CASE STUDY ON PROVIDING TELEMENTAL HEALTH VIDEO COUNSELING

SERVICES IN A SOBER LIVING HOME

by

Kenneth Ray Taylor

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

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Approved By:

Laurel Shaler, PhD, Committee Chair

Steve G Johnson, PhD, Committee Member

ABSTRACT

The purpose of this case study is to examine the process and report outcomes of providing telemental health video counseling to men who reside at Providence Home, a sober living facility located in Columbia, South Carolina. This case study is instrumental in design. The South Carolina Telehealth Alliance (SCTA) provided a $20,000 grant jointly, for Bright Side Counseling Center and Midlands Recovery Center to expand telehealth services into underserved populations. An extensive search, at the time of this writing, was conducted and we found no instances of telemental health video counseling services being provided to residents of sober living homes in the state of South Carolina. This study was limited to men living at Providence Home. Residents were asked to volunteer and receive, free of charge, four telemental health video counseling sessions via an internet broadband connection. A Licensed Professional Counselor (LPC) conducted the four counseling sessions over four to six weeks in October and November 2019. Volunteer participants completed the *Telemental Health Video Counseling Patient Satisfaction Survey* after the four counseling sessions. The Institutional Review Board (IRB) approved resident interview questions were used to conduct interviews with the residents that completed the four counseling sessions. Three staff members at Providence Home were also interviewed after all counseling sessions were completed, using IRB approved staff interview questions.

Keywords: Telemental Health, Substance Use Disorder, Co-occurring Disorder, Sober Living Home

Dedication

I dedicate this work to the men at Providence Home. These men chose to make changes in their lives and decided to pursue that change through a program based on the foundation of Jesus Christ. Because these men were willing to give of their time and open up their hearts to this therapist, there is hope that someday, sober living homes across the nation will be able to provide mental health services through the use of telemental health video counseling. These men will no longer be victims of a system that leaves them untreated. There is HOPE!

Acknowledgments

First and foremost, I would like to acknowledge my grateful reliance on God, whose wisdom and knowledge was ever-present in this endeavor. His comfort in times that I wanted to give up and His grace when I was frustrated with my progress made it possible to continue.

I would like to recognize my wife and most ardent cheerleader, Chong Im Taylor. Her moral support and inspiration were essential in my journey completing this work. While she spent most of her days working a full-time job, she always found time to make me comfortable through this dissertation process.

I am forever grateful for my committee chair, Dr. Laurel Shaler, and my committee member, Dr. Steve Johnson. Both were constant sources of knowledge and trust. Without guidance from these two individuals this would not have been possible. Their calm demeanor got me through some rough times, especially when resolving issues of my research design.

I am incredibly grateful to the men at Providence Home who were eager to take part in this case study. They were each willing to work on a delicate piece of their life so that I would have the chance to determine and prove a strong need for counseling in sober living homes.

I want to thank the staff at Providence Home for having the vision to see the possibilities for the future for all men who come to Providence Home for help and men and women in sober living homes everywhere.

I must say a special thank you to my friend and colleague, Adam Roberson, who was willing to listen to every complaint I had along the way and was eager to inspire me all the same.

Table of Contents

List of Figures

List of Abbreviations

American Psychiatric Association (APA)

Cognitive Behavior Therapy (CBT)

Cognitive Processing Therapy (CPT)

Diagnostic and Statical Manual of Mental Disorders Fifth Edition (DSM-5)

Dialectic Behavior Therapy (DBT)

Electronic Health Record (EHR)

Eye Movement Desensitization and Reprocessing (EMDR)

Health Insurance Portability and Accountability Act (HIPAA)

Institutional Review Board (IRB)

Licensed Professional Counselor (LPC)

Motivational Interviewing (MI)

Obsessive-Compulsive Disorder (OCD)

Post-Traumatic Stress Disorder (PTSD)

Rational Emotive Behavior Therapy (REBT)

South Carolina Telehealth Alliance (SCTA)

Substance Use and Mental Health Services Administration (SAMHSA)

Substance Use Disorder (SUD)

Veterans Affairs (VA)

World Health Organization (WHO)

CHAPTER ONE: INTRODUCTION

Overview

"I'm not telling you it is going to be easy; I'm telling you it's going to be worth it."

Art Williams

The purpose of this chapter is to give the reader a glimpse into what it would take to provide telemental health video counseling services into a sober living home located in an urban community. The background of sober living homes and substance use disorders establishes the need for this case study. It further will lay a foundation for why this service is essential for the residents who live in these homes and some of the background that led to determining why this case study is necessary.

Substance use and mental health disorders touch everyone in one way or another. They are common and often have dire consequences. Difficulties encountered as a result of substance use include all areas of one's life. Family, work-life, education, finances, encounters with law enforcement, physical and mental health all are affected by substance use (Koehn & Cutcliffe, 2012).

The World Health Organization (WHO) reported in a survey of 25 countries with 90,027 respondents, one in four reported either use of illicit drugs or non-prescribed use of prescription drugs in their lifetime (Degenhardt, et al., 2019).

The reality is they are treatable if services are available. According to the Substance Use and Mental Health Services Administration (SAMHSA), "substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home" (Administration, n.d.).

The Diagnostic and Statical Manual of Mental Disorders Fifth Edition (DSM-5) defines substance use disorders as a presence of behaviors where the use of substances falls into nine areas. These areas include impaired control over use or using the substance more often or in greater quantity than was intended, impaired social behavior or not fulfilling responsibilities in social or work situations and continuing to use the substance even though there are negative consequences. The practice is risky or physically harmful, tolerance is present, and withdrawal when the substance is removed (American Psychiatric Association, 2013).

For quite some time, drug and alcohol abuse has and continues to be a massive problem in our society. According to the American Psychiatric Association (APA) (2013), substance use disorders cover ten different types or classes of drugs. These include alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, and other or unknown substances.

In 2017, President Trump declared the opioid crisis a "Health Emergency" (n.d.). Numerous government agencies strive to curb the opioid crisis (Dyer, 2018). The use of opioids in general and overdose as a result of opioids has skyrocketed in recent years and has reached epidemic proportions. Over 2.4 million Americans were estimated to have opioid use disorder in 2018. In 2015, 50,000 Americans died from a drug overdose. Thirty-three thousand of those deaths were from opioids (Ryan, 2018). It is a significant mental health problem in the United States.

Social anxiety often accompanies the mental disorders found in communal living (Boddapati, Hunter, Jason, & Ferrari, 2014). In one study of individuals in treatment for substance use, in a sample size of 326 participants, almost one-third indicated they experienced anxiety and depression in addition to substance use disorder. Sixteen percent reported anxiety

alone (Charney, Palacios-Boix, Niegrete, Dobkin, & Gill, 2005). Additionally, co-occurring mental health conditions are prevalent. One research team looked at 77 studies and found that mental health and substance use disorders existed in two-thirds of adults and adolescents that were in substance treatment programs in the last year (Chan Ya-Fen, Dennis, & Funk, 2008).

    One of the many approaches to the treatment of substance use disorder is sober living houses. Whether a sober living home is successful or not is often influenced by its location. Community support enhances the stability of the home. When sober living homes are "good neighbors," the chances of the home's survival is increased (Polcin, Henderson, Trocki, Evans, & Wittman, 2012). Sober living houses assist in providing a dry living environment for those who experience substance use disorders (Jason, Olson, Ferrari, & Sasso, 2006). By the nature of placement in a sober living house, residents already have a substance use disorder (SUD) diagnosis (Jason & Ferrari, 2010; Argeriou, McCarty, & MacDonald, 1991). One such home located in Columbia, SC, is Providence Home. Providence Home is a Christian facility providing services to 25 to 35 men at any given time (Providence Home, 2019).

Unfortunately, there are many barriers to the treatment of substance use disorder beyond the availability of sober living homes. Some of the barriers to treatment include financial status, transportation, and proximity to mental health providers (Mojtabai, Chen, Kaufmann, & Crum, 2014). Negative stigma related to mental health treatment is also a barrier (Ciftci, Jones, & Corrigan, 2013). Often society will create stereotypes that identify subgroups of substance users. These stereotypes result in discrimination of members of the subset (Crapanzano, Hammarlund, Ahmad, Hunsinger, & Kullar, 2013).

Often there are co-occurring conditions with substance use disorders (Harris & Edlund, 2005), such as depression (Najt, Fusar-Poli, & Brambilla, 2011), chronic stress (Sher, et al.,

2008), anxiety (Brady & Sinha, 2005), post-traumatic stress disorder (Schumm & Gore, 2016), attention-deficit/hyperactivity disorder (Groenman, et al., 2019), and even personality disorders (Gregory, 2019).   Both substance use disorder and the co-occurring disorders often go untreated, sometimes due to the barriers discussed above (Harris & Edlund, 2005; Mojtabai, Chen, Kaufmann, & Crum, 2014). The Patient Protection and Affordable Care Act, commonly known as "Obama Care," made insurance coverage available to millions of Americans, but many still are either not taking advantage of the coverage or are not covered (Garfield, Lave, & Donohue, 2010).

Access to treatment for mental health, not just substance use disorder, is not easy when geographic barriers become a reason for not seeking treatment. The healthcare industry has made great strides using telemental health to get services into rural communities (Simms, Gibson, & O'Donnell, 2011; Davis, Boulger, Hovland, & Hoven, 2007; Gibson, O'Donnell, Coulson, & Kakepetum-Schultz, 2011; Morland & Kloezeman, 2013; Mehrotra, et al., 2017; Hilty, Green, Nasatir-Hilty, Johnston, & Bourgeois, 2015). Although not always located in rural communities, sober living home residents can experience the same barriers to seeking mental health services. Often residents move from being incarcerated or homeless to sober living. Many do not have jobs or transportation, so economic barriers and transportation become immediate impediments. These barriers also exist in Providence Home.

This case study seeks to look at telemental health video counseling as an alternative way of providing needed mental health services to residents of sober living homes. Providing therapy to the men who live in sober living homes is a way of giving hope. Common Factor research suggests that all counseling approaches include such attributes as hope, expectation, relationship with the therapist, belief, and corrective experience. The reliance on hope along with many of

the other aspects of therapy is a crucial part of recovery (Wampold & Imel, 2015). The goal of this study is to determine how effective it is using telemental health video counseling services for residents in a sober living facility in an urban setting? The same barriers exist for sober living homes when they are located geographically in an urban or rural community; therefore, I chose an urban environment. If successful, this alternative method of providing treatment has the potential of reaching every sober living home in the state of South Carolina and beyond. I am also seeking to identify the unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling services critical. Finally, I will investigate to see what the residents who receive treatment services find to be effective with telemental health video counseling.

Background

Historical Context

Video technology used in mental health services began in the 1950s and increased in popularity in the 1990s. Its uses include discharge planning, psychological assessments, suicide risk assessments, and is used in forensic settings (Vaitheswaran, Crockett, Wilson, & Millar, 2012). There has been a shift in providing mental health services from institutions to community-based delivery. Unfortunately, there are still many people who need mental health services that do not receive care. The need for care is most evident in people with serious mental illness. Because of the failures in community-based care, many end up in jails or prisons (Mechanic, 2007). Sober living homes have become a part of the solution. Support from the community is crucial for these homes to be successful. Conflict with the communities where sober living homes are can harm the success of the residents and may even result in the closure of the house (Polcin, Henderson, Trocki, Evans, & Wittman, 2012). The environment provided

by sober living homes can assist some in extending the number of abstinent days for residents in sober living homes (Polcin, Korcha, Bond, Galloway, & Lapp, 2010).

Social Context

An unstable living environment can be a considerable obstacle to sober living. When the living environment is not healthy, such as homelessness or where drugs and alcohol are present, sobriety can be extremely challenging. Sober living homes have shown that alcohol and drug use reduces, employment is often obtained and maintained, arrests drop, and psychiatric symptoms go down (Polcin, Korcha, Bond, & Galloway, 2010). Sober living home residents rely on support from other sober residents. The homes are drug and alcohol-free and usually require residents to be a part of an organized support network such as a 12-step group. The advantages of living in these homes include being self-supporting, increasing self-esteem, requiring residents to be employed, and contributing to the financial support of the house. Usually, residents can stay as long as they wish if they remain sober (Polcin, Korcha, Bond, & Galloway, 2010). In many underserved populations, such as rural communities, there is a lack of service providers (Fortney, et al., 2015).

Theoretical Context

The theoretical context in this study centers on the need for mental health services in underserved populations. The stability of the residents in the home can affect the outcome of this research. Residents that are not able to attend therapy are assumed to be more vulnerable to relapse. A comprehensive approach to recovery should improve outcomes. If necessary mental health services exist, improved health, and social consequences should result. Providing services that are easy to access are essential for there to be comprehensive substance use treatment (Cao, Marsh, Shin, & Andrews, 2011).

Situation to Self

As the Chief Executive Officer and Director of a mental health practice (Bright Side Counseling Center), as well as a Licensed Professional Counselor (LPC), I see the barriers to receiving mental health services daily. This experience has influenced my position when it comes to the administration of mental health services to underserved populations. This experience has also helped me to redefine my characterization of underserved communities to include men and women who live in sober living homes no matter where they exist geographically. I have a genuine heart for helping people as a professional counselor.

The barriers that I see often include a negative stigma that comes along with mental health treatment. Stigma comes in many forms for substance users. These include social stigma, self-stigma, stigma from healthcare providers, shame, guilt, and self-doubt (Crapanzano, Hammarlund, Ahmad, Hunsinger, & Kullar, 2013). The stigma is even more significant when gender and sexual minority identity is involved (Benz, Reed, & Bishop, 2019) or when the individual is human immunodeficiency virus (HIV) positive (Batchelder, et al., 2019). A qualitative study published in *Substance Abuse and Rehabilitative* found that a significant portion of those seeking treatment for substance use encountered one or more forms of stigma (Crapanzano, Hammarlund, Ahmad, Hunsinger, & Kullar, 2013). Often this stigma, unfortunately, comes from the religious community (Reeves, Beazley, & Adams, 2011). Because of these barriers and stigma, many who need mental health treatment go untreated (Henderson & Gronholm, 2018).

In my first position as a counseling student intern, I served as a board member for a sober living home where three men lived in 2011. Mental health treatment options for these men were minimal. Transportation was scarce, and some mental health treatment was not available. I can

now see with the availability of telemental health video counseling services; these men could have received additional help they so desperately needed. Unfortunately, that sober living home was destroyed by fire as the result of an impaired operator who drove his vehicle into the living room, causing the car to burst into flames. All three residents were present at the time, one of which left the living room only minutes before the crash.

Ironically, six months later, the driver of the vehicle became a resident of the sober living home that replaced the destroyed house. The sober living home referred to in this section was operated by First Baptist Church of Lexington, South Carolina. All the men who lived in these sober living homes experienced the same barriers to treatment that men and women who live in sober living homes experience every day.

Counseling services were not available unless we transported residents to a facility that could assist. Residents were not capable of paying for services because initial placement in the home required no employment, to allow the resident to acclimate to the sober living environment.

The stigma of going to a mental health provider is particularly pervasive among men, and we can avoid that stigma by using telemental health video counseling (Khlat, Legleye, Legleye, & Sermet, 2014). Telemental health video counseling services might have been a tremendous benefit to the men living in these sober living homes. I found that my personal and fundamental component of awareness was involved as I prepared this case study, and many relationships and ideas allowed for there to be generalizations and transfer of meaningful thoughts.

This case study explored the necessary logistics and revealed the value of providing telemental health video counseling into a sober living home. By conducting telemental health video counseling free of charge for men in a sober living home, I was able to identify the need

and present a framework for providing the services.

Problem Statement

There exist numerous barriers to obtaining mental health services for men who live in sober living homes. One of the significant obstacles of remaining sober when an individual has a substance use disorder, and in some cases, co-occurring disorders, is a stable living environment where recovery efforts are supported. While there are sober living houses that can provide the environment, even in these homes, there are barriers to treatment. Some of the barriers to treatment include the financial ability to pay for services. Many of the residents enter the homes unemployed. It takes time to find employment.

Transportation is also often a barrier. Most residents do not own vehicles, nor do they have money for a taxi or public transportation services. If the home is not close to city bus lines, their ability to go to scheduled mental health appointments diminishes. The proximity of mental health providers is crucial since most providers establish offices in city centers, not residential neighborhoods (Mojtabai, Chen, Kaufmann, & Crum, 2014).

Many residents of sober living homes often experience co-occurring conditions with substance use disorders, such as depression or anxiety. Both substance use disorder and the co-occurring disorders often go untreated, sometimes due to the barriers discussed above (Harris & Edlund, 2005; Mojtabai, Chen, Kaufmann, & Crum, 2014).

Purpose Statement

The purpose of this case study is to determine how effective using telemental health video counseling is for residents living in a sober living home in an urban setting. This case study is instrumental in design. This case study will also illustrate the unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling

services critical. Also, this case study will attempt to determine if residents who receive

treatment services find telemental health video counseling to be effective.

The South Carolina Telehealth Alliance (SCTA) provided a $20,000 grant to expand

telehealth services into underserved populations. Based on an extensive search, at the time of

this writing, there are no apparent telemental health video counseling services in sober living

houses in the state of South Carolina. This study will be limited to the men who live in

Providence Home in Columbia, South Carolina. The study will satisfy the South Carolina

Telehealth Alliance's request to expand telemental health services into underserved populations.

Significance of the Study

The significance of this study is to explain the empirical, theoretical, and practical

necessity and applicability of this study to the counseling community and the sober living homes

that are seeking ways to serve their residents (Stake, 1995).

This study will show how we can provide a widely needed service to a population of

individuals that would otherwise possibly not receive mental health services. Residents will be

able to receive these services through telemental health video counseling without having to leave

their residence, thereby eliminating transportation and location barriers to receiving services.

The substance use disorders that residents of the sober living home have, as well as any co-

occurring disorders, will be addressed rather than go untreated. The residents currently rely on a

dry environment (a place where alcohol and drugs are not allowed), Christ-centered principles of

living, and 12 step programs as their primary treatment options. A therapist trained in the

treatment of substance use disorders will be able to implement a plan of support that is

sustainable and scalable. Administrators of sober living homes will be able to see the value of

services easily accessed to become readily available with minimal coordination.

One substance that has stood out recently is opioids. The use of opioids in general and overdose as a result of opioids has skyrocketed in recent years and has reached epidemic proportions. Approximately 2.4 million Americans were estimated to have opioid use disorder in 2018. According to the National Institute on Drug Abuse, based on statistics revised in January 2019, more than 130 people die from opioid overdose everyday including prescription pain relievers, heroin and synthetic opioids such as fentanyl (2020). It is a significant mental health crisis in the United States.

There has also been a significant push to get mental health services into underserved populations. Unfortunately, most of these efforts were for mental health services into rural areas where services are not available (Matsea, Ryke, & Weyers, 2018). While sometimes located in urban neighborhoods, sober living homes experience some of the same barriers to receiving mental health services as rural residents (Polcin, et al., 2012). Residents of sober living houses find the same geographic restrictions and barriers, such as transportation and finances, that keep residents from accessing mental health services even though they may not be in a rural community (Davis, Boulger, Hovland, & Hoven, 2007). By the sheer nature of the purpose of sober living houses, all the residents have, at a minimum, a substance use disorder diagnosis, and many have other diagnoses as well. Mental health services would assist in preventing relapse. At the time of the publication of this study, we did not find any telemental health video counseling services for residents of sober living houses in the state of South Carolina. There is evidence of telehealth psychiatric services in home-based telehealth for medication management (Hungerbuehler, Valiengo, Loch, Rössler, & Gattaz, 2016). If counseling services are needed, they are generally provided by a licensed masters level clinician to the resident (Strachan, et al., 2012).

Research Questions

Central Question: How effective is using telemental health video counseling services for residents in a sober living facility in an urban setting?

Sub Question 1: What are the unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling services critical?

Sub Question 2: What did the residents who received treatment services find to be effective with telemental health?

Definitions

1. *Case Study* – an analysis of a group typically used in a model of medical, psychological, social, or psychiatric occurrences (Hancock & Algozzine, 2017).

2. *External Validity* – the extent to which the conclusions from a case study can be analytically generalized to other situations that were not part of the original research (Yin, 2018).

3. *Instrumental Case Study* – generally used to better understand a theoretical question or problem (Hancock & Algozzine, 2017).

4. *Internal Validity* – the strength of the causal or other "how" and "why" inferences made in a case study, in part reinforced by showing the absence of false relationships and the dismissal of rival hypotheses (Yin, 2018).

5. *Member Checking* – a method of checking data to ensuring accuracy by providing the information back to the participant for review and asking them to confirm its validity (Hancock & Algozzine, 2017).

6. *Semi-Structured Interview* – an interview where the interviewer is not required to follow an exact script and can use follow-up questions if necessary or desired (Yin, 2018).

7. *Single-Case Study* – a case study organized around a single case; the case might be a critical, standard, unusual, revelatory, or longitudinal case (Yin, 2018).

8. *Sober Living Home* – a residence for individuals with substance use disorders who live together and share expenses and support without drugs or alcohol (Polcin & Korcha, 2015).

9. *Telemental Health* – "telemedicine is the process of providing health care from a distance through technology, often using video conferencing, telemental health, a subset of telemedicine, can involve providing a range of services including psychiatric evaluations, therapy (individual therapy, group therapy, family therapy), patient education and medication management. Telemental health can involve direct interaction between a psychiatrist and the patient. It also encompasses psychiatrists supporting primary care providers with mental health care consultation and expertise. Mental health care is delivered live in an interactive communication format. It can also involve recording medical information such as images and videos, sending this to a distant site for later review". (American Psychiatric Association, 2017).

10. *Triangulation* – determining the convergence of the data collected from different sources of evidence to assess the strength of a case study finding and also to boost the construct validity of measures used in the case study (Yin, 2018).

11. *Qualitative Research* – qualitative research *is* research that does not use statistical procedures or quantification to reach a definitive finding (Hancock & Algozzine, 2017).

Summary

Residents of sober living houses are not receiving mental health services due to barriers to treatment, including transportation, finances, social stigma, and availability of mental health

professionals (Mojtabai, Chen, Kaufmann, & Crum, 2014). Telemental health services are an effective treatment option for substance use disorder (Jason, Olson, Ferrari, & Sasso, 2006). The Patient Protection and Affordable Care Act guarantees mental health services to everyone, but many still cannot take advantage of this coverage (Garfield, Lave, & Donohue, 2010).

Video technology has been available since the 1950s and became prevalent in mental health services in the 1990s (Vaitheswaran, Crockett, Wilson, & Millar, 2012). There is much emphasis placed on getting services into rural communities (Simms, Gibson, & O'Donnell, 2011). Sober living house residents experience the same barriers as rural community residents even if they are geographically located in urban communities. Sober living houses are effective in increasing the number of abstinent days for its residents (Polcin, Korcha, Bond, & Galloway, 2010).

CHAPTER TWO: LITERATURE REVIEW

Overview

"It does not matter how slowly you go as long as you do not stop."

-Confucius

Telehealth is delivering healthcare services through information and communications technologies consisting of telephones, remote patient monitoring devices, and other electronic means. This use of telehealth facilitates the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site, and the healthcare provider is at a distance site. Telemedicine offers four significant benefits: improved access, cost-effectiveness, improved quality, and meets patient demand (Pratt, 2015). It can also provide less expensive health care access (Pratt, 2015).

Pilot studies have found high levels of satisfaction using video conferencing-based treatment, especially for those clients who live a considerable distance from the treatment facility or lack transportation (Tarp et al., 2017). Most studies of interventions using the internet or telemental health use university students as participants (Cunningham, Gulliver, Farrer, Bennett, & Carron-Author, 2014). Improving access to healthcare, providing care in a more cost-effective method, and improving the quality of healthcare are all three primary goals of the Affordable Care Act. One way to accomplish all three is through telehealth and telemedicine (Pratt, 2015).

Theoretical Framework

This therapist chose to use a systems theory for a theoretical framework, in particular, Bronfenbrenner's Ecological System theory. Bronfenbrenner's Ecological System theory and the social organization that someone exists within looks at two major dimensions of a neighborhood's social organization. The first is the strength, prevalence, and interdependence of

social networks. The second is the extent of collective supervision that the residents direct and the personal responsibility they assume in addressing their problems (Majer, et al., 2008). This therapist who conducted the actual counseling sessions noted that Common Factor theory of counseling should be addressed. Common Factor theory posits that there are contributing factors present in all counseling that contribute to the success of the therapy. These can include things such as family support, religious experience, rapport with the therapist, and many others. In many of the comments from the participants it was evident that the skill and rapport established by the therapist was a significant part of the counseling success. Common Factor would indicate that any counseling conducted where the counselor ensures there is a positive rapport established, or that empathy is displayed by the therapist one might expect success of the therapy to increase (Karam, Blow, Sprenkle, & Davis, 2015). What Common Factor does not take into consideration is the differences in the delivery of the therapy. Using telemental health video counseling may not have improved or diminished the effectiveness of the therapy, telemental health video counseling was successful in reducing the barriers that exist when the recipients live in a sober living home. This researcher's theoretical framework is a result of existing research and positions that support the need for telemental health video counseling services in rural communities due to the barriers residents in rural communities must overcome to receive mental health services. Sober living homes often self-supervise, and their interdependence relies on their ability to function as a social network. This researcher's theory assumes that sober living homes are rural communities within an urban environment because the same barriers to obtaining mental health services exist for sober living home residents that exist for rural community residents. Additionally, the theoretical framework requires the residents to seek assistance or self-direct their efforts toward recovery. Using telemental health video counseling

already overcomes the barriers for rural community residents. If a system of providing services in a similar type community has proven successful, such as telehealth services being provided to rural communities, that same type of system should be able to deliver services in a community (sober living home) with the same barriers. Telemental health video counseling should also be effective in reducing the barriers for sober living home residents.
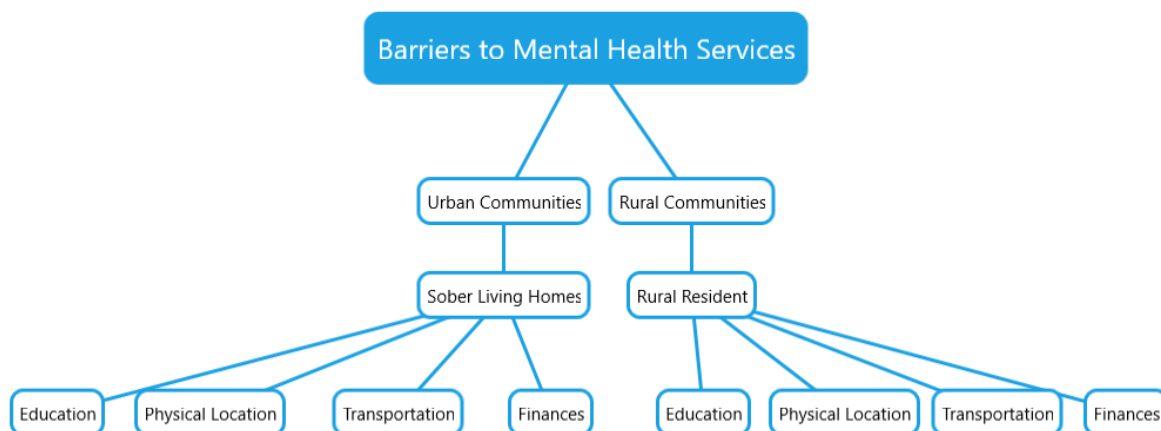
Figure 1 Barriers to Mental Health Services. This figure illustrates the sameness of the barriers found in a rural community and a sober living home in an urban neighborhood.

Internet technology and the delivery of services are rapidly changing, and America's health care system is lagging in the use of telehealth video technology. Our health care delivery system can benefit from the way we approach the delivery of healthcare services, mainly mental health services. Receiving care in the most efficient way that meets the needs of patients will provide better health outcomes. Virtual reality is here today (DeLeon, 2002). Telepsychiatry is "the provision of psychiatric care at a distance through technologies including phone care, e-mail, web-based systems, and mobile applications" (Shore, 2015, p. 469). Often the terms telepsychiatry and telemental health are used to mean the same thing. Telemental health includes all allied mental health professionals such as psychiatrists providing medication

management, psychologists providing assessments, social workers providing community services, or therapists providing counseling. Telepsychiatry alone usually implies care provided by a psychiatrist (Shore, 2015). For this study, a licensed professional counselor will perform video counseling. As technology develops and the internet becomes available in more settings, the use of telemental health is an option that we must consider. Telemental health is a cost-effective way to deliver mental health services (Bahloul & Mani, 2013). Telemental health is a "critical tool to improve access, increase quality, and reduce costs" (Shore, 2015, p. 469) of treatment.

Treatment for men and women who struggle with substance use disorder often find themselves without the necessary resources to make a successful recovery. The lack of stable housing is one factor that they face. Within the United States and throughout the world, sober living houses are becoming more and more available. While sober living homes address some of the needs of these individuals, they fail to take into consideration all mental health treatment needs of the residents.

Related Literature

Substance Use Disorder encompasses a wide range of substances. They are characterized by repeated use even when the user knows there are negative consequences associated with their use. There are often extreme levels of distress and can ultimately result in dependence on the substance. Symptoms often include withdrawals when the substance is no longer present (McHugh, Hearon, & Otto, 2010). Alcohol is among the top four most common mental health issues. The most common addiction and mental health concerns are depression, anxiety, alcohol use disorder, and smoking (Cunningham, Gulliver, Farrer, Bennett, & Carron-Author, 2014). In

2014, 22.5 million people over the age of 12 needed treatment for illicit drug or alcohol use. Only 4.2 million received treatment (National Institute on Drug Abuse, 2018).

Drug addiction is a disease that is chronic and characterized by uncontrollable or compulsive drug-seeking and use, even when there are known harmful consequences. There are notable changes in the brain that can be long-lasting. Relapse is seen in drug addiction when the user returns to drugs after an attempt to stop (National Institute on Drug Abuse, 2018). Many drug users start using drugs to cope with stress or emotional pain. Craving occurs when stress or pain exists, and the user turns to drugs to satisfy both the desire and reduce the stress or pain (Jabeen, et al., 2018).

Alcohol use disorders have a treatment adherence rate below 50%, and of those that drop out, 50% drop out in the first three months of beginning treatment (Tarp, Bojensen, Mejldal, & Nielsen, 2017). The use of alcohol has increased from 65.4% to 72.7% of a surveyed population between 2001-2002 and 2012-2013. Alcohol use disorder also increased during that same timeframe from 8.5% to 12.7% (Cheng, Kaakarli, Breslau, & Anthony, 2017). Increases in medication-assisted treatment have provided new hope for local communities and incarcerated individuals (Aaronson, Adelstein, & Csernansky, 2018).

Treatment for substance use disorders takes many forms. It requires an individualized approach. Cognitive Behavior Therapy (CBT) is one treatment method and can be applied to many different substance use problems. Other therapies might include Contingency Management, Motivational Interviewing, Dialectal Behavior Therapy (DBT), Rational Emotive Behavior Therapy (REBT), the Matrix Model, and 12-Step Facilitation (American Addiction Centers, 2019).

Many men and women who leave treatment facilities for substance abuse will return home to the same environment. This environment often is the same high-risk environment that made drugs or alcohol available to them. Their friends and support network are also unchanged. Relapse is almost inevitable. Recovery residences are one alternative to a return to an unhealthy environment (Jason & Ferrari, 2010).

Types of Recovery Residents

The National Association for Recovery Residences categorizes housing into four levels of residences (National Association of Recovery Residences, 2012). Level 1 residences are peer managed and located in local residential neighborhoods. Sober living houses in South Carolina are usually Level I residences. Level II residences have a house manager and are also typically found in local residential communities. Some level II residences are private residences, while others are multifamily or commercial residences. Level III residences have employed staff and provide on-site services. Level IV residences are usually treatment programs with therapeutic staff and licensed professionals. These facilities are generally not in residential areas due to zoning requirements (Polcin, 2018).

Unstable housing is associated with greater severity of substance use. In a study of 5,629 samples, 32% were either homeless or were marginally housed and at risk of becoming homeless (Eyrich-Garg, Cacciola, Carise, Lynch, & McLellan, 2008). Sober living houses where abstinence is required has shown to improve substance abuse treatment results (Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005). In a study where sober living houses conducted random drug testing, 75% reported negative samples compared to 67% negative samples where participants did not live in the sober living house (Rash, Alessi, & Petry, 2017).

Oxford House

One of the most successful sober living home organizations in the United States is Oxford House. In 2017 there were over 2,300 Oxford houses in the United States. All Oxford house residents pay rent, utilities, and any other household expenses. The monies collected in Oxford houses amounted to over $116,000,000 (Oxford House, 2018).

There is a high level of comorbid psychiatric conditions and substance use disorders. Having both a co-occurring mental health condition and substance use disorder does not deny residents a place to live in sober living houses (Majer, et al., 2008). A combination of factors can contribute to successful recovery initiatives. These can include 12 step programs, sober living houses, and professional services, including counseling. Attendance in outpatient treatment is modest, with only 20% reporting any follow-up sessions, and on average, those who did attend only attended less than one meeting per week (Bergman, Hoeppner, Nelson, & Slaymaker, 2015). As of November 26, 2018, there were 59 Oxford Houses located in the state of South Carolina with a capacity to serve 420 residents. There were 64 vacancies.

Seven Oxford houses are open to women and children, 13 are open to women only, and 39 are open to men only. The capacity of all Oxford houses in South Carolina is 427 residents. No Oxford houses are open to couples (Oxford House, 2018).

Telemental Health Video Counseling as a Treatment Option

Video conferencing as a way of providing treatment is gaining ground in addictions treatment as well as many other psychiatric areas. When patients used video conferencing, the dropout rate for treatment goes down (Tarp, Bojensen, Mejldal, & Nielsen, 2017). Evidence indicates that face-to-face and online interventions share the same effectiveness and patient satisfaction (Cunningham, Gulliver, Farrer, Bennett, & Carron-Author, 2014; Pratt, 2015).

Telemental health is the delivery of mental health services from a distance using information and communication technologies (Pruitt, Luxton, & Shore, 2014). The first instance of telepsychiatry occurred at the University of Nebraska in 1959. It was a live interactive video conference used for education, consultation, research, and treatment. In 1968 telepsychiatry was used in Boston and New Hampshire. The lower cost of therapy using telehealth allowed for the expansion of these services into additional facilities such as prisons and federal health systems. As late as 2011, telehealth using computers and the internet was still a controversial topic (Perle, Langsam, & Nierenberg, 2011).

Technology and the Internet

With the rapid growth of the world wide web, telehealth began to expand exponentially. However, mental health professionals were falling behind in taking advantage of this technology (Perle, Langsam, & Nierenberg, 2011) The Department of Veterans Affairs has taken the lead on the implementation of telemental health services in the home. As of 2013, the Department of Veterans Affairs reported having conducted over 650,000 telemental health visits. In 2013 alone, the VA conducted telemental health visits with over 80,000 veterans (Petzel, 2018). In 2017 the Department of Veterans Affairs introduced a National VA Video Connect platform that was more user friendly and provided a video enabled tablet to the veteran if necessary. In 2018, VA mandated that all mental health providers be trained in Video Telehealth by the end of FY2020 (Lindsay, et al., 2019).

Telemedicine allows for the exchange of healthcare information between patients and their healthcare provider regardless of physical distance or obstacles by way of secure video conferencing. Its use is increasing as we deliver mental health treatment. Expansion to treat substance use disorders will be natural (LaBelle, et al., 2018). Telehealth is growing with the

reduced cost of technology and the shortage of medical professionals in certain areas. Barriers to the use of telehealth include reimbursement, licensure, social stigma, legislative restrictions, available workforce, and costs. Our ability to meet the mental health needs of those restricted by geography, such as rural communities where transportation is not available, can be alleviated through the use of telemental health services (Pratt, 2015).

Treatment Options

Telemental health can treat many mental health conditions including substance abuse, bipolar disorder, Obsessive-Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD), depression, schizophrenia, and panic disorder (Bensink, Hailey, & Wootton, 2006; Brand & McKay, 2012; DelliFraine, 2008). Home-based telemental health is generally accepted to be both a feasible and effective treatment option. Evidence is also present that home-based telemental health can help prevent rehospitalization. It can also reduce days spent in psychiatric hospitals as well as enhance treatment satisfaction and compliance (D'Souza, 2002; Godleski, Darkins, & Peters, 2012).

The use of web-based video conferencing seems to provide the most flexibility and mobility. Web-based video conferencing reduces the amount of hardware, support, and connectivity needed. Telemental health eliminates issues of access, travel costs, and logistics, making mental health more readily available (Shore, 2015).

Telemental Health Video Counseling Acceptance

Overall acceptance and even expectation of the use of telehealth is high. Demand for video sessions is likely to increase in the future due to its acceptance by younger generations. Video sessions into homes should increase, thereby reducing the stigma of going to a mental health facility and serving as a convenience to the client. Patients will probably expect mental

health to be available in a delivery method that takes place in a comfortable environment, such as their own home. The technology required to conduct telemental health is open to the vast majority of patients in need of mental health services (Pruitt, Luxton, & Shore, 2014).

Advantages of Telemental Health Video Counseling

Advantages of telemental health include reduced travel, shorter appointment wait times, and less time off from work, all of which result in cost avoidance to the patient. Patients with children also may not need to arrange for childcare. These benefits have occurred in patients being more willing to seek treatment, maintain medication compliance, and attend appointments. Treating anxiety disorders can be done using home-based telemental health. Using home-based telemental health allows the practitioner to attend to the needs of these clients in the comfort of their own home rather than having to come to a therapy center (Pruitt, Luxton, & Shore, 2014).

If telehealth meets HIPAA requirements, concerns of privacy are comparable to conventional medicine. Unauthorized third-party access is a security concern for both. (Pratt, 2015).

Research by Lauckner and Whitten (2016) indicates that the use of telemental health by the Department of Defense and the Department of Veterans Affairs is successful, especially with clients in rural or underserved locations. One reason it appears to be so successful is that it is self-funding. Mental health professionals that work for these agencies receive compensation through congressional funding, and the recipients of these services are not required to pay for services provided, whether they are through telemental health video counseling or face to face counseling. Patients receive these services as a result of their veteran status or military, active duty status. Reimbursement by insurance companies is still a hindrance to many patients that need support.

Access to Treatment and Effectiveness

For treatment to be effective, quick access to treatment is necessary. The most common form of treatment is counseling with behavioral therapists. Treatment should also address other possible mental disorders (National Institute on Drug Abuse, 2018). In treating substance use disorders, when participants received continuing professional care, and there was one session per week, there was a 1.25 times greater chance for abstinence. For two sessions per week, there was a 1.5 times greater chance for sobriety and three sessions per week, there was a two times greater chance for abstinence. When the participant lived in a sober living environment such as an Oxford House, and if they were residents for 30 days, they had a 1.7 times greater chance of abstinence. If they had 60 days as a resident of a sober living house, they had a three times greater chance of sobriety. If they had 90 days as a resident of a sober living house, they had a 5.2 times greater chance of abstinence, and at 100 days, they had a 6.2 times greater chance of sobriety. Those who participated in one 12 step recovery meeting weekly had a 1.26 more significant chance of abstinence. Those who participated in two 12 step recovery program activities weekly had a 1.59 more substantial likelihood of abstinence. Those who participated in five 12 step recovery program activities weekly had a 3.2 higher chance of sobriety (Bergman, Hoeppner, Nelson, & Slaymaker, 2015). The treatment is enhanced when treating substance use disorders when using video conferencing-based treatment or when combined with face-to-face therapy because it decreases barriers of time and distance (Tarp, Bojensen, Mejldal, & Nielsen, 2017).

Incarceration Reentry Programs

It has been noted by some that "residential recovery homes in the community are good options for those who wish to pursue abstinence from drugs" (Polcin, Role of recovery

residences in criminal justice reform, 2018, p. 21). Incarcerating individuals for drug offenses have been counterproductive (Polcin, 2018).

With support to communities making up 5% or less of many state corrections budget (Engel, Larivee, & Luedeman, 2009; Subramanian, 2012), often states look to resources in the community to assist with reducing recidivism for men and women released from incarceration. Sober living houses often are a part of these resources (Hamilton & Campbell, 2014). Sober living homes are frequently self-governed, where residents pay for their expenses. Each resident is usually required to pay rent and share expenses.

Summary

Improving access to healthcare is one of the critical goals of the Affordable Care Act. The use of telemental health improves access to healthcare (Pratt, 2015). Most previous studies used university students and are not representative of all populations (Cunningham, Gulliver, Farrer, Bennett, & Carron-Author, 2014). Previous studies also seemed to concentrate on rural communities where residents live away from providers (Tarp, Bojensen, Mejldal, & Nielsen, 2017).

Telemental health provides improved access, is cost-effective, and meets patient needs (Pratt, 2015). Treatment for men and women who struggle with substance use disorders and other co-occurring mental illnesses can receive therapy via telemental health since this is a proven and effective delivery method (Bahloul & Mani, 2013). The worldwide web has expanded the availability of technology in the delivery of mental health services (Perle, Langsam, & Nierenberg, 2011). Telemental health removes barriers such as geography, transportation, and eliminates the stigma of going to mental health facilities (Pratt, 2015).

Sober living houses are also a useful tool in the treatment of substance use disorders (Polcin, et al., 2012). Sober living houses improve substance treatment results (Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005), especially when the sober living home environment combines with other treatment options such as 12-step groups, sober days increase (Bergman, Hoeppner, Nelson, & Slaymaker, 2015).

CHAPTER THREE: METHODS

Overview

"I understood myself only after I destroyed myself. And only in the process of fixing myself, did I know who I really was."

Anonymous

The purpose of this instrumental case study is to determine what is necessary to have telemental health video counseling services provided in a sober living facility. This chapter explains the method of research and logistics required for delivering these services. This chapter also discusses the collection of data and the analysis of that data. The researcher conducted telemental health video counseling with men living in Providence Home, a sober living facility located in Columbia, South Carolina.

Design

When collecting data in a natural setting, a researcher would typically use a qualitative approach (Creswell, 2013). This case study will be a qualitative study using a single instrumental case study design. In an instrumental case study, a specific instance (in this case, providing telemental health video counseling services into a sober living home), is examined to allow for the general understanding of the general principle surrounding the service (Stake, 1995). It is appropriate to select an instrumental case study when the understanding of a particular issue is not as important as the understanding of the theoretical explanation that underpins the issue (Hancock & Algozzine, 2017). In this case, the actual counseling that took place is not a part of this study. Instead, the impact the availability of therapy has on the sober living home environment was examined. Because we do not know much about providing telemental health video counseling into sober living facilities, a qualitative design is best (Hancock & Algozzine, 2017). The main goal of an instrumental design is to enhance the

understanding of a procedure or process (Hancock & Algozzine, 2017). Case studies exist for many research methods, including qualitative, quantitative, and mixed methods (Yin, 2018). Using a case study design allows for the exploration of an organization and the application of a procedure, whether it be simple or complex. It supports the deconstruction of what is needed to provide telehealth video counseling services into a sober living home (Baxter & Jack, 2008). A single instrumental case study design was chosen because the study is limited to one sober living home.

This case study will also be exploratory in design because it will seek to determine the feasibility of providing telemental health video counseling into a sober living home. By examining the procedures in this case study, we were able to make recommendations for additional work in the future (Hancock & Algozzine, 2017).

With the purpose of this study being to determine how effective using telemental health video counseling services for residents in a sober living facility in an urban setting, it would be necessary to take a sociological approach or look at the home and its residents in their existing environment. Using a sociological approach allowed for a view of Providence Home and the residents who participated in this project, in their current state. It was appropriate to choose interviews as the method of obtaining data since the design used a sociological approach (Hancock & Algozzine, 2017). Interviews provided empirical data needed to answer the research questions below.

Also, since the theoretical framework rests on Bronfenbrenner's Ecological System, the social organization of the recovery home was taken into consideration when choosing interviews as the method of obtaining data. The only way to investigate the social network is to question the individuals who exist within the social network being measured. In this case Providence

Home and the men who took part in the counseling sessions and the staff members responsible

for the operation of the home.

Eight face-to-face interviews provided the data in this case study. Three of the interviews

were with staff members of Providence Home. Five of the interviews were with the men who

fully participated in telemental health video counseling. Since there was a small number of

participants, I did not use group interviews. Using group interviews may not capture all

volunteers' viewpoints and contributions as some participants might choose not to contribute

(Hancock & Algozzine, 2017).

I conducted interviews face-to-face, on-site at Providence Home. Conducting the

interviews at Providence Home ensured the comfort of the volunteers. Interviews should be in a

location that increases the comfort of the interviewee (Hancock & Algozzine, 2017). A private

office was provided by the staff of Providence Home to ensure the privacy of the participants.

Hancock and Algozzine (2017) suggest interviews be recorded instead of making

handwritten notes during the interview since notes often lack detail, and memories can be faulty.

An Android Smart Phone was used to record the interviews, which were later transcribed

verbatim.

The interviews were also semi-structured, as recommended by Hancock & Algozzine in

case study applications (2017). Closed-ended questions allowed for demographic information to

be obtained, and open-ended questions allowed for a more comprehensive participative answer

from the individuals being interviewed. Asking open-ended questions also allowed for there to

be follow-up questions when needed. This allowed for clarification of comments when

necessary. Participants in the interviews reviewed copies of the interview transcript after

completed. The use of this member checking technique assured the reliability and credibility of the data (Carlson, 2010).

Research Questions

Central Question: How effective is using telemental health video counseling services for residents in a sober living facility in an urban setting?

Sub Question 1: What are the unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling services critical?

Sub Question 2: What did the residents who received treatment services find to be effective with telemental health?

Setting

A licensed professional counselor conducted telemental health video counseling while located at Bright Side Counseling Center, located in Lexington, SC, and the volunteers stayed at Providence Home in Columbia, SC, and participated via an internet connection. Residents of Providence Home used a secure room in which to participate in the counseling session. The reason Providence Home was selected is due to its location in an urban center of Columbia, SC. The men who reside there have admitted to a substance use disorder; therefore, providing counseling services would be appropriate. Generally, these men would not seek counseling at an established counseling center for a host of reasons. These include a lack of transportation, lack of funds, education of available resources, and the stigma associated with seeking mental health services. Providence Home is also a Christian based program, and that matches with the faith-based counseling provided by Bright Side Counseling Center.

Bright Side Counseling Center provided an ideal location since this researcher is the

Executive Director and a Licensed Professional Counselor (LPC) and, therefore, could provide the resources and expertise necessary to provide the counseling services.

Participants

The participants in the study will be the Providence Home Executive Director, the Providence Home Program Director, the Providence Home Development Director, the Providence Home residents, and the Bright Side Counseling Center Director.

According to Providence Home's website, their motto is, "Helping Men Celebrate Victory in Christ" (Providence Home, 2019). John Zenoni, a reformed alcoholic, founded Providence Home. Mr. Zenoni used his faith in God and a desire to help others get sober to establish Providence Home on a farm in Lexington county. Now located in Columbia, SC, it houses men working on staying sober. Jimmy Braddock operates the home. The mission of Providence Home remains the same: "to help stabilize the living conditions of dislocated men and to encourage progress in realizing their full personal potential in self-sufficient living through the power of Jesus Christ" (Providence Home, 2019).

Bright Side Counseling Center incorporated in 2014 as Bright Side Counseling, LLC, with Kenneth R Taylor as its founder. From May 2014 to June 2017, Mr. Taylor worked as an independent contractor at First Baptist Church of Lexington Counseling Center under the Bright Side Counseling LLC umbrella.

In August of 2017, Bright Side Counseling Center moved to its current location with only two therapists and has grown to its current workforce of seven therapists and two administrative staff members. Therapists conduct individual counseling, group counseling, marriage counseling, and family counseling. Bright Side Counseling Center provides a safe environment where clients are treated with respect, dignity, and patience. Clients include adults, couples,

adolescents, and children facing many of life's challenges. Specializations at Bright Side Counseling Center include Eye Movement Desensitization and Reprocessing (EMDR), Trauma Therapy, Sexual Offender Treatment Programs, and Certified Sexual Addiction Therapy (Bright Side Counseling Center, 2019). Bright Side Counseling Center's motto is *Building Healthy Families*.

Bright Side Counseling Center provided volunteer residents of Providence Home one hour of telemental health video counseling a week for four weeks based on any counseling service the resident might request. This study will not review the content of the counseling sessions, nor will diagnostic information on participants be provided as a part of this study.

Initially, there were nine volunteer participants from residents of Providence Home that agreed to be a part of this study. Three key staff members were interviewed as a part of this study to get their perspective on the needs of the residents. They answered questions about providing telemental health video counseling services and the overall success of the project. All participants and staff members responded to questions presented using a semi-structured interview process. I did not include the identity of Providence Home residents that took part in the telemental health video counseling. Not providing their identity protects their anonymity as would be expected in any professional counseling situation. Transcripts of all interviews follow.

Procedures

After receiving Institutional Review Board (IRB) approval, the Executive Director of Providence Home gave his permission to contact the residents and solicit volunteers to participate in the telemental health video counseling sessions. A second visit to Providence Home allowed us to request volunteer residents and staff using IRB approved scripts. From this visit, nine men volunteered to be a part of this case study. Three staff members also volunteered

to be a part of this case study. The script used to solicit volunteer participants is available in Appendix A for residents, and Appendix B for staff members. The nine volunteers were presented with informed consent documents (Appendix C) thoroughly explaining their part and rights in this case study. All nine volunteers signed documents stating they understood their rights as a part of this case study.

Providence Home identified a location where the men would be able to participate in counseling and have appropriate privacy. Providence Home also provided a laptop computer for the volunteers to use to receive the telemental health video counseling. Giving each volunteer a counseling appointment time, we began the counseling sessions. I conducted all counseling sessions from an office at Bright Side Counseling Center. At the end of each counseling session, I scheduled the next follow-up session with the volunteer.   Volunteer participants were not required to travel to Bright Side Counseling Center at any time during the collection of data for this study. During the collection of data for this case study, four of the original volunteers decided to leave Providence Home and, as a result, discontinued participation in the study. Five volunteers completed all parts of the study. There were a total of 23 telemental health video counseling sessions completed.

Procedures were coordinated with Providence Home staff to accommodate the possibility of emergency situations that may have come up during counseling sessions. This included an emergency phone contact at Providence Home who could take emergency action to call 911 or get supervisory assistance in the event a participant presented with suicidal or homicidal ideations that required immediate external attention. During the first counseling session, a review of informed consent and mandatory reporting requirements were discussed with each participant.

At the end of all counseling sessions, residents who participated in the study completed the *Telemental Health Video Counseling Patient Satisfaction Survey* (Appendix G) to determine the satisfaction level of the participants.

The Researcher's Role

In this case study, the researcher was responsible for conducting counseling sessions via telemental health video connection from the Bright Side Counseling Center. This researcher's role was the Licensed Professional Counselor that provided the actual counseling during the telemental health video counseling. In conducting this research, I used an emic approach to gain a perspective of the men in the home where they live.

Preparation for the case study required that I travel to Providence Home on three occasions. The first trip was to meet the staff at Providence Home and establish a rapport. Providence Home identified a secure office to use for the counseling sessions, and we conducted a test of the equipment to ensure connectivity. After IRB approval was received, I went to Providence Home to solicit volunteers to participate in the case study. Nine residents began as part of the study. After all counseling sessions were over, I interviewed the five remaining volunteer participants in the telemental health video counseling sessions. Additionally, I interviewed the Providence Home Executive Director, the Providence Home Program Director, and the Providence Home Development Director.

Data Collection

Data was collected using a survey after the completion of all telemental health video counseling. I prepared verbatim transcripts of interviews with all participants in the telemental health video counseling, and the three staff members of Providence Home. Interpreting data

using a conceptual context, I looked for patterns and themes of the success and efficiency of the telemental health video counseling process.

Interviews

These are the twenty-three interview questions developed for the Providence Home residents that participated in the telemental health video counseling sessions. These questions assisted in answering the research questions for this case study.

1. Please tell me your first name. Demographics.

2. How old are you? Demographics.

3. Have you been diagnosed with a substance use disorder before? This question provides data to assist in answering the central question & sub-question #1.

4. At what age did you first use substances? Demographics.

5. What is the longest time frame you have remained clean from substance use? Demographics.

6. How long have you lived at Providence Home? Demographics.

7. How did you come to end up at Providence Home? Demographics.

8. Why did you come to Providence Home? This question provides data to assist in answering the central question & sub-question #1.

9. Have you been in treatment for substance use disorder before? This question provides data to assist in answering the central question & sub-question #1.

10. What is your drug of choice? Demographic.

11. How long have you struggled with substance use? This question provided data to assist in answering the central question & sub-question #1.

12. How long have you been clean this time? This question provided data to assist in answering the central question & sub-question #1.

13. Have you ever sought out mental health services? This question provided data to assist in answering the central question & sub-question #1.

14. Do you have access to mental health services here at Providence Home? This question provided data to assist in answering the central question & sub-question #1.

15. Are there any barriers to your receiving mental health services here at Providence Home? This question provided data to assist in answering the central question & sub-question #1.

16. Are you able to pay for treatment for substance use disorder? This question provided data to assist in answering the central question & sub-question #1.

17. Do you struggle with more than one mental illness? This question provided data to assist in answering the central question & sub-question #1.

18. Do you take psychotropic medication? This question provided data to assist in answering the central question & sub-question #1.

19. Are you currently receiving mental health services? This question provided data to assist in answering the central question & sub-question #1.

20. Were you invited to participate in telemental health video counseling sessions? This question provided data to assist in answering the central question & sub-question #2.

21. Did you find telemental health video counseling sessions helpful? This question provided data to assist in answering the central question & sub-question #2.

22. If you had not received telemental health video counseling sessions, where would you have received mental health services? This question provided data to assist in answering the central question & sub-question #2.

23. Is there anything I could do differently that would have made the telemental health video counseling experience better? This question provided data to assist in answering the central question & sub-question #2.

In the interview for residents who participated in telemental health video counseling, questions 1, 2, 4, 5, 6, 7, and 10 provided data to collect demographic information on the participants. These questions provided data to allow a picture to be painted of what to expect from sober living home residents in terms of background, race, life circumstances that brought them to the point of needing a sober living home, substance choices, and ages.

Questions 3, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23 were included to assist in answering the central question in the case study. The central question is, "How effective is using telemental health video counseling services for residents in a sober living facility in an urban setting?". Question three provided data to ensure the foundational need for substance use mental health services were needed. Question eight helps to provide an understanding of what type of individual would end up in a sober living home. Questions nine, eleven, twelve, thirteen, seventeen, and eighteen provide information as to the extent of the substance use issues found in a sober living home. Questions 14, 15, and 19 probes the participant as to what services they are aware of as being available to them at present. Question 20 confirms that the participant was indeed a volunteer. Questions 20, 21, 22, and 23 encouraged comments about the telemental health experience.

Questions 3, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, and 19 were included to assist in answering sub-question #1. Sub question #1 is, "What are the unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling services critical?". Question three provided data to ensure there was a mental health need that I could treat through telemental health video counseling. Questions 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, and 19 were an attempt to determine if there were needs that existed before the residents came to Providence Home and to secure history for comparison to other participants. As to their current status of participants, substance use disorders, and co-occurring disorders if present.

Questions 21, 22, and 23 provided data to assist in answering sub-question #2. Sub question #2 is "What did the residents who received treatment services find to be effective with telemental health?". Questions 21, 22, and 23 encouraged participants to openly share the telemental health experience and make recommendations for improving the telemental health video counseling experience.

Surveys/Questionnaires

Each participant completed a survey to measure patient satisfaction administered after all telemental health video counseling sessions. A copy of the survey is available in Appendix A. Results of the survey are explained later in this report.

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Data Analysis

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The data obtained will be analyzed using a pattern-matching technique. Because I detected a pattern that I initially expected in the data, I chose a pattern matching design to analyze the data (Yin, 2018). This type of analysis is also known as the congruence method, and when the patterns found are similar, it can help to strengthen internal validity (Yin, 2018). Pattern-matching usually will look at the "how's" and the "why's" of a case study. One way of

showing the "how's" and "why's" is to focus on the process and outcomes. Pattern-matching allows for this process (Yin, 2018). If the patterns found in the data match the patterns expected before data collection began, one can draw conclusions about the current case study (Yin, 2018). While some might consider pattern-matching to not be a precise technique compared to statistical values, lower levels of precision allow for interpretive discretion by case study researchers. Being overly restrictive or lenient can allow room for criticism. To eliminate this criticism, I will attempt to avoid making predictions based on subtle patterns and will make sure whatever patterns identified are clearly matched so that the findings are less likely to be challenged (Yin, 2018).

Trustworthiness

Numerous steps were built into this study to ensure the methodological rigor and to enhance the integrity of this study's findings. Ensuring that all data is trustworthy, transcripts of data were presented to the interview participants (member check) for review before analysis of the data, as recommended by Yin (2018). Every effort was made by this researcher to avoid bias by noting both positive and negative outcomes in surveys and interview data (Yin, 2018).

Credibility

Credibility refers to whether research findings truthfully portray the phenomenon of the case study. Several strategies were employed to ensure the credibility of the study.

1. All interviews were audiotaped and transcribed verbatim. The verbatim transcription ensures that the data used in the analysis is accurate, and the words of those interviewed are exact, making sure the findings were precise.

2. Because the categories and subcategories were the same in numerous transcripts contributed by many of the participants, the findings were unique.

3. Categories were also consistent with other literature concerning telemental health video counseling and the interviews conducted.

Dependability and Confirmability

Dependability means that others who conduct similar research can review the process in this study and understand how decisions were made (Lincoln & Guba, 1985). Various notes were made throughout this study and maintained by this researcher.

Confirmability is the extent that any conclusions are based on the interpretation of the data and not on the opinions of this researcher (Lincoln & Guba, 1985). Interviews with the participants and accurately reporting their findings ensured confirmability.

Transferability

Transferability is the ability to apply findings to other contexts or, in this case, other sober living homes (Lincoln & Guba, 1985). By expressing the data in a way that is understandable and detailed, future researchers can apply these findings in other sober living homes.

The use of telemental health video counseling is a viable and acceptable practice within the mental health community. The credibility of this case study rests in the ability of future scholars being able to replicate this study in other sober living homes, including those for women and in all locations, urban or rural.

Ethical Considerations

Funding for this study comes from a $20,000 grant from the South Carolina Telehealth Alliance.

Identifying information of participants is not included in this study. The participants became clients of Bright Side Counseling Center, and documentation of their counseling sessions is in a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Health Record (EHR) system known as SimplePractice.

Paper files and notes were locked in a file cabinet inside this researcher's office when not in use to ensure there was no unauthorized access to any individual who did not have a right or need to access the data or information.

Summary

This case study was instrumental in design to determine what is necessary to have telemental health video counseling services provided in a sober living facility. The method of research was semi-structured interviews. It was essential to identify the logistics required for delivering these services. The researcher conducted telemental health video counseling with men living in Providence Home, a sober living facility located in Columbia, SC, to determine how effective is using telemental health video counseling services for residents in a sober living facility in an urban setting. Through semi-structured interviews, this researcher was able to determine what the unique needs were of residents living in a sober living home in an urban environment that makes telemental health video counseling services critical, and what the residents who received treatment services find to be effective with telemental health.

CHAPTER FOUR: FINDINGS

Overview

"Recovery didn't open the gates of heaven and let me in. Recovery opened the gates of hell and let me out!"

Anonymous

The staff and residents of Providence Home in Columbia, SC were the participants in this case study. I interviewed three staff members and the five residents who completed the telemental health video counseling services as a part of this case study.

The purpose of this case study was to determine how effective using telemental health video counseling is for residents living in a sober living home in an urban setting. This case study is instrumental in design. This case study sought to understand the unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling services critical. Also, this case study determined if residents who receive treatment services found those telemental health video counseling services to be effective.

The South Carolina Telehealth Alliance (SCTA) has provided a $20,000 grant to expand telehealth services into underserved populations. Based on an extensive search, at the time of this writing, no apparent telemental health video counseling services are being provided in sober living houses in the state of South Carolina. This study was limited to the men who live in Providence Home in Columbia, South Carolina. Since Providence Home does not provide services to women, there were none in this study. The study satisfied the South Carolina Telehealth Alliance's request to expand telemental health services into underserved populations.

Participants

Rob Settles

Figure 2. Rob Settles. Providence Home Executive Director

While interviewing Mr. Settles for this case study, I asked him why he came to Providence Home. He said, "I have a shepherd's heart, and somebody told me about the position. They thought I'd be just perfect for it, and when I talked to the former director, he thought the same thing."

Jimmy Braddock

Figure 3. Jimmy Braddock. Providence Home Program Director

In my interview with Mr. Braddock, he shared the reason he came to Providence Home. "Just having dealt with substance use disorder and being active in the recovery community, this seemed like the place for me to be."

Adele Little

Figure 4. Providence Home Development Director

In my interview with Mrs. Little, she stated, "I love working with people in transformation, seeking a changed life."

In addition to the staff of Providence Home, nine residents were solicited and volunteered to take part in this case study. After being given informed consent, all men signed documents of understanding and volunteered to take part. I did not include any identifying information in this study of the men who participated. Of the nine original men who volunteered, two left Providence Home and the program of recovery before any counseling sessions began. One participant completed only one counseling session, and another participant completed only two counseling sessions before they left Providence Home and the program of recovery. Five participants completed the four planned counseling sessions as a part of this case study.

<div align="center">

Results

</div>

Theme Development

After finalizing all telemental health video counseling sessions, the remaining participants completed a Telemental Health Video Counseling Patient Satisfaction survey (appendix G). Participants completed the survey on December 2, 2019.

Four of the five participants said they had never participated in telemental health video counseling before this study. Using a Likert scale where 1 = Very Dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, 5 = Very Satisfied, participants were asked to rate their experience based on eleven questions.

A summary of the demographic information received during the semi-structured interviews conducted after the completion of all counseling sessions follows. The five Men from Providence Home who participated and completed all counseling in this case study ranged in age from 27 years old to 58 years old. The mean age of the participants being 45.4 years old. During the interview following the completion of all counseling sessions, three (clients #2, #4, and #5) of the five men reported they had a substance use disorder in the past. Two (clients #1

and #3) said they did not have a substance use disorder prior to his moving into Providence Home however, his additional comments indicated a misuse of prescription drugs in the past. One of the two men who reported they did not have a substance use disorder was determined by this therapist to meet the diagnostic criteria found in the DSM-5 for substance use disorder. This is based on the history he gave during the interview. The other man denied any use of substances in the past.

The age that the five men reported using substances for the first time ranged from 15 years of age to 21 years of age with the mean age for the first use of substances being 17.6 years of age. The most protracted time frame the five men reported being clean from substance use ranged from two years to ten years. The mean time for the longest time the five men remained clean from substance use was 57.6 months.

The amount of time the five men had lived at Providence Home ranged from two months to five months with a mean time lived at Providence Home of 3.3 months. Three (clients #1, #2, and #5) of the five volunteer participants were referred to Providence Home from the prison reentry program while two (clients #3 and #4) of the volunteer participants self-referred to Providence Home based on a recommendation from a friend. The reason two (clients #2 and #4) of the men chose Providence Home was that the program is Christ-centered or religious focused. Two (clients #3 and #5) of the men chose Providence Home because they needed structure in their lives. One (client #1) chose Providence Home because his dad recommended the program.

Three (clients #2, #3, and #4) of the five volunteers who participated in this case study reported having been in some treatment for substance use disorder in the past. Two (clients #1 and #5) had never been in therapy before. Drugs of choice for the five volunteer participants included methamphetamines, marijuana, crack, beer, crack cocaine, valium, and alcohol. All

participants reported being abstinent from substance use at this time with sobriety time ranging from three months to 24 months and a mean of 12.0 months. One of the participants failed to answer this question since his position is that he does not have a substance use disorder. Note: While it was a requirement that participants have a SUD diagnosis, this participant did not feel he met the diagnostic criteria. Based on his self-report during counseling and in his interview, he does meet the diagnostic criteria.

Research Question Responses

Central Question: How effective is using telemental health video counseling services for residents in a sober living facility in an urban setting?

Based on information obtained from the five participants who completed all four counseling sessions and the information collected from interviews of the participants as well as three staff members, This researcher concluded that providing telemental health video counseling services to residents of a sober living facility in an urban setting, specifically, Providence Home was effective in this population. The results of the Telemental Health Video Counseling Patient Satisfaction Survey indicated that all participants rated the overall experience between Satisfied and Very Satisfied.

Comments made by residents who participated in telemental health video counseling support the overall satisfaction in the telemental health services provided.

Client #1 stated that he found telemental health video counseling to be helpful.

Client #3 "I found it (telemental health video counseling) very, very, very good and helpful to me."

Client #4 stated, "You hit everything on the nail, most of it. You took it seriously."

Sub Question 1: What are the unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling services critical?

I was able to identify some of the unique needs of residents living in the sober living home from comments made by the residents that participated in the telemental health video counseling sessions and later interviewed. Transportation by bus to appointments and work were cumbersome. Some residents were able to receive minimal mental health services at county mental health facilities, but the residents wanted Christian-centered therapy and were not able to get that at government facilities. Some of the men would not have received any mental health services were it not for the services provided through this project. Residents did not have the financial resources to pay for the services they needed. This project was funded by a grant. Future funding will need to be addressed for follow on mental health services.

Some of the residents' comments follow.

Client #1, client #2, and client #5 came to Providence Home as a result of a prison reentry program referral.

Client #1 stated he did not feel he had a substance use problem yet during his interview made the statement, "I take a little Valium."

Client #1 stated that when he left prison, he went to R***** County Mental Health, where, after being given an assessment, "they said everything was okay."

Client #1 stated that he had to ride a bus to get to any mental health appointments that might come up.

Client #1 stated that if he had not received telemental health video counseling services, he would not have received the help.

Client #2 stated that he chose Providence home because it was Christ-centered.

Client #2 indicated he would not be able to pay for mental health services and hoped that in the future, he would have health insurance or some grant.

Clients #2 and #4 indicated they struggled with co-occurring mental health disorders.

Client #3 denied struggling with a mental illness yet admitted to struggles with depression and abusing marijuana and alcohol. "I say that one holds hands with the others because I was in pain emotional trauma due to and it turned to depression and depression turned to abuse of substances."

Client #3 stated he was against the use of psychotropic medication because "I don't believe I need to. I have the Word of God, Jesus Christ, in my life."

Two staff members indicated that mental health resources were limited and, in some cases, nonexistent. One stated, "I know what you are doing is helping, but we need much, much more. Another said, "With what you have done, it has been a huge breakthrough" for them.

All staff members identified barriers to receiving mental health services for the residents. Two stated that public mental health services were available on a "limited" basis.

One staff member said concerning the availability of other mental health services, "Honestly, the ones who participated, they may not have received them at all.

Sub Question 2: What did the residents who received treatment services find to be effective with telemental health?

Residents found telemental health video counseling services to be effective. Comments from residents included:

Client #3 "What I liked most about it was there was a genuine concern."

Client #3 "I felt like you cared about what you were doing, and I felt like you wanted to understand me."

Client #3 "I found it (telemental health video counseling) very, very, very good and helpful to me."

Client #4 stated, "You hit everything on the nail, most of it. You took it seriously."

Client #4 stated, "Yes, it helped me because you were counseling at the right time because I was going through some things."

Client #5 said, "Very productive. They (telemental health video counseling sessions) showed me things I can accomplish if I put my mind to it."

As stated earlier, at least some of the success of the conducted counseling was a result of Common Factors found in most counseling no matter the delivery method. This is evident in the many client's comments indicating the therapeutic alliance they were able to form with the therapist being an important part of the process. Common Factors are important whether the counseling is done face to face or using telemental health video counseling. Therapists that use either method of delivering counseling services will need to be mindful of the benefits of a strong therapeutic alliance. What we can say is that a therapeutic alliance can be successfully accomplished in telemental health video counseling and at the same time eliminate the barriers to counseling experienced by the men who live in sober living homes.

All three staff members indicated they saw a difference in the men who participated in the telemental health video counseling services and requested that we find a way to continue the services. One stated, "One of the reasons is I had seen some guys that come here; we don't talk about what you shared with them or what they shared with you. But I know some of the guys here, and they have had trauma based in their past. Trauma-based problems that they have been self-medicating with, so to see you working with the guys that I see coming in here has been a blessing to watch." Another said, "I talked with a couple of residents that were so glad to have this available when it was set up initially, and I would see them waiting, and they would say 'well, I get to go in and do that,' and they were very grateful, so I don't know the specifics about outcomes, I know that they were very glad to have it."

During the staff member's interviews, they were asked what could be done differently. One said, "First of all, I want it to continue if at all possible and then, is there any chance that you can do a group session with the men?" Another said, "The ability to do it here and not have to go to somebody's office or something else and being unfamiliar helped put our guys at ease."

From these statements, A conclusion was drawn that not only were the sessions effective, but also identified the needs of the resident participants. The resident participants stated they found the counseling effective. The residents also were not required to travel to a counseling center or mental health facility eliminating transportation barriers since some residents do not have cars or money for gas. The stigma associated with being seen going for mental health counseling was minimized by being able to conduct the therapy via telemental health video counseling since the residents could stay at Providence Home and receive the treatment. The use of telemental health video counseling to deliver the counseling services helped residents to overcome some of the barriers.

Summary

While there are some differences in the data, the general overriding consensus is that telemental health video counseling is useful when using telemental health video counseling services for residents in a sober living facility in an urban setting. Further, this study identified the unique needs of residents living in a sober living home in an urban environment that makes telemental health video counseling services critical. The men interviewed pointed out they would not have received mental health services if it were not provided by telemental health video counseling as a part of this case study. Being able to receive these services at Providence Home instead of having to travel to a counseling center saved them money and time as well as eliminated barriers such as transportation. Additionally, the residents who received treatment services found Common Factors such as the counselor's taking the needs of the residents seriously, being genuine, and being available at the right time, is effective with telemental health.

CHAPTER FIVE: CONCLUSION

Overview

"Recovery is not for people who need it; it's for people who want it."

Anonymous

As stated earlier, the purpose of this case study is to determine the effectiveness of using telemental health video counseling in a sober living home in an urban setting. This case study is instrumental in design. This case study will also recognize the unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling services essential. Also, this case study will conclude if residents who receive treatment services find those services to be effective using telemental health video counseling.

The South Carolina Telehealth Alliance has provided a $20,000 grant to expand telehealth services into underserved populations. Based on an extensive search, at the time of this writing, there is no apparent telemental health video counseling in sober living houses in the state of South Carolina. This study will be limited to Providence Home in Columbia, South Carolina. Sober living home residents are an underserved population, and therefore this study will satisfy the South Carolina Telehealth Alliance's request to expand telemental health services into underserved communities.

Although not a part of this case study, the residents who participated in the counseling will not be left without services. Bright Side Counseling Center will conduct counseling services using graduate student counseling interns to provide the services. This will serve two purposes. First, the residents continue to receive services and second student interns are exposed to telemental health video counseling as a service delivery platform under the supervision of a licensed professional counseling supervisor.

Summary of Findings

Central Question: How effective is using telemental health video counseling services for residents in a sober living facility in an urban setting?

Based on data collected from interviews with resident participants and staff members, it appears that providing telemental health video counseling services to residents of a sober living home in an urban setting, specifically, Providence Home, appears to be as effective as face to face counseling services for those interested in the service. The effectiveness exists within the comments of the residents and staff as well as the results of the Telemental Health Video Counseling Patient Satisfaction Survey. The results of the Telemental Health Video Counseling Patient Satisfaction Survey indicated that all participants rated the overall experience between Satisfied and Very Satisfied. Participants indicated they had been clean "this time" an average of 12.0 months. Only one of the five had sought out mental health services in the past. This may be a result of unavailability of services or barriers to receiving services. We know mental health services help. With available services being provided through telemental health video counseling we can expect that clean time will be extended.

Sub Question 1: What are the unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling services critical?

The unique needs of residents living in a sober living home in an urban setting that makes telemental health video counseling services critical included clarifying definitions of substance use disorders and mental health in general. Some of the men did not realize they met the criteria for a substance use disorder. While it is true and was validated by the men who said so in their interview, the men would not have received mental health services if it were not for telemental health video counseling provided as a result of the grant from the South Carolina Telehealth

Alliance. Travel, finances, and health care insurance were all identified by the men as barriers to receiving mental health services

Sub Question 2: What did the residents who received treatment services find to be effective with telemental health?

Many of the residents were complementary to the therapist providing the services but also pointed out that they felt the services were effective means of treatment. Significant resident comments stated that the counseling was genuine, serious, and available at the right time. Since time was taken to physically go to Providence and meet these men (to solicit volunteers and explain informed consent) prior to beginning counseling, the therapeutic alliance began prior to the beginning of any counseling session.

Discussion

Empirical literature discussion

A review of the literature, as presented in chapter two, indicates that the treatment of substance use disorders is a critical mental health need, and sober living homes are a viable partial solution option. Psychotherapy and 12 step programs are effective treatment options, as well. In sober living homes, the sober environment contributes to the success and extension of sober time. Of the treatment options available, psychotherapy is the one most difficult to access due to barriers such as transportation, finances, social stigma, and availability of therapists.

The medical and psychiatric community has identified providing services into rural communities as challenging due to barriers such as transportation, geographic location, and availability of doctors, psychiatrists, and therapists. For this reason, telehealth has emerged as a solution to providing medical and mental health services into rural communities.

Theoretical literature discussion

Sober living homes tend to locate in urban communities, but because of the nature of substance use disorder and often the presence of co-occurring conditions, the residents experience some of the same barriers to treatment. Often the residents who live in sober living homes do not have vehicles, and the sober living homes are not on public transportation routes requiring residents to rely on borrowed rides or rides provided by sober living home vehicles to attend appointments. When residents first come to sober living homes, they often are unemployed and therefore do not have health insurance or money to pay for mental health services.

The barriers that residents of sober living homes in urban areas find are the same barriers of residents that live in rural communities. For sober living homes, it doesn't matter where they locate, the barriers exist and are real.

Implications

Theoretical Implications

Substance use disorder, notably opioid use disorder, has become a national crisis, and treatment options of all kinds must be explored. Sober living homes provide a place for men and women to find a sober space to recover. Therefore, choosing to use an Ecological System perspective as well as Common Factor variables for effective counseling to work with the men in the environment where they live seemed best. Often the only mental health services available to residents of sober living homes are 12 step and peer support recovery programs. Mental health services, such as counseling therapy, are often unavailable. Chances for sustained recovery are compromised when mental health services are not available.

Empirical Implications

Telemental health video counseling is a proven method of providing mental health services into homes, clinics, and schools. It can extend to any location where there is a computer that can receive an internet signal. Telehealth works for medical, psychiatric, and other mental health services.   With the current opioid epidemic within the United States, we cannot afford to ignore any option of recovery available to those who suffer from a substance use disorder and especially when a co-occurring disorder is also present.

Practical Implications

Telemental health video counseling can eliminate many of the barriers to receiving mental health services that residents of sober living homes face. Transportation to a mental health provider is not necessary. The resident can stay at the sober living home and participate in mental health counseling services via a video connection on a computer.

Delimitations and Limitations

Providence Home was the only sober living home used in this case study. There were only nine original volunteers out of the thirty-six men who live at Providence Home. This study only conducted this case study in a men's sober living home; therefore, the findings of this study cannot transfer to all sober living homes without further research. Given that so many of the comments provided by the participants during the interviews conducted mentioned the relationship or skill of the therapist, further research on the therapeutic alliance and its effect in the effective delivery of telemental health video counseling might be in order.

Recommendations for Future Research

This researcher recommends additional research women's sober living homes as well as other men's sober living homes. Research also needs to be conducted in sober living homes

where the residents are self-supervised such as Oxford Homes. Also, meeting with the participants face to face prior to delivery of telemental health video counseling services was accomplished during this study. Further research might look at whether meeting with participants face to face prior to delivery of telemental health video counseling services provide a better counseling experience or extend sober time.

Payment for counseling services provided during this case study was the result of a grant from the South Carolina Telehealth Alliance to offer telehealth services to underserved populations. Recommend federal and state grant monies, as well as other funding opportunities, be investigated so that services can be reliable and continuing.

Summary

Based on information obtained from the five participants who finished all four counseling sessions and the information collected from interviews of the participants as well as three staff members, it appears that providing telemental health video counseling services to residents of a sober living facility in an urban setting, specifically, Providence Home appears to offer effective counseling services to this population. The unique needs of residents living in a sober living home in an urban environment that makes telemental health video counseling services critical include clarifying definitions of substance use disorders and mental health in general. Many of the residents were complementary to the therapist providing the services but also pointed out that they felt the services were an effective means of treatment. Critical comments stated that the counseling was genuine, serious, and available at the right time.

A review of the literature, as presented in chapter two, indicates that the treatment of substance use disorder is a critical mental health need, and sober living homes are a viable partial solution option. The medical and psychiatric community has identified providing services into

rural communities as challenging due to barriers such as transportation, geographic location, and availability of doctors, psychiatrists, and therapists. Sober living homes tend to locate in urban communities, but because of the nature of substance use disorder and often the presence of co-occurring conditions, the residents experience some of the same barriers to treatment.

The barriers that residents of sober living homes find are the same barriers of residents that live in rural communities. Substance use disorder, notably opioid use disorder, has become a national crisis, and treatment options of all kinds must be explored. Telemental health video counseling is a proven method of providing mental health services into homes, clinics, and schools. Telemental health video counseling can eliminate many of the barriers to receiving mental health services that residents of sober living homes face. Providence Home was kind enough to make their residents available for this study, but we must look at other locations as well since, without additional studies, generalization to different sites cannot be assumed. As to recommendations for further research, funding opportunities are critical and must be investigated. Providing telemental health video counseling services for women and men located in various sober living homes should be explored.

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Appendices

Appendix A

CONSENT FORM (Residents)

CASE STUDY ON PROVIDING TELEMENTAL HEALTH VIDEO COUNSELING
SERVICES IN A SOBER LIVING HOME

Kenneth R. Taylor

Liberty University
School of Behavioral Sciences

You are invited to be in a research study on the effectiveness of using telemental health video counseling services for residents in a sober living facility in an urban setting. You were selected as a possible participant because you are 18 years of age or older, a resident of Providence Home in Columbia, SC, and have a diagnosis of substance use disorder. Please read this form and ask any questions you may have before agreeing to be in the study.

Kenneth R. Taylor, a doctoral candidate in the School of Behavioral Sciences at Liberty University, is conducting this study.

Background Information: The purpose of this study is to determine the effectiveness of using telemental health video counseling services for residents in a sober living facility in an urban setting.

Procedures: If you agree to be in this study, I will ask you to do the following things:

1. Participate in four, one-hour long telemental health video counseling sessions. The first session will consist of an intake assessment where you are located at Providence Home in Columbia, SC and your counselor is located at Bright Side Counseling Center in Lexington, SC. These sessions will not be recorded but will be documented using HIPAA approved Medical Health Records.
2. Complete a survey at the end of your last session to determine what you found to be effective in the service you received. This will take approximately 10 minutes to complete.
3. Complete a face-to-face interview about your experience using telemental health video counseling. The interview will be recorded and later transcribed. You will be given the opportunity to review the transcription for accuracy. The interview will take approximately 30 minutes and review of the transcript will take approximately 15 minutes.

Risks: The risks involved in this study are minimal, which means they are equal to the risk you would encounter in everyday life. As a mandatory reporter, the researcher is required to report any incidence of child abuse, child neglect, elder abuse, or intent to harm self or others.

Benefits: The direct benefits participants should expect to receive from taking part in this study are receiving three counseling session at no cost to the participant on any issue the participant wishes to pursue as long as the subject is not outside the therapist's scope of practice.

Benefits to society include residents in a sober living facility receiving mental health services they might not otherwise have access to therefore improving the resident's contribution to the social environment in which they live.

Compensation: Participants will not be compensated for participating in this study.

Confidentiality: The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher and the researcher's faculty chair will have access to the records. I may share the data I collect from you for use in future research studies or with other researchers. If I share the data that I collect about you, I will remove any information that could identify you, if applicable, before I share the data.

- Participants will be assigned a pseudonym. I will conduct the interviews and counseling sessions in a location where others will not easily overhear the conversation.
- Notes from counseling sessions will be stored in a HIPAA approved Electronic Health Records system at Bright Side Counseling Center.
- Data will be stored on a password locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

Conflicts of Interest Disclosure: Kenneth R. Taylor is the recipient of a grant from the South Carolina Telehealth Alliance in order to conduct this study and therefore has a financial interest related to the conduct or outcome of the study. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or Providence Home. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

How to Withdraw from the Study: If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Contacts and Questions: The researcher conducting this study is Kenneth R. Taylor. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at 888-796-1117 and/or ktaylor150@liberty.edu. You may also contact the researcher's faculty chair, Dr. Laural Shaler, at lshaler@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information for your records.

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

_____

Signature of Participant   Date

_____

Signature of Investigator   Date

Appendix B

CONSENT FORM (Staff)

CASE STUDY ON PROVIDING TELEMENTAL HEALTH VIDEO COUNSELING
SERVICES IN A SOBER LIVING HOME

Kenneth R. Taylor

Liberty University
School of Behavioral Sciences

You are invited to be in a research study on the effectiveness of using telemental health video counseling services for residents in a sober living facility in an urban setting. You were selected as a possible participant because you are 18 years of age or older and a Program Director, Development Director, or Executive Director of Providence Home in Columbia, SC. Please read this form and ask any questions you may have before agreeing to be in the study.

Kenneth R. Taylor, a doctoral candidate in the School of Behavioral Sciences at Liberty University, is conducting this study.

Background Information: The purpose of this study is to determine the effectiveness of using telemental health video counseling services for residents in a sober living facility in an urban setting.

Procedures: If you agree to be in this study, I would ask you to do the following things:

4. Complete a face to face interview about your perception of making telemental health video counseling available to the residents of Providence Home. The interview will be recorded and later transcribed. You will be given the opportunity to review the transcription for accuracy. The interview will take approximately 30 minutes and review of the transcript will take approximately 15 minutes.

Risks: The risks involved in this study are minimal, which means they are equal to the risk you would encounter in everyday life. As a mandatory reporter, I have a requirement to report any incidence of child abuse, child neglect, elder abuse, or intent to harm self or others.

Benefits: Participants should not expect to receive a direct benefit from participating in this study.

Benefits to society include residents in a sober living facility receiving mental health services they might not otherwise have access to, therefore, improving resident's contribution to their social environment in which they live.

Compensation: Participants will not be compensated for participating in this study.

Confidentiality: The records of this study will be kept private. In any sort of report, I might publish, I will not include any information that will make it possible to identify a subject (unless permission has been otherwise given). Research records will be stored securely, and only the researcher and the researcher's faculty chair will have access to the records. I may share the data I collect from you for use in future research studies or with other researchers. If I share the data that I collect about you, I will remove any information that could identify you, if applicable, before I share the data.

- Since your position at Providence Home is public knowledge, your identity will be used in my study unless you object. If you object, I will refer to you only as a "staff member". I will conduct the interviews in a location where others will not easily overhear the conversation.
- Data will be stored on a password locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

Conflicts of Interest Disclosure: Kenneth R. Taylor is the recipient of a grant from the South Carolina Telehealth Alliance in order to conduct this study and therefore has a financial interest related to the conduct or outcome of the study. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting this relationship.

How to Withdraw from the Study: If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Contacts and Questions: The researcher conducting this study is Kenneth R. Taylor. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at 888-796-1117 and/or ktaylor150@liberty.edu. You may also contact the researcher's faculty chair, Dr. Laural Shaler, at lshaler@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information for your records.

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

☐ The researcher has my permission to use my name and/or other identifying information in the documentation and publication of this study.

☐ The researcher does NOT have my permission to use my name and/or other identifying information in the documentation and publication of this study. Please use a pseudonym.

_____

Signature of Participant   Date

_____

Signature of Investigator   Date

Appendix C

Interview questions – Residents

1. Please tell me your first name _____. Demographics
2. How old are you? Demographics
3. Have you been diagnosed with a substance use disorder before? Central Question & Sub Question #1
4. At what age did you first use substances? Demographics
5. What is the longest time frame you have remained clean from substance use? Demographics
6. How long have you lived at Providence Home? Demographics
7. How did you come to end up at Providence Home? Demographics
8. Why did you come to Providence Home? Central Question & Sub Question #1
9. Have you been in treatment for substance use disorder before? Central Question & Sub Question #1
10. What is your drug of choice? Demographics
11. How long have you struggled with substance use? Central Question & Sub Question #1
12. How long have you been clean this time? Central Question & Sub Question #1
13. Have you ever sought out mental health services? Central Question & Sub Question #1
    a. If so, what kind?
    b. If so, when?
    c. If so, where?
    d. If so, what worked about the services?
    e. If so, what didn't work about the services?
14. Do you have access to mental health services here at Providence Home? Central Question & Sub Question #1
    a. If so, what kind?
    b. If so, have you used these services?
15. Are there any barriers to your receiving mental health services here at Providence Home? Central Question & Sub Question #1
    a. If so, what barriers and how do you overcome them?
16. Are you able to pay for treatment for substance use disorder? Central Question & Sub Question #1
17. Do you struggle with more than one mental illness? Central Question & Sub Question #1
18. Do you take psychotropic medication? Central Question & Sub Question #1
19. Are you currently receiving mental health services? Central Question & Sub Question #1
    a. If so, what kind?
    b. If so, when?
    c. If so, where?
    d. If so, what worked about the services?
    e. If so, what didn't work about the services?

20. Were you invited to participate in telemental health video counseling sessions? Central Question & Sub Question #2
    a. If so, how many sessions did you participate in?
    b. If so, what did you like most about the sessions?
    c. If so, what did you like least about the sessions?
21. Did you find telemental health video counseling sessions helpful? Central Question & Sub Question #2
    a. If so, how were they helpful?
    b. If not, why not?
22. If you had not received telemental health video counseling sessions where would you have received mental health services? Central Question & Sub Question #2
23. Is there anything I could do different that would have made the telemental health video counseling experience better? Central Question & Sub Question #2

Appendix D

Interview questions – Staff

1. Please tell me your first name _____. Demographics
2. How old are you? Demographics
3. How long have you worked at Providence Home? Demographics
4. Why did you come to Providence Home? Central Question & Sub Question #1
5. Do the residents have access to mental health services here at Providence Home? Central Question & Sub Question #1
   a. If so, what kind?
   b. If so, have they used these services?
6. Are there any barriers to the residents receiving mental health services here at Providence Home? Central Question & Sub Question #1
   a. If so, what barriers and how do the residents overcome them?
7. Is Providence Home able to pay for treatment for mental health services for the men who live here? Central Question & Sub Question #1
8. Do you believe telemental health video counseling sessions were helpful for the men who live here at Providence Home? Central Question & Sub Question #2
   a. If so, how were they helpful?
   b. If not, why not?
9. If the men had not received telemental health video counseling sessions where would they have received mental health services? Central Question & Sub Question #2
10. Is there anything you believe would improve telemental health video counseling at Providence Home in the future? Central Question & Sub Question #2

Appendix E

Recruitment Script for Residents

Hello, my name is Kenneth Taylor and I am a graduate student in the School of Behavioral Sciences at Liberty University. I am conducting research as part of the requirements for a Doctor of Education in Community Care and Counseling degree. The purpose of my research is to examine the process and report outcomes of providing telemental health video counseling to men who reside at Providence Home and I am here to invite you to participate in my study.

If you are 18 years of age or older, have a substance use disorder diagnosis, are a resident of Providence Home, and are willing to participate, you will be asked to participate in four, one-hour long telemental health video counseling sessions. The first session will consist of an intake assessment. All sessions will be provided free of charge. You will be required to have access to an internet connection where you can receive an internet digital video signal. Counseling sessions will be conducted on a laptop provided by Providence Home. Providence Home will provide a room where residents can receive telemental health video counseling privately. At the end of the last counseling session, you will be asked to complete a *Telemental Health Video Counseling Patient Satisfaction Survey* to determine your satisfaction level. You will also be asked to complete an interview with the researcher concerning the counseling process. With your permission, the interview will be recorded, and a transcript prepared. You will be given the opportunity to review the transcript for accuracy. It should take approximately one hour a week for you to complete the procedure's listed. Your name and other identifying information will be requested as part of your participation, but the information will remain confidential.

If you would like to volunteer to participate you can let me know today and we will complete the necessary, consent documents. The consent document contains additional information about my research. You will need to sign and return these documents at this time if you agree to participate in this project.

If you have any questions about the telemental health counseling process, I would be happy to answer them now.

Appendix F

Recruitment script for staff

Hello, my name is Kenneth Taylor and I am a graduate student in the School of Behavioral Sciences at Liberty University. I am conducting research as part of the requirements for a Doctor of Education in Community Care and Counseling degree. The purpose of my research is to examine the process and report outcomes of providing telemental health video counseling to men who reside at Providence Home and I am here to invite you to participate in my study.

If you are 18 years of age or older, a Program Director, Development Director, or Executive Director at Providence Home, and you are willing to participate, you will be asked to participate in an interview conducted by me after the resident counseling sessions are completed. The interview will take approximately 30 minutes to complete. A transcript of the interview will be prepared, and you will be given an opportunity to review the transcript for accuracy. Your name and/or other identifying information will be collected as part of your participation, but this information will remain confidential unless permission is given to utilize your name and other identifying information in study documentation and publication.

If you would like to participate in this study, you can let me know at this time and we can complete the necessary consent documents today. The consent document contains additional information about my research.

Appendix G

Telemental Health Video Counseling Patient Satisfaction Survey

Date of Survey _____

Have you ever been involved in video counseling before?   Yes   No

How would you rate the telemental health video counseling you received on the factors listed below?

1. Very Dissatisfied
2. Dissatisfied
3. Neutral
4. Satisfied
5. Very Satisfied

	Score
1. Does the ability to provide telemental health video counseling improve your confidence in your therapist?	
2. Explanation of what is being done for your mental health condition.	
3. Met your mental health care needs.	
4. Overall quality of care provided.	
5. Ability to talk freely over telemental health connection.	
6. Ability to understand the recommendations made.	
7. Quality of the visual image.	
8. Quality of the audio sound.	
9. Courtesy of counseling therapist.	
10. Knowledge and skills of the therapist.	
11. Overall telemental health video counseling experience.	

12. Which would you prefer?
    - _____ Telemental health video counseling
    - _____ Face to face
13. Would you participate in another telemental health video counseling session if available?
    - _____ Yes
    - _____ No
14. Do you have any suggestions for improving the telemental health video counseling experience?

Appendix H

IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

October 7, 2019

Kenneth R. Taylor
IRB Approval 3932.100719: Case Study on Providing Telemental Health Video Counseling Services in a Sober Living Home

Dear Kenneth R. Taylor,

We are pleased to inform you that your study has been approved by the Liberty University IRB. This approval is extended to you for one year from the date provided above with your protocol number. If data collection proceeds past one year or if you make changes in the methodology as it pertains to human subjects, you must submit an appropriate update form to the IRB. The forms for these cases were attached to your approval email.

Your study falls under the expedited review category (45 CFR 46.110), which is applicable to specific, minimal risk studies and minor changes to approved studies for the following reason(s):

4. Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.)
Examples: (a) physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject=s privacy; (b) weighing or testing sensory acuity; (c) magnetic resonance imaging; (d) electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography; (e) moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

Thank you for your cooperation with the IRB, and we wish you well with your research project.
Sincerely,

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U N I V E R S I T Y.

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