NARRATOR: Welcome to Intersections: The RIT Podcast. Today, Caroline Easton, professor in RIT’s School of Behavioral Health, talks with Jacob Wadsworth, a doctoral intern in the university’s priority psychology internship program, about a project that uses telemedicine, the process of using telecommunication to evaluate, diagnose and treat patients, to help homeless people access mental health and drug addiction counseling.

CAROLINE: Jake, as you know, in the last decade there’s been a lot of dialogue about addiction and mental health. It’s a regular topic when you turn on the news. It’s everywhere. It’s in our communities. It’s across the United States. What drew you here and had you become interested in this topic?

JACOB: From my previous experiences when working with kids with trauma, they – not just kids with trauma, but anybody with trauma – they have other issues going on. And one of those issues can be that they cope with substance use. And then addiction becomes part of that. Right? So, I’m getting that experience in the internship program at my primary site, but also at the House of Mercy, which you introduced us to this year. The House of Mercy is a homeless shelter here in the Rochester area. They bring services to the homeless population that are not just residents there but also people who just come in and are looking for a safe haven.

CAROLINE: We typically see a lot of addiction there as well in mental health. What sort of issues are you seeing among the homeless in particular?

JACOB: They’re not getting access to mental health services. And what I’m learning is that some of them don’t even know what mental health services are, what therapy entails. And some of them have had an adverse experience. So, some of them aren’t so sure what we’re there to do. Some of them, we’re there to end the stigma and try to help them there on the spot or connect them with other services.

CAROLINE: As you know, we recently won an award, over $1 million, here in our internship training program from the U.S. Department of Health and Human Services, the HRSA grant. And we are building a library of training services with the grant funds. It’s allowing us to purchase telehealth equipment and set up a whole telehealth and integrative technology within the homeless shelter. And you’re working with us on that, and the interns are sort of feet on the ground and in the trenches there at the shelter. We both have sort of been building this together: you; me; and the rest of the interns. From the ground up, creating an infrastructure and confidential space and looking at the homeless guests as our partner in this and how we can meet them where they’re at. We do have them coming to us with all these needs, meaning they have untreated medical, they have untreated mental health, they have untreated addiction. Just about everything that they’ve disclosed to us that they’re struggling with. One common thread is trauma, and addiction is a coping skill that many of them have resorted to. And also, at the same time, knowing that it is a transient population and we may never see them again because they’re homeless and they may rotate to another shelter or they may go back to under a bridge or a shanty. So, it’s like, how can we do possibly harm reduction in the
moment, decrease their distress level, give them information and linkages to care? So, that has been something that we’re all working together on. How do you think that’s going with your feet on the ground and the other interns?

JACOB: I think it’s going pretty well for us because we have, as you’ve said, we’ve hit the ground and we got our feet wet. And sometimes in the moment we recognize that they need a service right then and there and we’ll even engage in helping them call the next step if they need to do an in-patient or if they need a bed there. We’ll sit there with them and make the call. So, sometimes in that moment we are the connection between them and other services.

CAROLINE: A big piece of this training at the House of Mercy is that we are bringing evidence-based care to the underserved and underrepresented. And we’re also integrating telehealth into that. Do you want to talk about what is telehealth? What is telepsychiatry and how are we going to be using it with them?

JACOB: So, telehealth generally speaking is when we work remotely from one location than where the client is. So, at House of Mercy, they will have the equipment to sit in front of a screen, and we may be sitting here at RIT and we can provide them with those therapeutic services via the telehealth and those machines. Just because we may not be able to be physically there, we can still provide them with that therapeutic level of care and in some ways be more efficient about it as well.

CAROLINE: Right. And we talked about this. That the homeless guests, we meet them where they’re at. They’re a consumer in a way and they have choices. In meeting them where they’re at, some of them may want telehealth and some of them may not want telehealth. Asking them how important it is to get to know the technology. Do they even use the technology? And we’ve had a fairly good response of clients saying that they would use it. But we’re just getting ready to integrate that. And we just recently got some of the equipment in. And we know exactly what we’re building and going to be using there. Can you think about some clients it may be helpful for based on what you’ve been doing to date?

JACOB: Oh yeah. Absolutely. And I think it’s very exciting because we are the first intern group to do this with you, and you’re also the first person to bring this over to them. I think that’s all very exciting. But I think one of the advantages to having the telehealth there is that we can work with the people who experience violence – are victims of violence or perpetrators of violence – as well as anger management in that moment, providing those kinds of skills as well. But also, you can see the benefit of it for crisis, but you can also see the benefit of it once we have some rapport built, whether over telehealth or just in person as well. Moving over if we’re not already in the telehealth to having those long, sustaining sessions with clients and using some of our motivational enhancement therapy skills.

CAROLINE: We have talked about how it becomes a way of providing some efficiency in allowing for access where they may not necessarily have had access before. So,
having some set intake hours and having some people there by having a room set aside for the telehealth equipment. And they’re set up just like a regular therapy session, it’s just they’re sitting in a seat that’s looking at a screen where they’re seeing us also sitting in a therapeutic chair also looking at the screen like we’re together in the room, but we’re not. They can see us, it’s a good resolution. But it provides a way that we can – they’re introduced to the intake in the screen and told that they’ll be meeting with their therapist and introduced to the therapist. And then the door closes like a confidential therapy session, and we start an intake process, walking them through the intake questions, and then at the end also doing some harm reduction. So, it is like a regular therapy appointment. It’s just educating them on the use and access to care.

JACOB: Once we get them acquainted with just talking with us and almost that psychoeducation of how to have this therapeutic session with just us, we can connect them with other telehealth services as well.

CAROLINE: And many times this telehealth, improving or increasing access to care, is in the moment extremely helpful, where 911 may have been called instead, or an ambulance, or an ER visit. Whereas, they really just needed someone to talk to because they’re in crisis and they’re distressed. And by walking through some mindfulness skillsets or just giving them the emotional support that they need or some crisis management in the moment helps alleviate that. At the very least we’re seeing a decrease in distress levels. We’re literally collecting that data now and we’re seeing the pre/post differences in distress levels. We know something is happening that is working.

JACOB: Yeah. And it’s really interesting almost on an anecdotal level is watching that happen before our eyes within that 30 to 45 minute period. It’s watching them go from a nine to a three. You can see it happening just giving them the opportunity to talk about what they want to talk about. But also us making it meaningful and connecting it to care and having that conversation and just giving them some resources immediately after and letting them know that we’ll be back, and you can talk to us again, and we’ll provide more therapeutic care as well.

CAROLINE: Yes, absolutely. And I feel that we’ve done a good job as a group in trying to break it down for them because it’s transient – we may never see them again – and not burden them or tax them with tons of paperwork. And trying to put it to them in terms that they can digest. Just like you go in because you’re having surgery or something and you’re in a lot of pain and you’re asked on a scale from one to 10. You’re shown these pictures of these faces indicating 10 is the most physical pain you are experiencing right now. We ask them on a scale from zero to 10, 10 being the most pain, where are you in terms of your depression or your trauma? And they can relate to that and give us a score, so that we can tell how well they’re doing and how we can help with that. We’re hoping the telehealth just helps us be able to provide more care by freeing up resources and allowing for better access.
JACOB: This is an experience that some of us have never had. The telehealth is a new learning experience. That’s an experience that we get to learn and get supervision from with you.

CAROLINE: And how has this been different than what you learn in the books? When you came from your grad program to our internship site, how has working with the homeless and using these technologies to provide care been different from what the traditional approach is and what you learned in the textbooks are? What can you say to that?

JACOB: At House of Mercy, we’ve gotten a lot of good crisis management training. The difference between what we’re learning in the textbooks and what we’re experiencing there with the client is: we have all these higher level techniques; but sometimes it’s looking at those very basic techniques and the humanistic approach of empathy and unconditional positive regard. But it’s also providing them with what they need then and there, not looking at it as we’re going to have this 12-week period, we’re going to work on this one thing over and over again. They have needs right then and there that need to be met. And we need to help them right then and there and try to connect them to services.

CAROLINE: That’s a good point. It’s from textbook to real world, sort of jumping in the fire and adapting to the crisis that’s happening. And the partnership has been really nice in that many of the people who are at that shelter are volunteers, and we are integrating the technology and bringing the resources to them through this grant and hopefully future grants to come.

JACOB: And they’re incredibly grateful for what we’re doing there as well. I’m getting that sense from the staff.

CAROLINE: It’s a partnership. We all work together. And the homeless as well. They’re our partner. We’re working with them to meet them where they’re at.

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