Identifying and Overcoming Barriers When Implementing the Delivery of Behavioral Health Disorders Treatment Through Videoconferencing in Correctional Settings

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Joyce Hartje:	Welcome to the podcast. My name is Dr. Joyce Hartje. I am the senior project manager for evaluation research at the Center for the Application of Substance Abuse Technologies located at the University of Nevada, Reno.
	The presenter for this podcast is Dr. Ashley Batastini, who is an assistant professor, licensed psychologist, and a researcher at the University of Southern Mississippi.
	The title of this podcast is "Identifying and Overcoming Barriers When Implementing the Delivery of Behavioral Health Disorders Treatment Through Video Conferencing in Correctional Settings." As a follow-up to the "Telemental Health in Correctional Settings" webinar she presented in July, Dr. Batastini will highlight how to identify and overcome barriers when considering implementing video conferencing to deliver behavioral health disorders treatment in correctional settings.
	Thank you, Dr. Batastini, for sharing your experience and expertise with us.

Ashley Batastini: Thank you for having me.

Hartje: As you discussed in the webinar, the use of video conferencing to provide behavioral health services in health care and justice settings is increasing as a way of expanding and enhancing service delivery, especially for hard-to-reach populations; for example, individuals residing in rural or remote areas and individuals in correctional settings.

    You also touched on the fact that there are a number of barriers related to setting up a telemental health program in correctional settings. Could you talk a little bit more about what you see as the biggest barriers to prepare for when setting up a telemental health program in correctional settings?

Batastini: Sure. So just to preface my background a little bit—I think I spoke to this in the webinar as well, but I'm coming from a bit of an outsider perspective—I, as you talked about your introduction, Joyce, I'm an assistant professor at the University of Southern Mississippi. I'm not an employee of a correctional agency. I don't currently have that kind of connection. So I understand that a lot of people who are listening to this may already be employees of the correctional agencies or local counties or things like that. So my responses to these questions are coming largely from my experience as someone who is not directly under the umbrella of one of those agencies. So we may have people listening who may have some different ideas about barriers and how to overcome them.

    But one of the biggest challenges for me as somebody who's not directly with a correctional agency is just understanding some of the bureaucracy and who makes the decisions. There are a lot of people who need to come to the table to not only get on board with your idea and the services that you want to provide through a telepsychology clinic, for example, but you need a number of people who are also willing to help share responsibility in making it happen—it all comes together. So getting all the relevant people together and knowing exactly who those people are and what their role is, or what their role could be in the process of setting up a telehealth clinic, is a really big step.

So for me, I needed to figure out who I needed to get to the table to talk to about this and who are the ones who are really able to make things happen, who had the authority to pull everyone together. You need to get all those people together to agree on a plan and to coordinate with each other. Some of the people that I had to get on board with this idea and other people that might be relevant are people who are within the Department of Corrections—officials, administrators, maybe the warden of a particular agency that you want to try or pilot the clinic through.

For me in setting up our telehealth clinic with a county jail, the two biggest players I think that helped us really push this forward were the county sheriff and several county judges. They were really the people who were able to influence the organization and get people to move on this.

You also need to get legal teams for all parties involved. Again, using myself as an example, we have us at the University of Southern Mississippi, we have the county where we're providing services to, and then we also have the University of Mississippi Medical Center who is serving as our funding source, and they're also a referral source for medication management. So we have really three entities that are involved. So the legal teams of all three of those organizations have to come together and agree on numerous contracts that need to take place for things to happen, from contracts related to service delivery to the use of the equipment and whatever else might be involved. But just getting those legal teams together and to agree—

IT personnel from, again, all sites. So we had to have the USM IT people coordinate with the medical center IT people, and then they all had to coordinate with the IT people at the county.

Frontline staff—so site nurses and sheriffs' deputies or sergeants, and the county clerk, other mental health providers within the facility, are people whose voices are really important in all of this.

Other allied health professionals—so, for example, you may have a clinic, and there's other people providing ad hoc or support services. We had one county where we were going to provide the counseling services, but they had another contracted agency that was providing crisis intervention and medical treatment and medication and things like that. So getting those providers to the

table to discuss is important. And sometimes even just getting the legislature involved in making something like this happen. But that's definitely a big barrier—trying to find out who needs to be at the table and how you can get all those people together and agree on a plan to move forward.

I think another barrier is obtaining money up-front. Money is always a big thing. This kind of thing isn't free, and setting up a clinic can sound pretty costly. And sometimes it is pretty costly initially because you need to pay for the computers at both the remote site and the site delivering services, which might also include monitors, headsets, webcams, maybe materials to secure the equipment. So if you're working at a correctional agency, prison, jail, you might need to get some plexiglass to cover the equipment so that it's not damaged. So there's just a lot of things. IT specialists secure hard lines. Those are all things that cost money, and grant money isn't always easy to come by, and it can sometimes take months to figure out or even years to figure out grant funding. That's another barrier.

And then finally I would say at the top of my list for barriers would be getting people to see how you can help or what virtual treatment can add to existing programs. I think sometimes agencies feel that they already have it covered or that they don't need your services or they don't understand how the services can be beneficial, and often it's difficult to get people to move or think beyond the "Well, how is this going to make more work for me?" kind of mentality. So just trying to get through that point where people see value in adding a telehealth clinic.

Hartje: Thank you for that comprehensive answer, and I really appreciate you early on clarifying your role, and sometimes it's helpful to have an outside perspective on things that need to be considered. One of the things, just to summarize all of the things that you just mentioned, it sounds like you're bringing a lot of people to the table. There's a lot of people that need to be considered in this and consulted in this whole process.

I'm wondering if you could speak a little bit to any tips that you might have for getting buy-in, because it sounds like that might be a big barrier is getting buy-in from all of these different entities.

Batastini: Yeah, sure. So again, coming from a bit of an outsider trying to work my way in, for me I found that one of the most helpful things was to find an insider advocate. I've come to call them the champion of the cause.

Somebody who is on the other side who can get everybody else on board, because if somebody on the other side thinks that this is a good idea, they probably have a better shot of convincing people within their organization as opposed to me, who's outside their organization. But for people who are already inside the organization trying to find—I have a similar recommendation—so finding someone else within the organization who is on your side. So maybe you don't go straight to the boss and you say, "Here's what I'd like to do," but you start getting your coworkers onboard or you start getting—maybe you get some feedback, initially from a couple of inmates or clients. We have this idea for telehealth you think that might fit. And then the more people you can get to agree on this idea, then you have a little bit more pull, I think, to go higher up the chain.

So finding someone else who can help you promote the cause and the rationale. And they can also, for me, again, as an outsider, the insider advocate can also tell you who should be at the table. So who are the people who get things done around town, and who are the people who have authority?

: Another tip I have regarding that is to figure out what the mission of the agency is. So again, from my perspective, I'll just often go on the website and look at a mission statement and try to figure out how I can fit that mission statement.

Usually, it has something to do with improved safety and lower cost. So I think if you can connect your idea and how the services you want to provide through telehealth can improve safety and lower costs, you'll have their attention.

So even though it may be costly up-front, telehealth clinics are shown to be cost-effective in the long term. You can offer evidence-based services to more people with greater continuity. So having a list of how this could be beneficial once you get past the initial barriers of costs and things like that.

So I think tying it to a mission, tying it to what's missing already—so here's what's missing and here's how I think this could fill in the gap. Again for me, I have to be careful with that a little bit because I don't want to overstep or make it sound like anybody's doing anything wrong. But it's helpful to highlight what they're doing well and how these services could enhance what's already going on. So not going in and saying, "Well, you're doing all these things wrong, and here's what I think you should do," but, "Here you're doing things really well. Here's how I think this could enhance what you're doing and at the same time improve safety, improve costs, get more people services that they might need."

Hartje: What I hear you saying basically then is that it's not a one-size-fits-all. It's really an individualized plan that you have to look at what the setting already provides and how can telehealth be used to enhance what they're already doing, and how can they build on the resources that they already have.

Batastini: Right, right. And how could you integrate other resources that they have?

Hartje: Right.

Batastini: So we had one county who, again, had contracted crisis intervention and medication oversight from the local mental health clinic here, but they didn't really provide a lot of intensive counseling or long-term counseling. So our hope was to try to add that to the regimen and also add some more evidence-based risk assessment up-front to help tailor intervention both to someone's risk level but also what dynamic risks could we focus on in treatment, like substance abuse reduction or reducing criminal thinking errors and things like that that you can change. So we were advocating to add some more in-depth assessment and longer-term counseling interventions to supplement what they were doing with crisis intervention.

Hartje: That's a lot of good things to take into consideration.

On the webinar, you also focused on a lot of considerations for actually setting up a telemental health program. There's some things related specifically to service delivery or working with folks in

the correctional setting using telehealth or video conferencing that people in those correctional settings should be aware of. Is there anything else that you could add to the actual service delivery that they should consider?

Batastini: Yeah, so this was, I had this in my webinar and I, of course, babbled too long to really get the gist of what I wanted to say.

Hartje: You've got a lot of good information.

Batastini: I always do that. I tend to make the PowerPoint a lot longer than what I end up getting to, but hopefully at least people have that information if they want it. But I would certainly like to speak a little bit more to that.

So I guess for those of you listening who work in correctional agencies, you already have a good sense of what it's like to work with that population. They're not the easiest population to work with. They can be—they're just difficult. They're difficult to get buy-in from often. They have a tendency to be a little manipulative. Some of them have short fuses. They don't always think about the consequences of their behavior. A lot of those things are universal, whether you're going to sit in a room with somebody or you're going to treat them through a video monitor.

But I think a couple of things that are unique about the virtual experience that is good to keep in mind. One is assessing someone's comfort level with technology. So it's possible that you could have somebody who's been incarcerated for a really long time and they don't have a whole lot of firsthand experience with technology. That doesn't mean that they can't learn how to use it or can't become comfortable with it, but they may not be very initially comfortable with that. So assessing someone's comfort level—maybe taking some time to dispel any myths about the use of technology or why technology is being used with them—and just spending some time getting them to understand the benefit of technology and how this could still be helpful to them, even though you're not sitting in the room with them.

And then along with that, also assessing any potential deficits that might impact communication. So can they hear you okay? Can they see you okay? Is the webcam positioned in a way that you're visible on the screen?

Some other logistics to think about that you don't have to think about when you're sitting in person with somebody are things like eye contact. Often, you've probably had experience with Skype or FaceTime or whatever, but you are looking into the phone—but the camera is a little bit above you, and so it doesn't look like you're really making direct eye contact with people, even though from your end it looks like you're looking at them.

So just addressing things like that to help minimize any kind of damage to rapport. So, for example, in our clinic we have double computer monitors, and so one monitor is to see the individual and the other monitor has paperwork and documentation on it that the counselor might fill out as they're going through the session. And so I've talked to my student counselors about how to address that with clients on the other end and just saying something like, "You may actually see me look away from time to time. I'm still listening to you, but I've got another monitor in front of me where I'm taking notes," or "I'm marking off certain things that are related to our session," or whatever. So just there may be a need to be more verbal as far as what you're doing and why you might be looking away from the camera and not directly at them. Just some things that you might not have to think about while being in person with them.

I mentioned this earlier, but the security of equipment—making sure that if the equipment needs to be secure, that it's secure in whatever way in keeping with the agency's policies.

Figuring out the role of staff, I think, is important. In most agencies, they're not going to be allowed to be either in the room by themselves, or there won't be a security officer too far away from them. So the most ideal situation is that the room is monitored, is private—but monitored in terms of video but not audio, because you don't want the individual to be concerned that other people, other staff members, might hear what they are saying or talking about in counseling.

Hartje: That's a really good point. I'm sorry to interrupt at this point, but do you find that it takes a while to build that trust and confidence that they're being watched just by video and that people aren't actually listening in to their private conversations with the counselor? Does that take a while to build that trust?

Batastini: I think some of it's also tied to the comfort. I think there's another reason if that's their comfort with the technology, and I guess, to expand that, their comfort with just the general setting.

For our clients, they have headsets, too, so that at most anyone nearby would only be able to hear one side of the conversation.

That might minimize some of it to some extent. There may also be some cases where you have somebody who has some delusional beliefs related to technology, and so making sure that that's not contributing to their beliefs about technology, that you're, I don't know, forming some kind of conspiracy around that. There's been some commentary written about the appropriateness of telehealth for people who have psychotic symptoms, but I think that would be something to roll into, again, just an assessment of comfort and general perceptions of the technology so that you can have an open conversation about that with the individual.

I'm going to add as far as the justice-involved persons in general, they—again, this is something that people who are working in these environments already know—but they tend to like a good reason not to do things. Right? So it's possible that with the implementation of any new programming, there might be some pushback or "Oh, we're just—" I've heard this before when I've done treatment and group therapy and things like that—or "We're just your guinea pigs and we're just here for you to—" A lot of times they'll say, "We're just here for you to make money or whatever." Which I don't think they know what psychologists do or how much we get paid. But sometimes there's just a general resistance of "Oh well, this is a new thing. How can I push back on it and how can I be resistant towards it?"

And again, that's something to use clinical skills with, be patient, roll with resistance—just however you would deal with somebody who's generally resistant to treatment. But that could come up, right? This is a new thing. How come we're the only site that's doing it, if you have a pilot site or whatever?

And then establishing clear rules for your interactions and following through with them when those interactions are broken. So again, like you would do if you were talking with these types of clients in person, if they start cursing at you, if they start shaking the computer screen or they start banging on the keyboard, are you going to stop treatment with them and say, "You need to calm down—I'll see you next week," kind of thing? Or how are you going to handle it when somebody gets a little bit unruly in the session?

For us being remote, we have emergency contact numbers, so that if anybody becomes violent or, on the opposite end of that, becomes suicidal, or there's some kind of emergency that we need to call someone security-wise or call the nurse or somebody that we can get in touch. And that same person can serve as a point of contact if something happens, like you get disconnected or something like that. But those are just, I guess, some client considerations that I've thought of with regard to telehealth.

But I think in large part the client considerations are just the same as you would in any other setting. So yeah, they can be a difficult group sometimes.

Hartje: That was all very interesting and very helpful. Do you have any other thoughts that you wanted to share before we close the podcast?

Batastini: Yeah, I'll just add one thing really quick about money. So I brought that up as a barrier before and that it does cost money to set this stuff up. And I mentioned the importance of grants, that those help.

I just wanted to add that, at least for me, it was really helpful to partner with basically another academic partner. Our money to start the jail clinic came from, like I said, the University of Mississippi Medical Center, who also happens to have a center for telehealth.

And a lot of medical universities do have telehealth centers. I know when I was at Texas Tech, our health sciences center had one. The University of Kansas has a big one. So chances are there may be some people already doing this kind of thing that you can partner with, or just finding universities to partner with in general I think can help expedite the grant-funding process because they often have connections or they have people whose job it is to look

specifically for funding opportunities. And there's a lot of funding now geared towards increasing access to health care for rural populations that telehealth clearly fits into that bin.

I know I mentioned on the webinar the Health Resources and Services Administration, which is under the U.S. Department of Health and Human Science, excuse me, the Health and Human Services. That's the funding agency that the Mississippi Medical Center receives funding through. And so our project is a sub 1 of, I think, 20 different subawards within that multimillion-dollar grant agency. So sometimes it's just a matter of finding and connecting

with other people who have connections and getting on board with things that are already going on.

So that would be my advice in terms of finding money—is to get an academic or university partner. Especially if you can find a medical center that already has the center for telehealth, and they often have people internally, again, whose job it is to look for grants to get this stuff going.

Hartje: Right. Yeah. Even our center here at the University of Nevada, Reno, we are grant-funded and so we apply for a lot of grants. We've been specifically focused on rural health, but we've also been getting into more of the telemental health, some in the correctional settings as through those co-op projects.

But just one question: The settings that you've worked with, are they more echo project, echo-type programs or just general telehealth programs—some of the ones that you're familiar with?

Batastini: Yeah. I think UMMC, the University of Mississippi Medical Center, they do have an echo project and we have a subaward under that umbrella. I'm honestly not sure if the clinic that we have is under that as well. But they do have some echo projects.

Hartje: Yeah. I was just curious.

Okay. I really want to thank you a lot for taking the time and sharing your valuable insights into what to consider when implementing telehealth services in correctional settings. I hope the audience has found it very helpful, and I'm hoping also that people will contact

you if they have additional questions or things that they would like to find out from you.

Batastini: Yeah, of course. Anyone's open to call me. My office number is (601) 266-6479 or email me, ashley.batastini@usn.edu.

Hartje: Okay. Thank you.

Batastini: Thanks again for having me.

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