



SUPPORT ACT 101: CLIENT ENGAGEMENT & TELE-BEHAVIORAL HEALTH

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LICENSED CLINICAL SOCIAL WORKER

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QUESTIONS?

IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT
HESITATE TO CONTACT ME AT

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PROGRAM OUTLINE

I. TELE-BEHAVIORAL HEALTH BASICS

II. MOTIVATIONAL INTERVIEWING

III. CASE MANAGEMENT

The slide features a light gray gradient background with several realistic water droplets of varying sizes scattered in the corners. The text is centered and consists of three lines: a main title, a subtitle, and a section title.

I. INTRODUCTION:
TELE-BEHAVIORAL
HEALTH BASICS

TELE-BEHAVIORAL HEALTH

We first need to admit that most of us do not enjoy “connecting” with clients this way; “I didn’t go to school for this!”

We also need to acknowledge that not all clients have access to technology to participate in tele-behavioral health and so we have to improvise

Therefore practitioners and clients are using phones, Skype and FaceTime to conduct sessions; and getting creative in other ways

Clinicians do not have to use HIPAA-compliant video conferencing technology during the current National Emergency; Health & Human Services will waive any penalties for HIPAA violations related to the platform used during this emergency

TELE-BEHAVIORAL HEALTH: CLINICIAN

- HAVE A SPACE SET UP WHERE YOU CAN CONNECT WITH YOUR CLIENT WITHOUT BEING DISTURBED
- YOUR WORK-SPACE SHOULD PROVIDE SOME PRIVACY FOR YOUR CLIENT
- INTERNET CONNECTIVITY AND/OR PHONE SIGNAL STRENGTH SHOULD BE TESTED PRIOR TO ENGAGING IN TELE-BEHAVIORAL HEALTH
- IF CONDUCTING A GROUP THERAPY SESSION, EDUCATE CLIENTS ON MUTING THEMSELVES UNLESS THEY ARE SPEAKING
- I RECOMMEND AGAINST USING YOUR PERSONAL PHONE, BUT SOMETIMES THIS CANNOT BE AVOIDED
 - IF USING A PERSONAL DEVICE, I WOULD SET FIRM BOUNDARIES WITH CLIENTS REGARDING WHEN THEY CAN CONTACT YOU



You'll likely notice that the flow of clinical sessions will be slower than in-person



Be aware that you will likely need to speak slower than in person



Try to express empathy with your voice, especially when not connecting via video

TELE- BEHAVIORAL HEALTH: CLINICIAN

TELE- BEHAVIORAL HEALTH: CLIENT

- TRY TO HAVE A PRIVATE SPACE WHERE YOU CAN CONNECT WITH YOUR COUNSELOR THAT IS ALSO FREE FROM INTERRUPTIONS AND DISTRACTIONS
- TEST OUT YOUR COMMUNICATIONS SYSTEM (CONNECTIVITY) PRIOR TO MEETING WITH YOUR COUNSELOR
- MOST OF US (COUNSELORS ESPECIALLY) DON'T LIKE MEETING THIS WAY, SO REMEMBER THIS IS TEMPORARY AND WE (LIKE YOU) LOOK FORWARD TO MEETING FACE-TO-FACE AGAIN

CREATIVE WAYS CLINICIANS ARE CONNECTING WITH CLIENTS

Some clients do
not have access
to remote
technology at all

What are some
ways that people
are connecting
during this time?

INFORMED CONSENT TO TREATMENT

Informed consent should be obtained prior to the start of tele-mental health

I recommend that the clinician review all aspects of the Consent to Treatment form with the client prior to the start of treatment to ensure that the client understands what is expected in treatment and the limits of what the clinician can and cannot disclose without the client's permission

The National Association of Social Workers has developed an example of a Telemental Health Informed Consent you can find at:

<https://www.socialworkers.org/LinkClick.aspx?fileticket=fN67-dWQReM%3d&portalid=0>

2020

INFORMED CONSENT TO TELE-BEHAVIORAL HEALTH TREATMENT—ESSENTIAL ELEMENTS

- A STATEMENT EXPLAINING WHAT TELE-BEHAVIORAL HEALTH WILL LOOK LIKE FOR YOU AND THE CLIENT (METHODS TO BE UTILIZED: FACETIME, PHONE, ETC.)
- A STATEMENT DISCUSSING THE RISKS OF TELE-BEHAVIORAL HEALTH (TECHNOLOGY LIMITATIONS AND FAILURES; POSSIBLE/UNINTENTIONAL BREACHES OF CONFIDENTIALITY)
- A STATEMENT AGREEING THAT THE SESSIONS WILL NOT BE RECORDED BY EITHER PARTY
- A STATEMENT EMPHASIZING THAT THE CONTENT OF THE SESSION IS CONFIDENTIAL AND THAT A WRITTEN RELEASE IS REQUIRED FROM THE CLIENT TO RELEASE INFORMATION
- A STATEMENT NOTING THE LIMITS OF CONFIDENTIALITY, INCLUDING HAVING TO REPORT SUSPECTED CHILD ABUSE, VULNERABLE ADULT ABUSE, DANGER TO SELF OR OTHERS

INFORMED CONSENT TO TELE-BEHAVIORAL HEALTH TREATMENT—ESSENTIAL ELEMENTS

- A STATEMENT EXPLAINING WHAT STEPS MUST BE TAKEN SHOULD THE CLINICIAN BELIEVE THAT THE CLIENT IS A DANGER TO THEMSELVES, A DANGER TO OTHERS OR IS UNABLE TO CARE FOR THEMSELVES
 - THIS COULD INCLUDE A STATEMENT THAT PARTICIPATION IN TELE-BEHAVIORAL HEALTH MAY NOT BE APPROPRIATE AND A HIGHER LEVEL OF CARE COULD BE REQUIRED
- A STATEMENT DESCRIBING HOW YOU WILL HANDLE TECHNICAL PROBLEMS SHOULD THEY ARISE
- A STATEMENT EXPLAINING THAT THE CLIENT MUST DISCLOSE THEIR PHYSICAL LOCATION DURING THE SESSION AND AN INDIVIDUAL THE CLINICIAN CAN CONTACT IN CASE OF AN EMERGENCY
- A STATEMENT THAT YOU ARE CONTINUING TO MAINTAIN TREATMENT RECORDS DURING THIS TIME

DOCUMENTATION

- **IF YOU DON'T WRITE IT DOWN, IT NEVER HAPPENED**
- RECORD WHERE THE CLIENT SAYS THEY ARE CONTACTING YOU FROM
- RECORD, IN DETAIL, ALL ASPECTS OF CLIENT INTERACTIONS, INCLUDING ANY KNOWN PRECIPITATING EVENTS, INTERVENTIONS, OUTCOMES, STAFF MEMBERS INVOLVED AND ALL CONTACTS WITH OUTSIDE AGENCIES
- DO THIS AS QUICKLY AS POSSIBLE FOLLOWING THE SESSION
- **STICK TO THE FACTS;** DO NOT PRESUPPOSE OR ASSUME ANYTHING
- SEE DOCUMENTATION AS A NECESSARY MEANS TO PROTECT YOURSELF, THE PEOPLE YOU SERVE, AND YOUR ORGANIZATION

II. MOTIVATIONAL INTERVIEWING

MOTIVATIONAL INTERVIEWING

KNOWLEDGE X MOTIVATION = CHANGE
RESISTANCE

(MOTIVATIONAL ENHANCEMENT THERAPY [MET] = MI +
ASSESSMENT FEEDBACK AND SOME NEGATIVE FEEDBACK)



Identify target behavior



Reduce resistance to change/treatment



Build desire to change (increase its perceived importance)



Build confidence to change



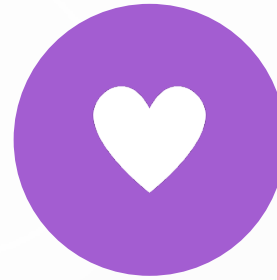
Elicit a commitment/plan to change

TASKS OF MOTIVATIONAL INTERVIEWING

(SMOUT, 2008, P. 7)



Roll with resistance



Express empathy



Develop
discrepancy



Support self-
efficacy

THE PRACTICE OF MOTIVATIONAL INTERVIEWING (SMOUT, 2008, P. 7)

MOTIVATIONAL INTERVIEWING

RESISTANCE IS TO BE EXPECTED AND IS A KEY CONCEPT OF MI

- ROLLING WITH RESISTANCE IS ONE OF THE HALLMARKS OF MI
- INSTEAD OF CONFRONTING THE CLIENT'S RESISTANCE OUTRIGHT, THE RESISTANCE IS REFRAMED:

CLIENT: HOW ARE YOU SUPPOSED TO HELP ME?

SOCIAL WORKER: YOU ARE CONCERNED ABOUT MY QUALIFICATIONS IN BEING ABLE TO HELP YOU? THAT IS OKAY. I AM GLAD THAT YOU ARE THINKING ABOUT HOW I CAN HELP YOU

MOTIVATIONAL INTERVIEWING KEYS

- CLIENT-CENTERED (**THE CLIENT IS THE EXPERT**), DIRECTIVE THERAPY, ORIGINALLY DEVELOPED TO TREAT SUBSTANCE ABUSE; NOW USED TO TREAT A VARIETY OF ISSUES
- THE COUNSELOR'S STYLE AND ABILITY TO CONNECT WITH THE CLIENT ARE KEY
- MI EXPLORES AND RESOLVES THE CLIENT'S AMBIVALENCE BY FOCUSING ON COLLABORATION
- USES IDEAS AND BACKGROUNDS FROM A VARIETY OF THEORIES, BUT GREW OUT OF A DISTASTE OF OLDER, CONFRONTATIONAL MODELS

O: Open-ended Questions

- “How can I help you with _____?”
- “Help me understand _____?”
- “How would you like things to be different?”
- “What have you tried to do before to make a change?”
- “What do you want to do next?”

A: Affirmations

- “You handled yourself very well in that situation”
- “I have enjoyed talking with you today”
- “That is a good suggestion”
- “You clearly have a lot of strengths”

MI
TECHNIQUE:
OARS

R: Reflective Listening

- “So you feel....”
- “It sounds like you....”

S: Summarizing

- “Let me see if I understand so far...”
- “Here’s what I’ve heard. Tell me if I’ve missed anything”
- *Pay special attention to change statements:*
 - “My use has gotten out of hand at times”
 - “If I don’t stop, something bad is going to happen”
 - “I’m going to do something, I’m just not sure yet”

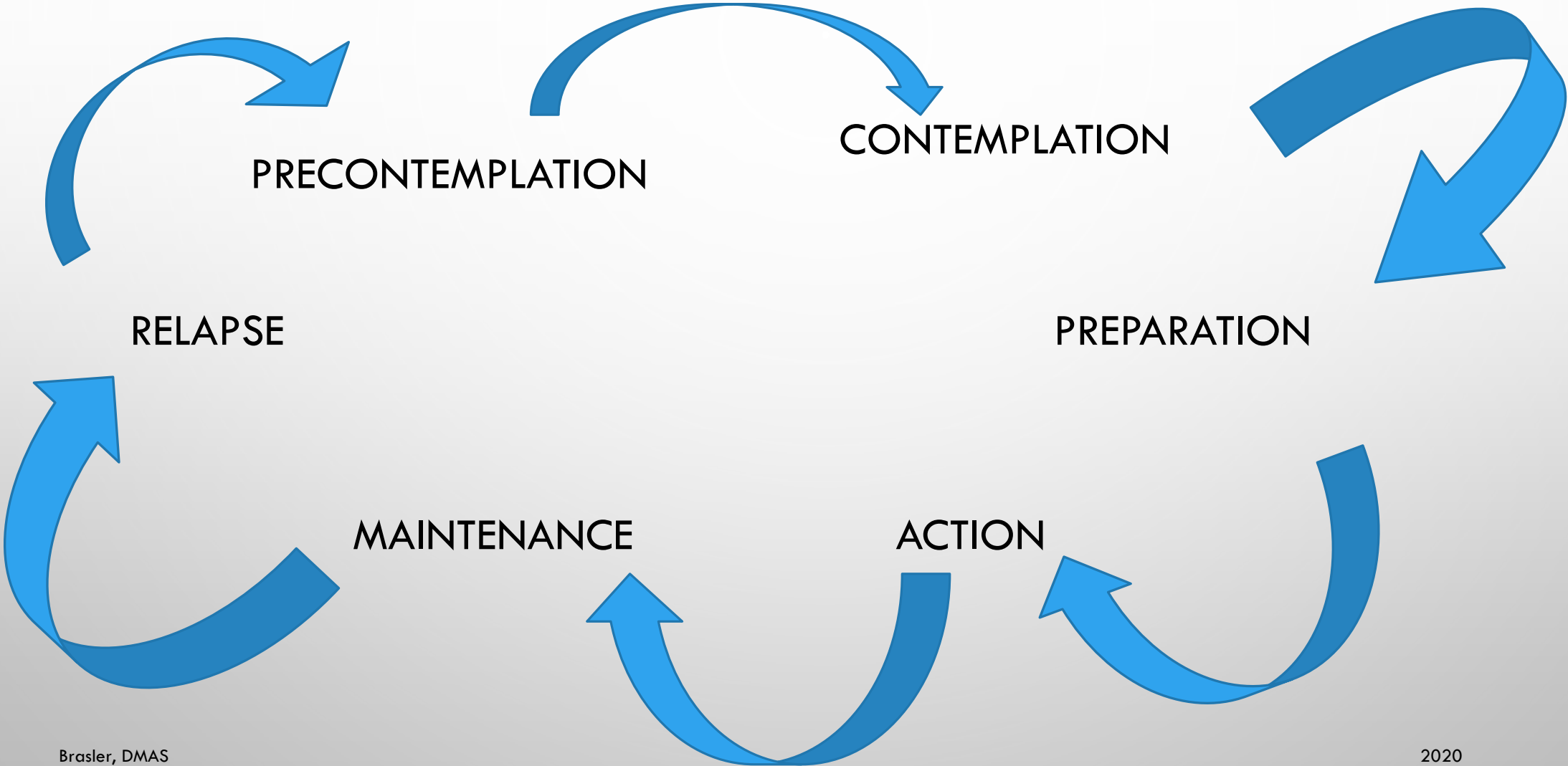
MI
TECHNIQUE:
OARS

MORE MI STRATEGIES AND TECHNIQUES

Brasler, DMAS

- CHANGE TALK; OPTIMISM TO CHANGE
- NORMALIZING
- COLUMBO APPROACH
- SUPPORTING SELF-CONFIDENCE
- READINESS TO CHANGE SCALE
- GIVING ADVICE
- THERAPEUTIC PARADOX: “WHAT IF YOU KEPT DOING WHAT YOU ARE DOING?”

STAGES OF CHANGE MODEL



STAGES OF CHANGE MODEL

PRECONTEMPLATION

- THE PERSON MAY BE UNAWARE OF ANY REASONS FOR CHANGING BEHAVIOR
 - “PROBLEM? WHAT PROBLEM?”
- MAY RESIST BEING TOLD WHAT TO DO
- MAY HAVE RATIONALIZED WHY THEY DO NOT THINK THEY NEED TO CHANGE
- OR MAY FEEL HOPELESS ABOUT EVER CHANGING AND HAVE THEREFORE GIVEN UP ANY DESIRE TO CHANGE
- NEED THE OPPORTUNITY TO LEARN AND REFLECT ON THEIR BEHAVIOR’S IMPACT ON THEIR LIFE

STAGES OF CHANGE MODEL

CONTEMPLATION

- THE PERSON RECOGNIZES THAT THERE IS A PROBLEM...
- ...BUT THEY ARE EITHER AMBIVALENT ABOUT MAKING ANY CHANGES OR ARE NOT COMMITTED TO CHANGING AT THE PRESENT TIME
- PEOPLE IN THIS STAGE ARE USUALLY MORE OPEN TO COLLECTING INFORMATION ABOUT THE BEHAVIOR AND WEIGHING THE PROS AND CONS OF CHANGING OR NOT CHANGING
- REMEMBER THAT JUST BECAUSE A PERSON HAS AN INTEREST IN CHANGING DOES NOT MEAN THAT THEY ARE READY TO DO SO

DECISION BALANCE

Make the Change

Don't Change

PROS

CONS

STAGES OF CHANGE MODEL

PREPARATION

- THE PERSON HAS ACCEPTED THE IDEA OF MAKING CHANGES AND BEGINS TO LOOK AT WAYS TO MAKE THE CHANGES
- THIS COULD INVOLVE ATTEMPTS TO DECREASE THE AMOUNT OF USE, OR SETTING A DATE TO STOP USING
- THE PERSON MAY BEGIN TO CHANGE (OR MAKE ATTEMPTS TO CHANGE) OTHER THINGS IN THEIR LIFE THAT COULD SUPPORT THE MAIN CHANGE

STAGES OF CHANGE MODEL

ACTION

- TAKING A DEFINITIVE STEP SUCH AS ENTERING TREATMENT (INCLUDING WORKING A 12-STEP PROGRAM, AND NOT JUST ATTENDING GROUP)

MAINTENANCE

- ACKNOWLEDGING THAT LAPSES CAN OCCUR AND CONTINUOUSLY DEVELOPING STRATEGIES TO ADDRESS POTENTIAL LAPSES (EX. SERVING AS A SPONSOR, ETC.)

RELAPSES HAPPEN

- **RELAPSE** IS DEFINED AS A RETURN TO REGULAR USE AFTER A PERIOD OF SOBRIETY; **LAPSES** ARE SOMETIMES DIFFERENTIATED AS A SINGLE PERIOD OF USE WITHOUT A RETURN TO REGULAR USE
- A GOAL OF SUD TREATMENT IS TO ANTICIPATE RELAPSES, AND DEVELOP WAYS TO BOTH AVOID THEM AND DEAL WITH THEM IF THEY HAPPEN
- EXPECT RELAPSES TO HAPPEN, AND DO NOT JUDGE THE CLIENT FOR THIS AND REFRAME THEM AS OPPORTUNITIES FOR CONTINUED GROWTH IN TREATMENT
- BE SURE TO RE-ASSESS THE CLIENT FOLLOWING A RELAPSE TO DETERMINE IF THEY REQUIRE PROMPT MEDICAL ATTENTION
- HELP CLIENTS RECOGNIZE RELAPSE WARNING SIGNS/TRIGGERS

TRIGGERS TO RELAPSE

HALT (HUNGRY, ANGRY, LONELY, TIRED)

RIID (RESTLESS, IRRITABLE, ISOLATED, DISCONTENT)

BAAD (BORED, ANXIOUS, ANGRY, DEPRESSED)

- ENVIRONMENTAL CUES CAN INCLUDE SIGHTS, SMELLS, SOUNDS, TASTES, LOCATIONS, ETC.
 - “PEOPLE, PLACES AND THINGS”

RELAPSE PREVENTION: STRATEGIES

(HERRON & BRENNAN, 2015, P. 379 - 381)

- HELP CLIENTS UNDERSTAND RELAPSE AS A PROCESS AND EVENT, AND LEARN TO IDENTIFY WARNING SIGNS
- HELP CLIENTS IDENTIFY THEIR HIGH-RISK SITUATIONS AND DEVELOP EFFECTIVE COGNITIVE AND BEHAVIORAL COPING [SKILLS]
- HELP CLIENTS ENHANCE THEIR COMMUNICATION SKILLS AND INTERPERSONAL RELATIONSHIPS AND DEVELOP A RECOVERY SOCIAL NETWORK
- HELP CLIENTS REDUCE, IDENTIFY, AND MANAGE NEGATIVE EMOTIONAL STATES
- HELP CLIENTS IDENTIFY AND MANAGE CRAVINGS AND CUES THAT PRECEDE CRAVINGS

RELAPSE PREVENTION: STRATEGIES

(HERRON & BRENNAN, 2015, P. 379 - 381)

- HELP CLIENTS IDENTIFY AND CHALLENGE COGNITIVE DISTORTIONS
- HELP CLIENTS WORK TOWARD A MORE BALANCED LIFESTYLE
- CONSIDER THE USE OF MEDICATIONS IN COMBINATION WITH PSYCHOSOCIAL TREATMENTS
- FACILITATE THE TRANSITION BETWEEN LEVELS OF CARE FOR PATIENTS COMPLETING RESIDENTIAL OR HOSPITAL-BASED INPATIENT TREATMENT PROGRAMS, OR STRUCTURED PARTIAL HOSPITAL OR INTENSIVE OUTPATIENT PROGRAMS
- INCORPORATE STRATEGIES TO IMPROVE ADHERENCE TO TREATMENT AND MEDICATIONS



III. CASE MANAGEMENT

CASE MANAGEMENT

- CASE MANAGEMENT (SOMETIMES CALLED CARE COORDINATION) IS AN INTEGRAL PART OF ANY LEVEL OF SUD TREATMENT
- ALL THERAPY USUALLY INCLUDES SOME CASE MANAGEMENT
- THE PRIMARY GOAL OF CASE MANAGEMENT IS TO HELP CLIENTS CONNECT WITH SERVICES AND RESOURCES THAT ENHANCE THEIR TREATMENT
- CM IS HELPING THE CLIENT LEARN TO ACCESS THE THINGS THEY NEED INSTEAD OF DOING THINGS FOR THE CLIENT THAT THEY CAN DO FOR THEMSELVES
- IT IS VITAL THAT CLINICIANS REMAIN AWARE OF UP-TO-DATE SERVICES WITHIN THEIR CLIENTS' COMMUNITIES

CASE MANAGEMENT: BUILDING ON RECOVERY CAPITAL

- **PERSONAL RECOVERY CAPITAL:** THE CLIENT'S PHYSICAL HEALTH, EMOTIONAL SUPPORTS AND THINGS THAT SUPPORT RECOVERY (HOUSING, INCOME, INSURANCE, FOOD, SAFETY)
- **FAMILY/SOCIAL RECOVERY CAPITAL:** THE RESOURCES AND SUPPORT AVAILABLE TO THE CLIENT FROM THEIR FAMILY AND FRIENDS (EMOTIONAL, FINANCIAL, HELP WITH CHILDCARE, TRANSPORTATION)
- **COMMUNITY RECOVERY CAPITAL:** RESOURCES AVAILABLE IN THE CLIENT'S COMMUNITY (HEALTHCARE, CHILDCARE, TRANSPORTATION, HOUSING, ETC.)

SOME CASE MANAGEMENT NEEDS

- MEDICAL APPOINTMENTS
- MEDICAL TREATMENT
- OBTAINING HEALTH INSURANCE
- DENTAL CARE
- TRANSPORTATION
- CHILDCARE
- JOB SEARCH
- HOUSING
- ENROLLING IN JOB TRAINING
- LEGAL AID
- MEETING LEGAL SYSTEM OBLIGATIONS (COORDINATE WITH PROBATION/PAROLE)
- FINANCIAL ASSISTANCE
- OBTAINING FOOD VOUCHERS
- ACCESS FOOD PANTRIES
- CLOTHING
- ENROLLING CHILDREN IN SCHOOL
- IMMIGRATION NEEDS
- ADDITIONAL MENTAL HEALTH NEEDS

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