TeleBehavioral Health 2025 Training Series

Behavioral Health Institute (BHI)
Harborview Medical Center
Website: https://bhinstitute.uw.edu
Email: bhinstitute@uw.edu

Northwest Regional
Telehealth Resource Center (NRTRC)
Website: https://nrtrc.org
Email: info@nrtrc.org

December 12, 2025

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The **Harborview Behavioral Health Institute** (BHI) is a program of Harborview Medical Center that is dedicated to advancing innovation, research and clinical practice to improve community mental health and addiction treatment. The BHI also serves as a resource for the advancement of behavioral health outcomes and policy, and supporting sustainable system change.

The BHI brings the expertise of Harborview Medical Center/UW Medicine and other university partners together to address the challenges facing Washington's behavioral health system, through innovation and improving access to effective behavioral health care. BHI pillars include:

- Clinical Services
- Research and Program Evaluation
- Training, Policy and Workforce Development
  - **Expanded Digital and Telehealth Services and Training**

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

The NRTRC delivers telehealth technical assistance and shares expertise through individual consults, trainings, webinars, conference presentations and the web.

Their mission is to advance telehealth programs' development, implementation and integration in rural and medically underserved communities.

The NRTRC aims to assist healthcare providers, organizations and networks in implementing cost-effective telehealth programs to increase access and equity in rural and medically underserved areas and populations.

These sessions were made possible in part by grant number U1UTH42531-03 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

Speaker Disclosures

None of the series speakers have any relevant conflicts of interest to disclose.

Planner disclosures

The following series planners and team have no relevant conflicts of interest to disclose:

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DISCLAIMER

Please be aware that policy changes may take place after the original date of this presentation.

Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.

Please consult with legal counsel, billing & coding experts, and compliance professionals, as well as current legislative and regulatory sources, for accurate and up-to-date information.

We gratefully acknowledge the support from

Washington State Health Care Authority

NRTRC NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

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Adapting Cognitive Behavioral Therapy for Psychosis (CBTp) for Telehealth Delivery

Sarah L. Kopelovich, PhD, ABPP
Associate Professor | Professorship in Cognitive Behavioral Therapy for Psychosis
University of Washington SOM | Dept of Psychiatry & Behavioral Sciences

Learning Objectives

By the end of this webinar, participants will be able to:

1. **Explain** the importance of enhancing access to CBTp for individuals with psychotic spectrum disorders and the role of telehealth in reducing barriers to care.

2. **Identify** key considerations in selecting appropriate clients and delivering CBTp services effectively and safely through telehealth.

3. **Describe** core adaptations to CBTp techniques and session structure that support engagement, collaboration, and therapeutic outcomes in virtual settings.

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Learning Objective 1

By the end of this webinar, participants will be able to:

1. **Explain** the importance of enhancing access to CBTp for individuals with psychotic spectrum disorders and the role of telehealth in reducing barriers to care.

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Psychotic Disorders

- **Low base rate condition; lifetime prevalence**
  - Psychosis = 3%
  - Schizophrenia = 1%

- **Poorly managed schizophrenia is…**
  - among the top causes of disability worldwide (Vos et al. , 2017) and
  - shortens life expectancy by an average of 28.5 years (Olfson et al., 2015)



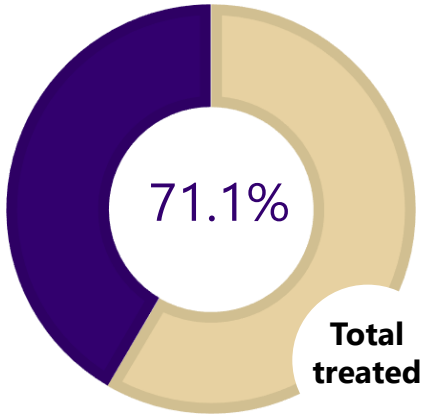
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Why Focus on CBT?

- Can function as both a therapeutic and prophylactic
- Transdiagnostic
- Flexibly delivered
- Adjunctive to medications to translate symptom relief to meaningful recovery.

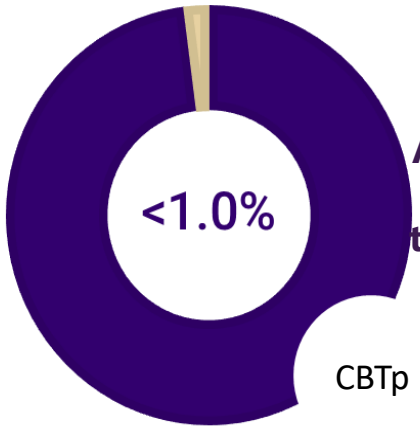
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Access to CBTp for SMI



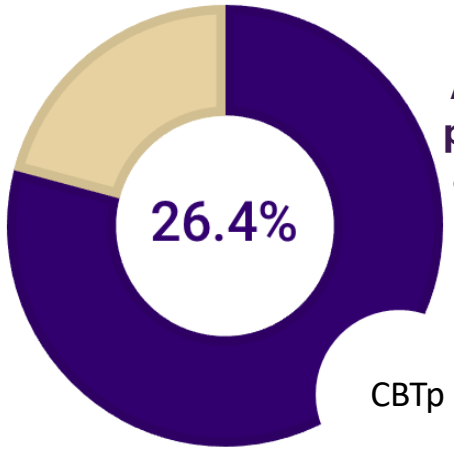
Adults (>18) with SMI receiving any treatment SAMHSA (2024)

United States



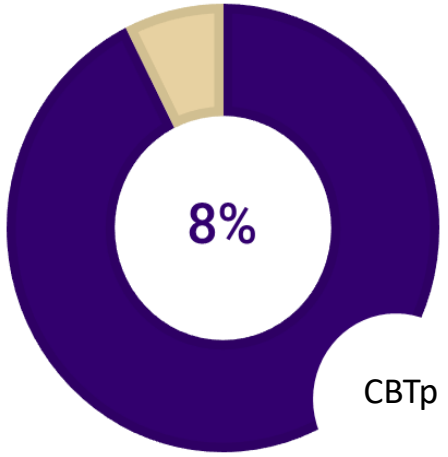
Adults (>18) with psychosis treated with CBTp Kopelovich et al. (2021)

England



Adults (>18) with psychosis received at least two CBTp session Colling et al. (2017)

Australia



Adults (>16) with psychosis in NSW accessing publicly funded service received at least one CBTp session Davies et al. (2023)

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SPIRIT

In the U.S….

- ~70% of Americans with a psychotic disorder own a smartphone (Hosgelen et al., 2020)
- Most community clinics are under-utilizing telehealth and digital therapeutics (Luther et al., 2022)



Telehealth is a Digital Inclusion Strategy



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CBTp Telehealth Facilitators and Barriers

	PATIENT	PRACTITIONER	SYSTEM
FACILITATOR	Preference for telehealth Potential symptom interference**	Telehealth familiarity Reduced rate of no shows and cancellations Intact therapeutic alliance	Telehealth infrastructure [Telehealth reimbursement parity]
BARRIER	Technical skills Tech/Internet access Security/privacy concerns Withdrawal/isolation	Prohibit some experiential techniques Assumptions r/t suitability Insufficient tech support	Logistics associated with emergent crises, need for increased level of care

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Learning Objective 2

By the end of this webinar, participants will be able to:

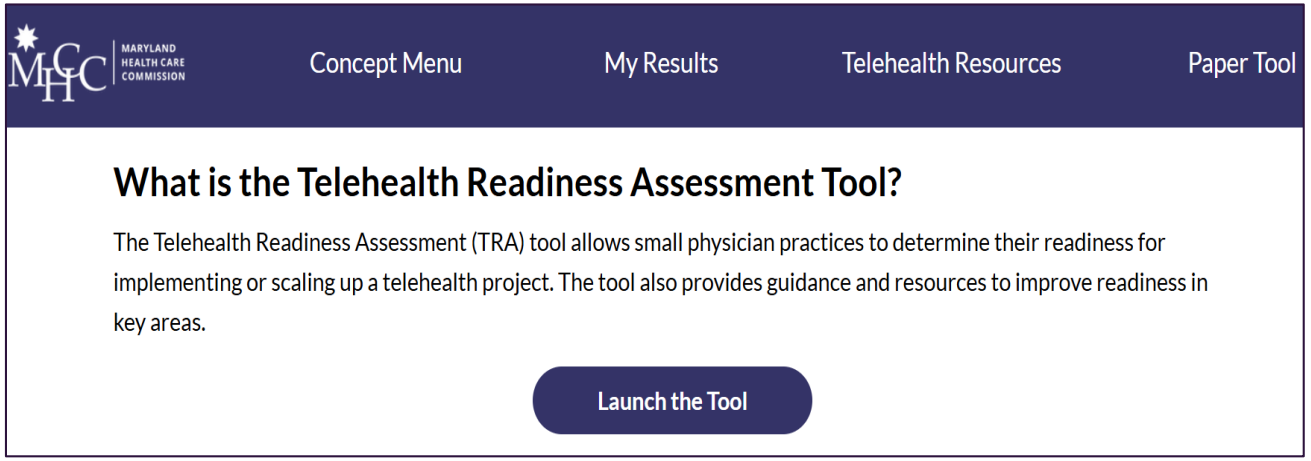
2. Identify key considerations in selecting appropriate clients and delivering CBTp services effectively and safely through telehealth.

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Assessing Telehealth Readiness

Telehealth Readiness Assessment (TRA)

- Core readiness
- Financial considerations
- Operational aspects
- Staff engagement
- Patient preparedness



http://mhcctelehealthtool.herokuapp.com

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TeleCBTp Readiness

The higher the score on these…

- Clinician-Rated Dimensions of Psychosis Symptom Severity (CRDPSS)
- Columbia Suicide Severity Rating Scale (C-SSRS)
- Abnormal Involuntary Movement Scale (AIMS)

and the lower the score on these…

- SOFAS
- MoCA

the less likely I am to offer teleCBTp.

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Learning Objective 3

By the end of this webinar, participants will be able to:

3. **Describe** core adaptations to CBTp techniques and session structure that support engagement, collaboration, and therapeutic outcomes in virtual settings.

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Community Mental Health Journal (2021) 57:30–34
https://doi.org/10.1007/s10597-020-00718-0

BRIEF REPORT

Remote CBT for Psychosis During the COVID-19 Pandemic: Challenges and Opportunities

Sarah L. Kopelovich[1] · Doug Turkington[2]

Received: 19 April 2020 / Accepted: 25 September 2020 / Published online: 1 October 2020
© Springer Science+Business Media, LLC, part of Springer Nature 2020

https://link.springer.com/article/10.1007/s10597-020-00718-0

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Key Findings from Kopelovich & Turkington (2021)

- **High-yield cognitive behavioral techniques for psychosis (HY-CBt-p)**

- **In-session strategies to promote encoding, retention, and bx change:**
  - PowerPoint or whiteboard for visuals
  - Screen sharing for fillable worksheets, videos, and data dashboards
  - Natural support in-session
  - Environmental scans

- **Between session strategies:**
  - Sending secure communications via SMS, email, or mail
  - Behavioral tailoring for medication consistency
  - Smartphone apps to prompt skill use, behavioral activation
  - Calendar or natural support reminders to engage in weekly action plan

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APA PsycArticles: Journal Article

Implementation of Cognitive Behavioral Therapy for psychosis via telehealth: An expert consultation and clinical service model.

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Gaither, M. L., Bassett, E. D., Wilson, A. L., Marder, S. R., Bradford, D. W., Bernard, J. D., & Glynn, S. M. (2024). Implementation of Cognitive Behavioral Therapy for psychosis via telehealth: An expert consultation and clinical service model. *Psychological Services, 21*(3), 461–472.
https://doi.org/10.1037/ser0000864

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Key Findings from Gaither et al. (2024)

- **Veteran's Administration National Psychosis Telehealth Program added a CBTp Service in 2021**
  - 47 Veterans were referred
  - 43 (91%) attended intake appointment
  - 39 (90%) accepted into treatment
  - 24 have completed treatment

- **Considerations for telehealth delivery and program use**
  - Importance of appropriate referrals to program
  - Need for video calls rather than telephone calls
  - Coordination of care between local team and remote provider is essential

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Case Example: Ms. A

- 38yo HF
  - Born and raised in Auburn
  - Diagnosed with schizophrenia ~24y (paranoia, IOR, AH)
- Resides with sister
- History of high lethality suicide attempts
  - Most recent: 01/2018
- CC:
  - Voice-related distress
  - Agoraphobic avoidance



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Ms. A: Baseline Assessment

- Symptoms
- Functioning
- Safety
- Continuous monitoring
- Telehealth capabilities



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Ms. A: Telehealth Protocol

- Identify & location
- Emergency contact(s)
- Technology & privacy checks
- Telehealth comfort agreement
- Local resources & commitment law



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Ms. A: Safety & Crisis Protocols

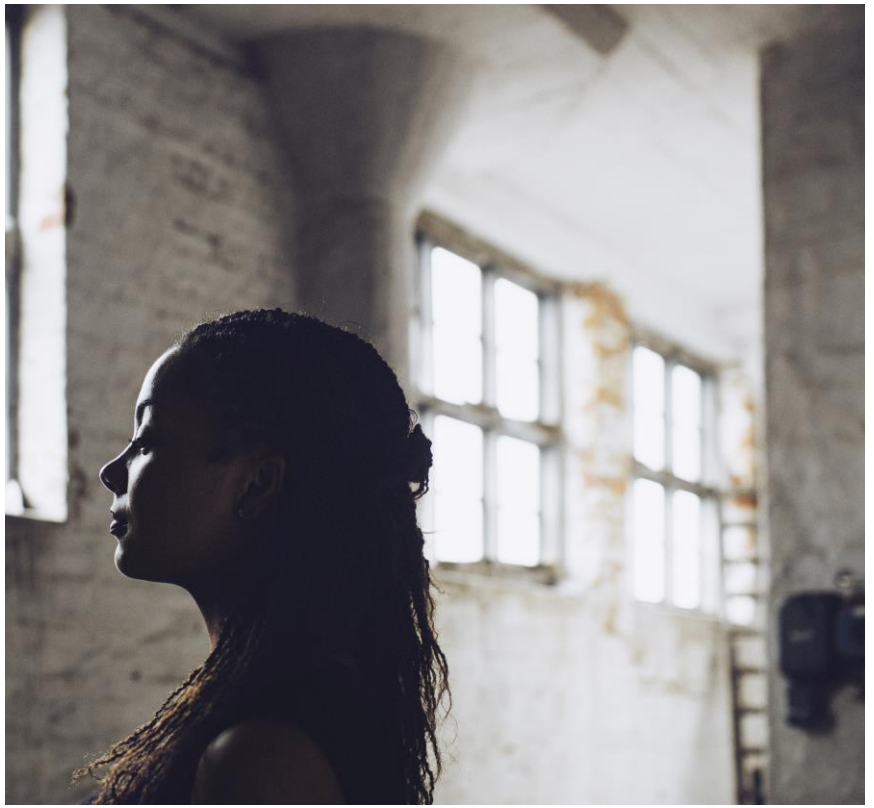
- Confirm physical address, who is present
- SI disclosure protocol; Stanley-Brown Safety Plan shared w sister and care team
- Attempt to address concerns r/t technology
- No–show escalation



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Ms. A: CBTp Phase 1

- **PHASE 1: Engagement (Sessions 1—4)**
  - Heavy emphasis on befriending
  - Informed consent to CBTp & Telehealth
  - Baseline assessment
    - consider Cultural Formulation Interview
  - Safety plan
  - Draft shared treatment goals that align with recovery goals



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Ms A: CBTp Phase 2

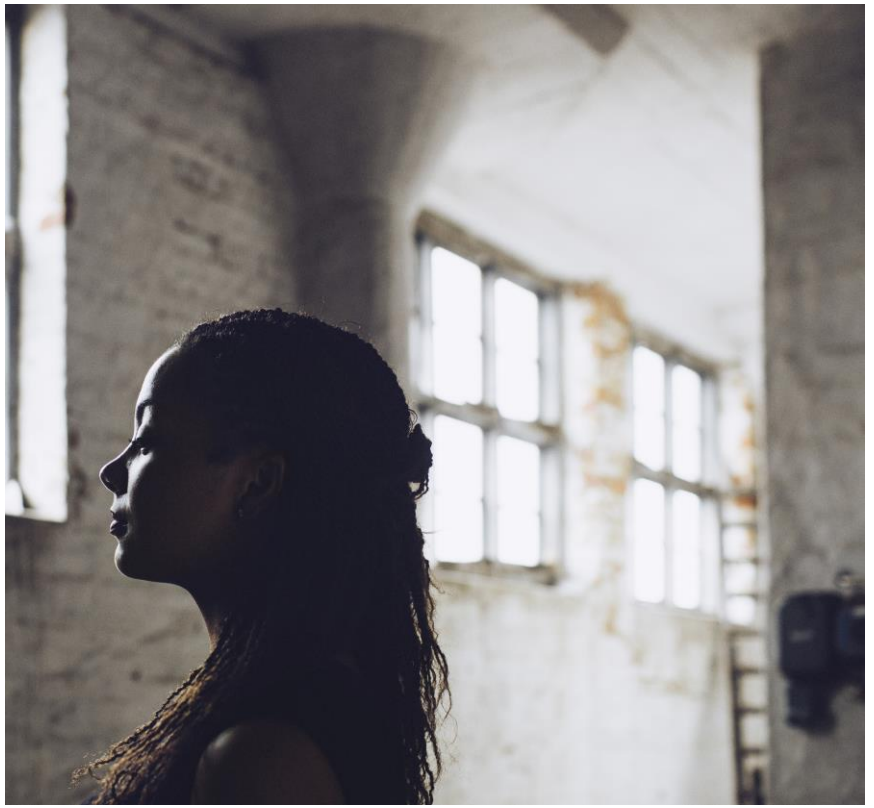
- **Psychoeducation & Formulation (Sessions 5—7)**
  - Psychoeducation and normalization
    - Video content
  - Understanding problems through the lens of
    - Stress-vulnerability model
    - Cognitive model
  - Collaborative formulation
  - Shared goals
    - Bring voice-related distress from 85 to 50
    - Walk dog 3x/week
    - Attend in-person appointments 1x/month



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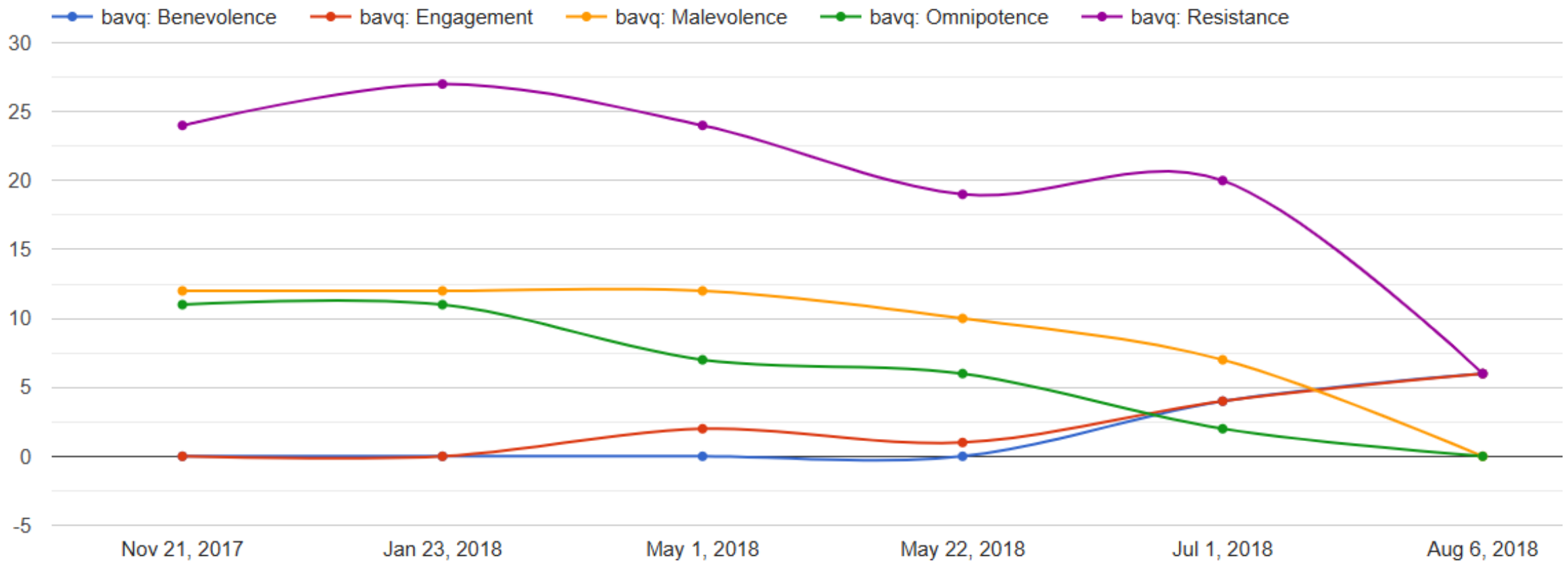
Ms. A: CBTp Phase 3

- **Skill Acquisition & Symptom Mgmt (Sessions 8—20)**
  - Voice-specific interventions:
    - voice appraisal
    - compassionate stance
    - behavioral responses
  - Cognitive restructuring for threat appraisals
  - Behavioral experiments
  - In-session modeling via role-plays



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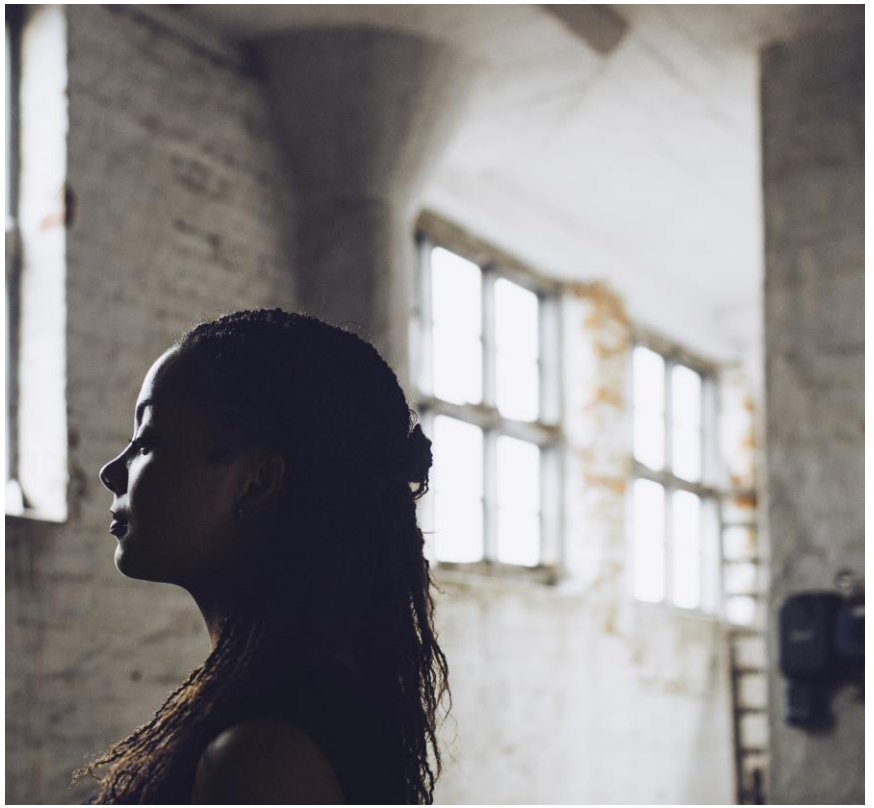
Visualizing Response to Tx



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Ms. A: CBTp Phase 4

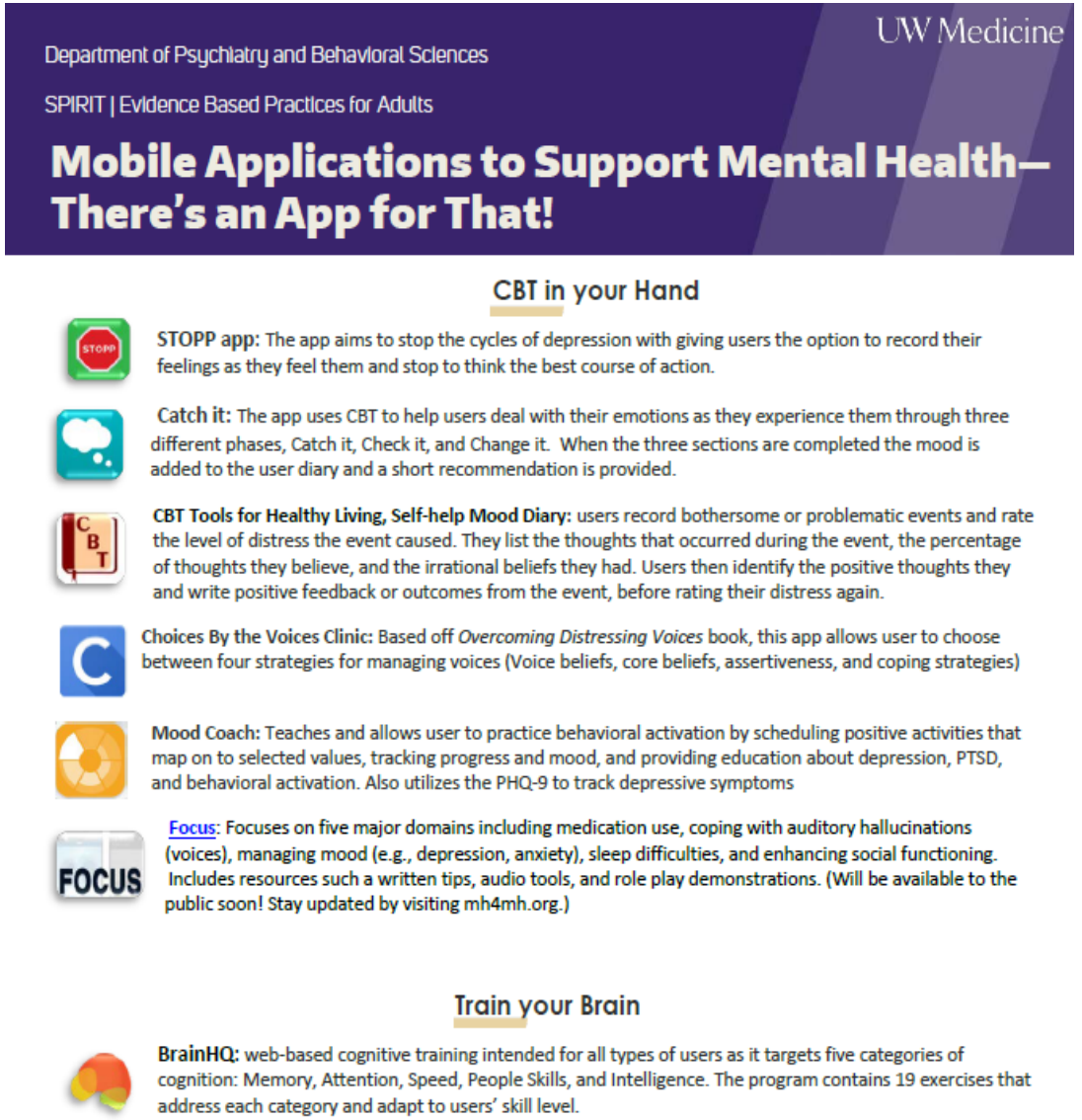
- **Wellness Planning (Sessions 21—24)**
  - Measure outcomes and collaboratively interpret; make sense of treatment gains
    - AH distress – 30/100 most days
    - Walking dog 3x daily
    - Applying to jobs
  - Strengthen coping plan
  - Facilitate confidence, mastery, and contributing by referring client to in-person groups, peer mentorship, or mutual aid
  - Update crisis plan, mental health advanced directive



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Ancillary Resources

- OnTrackNY Video Library
- Hearing Voices Network USA
- treatingparanoia.com
- Bibliotherapy:
  - *Overcoming Distressing Voices* (Hayward)
  - *Overcoming Paranoid and Suspicious Thoughts* (Freeman et al.)
  - *Overcoming Low Self-Esteem*
  - *Living Well with Psychosis* (Brinen)
  - *Think Your Crazy? Think Again* (Morrison)



Department of Psychiatry and Behavioral Sciences

UW Medicine

SPIRIT | Evidence Based Practices for Adults

Mobile Applications to Support Mental Health– There's an App for That!

CBT in your Hand

STOPP app: The app aims to stop the cycles of depression with giving users the option to record their feelings as they feel them and stop to think the best course of action.

Catch it: The app uses CBT to help users deal with their emotions as they experience them through three different phases, Catch it, Check it, and Change it. When the three sections are completed the mood is added to the user diary and a short recommendation is provided.

CBT Tools for Healthy Living, Self-help Mood Diary: users record bothersome or problematic events and rate the level of distress the event caused. They list the thoughts that occurred during the event, the percentage of thoughts they believe, and the irrational beliefs they had. Users then identify the positive thoughts they and write positive feedback or outcomes from the event, before rating their distress again.

Choices By the Voices Clinic: Based off *Overcoming Distressing Voices* book, this app allows user to choose between four strategies for managing voices (Voice beliefs, core beliefs, assertiveness, and coping strategies)

Mood Coach: Teaches and allows user to practice behavioral activation by scheduling positive activities that map on to selected values, tracking progress and mood, and providing education about depression, PTSD, and behavioral activation. Also utilizes the PHQ-9 to track depressive symptoms

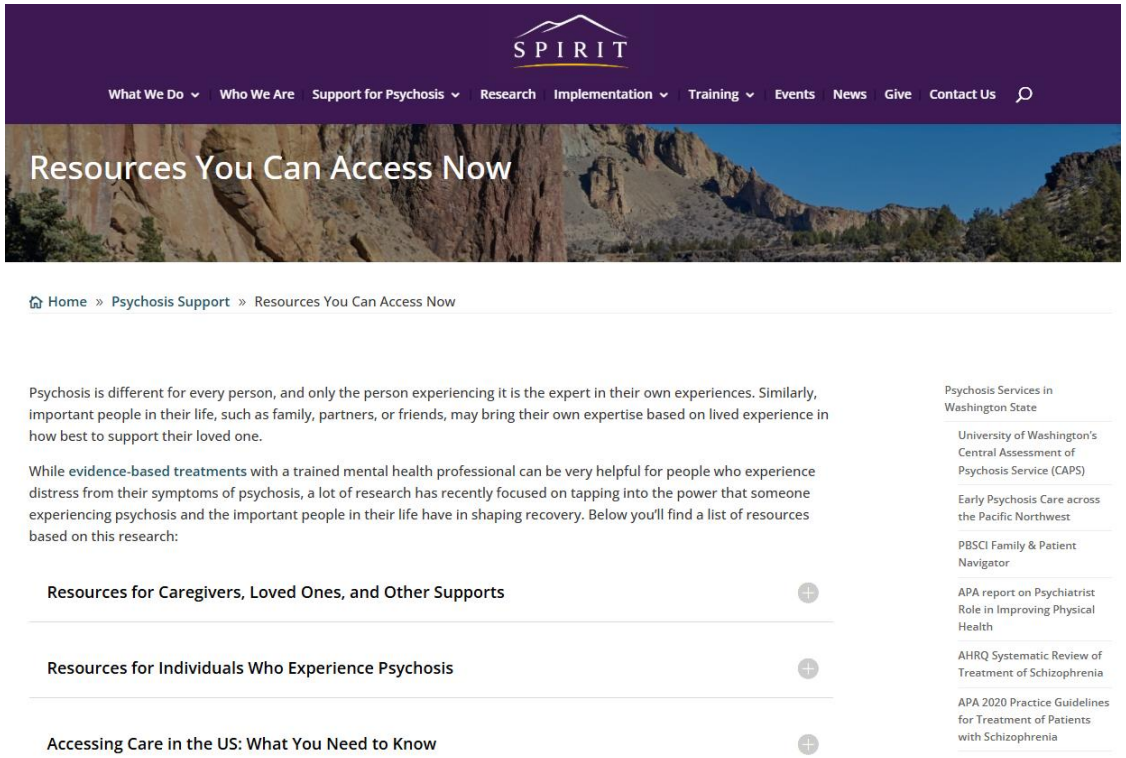
Focus: Focuses on five major domains including medication use, coping with auditory hallucinations (voices), managing mood (e.g., depression, anxiety), sleep difficulties, and enhancing social functioning. Includes resources such a written tips, audio tools, and role play demonstrations. (Will be available to the public soon! Stay updated by visiting mh4mh.org.)

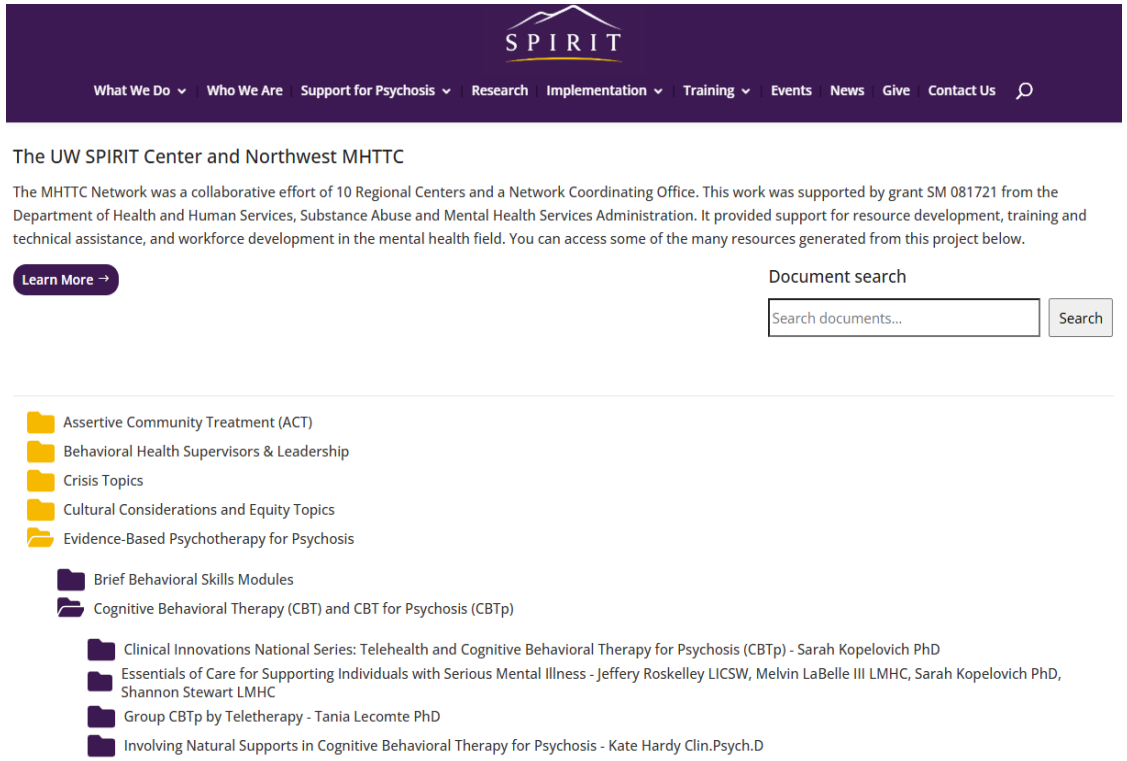
Train your Brain

BrainHQ: web-based cognitive training intended for all types of users as it targets five categories of cognition: Memory, Attention, Speed, People Skills, and Intelligence. The program contains 19 exercises that address each category and adapt to users' skill level.

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Ancillary Resources

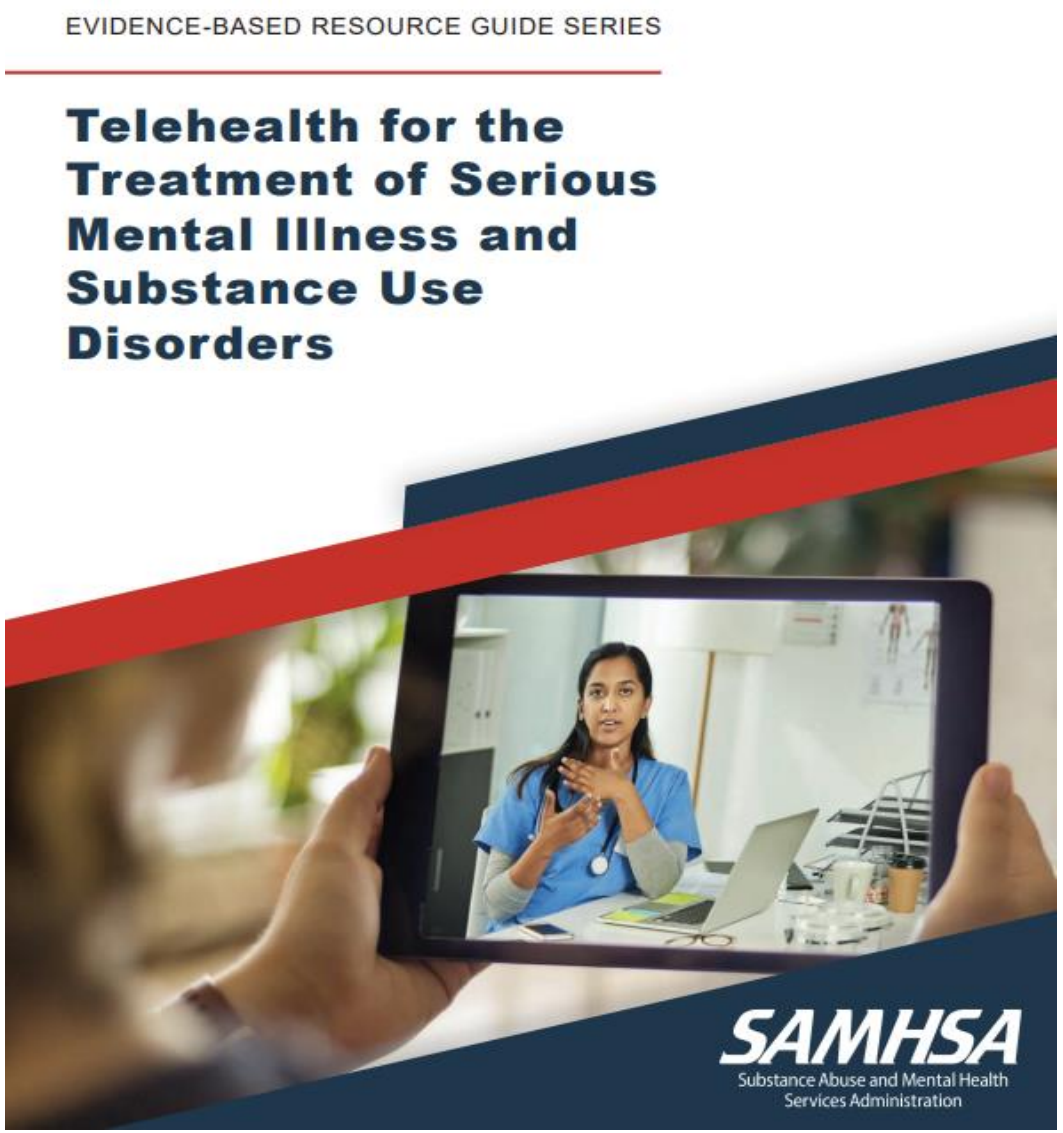




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Ancillary Resources



Source:
https://library.samhsa.gov/sites/default/files/pep21-06-02-001.pdf

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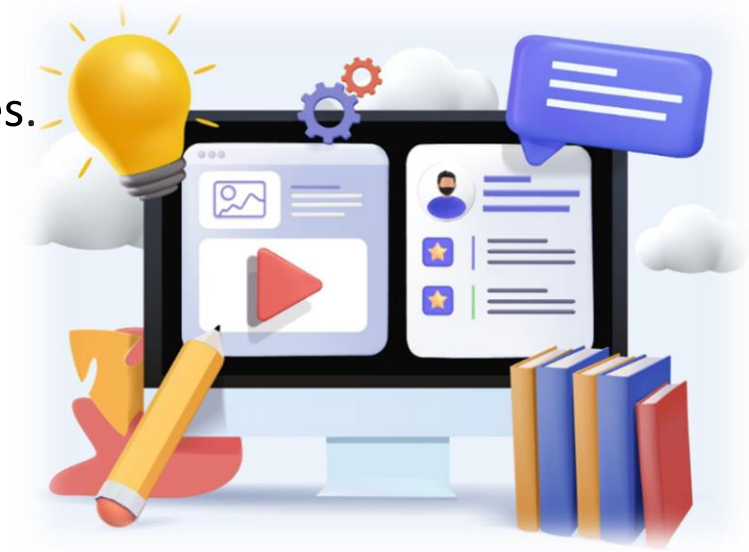
For more information on CBTp research, training, or implementation,
email skopelov@uw.edu



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TeleBehavioral Health On-Demand Training Series

In partnership with the NRTRC, the **TeleBehavioral Health 101, 201, 301, 401, and 501** series are available **on-demand and free of charge**.



- Series 101, and 401 & 501 are **accredited for Continuing Medical Education (CME)** and are clearly marked as such. Nominal fee applies.

- A **Continuing Education (CE) certificate** will be provided for *all* sessions, at no cost.
- These certificates may be accepted by various licensing boards to meet continuing education or licensure renewal requirements.
- Please contact your licensing board to confirm eligibility.

- Course 101 #1 module meets Washington State Telehealth Training requirement.

Access the trainings: bhinstitute.uw.edu/tbh-on-demand

Looking for Health Ethics & Equity Training?

Empowering Recovery: Ethics & Collaborative Decision-Making in Behavioral Health

- Free two-hour module
- On-demand & self-paced
- Meets **Law & Ethics** training requirements in WA State

Cultural Humility In Behavioral Health Care

- Free two-hour module
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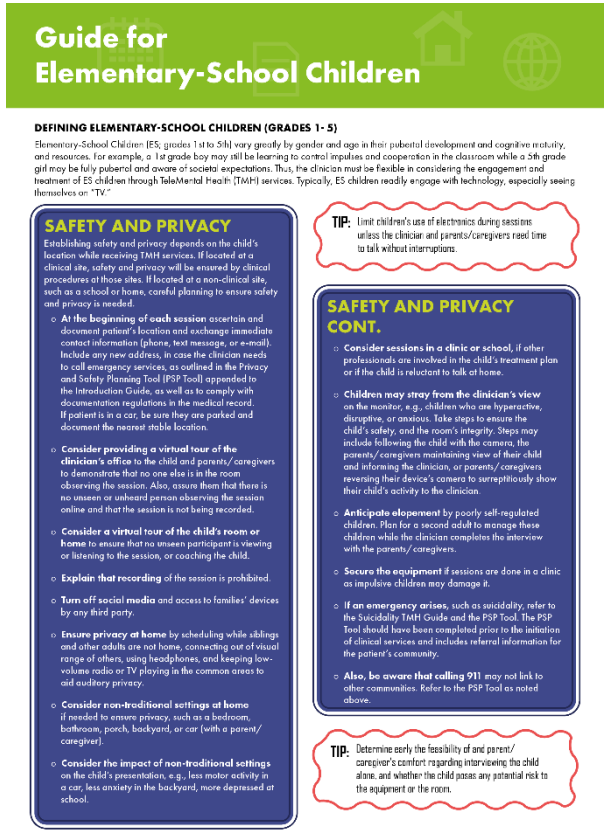


Learn more at: https://bhinstitute.uw.edu/learn-online

TeleMental Health Guides for Infancy to Young Adults

Guides (8)

- Infancy and Toddlers
- Pre-schoolers
- Elementary School Children
- Middle School Youth
- High School Teens
- Young Adults
- Neuropsychological Testing
- Suicidality



Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1- 5)

Elementary-School Children (ES; grades 1st to 5th) vary greatly by gender and age in their pubertal development and cognitive maturity, and resources. For example, a 1st grade boy may still be learning to control impulses and cooperation in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Thus, the clinician must be flexible in considering the engagement and treatment of ES children through TeleMental Health (TMH) services. Typically, ES children readily engage with technology, especially seeing themselves on "TV."

SAFETY AND PRIVACY

Establishing safety and privacy depends on the child's location while receiving TMH services. If located at a clinical site, safety and privacy will be ensured by clinical procedures at those sites. If located at a non-clinical site, such as a school or home, careful planning to ensure safety and privacy is needed.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patient is in a car, be sure they are parked and document the nearest stable location.
- **Consider providing a virtual tour of the clinician's office** to the child and parents/caregivers to demonstrate that no one else is in the room observing the session. Also, ensure them that there is no unseen or unheard person observing the session online and that the session is not being recorded.
- **Consider a virtual tour of the child's room or home** to ensure that no unseen participant is viewing or listening to the session, or coaching the child.
- **Explain that recording** of the session is prohibited.
- **Turn off social media** and access to families' devices by any third party.
- **Ensure privacy at home** by scheduling while siblings and other adults are not home, connecting out of visual range of others, using headphones, and keeping low-volume radio or TV playing in the common areas to aid auditory privacy.
- **Consider non-traditional settings at home** if needed to ensure privacy, such as a bedroom, bathroom, porch, backyard, or car (with a parent/caregiver).
- **Consider the impact of non-traditional settings** on the child's presentation, e.g., less motor activity in a car, less anxiety in the backyard, more depressed at school.

TIP: Limit children's use of electronics during sessions unless the clinician and parents/caregivers need time to talk without interruptions.

SAFETY AND PRIVACY CONT.

- **Consider sessions in a clinic or school,** if other professionals are involved in the child's treatment plan or if the child is reluctant to talk at home.
- **Children may stray from the clinician's view** on the monitor, e.g., children who are hyperactive, disruptive, or anxious. Take steps to ensure the child's safety, and the room's integrity. Steps may include following the child with the camera, the parents/caregivers maintaining view of their child and informing the clinician, or parents/caregivers reversing their device's camera to surreptitiously show their child's activity to the clinician.
- **Anticipate elopement** by poorly self-regulated children. Plan for a second adult to manage these children while the clinician completes the interview with the parents/caregivers.
- **Secure the equipment** if sessions are done in a clinic as impulsive children may damage it.
- **If an emergency arises,** such as suicidality, refer to the Suicidality TMH Guide and the PSP Tool. The PSP Tool should have been completed prior to the initiation of clinical services and includes referral information for the patient's community.
- **Also, be aware that calling 911** may not link to other communities. Refer to the PSP Tool as noted above.

TIP: Determine early the feasibility of and parent/caregiver's comfort regarding interviewing the child alone, and whether the child poses any potential risk to the equipment or the room.



TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

Abdul is a 10 y/o Afghani refugee boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and falling behind academically. The Mother noted similar difficulties in the home, especially regarding homework. Both parents worked and lived in an urban neighborhood with poor transportation options, so they agreed to home-based TMH. The family used their smartphone for the sessions, with adequate, but not optimal, cell reception. Sessions were held in the parent's bedroom, for privacy. An older sister watched the siblings in another room or took them for a walk.

Abdul was readily engaged over the smartphone and told of his favorite videogame, his love of Legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Even with the spotty connectivity, the clinician appreciated Abdul's good verbal skills, intellect, charming personality, as well his impulsive intrusiveness and mild mid-facial and guttural tic. To assess his gross motor skills, the clinician asked Abdul to do some movements, including some dance movements. He was awkward and had difficulty cooling down once wound up. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, Abdul was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly returned to the smartphone to show his artwork: not an animal, but he enthusiastically told of its meaning, demonstrating his creativity and knowledge.

The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services, and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

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Additional Free Resources for Washington State Behavioral Health Providers

*EDUCATIONAL SERIES:

- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO
- **UW TelePain series**

**Open to all attendees*

PROVIDER CONSULTATION LINES

- **UW Pain & Opioid Provider Consultation Hotline (WA & MT)**
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line

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