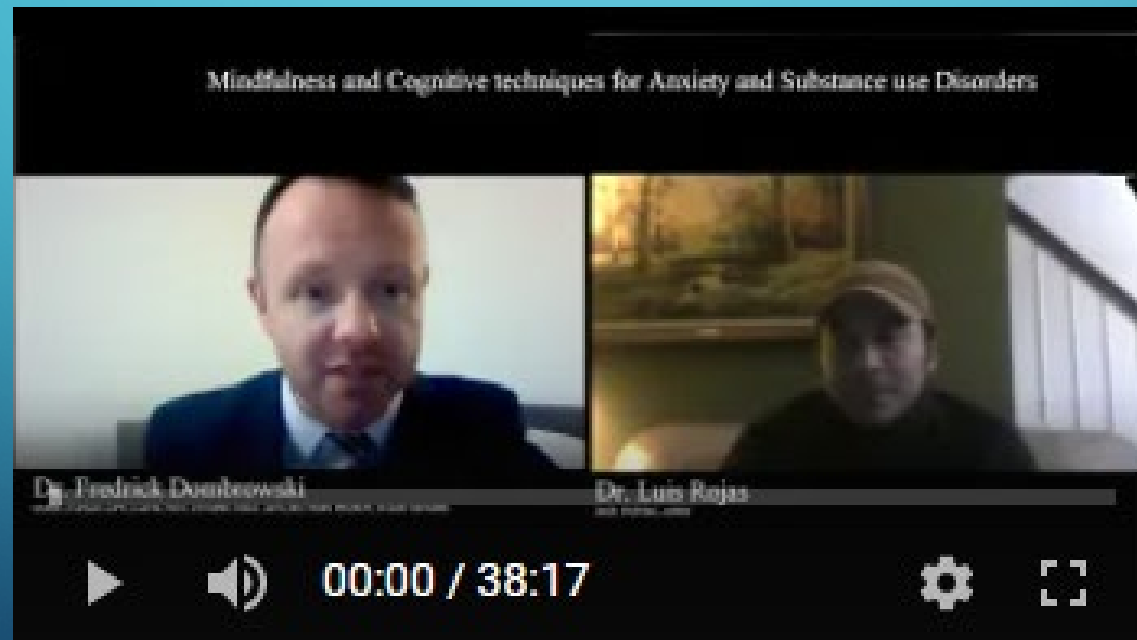
THOUGHT CHALLENGING AND NEW ACTIONS

| Triggers | Thoughts | Feelings (1 to 10) | Actions |
|-------------------------------------|--------------|--------------------|-------------|
| | | | |
| What distortions am I experiencing? | New Thoughts | New Feelings | New Actions |
| | | | |

EXAMPLE

<https://www.youtube.com/watch?v=OsY7Wrp-5aI>

23:47



REVIEW

- Patient identified several distortions
- Showed adjusted affect as time went on
- Was willing to challenge himself during review
- The patient was doing the work
- Connects into the bigger CBT picture

WHAT HAS CHANGED?

- Differences in presentation
- Potential romanticizing
- Focus on the negatives
- Missing sessions
- Did not attend meetings

WHAT SKILLS SKILLS?!

Observe

Notice the sensation
Watch thoughts come and go
Allow thoughts to happen
View inside and out

Describe

Label observations
Put words to experience
Describe minus judgment

Participate

Be in the moment
Here and now
Fully experience
Be effectvtive

HOW SKILLS

Nonjudgmentally

- Letting go of qualitative judgments
- Avoiding preference

One-Mindfully

- Being fully present
- In the moment
- Refocusing to now

Effectively

- Identify what works

REACTION

- Patient buy in
- Refocusing on here and now
- It is OK if patient struggles to identify benefit
- Validate
- Want to integrate mindfulness regularly
- Various mindfulness methods

MINDFULNESS ACTIVITIES:

SENSORY RELATED

- Skittles
- Aromas, scents
- Jenga
- Pennies
- Music

INTERNAL RELATED

- Guided imagery
- Ball of light
- Progressive Muscle Relaxation
- Another place/ time

CRISIS IN TELEHEALTH

Obtain patient's location at the beginning of EVERY session.

Review emergency contact info.

Create a plan to contact crisis services before doing telehealth.

Identify options to stay on the telephone.

Traditional suicide assessment.

Discuss benefits to higher level of care.

Have emergency services info available every session.

Remain calm (it is OK to be concerned).

ADDITIONAL INFORMATION

- Thoughts, intent, means, and access to self harm.
- If patient refuses to go, contact crisis services for home visit.
- Stay on phone with patient until crisis services or 911 arrives.
- Connect with emergency contact.
- Be aware of state laws regarding breaking of confidentiality.

MAINTAINING CLIENTS

- Mantra of technology
- Instilled in informed consent
- Commitment of liaison to identify appropriate apps for company
- Reviewed during treatment planning
- Aware of variance in generations
- Flexibility to change level of care based on needs
- Build good rapport with face to face clinics

CONCEPTUALIZING CRISIS

- Informed consent requires patient to provide address every session.
- Patient agrees to limitations of confidentiality.
- Patient agrees to referral to higher level of care if deemed necessary.
- Emergency and collateral contacts provided during informed consent.
- Counselor and patient research together local services.
- Med ER, Psych ER, Crisis Services, local police, local agencies
- Have crisis plan completed before crisis
- Supervision remains mandatory for counselor providing telehealth

WARNING SIGNS OF CRISIS

- Marked change in mental status
- Patient mentions suicide or self harm
- Hesitant to communicate
- Physical bruising observed on patient
- Previous suicide attempts
- Return to substance use
- Hopelessness

MANAGING CRISIS

- Remain calm, empathic, and nonjudgmental
- Identify current factors and triggers
- Use assessment tool (SAMSA SAFE-T)
- Create plan to use emergency services for check ins
- Identify plan to use emergency/ collateral contacts
- Keep supervisor updated- coordinate with supervisor
- Arrange for the client to go to the nearest ER
- Stay on the phone with the client until other care is present

SAFE-T

- Identify Risk Factors: what can be modified?
- Protective Factors: what can be used?
- Inquiry: thoughts, plan, intent, means?
- Risk and action: create plan based on need
- Document: risk, rationale, intervention, follow up

CONCERN: YOU ARE NOT ABLE TO FULLY ASSESS MSE

LIMITATIONS

- Can't fully see patient
- Can't fully hear patient
- Can't smell patient
- Pt can fake IT problems
- Difficulty obtaining UA

RESPONSES

- Compare to previous sessions
- Ask to see environment
- Other signs (missing appts, lack of follow through)
- Maintain contact with ref source
- Joint meeting with adjunct svcs
- Coordinate observe UA

CONCERN: PATIENT'S AND TECHNOLOGY

LIMITATIONS

- Socioeconomic status
- Limited internet
- Tech unfamiliarity
- Reluctance due to HIPAA
- Preference for face to face

RESPONSES

- Ask referral source to assist if possible
- Use family supports to educate
- Devote time to educate and train
- Use HIPAA compliant software
- Indicate hope to resume face to face
- Validate concerns

CONCERN: THERAPEUTIC ALLIANCE

LIMITATION

- Automatic distrust of svcs.
- Pt. limited access to svcs.
- Tech may miss minutia
- Cultural concerns
- Lack of pt follow through

RESPONSES

- OARS skills and validation
- Enhanced contact attempts
- Maintain consistency
- Cultural humility
- MI to enhance follow up
- Assess for higher level if something is missed

SUPERVISION: NAADAC ETHICS

- Supervisors shall be competent in the use of specific technologies.
- Supervisors shall discuss the risks and benefits of using e-supervision.
- Supervisors shall determine how to utilize specific protections, which shall include, but shall not be limited to encryption necessary for protecting the confidentiality of information transmitted through any electronic means.
- Supervisors and supervisees shall be aware that confidentiality is not guaranteed when using technology as a communication and delivery platform.

SUPERVISOR MODELING

- Model to employees what will happen via telehealth
- Expect supervisees to treat telehealth like real sessions
- Doing anything additional or other than a session is UNETHICAL
- Knowledgeable supervisor, committed to telehealth
- Training for supervisees BEFORE they see a client via telehealth
- Ask for proof of certification

CONCERNS REGARDING SUPERVISION

- Supervisee may miss supervision
- Supervisee may indicate camera doesn't work
- Ongoing technology issues
- Problems with supervision can easily be problems in treatment
- Supervisors have support of administrators
- Clear and accessible policy and expectations for workers engaging in telehealth

CONCLUSION

- Telehealth is here to stay
- Various options for telehealth
- Secure software
- Full informed consent
- HIPAA compliant
- Not all clients are appropriate
- Formal policy is required
- Avoid telehealth over state lines
- Can apply various treatments
- Have services close to client on hand
- Supervision is mandatory

QUESTIONS

It has been a pleasure connecting with you



freddombrowski@gmail.com



REFERENCES

- <https://www.faegredrinker.com/en/insights/publications/2020/3/a-day-in-telehealth-history>
- <https://www.ncbi.nlm.nih.gov/books/NBK207141/>
- http://www.people.ku.edu/~tkrieshok/epsy888/mi_cliff_notes.pdf
- http://suicidesafetyplan.com/uploads/SAFETY_PLAN_form_8.21.12.pdf
- <https://mhanys.org/wp-content/uploads/2020/03/NYSPI-CPI-Telehealth-Tips-with-Suicidal-Clients-03-25-20.pdf>
- Ebbert, J. et al., (2021). Patient preferences for telehealth services in a large multispecialty practice. *Journal of Telemedicine and Telecare*. <https://doi.org/10.1177/1357633X20980302>
- Hadler, N., Bu, P., Winkler, A., Alexander A. (2021). College student perspectives of telemental health. *Current Psychiatry Reports*, 23(6). <https://doi.org/10.1007/s11920-020-01215-7>
- Lu, C., Chu, W., Madden, S., Parmanto, B., Silk, J. (2021). Adolescent Perspectives on How an Adjunctive Mobile App for Social Anxiety Treatment Impacts Treatment Engagement in Telehealth Group Therapy. *Social Sciences*, 10(10). <https://doi.org/10.3390/socsci10100397>
- Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People to Change*(2nd edition). New York: Guilford.
- Molfenter, T. et al. (2021). Use of Telehealth in Substance Use Disorder Services During and After COVID-19: Online Survey Study. *JMIR Mental Health*, 8(2). doi: [10.2196/25835](https://doi.org/10.2196/25835)
- Motivational Interviewing Training”(Lesson Plans), Justice System Assessment & Training (<http://nicic.gov/Library/019791>)
- Motivational Interviewing website www.motivationalinterview.org