Building a Comprehensive Client-Centered System of Care

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www.umbc.edu/psych/habits

www.mdquit.org

Recovery and Change

* SAMHSA's working definition of recovery from mental health and substance use disorders is
* "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012).

Recovery Oriented Systems of Care

* Recovery is not simply an absence of symptoms or substances
* Recovery involves wellness and health
* Recovery requires integrated care that is comprehensive
* Systems of care must be responsive to the multiple needs of the consumers in their care
* Open rather than closed systems

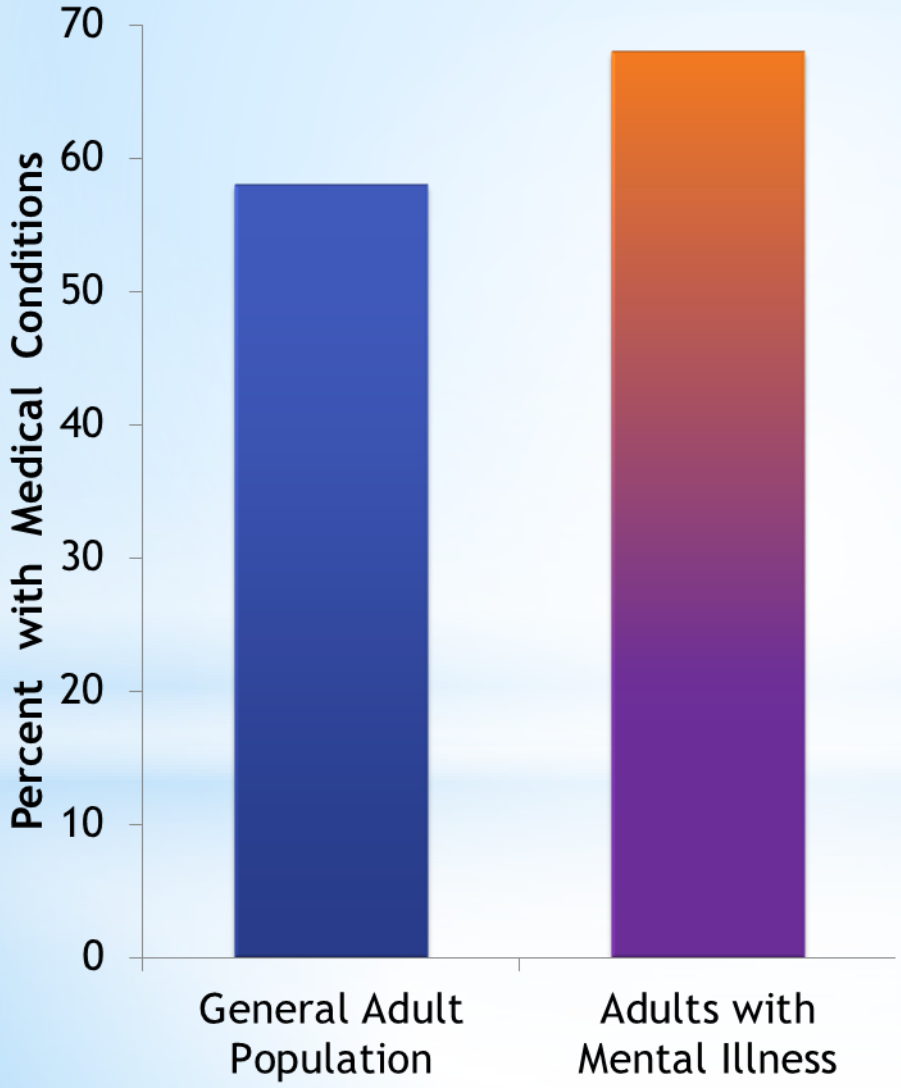
* Requires understanding
* Change Burden
* Change Process
* Consumer-Focused Collaborative Care

* Building a Recovery Oriented System of Care

* Both Mental Health and Substance Use Disorders involve:

* Problems in the neurobiological systems
  * Genetic and/or substance induced brain changes
  * Disrupting pleasure and pain systems, emotion regulation, and cognitive control mechanisms
* Problematic Self-Regulation and Self-Control
  * Increased impulsivity, problematic decision making, lack of frustration tolerance, ignoring feedback and consequences
* Complicating Co-Occurring Conditions and Problems
  * Dual or more diagnoses, serious problems in the life context independent of or connected with the disorders

* Change Burden

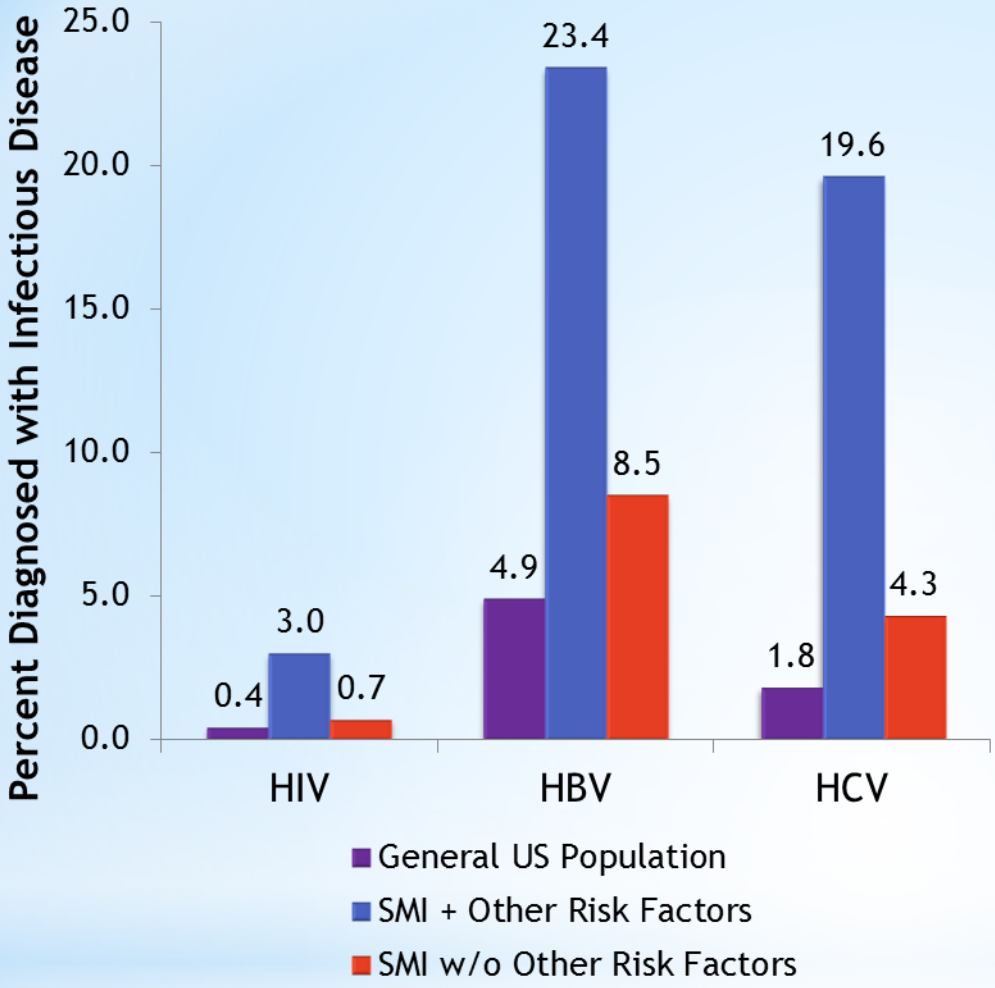


Mental health disorders may exacerbate or be related to other health problems and chronic medical conditions.

Individuals with serious mental illness die an estimated 5 to 25 years earlier than the general population, largely due to medical conditions.

*Mental Health & Primary Care

(SAMHSA, 2013)



Among individuals with SMI:

- rates of HIV infection are 8 times greater,
- rates of HBV are 5 times greater, and
- rates of HCV are 11 times greater

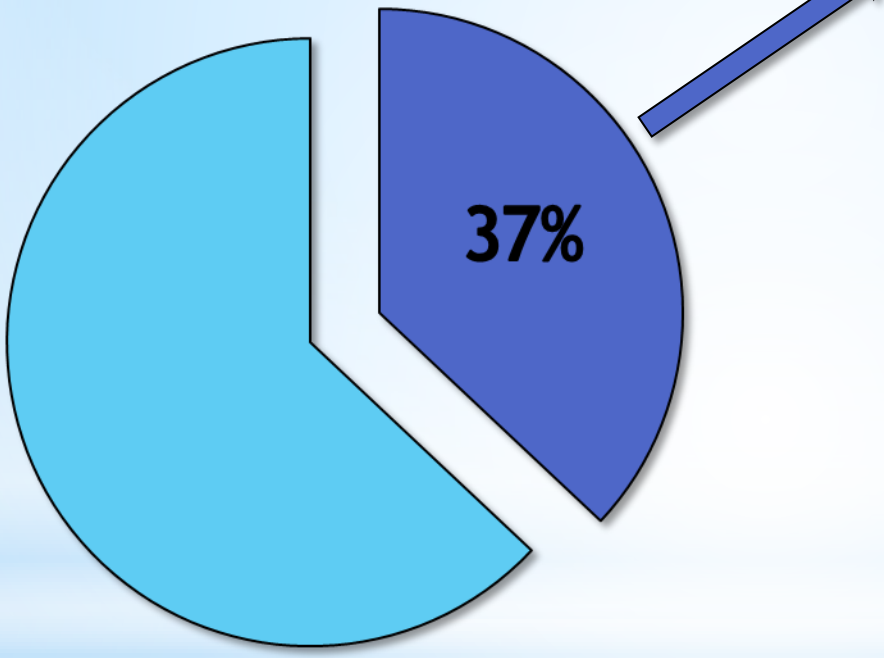
than among the general US population.

The difference in infection rates is dramatically reduced when other risk factors (e.g., injection drug use, substance use disorder, sex work, other STIs) are not present.

*Severe Mental Illness & Infectious Disease

(Rosenberg et al., 2001)

*Substance Use & HIV



Among people diagnosed with HIV, **37%** reported a drug or alcohol risk behavior in the previous 30 days

In the past 30 days:

27% reported cocaine use
23% reported marijuana use
22% reported alcohol use
19% report being active injection drug users
14% reported having sex while under the influence of alcohol or drugs

(CDC, 2008; SAMHSA, 2011)

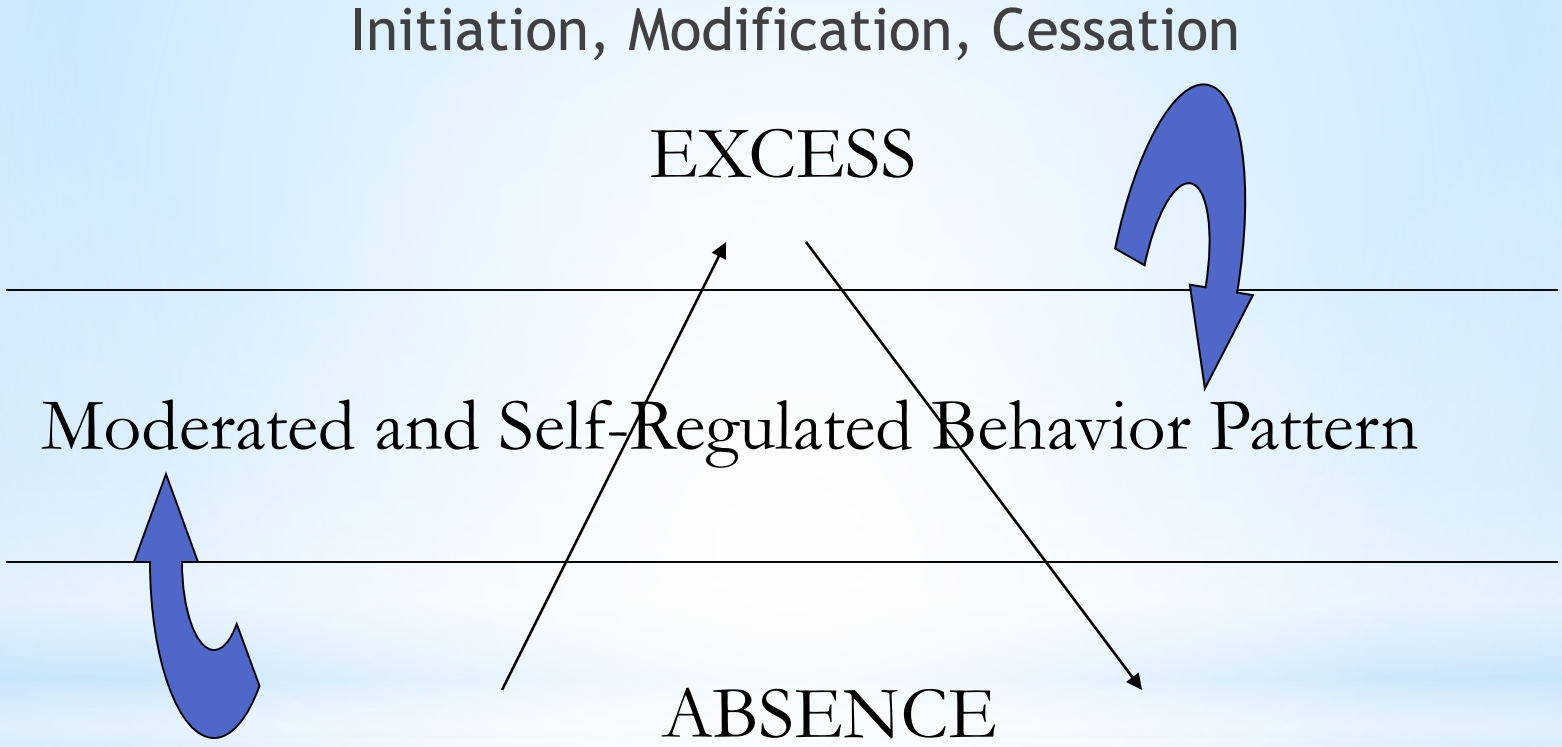
* Our work on the process of change began with understanding psychotherapy and how people change addictions, especially focused on nicotine addiction and smoking
* However, very soon it became very clear that this process was describing how individuals change many different behaviors
* Thus this is a more general model of intentional behavior change that can apply to both individuals and systems
* Does not apply to all kinds of change (developmental, imposed, biological)

* Beyond Addiction, Mental Illness, and Recovery

HEALTH PROMOTION & DISEASE PREVENTION	REQUIRE	BEHAVIOR CHANGE
CANCER PREVENTION		INITIATION
HEALTH PROMOTION		
SAFETY & INJURY PREVENTION		MODIFICATION
HEALTH PROTECTION		
SUBSTANCE ABUSE		CESSATION

True for Individuals and for healthcare policies and programs

Different Patterns of Behavior Change



Common Behavior Change Targets

- **Initiating Health-Promoting or Desirable Behaviors**
  - Screening (Cancer, Infectious Disease, etc.)
  - Physical Activity
  - Sleep Hygiene
  - Utilizing Stress Management Skills
  - Condom Use
  - Medication Adherence
- **Modifying Behaviors**
  - Reducing Caloric Intake
  - Anger/Affect Management
  - Drinking and Driving
- **Cessation of Health-Defeating or Undesirable Behaviors**
  - Tobacco Use
  - Illicit Substance Use
  - Abstinence from Alcohol
  - Domestic Violence


THE BEST WAY TO ACHIEVE GOOD HEALTH IS TO TAKE CARE OF YOURSELF.
YOUR LIFESTYLE IS DESTROYING YOU.
YOU SHOULD CHANGE YOUR EATING HABITS, AND STOP SMOKING AND DRINKING.
START AN EXERCISE PROGRAM. GET PLENTY OF REST. LEARN HOW TO HANDLE STRESS.
YOU'RE RIGHT, DOC. THANKS!
MAN! I'VE GOT TO FIND ANOTHER DOCTOR!
© 1983 by NEA, Inc.

DESIRED HEALTHCARE BEHAVIORS

- *MULTIPLE
- *MULTIDIMENSIONAL
- *VARY IN FREQUENCY
- *VARY IN INTENSITY
- *REQUIRE DIFFERING LEVELS OF MOTIVATION
- *CAN BE INTEGRATED INTO DIFFERENT LIFESTYLES TO VARYING DEGREES
- *UNDERSTANDING THE CHANGE BURDEN – especially important for medical and behavioral health professionals

*Includes Mental Health, Addiction, and Health Promotion/Protection Behaviors

*How do People Change ?

How Do People Change?

- People change voluntarily only when
  - They become ***interested and concerned*** about the need for change
  - They become ***convinced*** the change is in their best interest or will benefit them more than cost them
  - They organize a ***plan of action*** that they are ***committed*** to implementing
  - They ***take the actions*** necessary to make the change and sustain the change

Stage of Change: Labels and Tasks

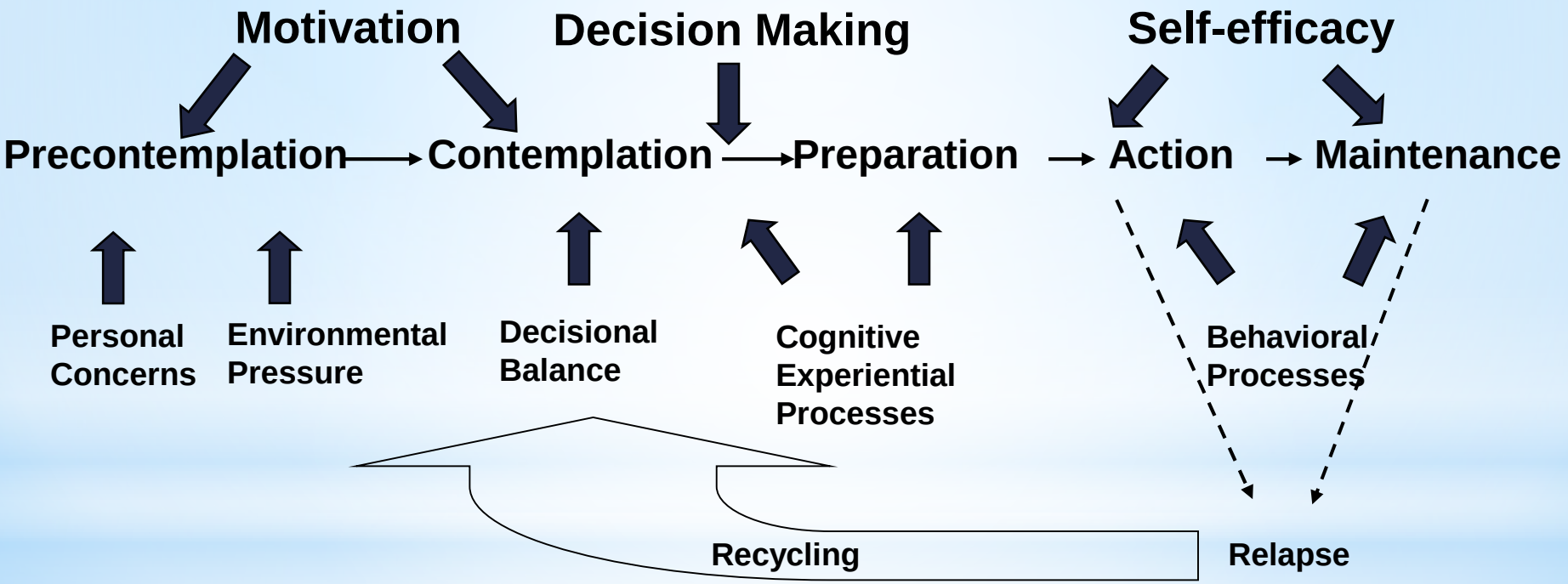
- Precontemplation
  - Not interested
- Contemplation
  - Considering
- Preparation
  - Preparing

Action

- Initial change
- Maintenance
  - Sustained change

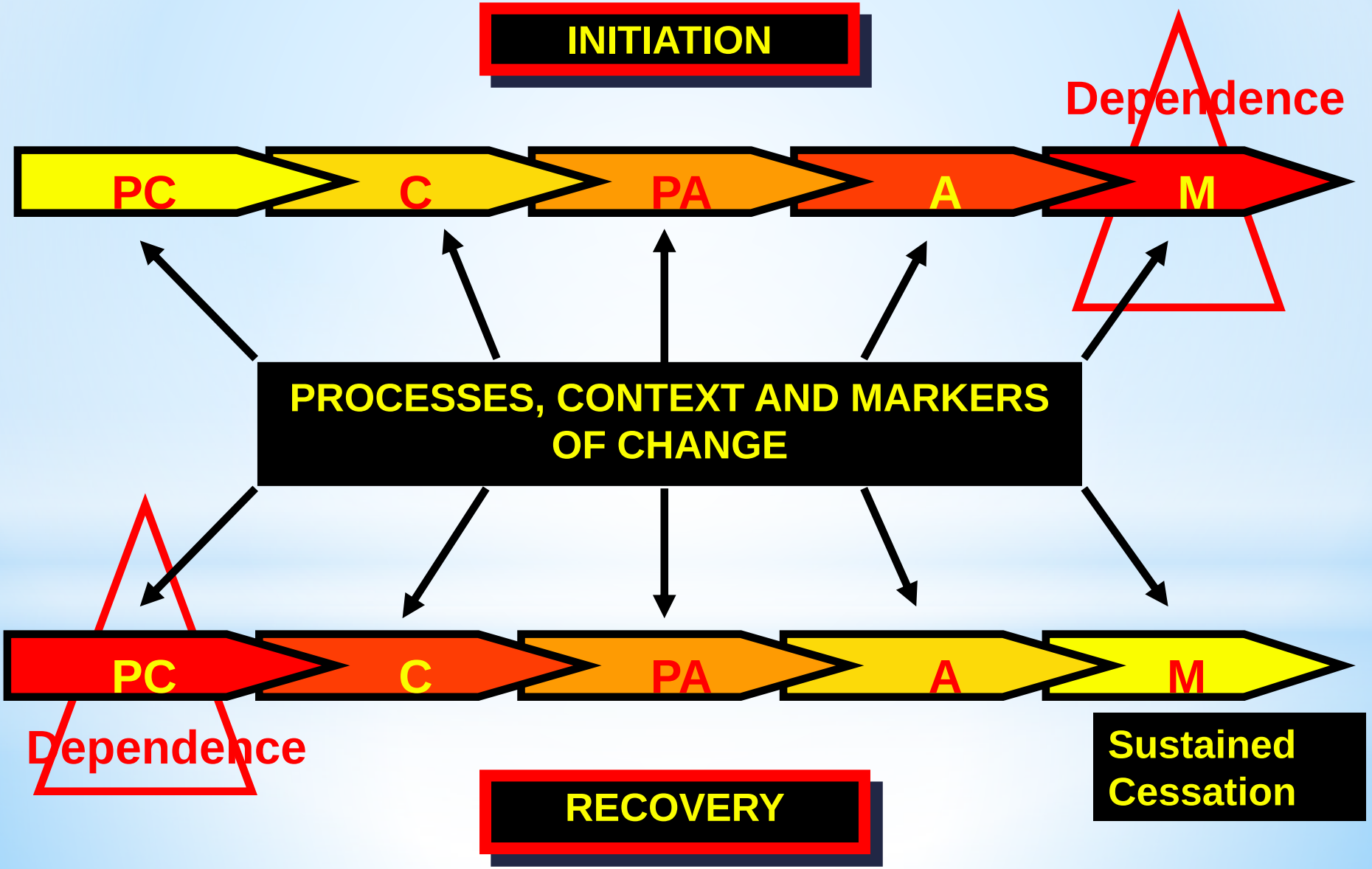
- Interested and concerned
- Risk-reward analysis and decision making
- Commitment and creating an effective/acceptable plan
- Implementation of plan and revision as needed
- Consolidating change into lifestyle

Theoretical and Practical Considerations Related to Movement Through the Stages of Change



What would help or hinder completion of the tasks of each of the stages and deplete the self-control strength needed to engage in the processes of change needed to complete the tasks?

* THE STAGES OF CHANGE FOR ADDICTION AND RECOVERY



Tasks and Goals for Precontemplation

* ***PRECONTEMPLATION*** - The state in which there is little or no consideration of change of the current pattern of behavior in the foreseeable future. (NOT PRECONTEMPLATOR)

* **TASKS:** Increase awareness of need for change and concern about the current pattern of behavior; envision possibility of change

* **GOAL:** Serious consideration of change for this behavior

* Reveling - Like the behavior
* Reluctant – Change disrupts
* Rebellious – Nobody tells me
* Resigned – I cannot do it
* Rationalizing – I have reasons

* The "Five R's" of How and Why People Stay in Precontemplation

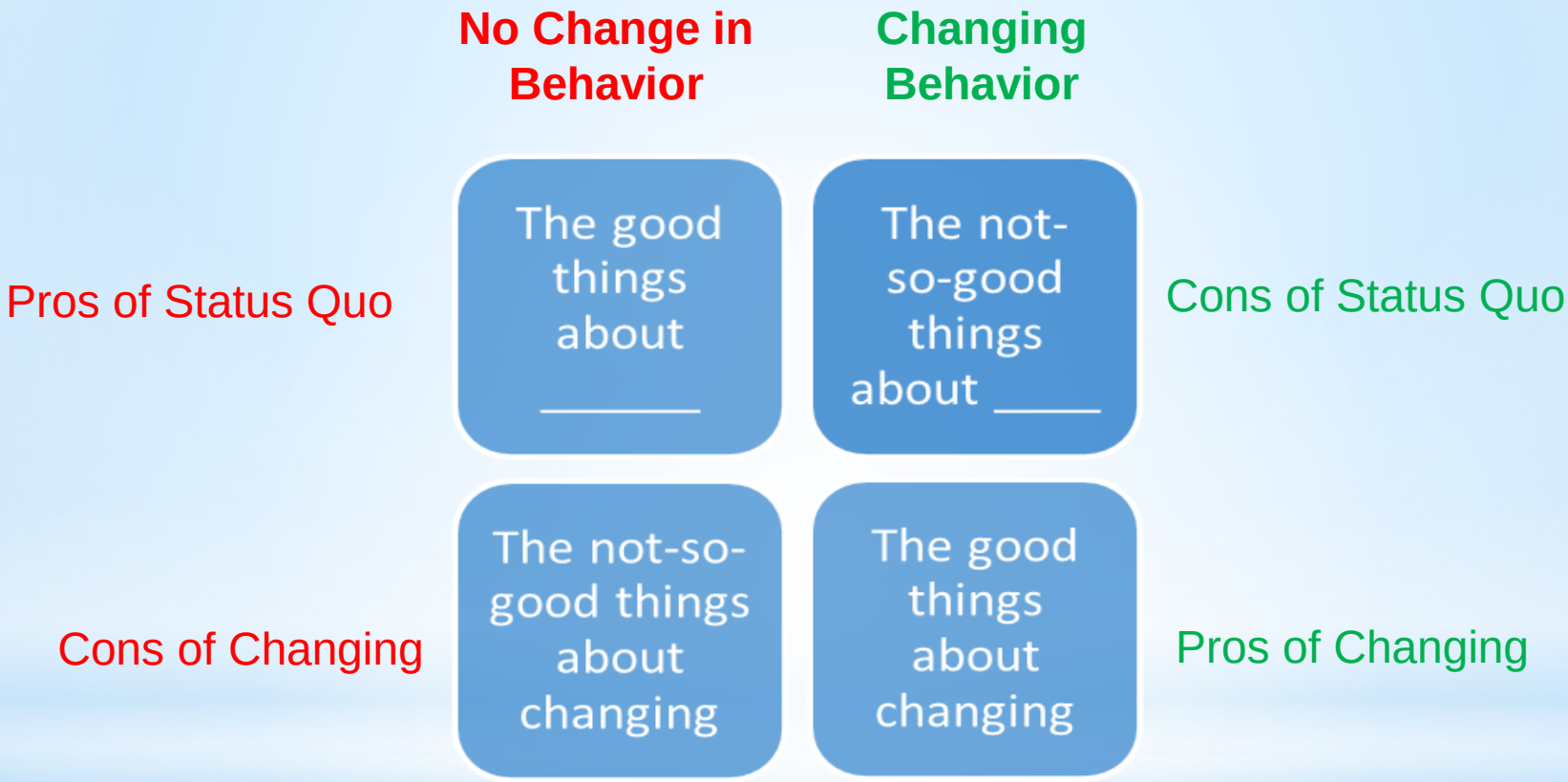
Tasks and Goals for Contemplation

* ***CONTEMPLATION*** – The stage where the individual examines the current pattern of behavior and the potential for change in a risk – reward analysis.

* **TASKS:**
  * Analyzing pros and cons of the current behavior pattern and costs and benefits of change.
  * Decision-making.

* **GOAL:** A thoughtful evaluation that leads to a decision to change.

*Decisional Balance (Pros & Cons)



- Precontemplation: Pros of Changing < Cons of Changing
- Contemplation: Pros & Cons often carry equal weight = Ambivalence
- Preparation: Pros of Changing > Cons of Changing

MOTIVATED TO CHANGE

* Admit that the status quo is problematic and needs changing
* The pros for change outweigh the cons
* Change is in our own best interest
* The future will be better if we make changes in these behaviors

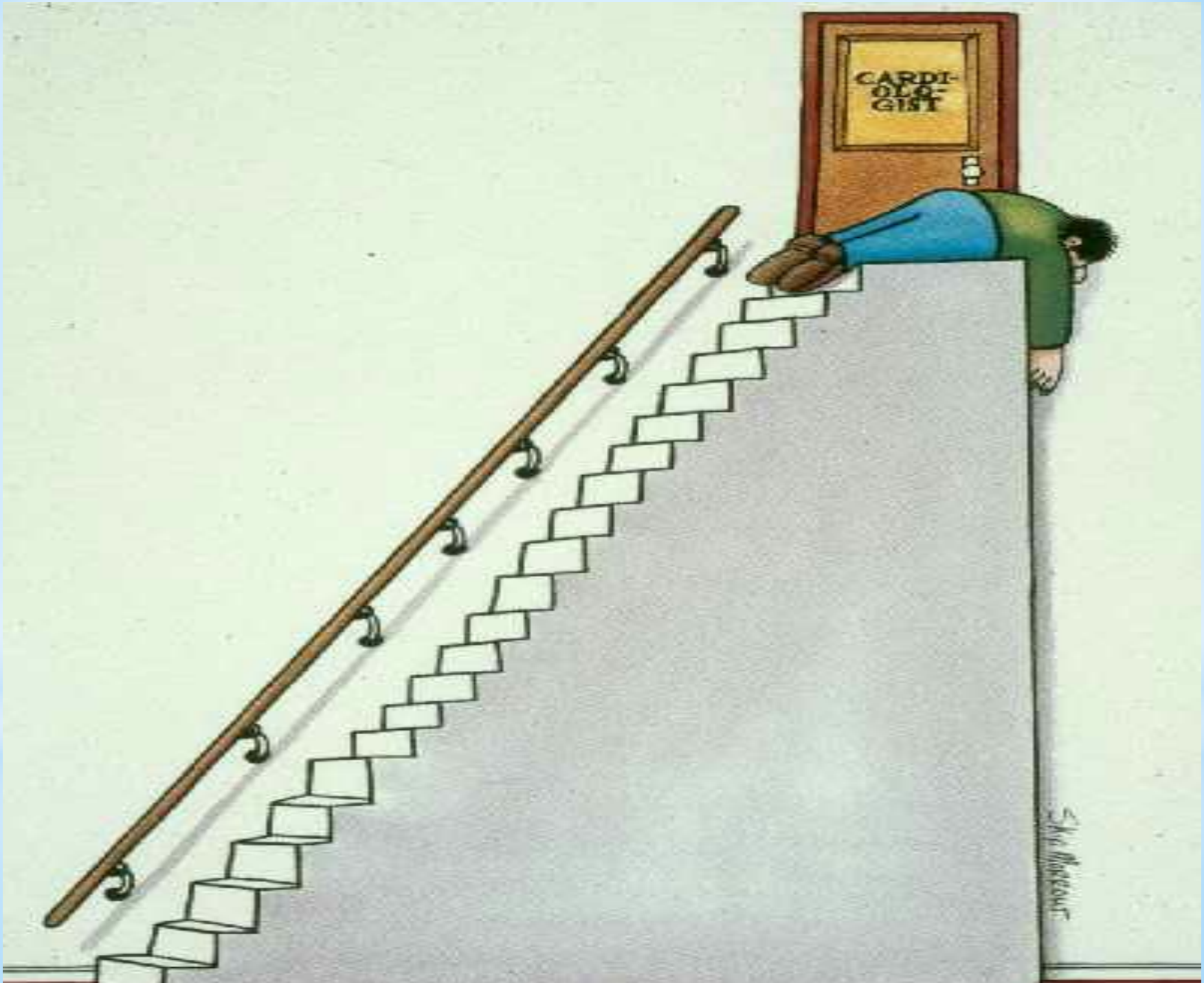

RANCIS, THE MOTHERS CLUB IS OFFERING MOTIVATIONAL SEMINAR TONIGHT CALLED STOP MAKING EXCUSES." WOULD YOU LIKE TO GO WITH ME?
NAH. IT'S TOO HOT, I'M TIRED AND I CAN'T FIND MY SOCKS.

Tasks and Goals for Preparation

* ***PREPARATION*** – The stage in which the individual makes a commitment to take action to change the behavior pattern and develops a plan and strategy for change.

* **TASKS:** Increasing commitment and creating an effective, acceptable & accessible change plan.

* **GOAL:** An action plan to be implemented in the near term.


CARDI-
OLO-
GIST

* COMMITMENT TO TAKE ACTION
* SPECIFIC ACCEPTABLE ACTION PLAN
* TIMELINE FOR IMPLEMENTING PLAN
* ANTICIPATION OF BARRIERS

* WILLING TO MAKE CHANGE

Action: Key Issues and Intervention Considerations

- Support for Change
  - Create support for continued engagement in the behavior for at least 3 to 6 months
  - Focus on and create alternatives & benefits of change
  - Consider rewarding progress, or encouraging to create and apply their own rewards
    - E.g., If I stick to my plan today, I can watch my favorite show tonight.

- Adjusting the Plan, As Needed
  - Plans often need to be revised
  - Flexible and responsive problem solving
  - Continued refining skills needed to implement the plan

Tasks and Goals for Maintenance

* ***MAINTENANCE*** – Stage in which new behavior pattern is sustained for an extended period of time & consolidated into the lifestyle of the individual.

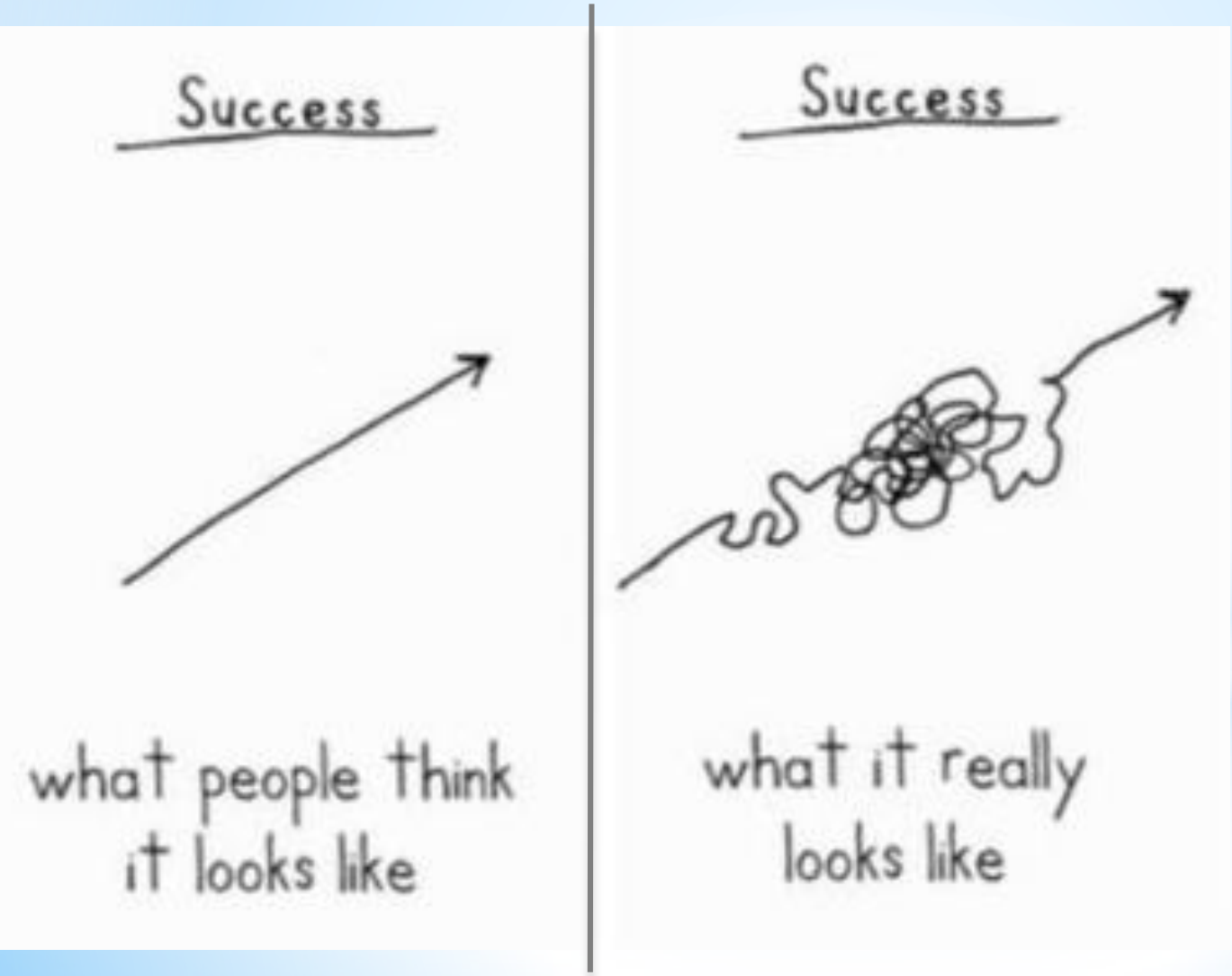
* **TASKS:**
  * Sustaining change over time & across a wide range of situations.
  * Avoiding partial or complete return to prior behavior pattern.

* **GOAL:** Long-term sustained change of the old pattern & establishment of a new pattern of behavior.

* Continued Commitment
* Skills to Implement the Plan
* Long-term Follow Through
* Integrating New Behaviors into Lifestyle or Organization
* Creating a New Behavioral Norm

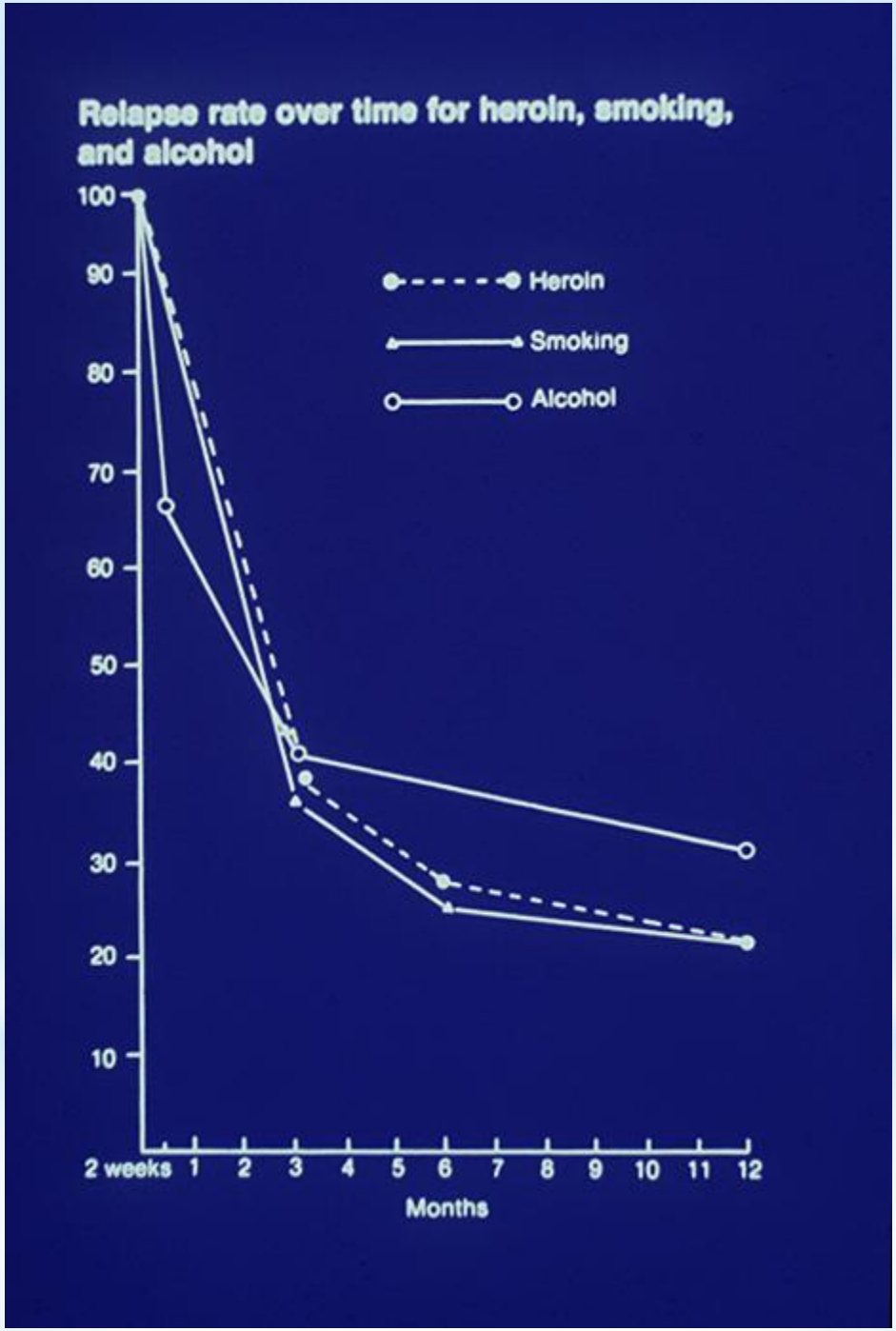
* ABLE TO CHANGE

*Change ≠ Linear Process: Relapse & Recycling



Regression, Relapse and Recycling through the Stages

- **Regression** represents movement backward through the stages
- **Slips** are brief returns to the prior behavior that represent a some problems in the action plan
- **Relapse** is a return or re-engaging to a significant degree in the previous behavior after some initial change
- After returning to the prior behavior, individuals **Recycle** back into pre-action stages (precontemplation, contemplation, or preparation).

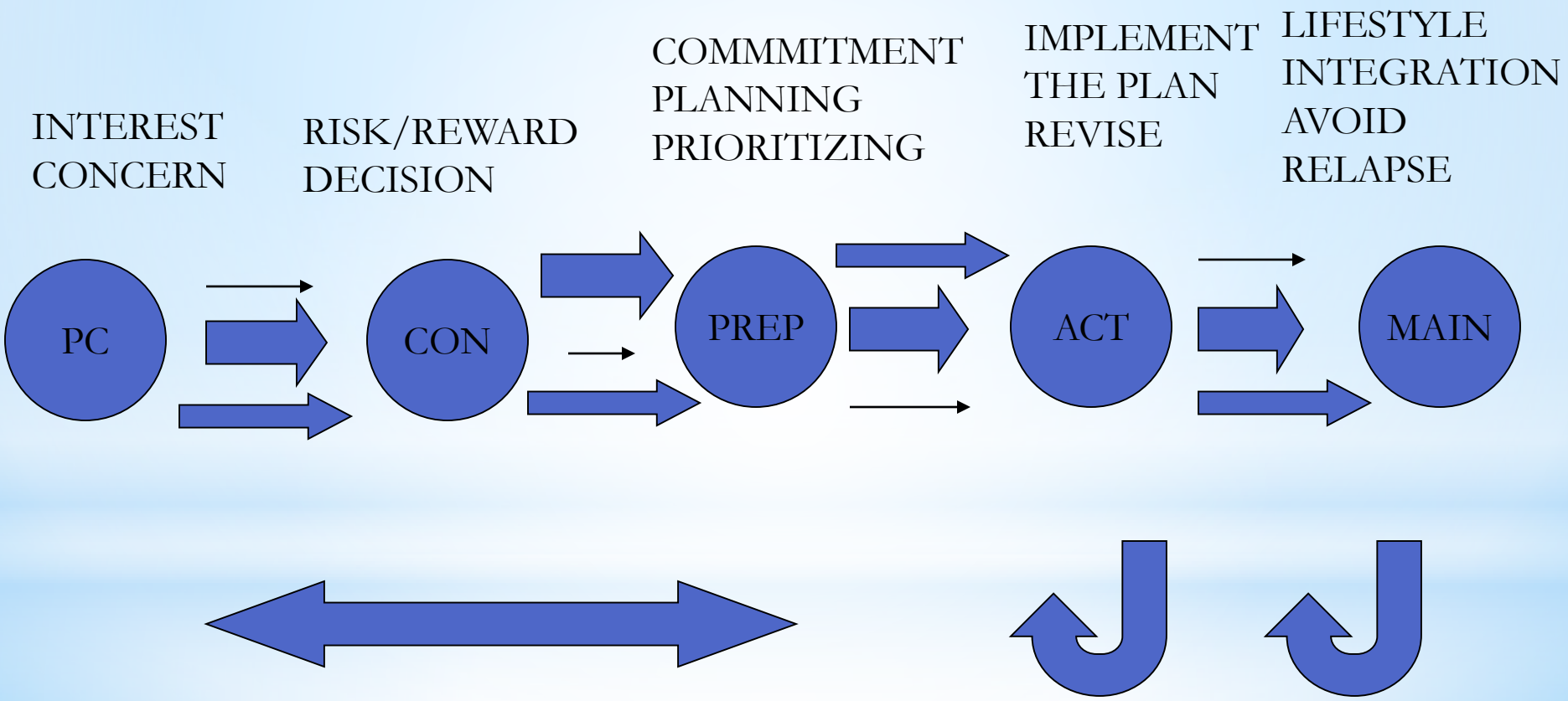

Relapse rate over time for heroin, smoking, and alcohol
100
90
80
70
60
50
40
30
20
10
Heroin
Smoking
Alcohol
2 weeks
1
2
3
4
5
6
7
8
9
10
11
12
Months

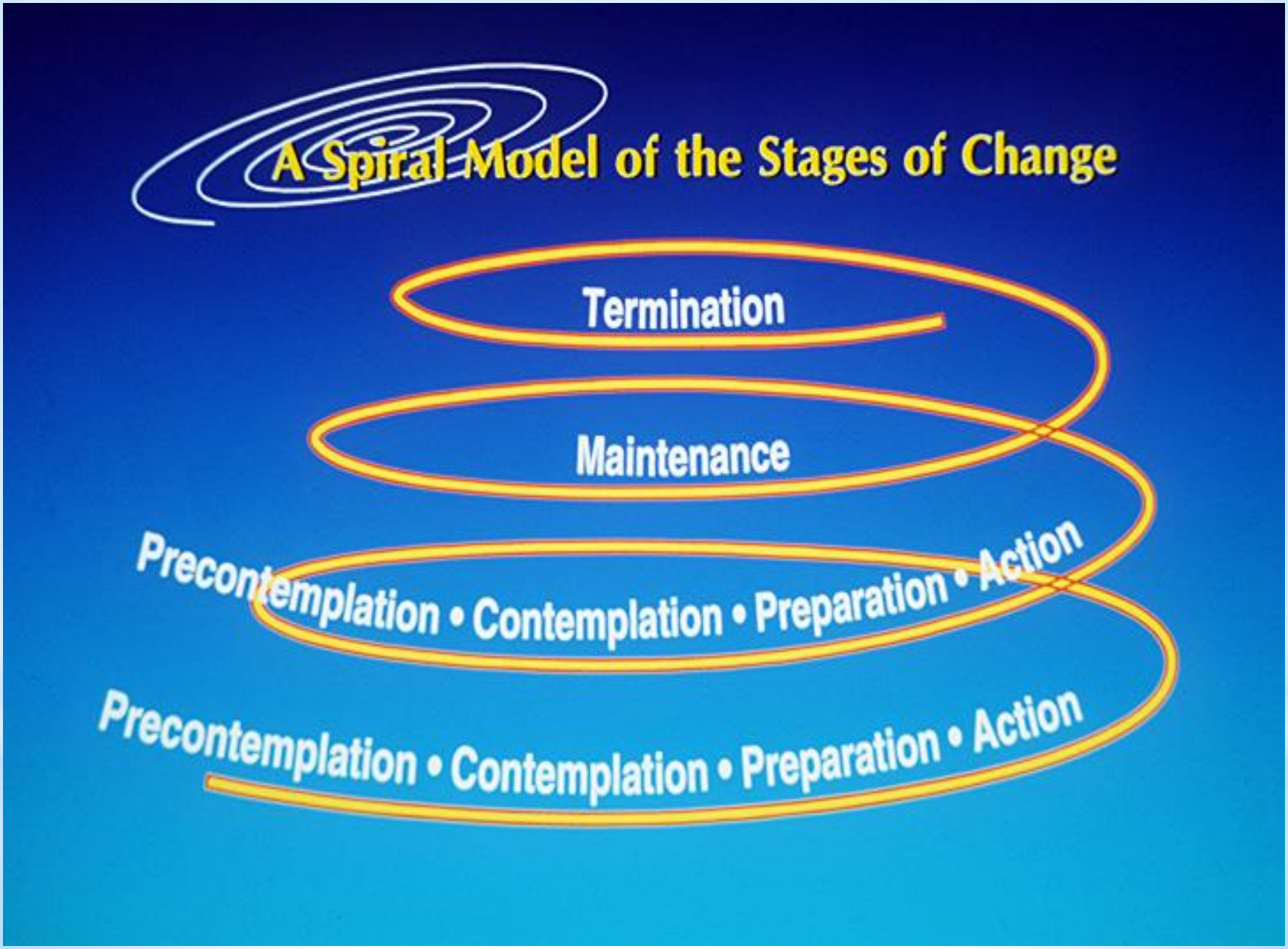
*Relapse & Recyclin

* Relapse shouldn't be seen as a problem of substance abuse or addictions—Relapse & Recycling are a natural part of the process of behavior change.

- Most successful changers make repeated efforts to get it right that are part of a learning process to correct for inadequate completion of stage tasks.

*TASK COMPLETION AND MOVEMENT BETWEEN STAGES




A Spiral Model of the Stages of Change
Termination
Maintenance
Precontemplation • Contemplation • Preparation • Action
Precontemplation • Contemplation • Preparation • Action

* Identify stages of change and understand implications of being in this stage

* Focus on the tasks of these stages in how you approach and interact with individuals you encounter or are working with.

* Think about what you can do when you encounter individuals in each of these stages for promoting recovery?

* How to keep people safe during the time it takes to successfully move through the process

* What does this mean and how can we use this model?

The Personal Process of Change

* The Person must make this Journey through the Stages of Change

* Our Job is to Create Systems of Care that focus on the
  * PERSON
  * AND THE
  * PROCESS

Helping Change Happen

- Focus on where person is in stages
  - For what change (taking medications, entering treatment, screening, cutting down, sharing needles, getting methadone, quitting opiates)
  - Readiness ruler (On a scale of 1 to 10)
- Focus on important personal values and possibility of change
- Help them with current challenges
- Offer support to scaffold severity mechanisms (impaired brain, loss of self-control, loss of pleasure and functional lifestyle
- Create conversations about change

Motivation Challenges

- Motivated to do What?
  - Enter treatment
  - Take medication
  - Abstinence
  - Reduction
  - Continue doing what I am doing
  - Get housing (Housing First)
  - Use clean needles or clean existing needles with bleach (i.e., harm reduction)

What is Harm Reduction?

- Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to **meet drug users "where they are," in their personal process of change** addressing conditions of use along with the use itself.
- Getting the change we can while waiting for the change we want.
- Preventing death and deterioration as we search for more complete and comprehensive solutions

Harm Reduction Coalition, 2018

*Meeting People Where They Are

Stages of Change				
Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Risk reduction Respite care, suicide prevention, PrEP, condoms, clean syringes	Risk reduction + prevention- Early Intervention, Screening, Managing complicating problems Reduction Sobriety Sampling Hiv testing and counseling, PrEP discussion		Initiation Action Medications, Self-Help, Counseling, Starting PrEP, Using Condoms, Building social support	Long-term sustained behavior change Lifestyle integration Support Managing other Problems

Programs & Peers

Examples of Harm Reduction for Addiction and HIV

- Naloxone distribution and training
- Condom distribution
- Mobile STI testing clinics
- Supervised injection facilities
- Syringe service programs (SSPs)
- 911 Good Samaritan policies
- Opioid replacement/substitution therapy
- PrEP/PeP for HIV prevention

Drug Policy Alliance, 2018

Rationale for Harm Reduction

- Reduces drug overdoses (Seal et al., 2005; Tobin et al., 2009)
- Increases entry into drug treatment (Hagan et al., 2009; Strathdee et al., 1999)
- Reduces prevalence of STIs/IDs(Des Jarlais et al., 2014; Institute of Medicine, 2017; van den Berg et al., 2007; Wodak & Cooney, 2006; Wodak & Maher, 2010)
- Promotes respect, compassion, and understanding toward drug users
- Meets people where they're at- everyone can benefit from HR (Marlatt, 1996)
- Applies commonly used HR principles to drugs- e.g., sex ed., sober rides, legalizing sex work/drugs (Leslie, 2008; Rekart, 2006)

Debunking Common Misconceptions about HR

* MYTH: Tolerating risky/illegal behavior sends message that these behaviors are acceptable

* FACT: No evidence that HR increases drug use (Watters et al. ,1994; Normand et al., 1995; Paone et al., 1995) or reduces readiness to change drug use (Bluthenthal et al., 2001; Henderson et al., 2003)

*Debunking Common Misconceptions about HR

*MYTH: Evidence does not support HR

*FACT: There is evidence to support HR, especially SSPs. HR is especially effective in conjunction with drug treatment (Kidorf et al., 2011)

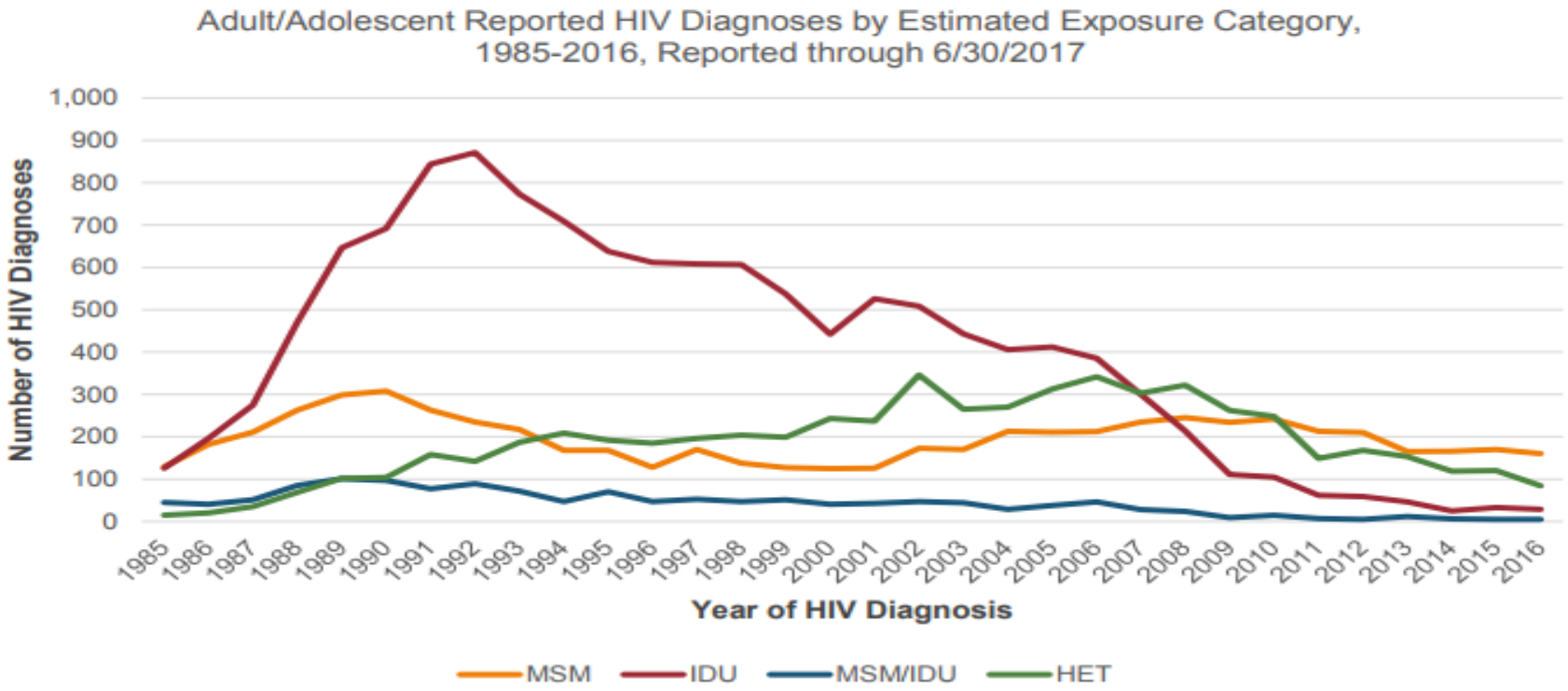
"When properly structured, SSPs provide a unique opportunity for communities to reach out to the active drug injecting population and provide for the referral and retention of individuals in local substance abuse treatment and counseling programs and other important health services."- Surgeon General's Review of SSP Effectiveness

Seattle SSP users were 5x more likely to enter treatment than PWID who didn't use the SSP

* SSPs Can Bridge Users to Help

Figure 6 – Trends in Adult/Adolescent Reported HIV Diagnoses by Estimated Exposure Category, 1985-2016, Reported through 6/30/2017

Number and Percent by Estimated Exposure Category[§] of Adult/Adolescent Reported HIV Cases, Age 13+ at HIV Diagnosis, with or without an AIDS Diagnosis (Adult/Adolescent Reported HIV Diagnoses) by Year of HIV Diagnosis from 1985 through 2016, as Reported through 6/30/2017



*SSPs Save Lives

Building a Comprehensive Client-Centered and Consumer Focused Recovery Oriented System of Care

Where is my agency and where am I?

Are we part of the solution or part of the problem?

* Most of our healthcare focuses on defining care by problem type (diabetes, cancer, HIV, alcohol, illegal drugs, serious mental illness)
* Specialty care often defines problems by Provider types (need to see a psychiatrist, a podiatrist, a gastroenterologist, a cardiologist)
* Focusing on problems makes people “patients” and simply problem carriers
* Most client/patients have multiple problems

* How to Integrate Care?

Mental Health and Substance Abuse Services

- Often isolated systems or worse treatment programs
- Stigma breeds hyper confidentiality and unwillingness to share information
- Focus has been unitary and even if a diagnosis is in the same set of ICD or DSM categories, the programs are segregated (TRIMS experience)
- Workers are not cross trained to address co-occurring conditions

*Why A Comprehensive Integrated Care System ?

- We need to treat people not diagnoses
  - The whole person not a single problems
- Every change of a targeted problem really involves multiple changes and often is complicated by problems and changes needed in multiple life domains
- Healthcare providers are facing this reality particularly with Non Communicable Diseases (CVD, COPD, Diabetes, Addictions) responsible for 70% of mortality worldwide (WHO report 2015)

Why Focus on the Client/Consumer

- Key **mechanisms** reside in the individual who needs to make a change for intentional change to be sustained
- Clients are really **consumers** of services and to be engaged and valued, and for whom these products and services need to be tailored to be consumer focused and friendly
- Each client has a **unique history** and set of problems that make change challenging

* Need an integrative perspective to be able to create integrated care
* A focus on the process of change shifts the focus from problems to how to develop resilience and coping activities that addresses what needs to be changed
* Shift from etiology and how problems develop to wellness and how to manage needed changes in behavior, lifestyle, and environment

* Focus on patient and not simply provider or problem

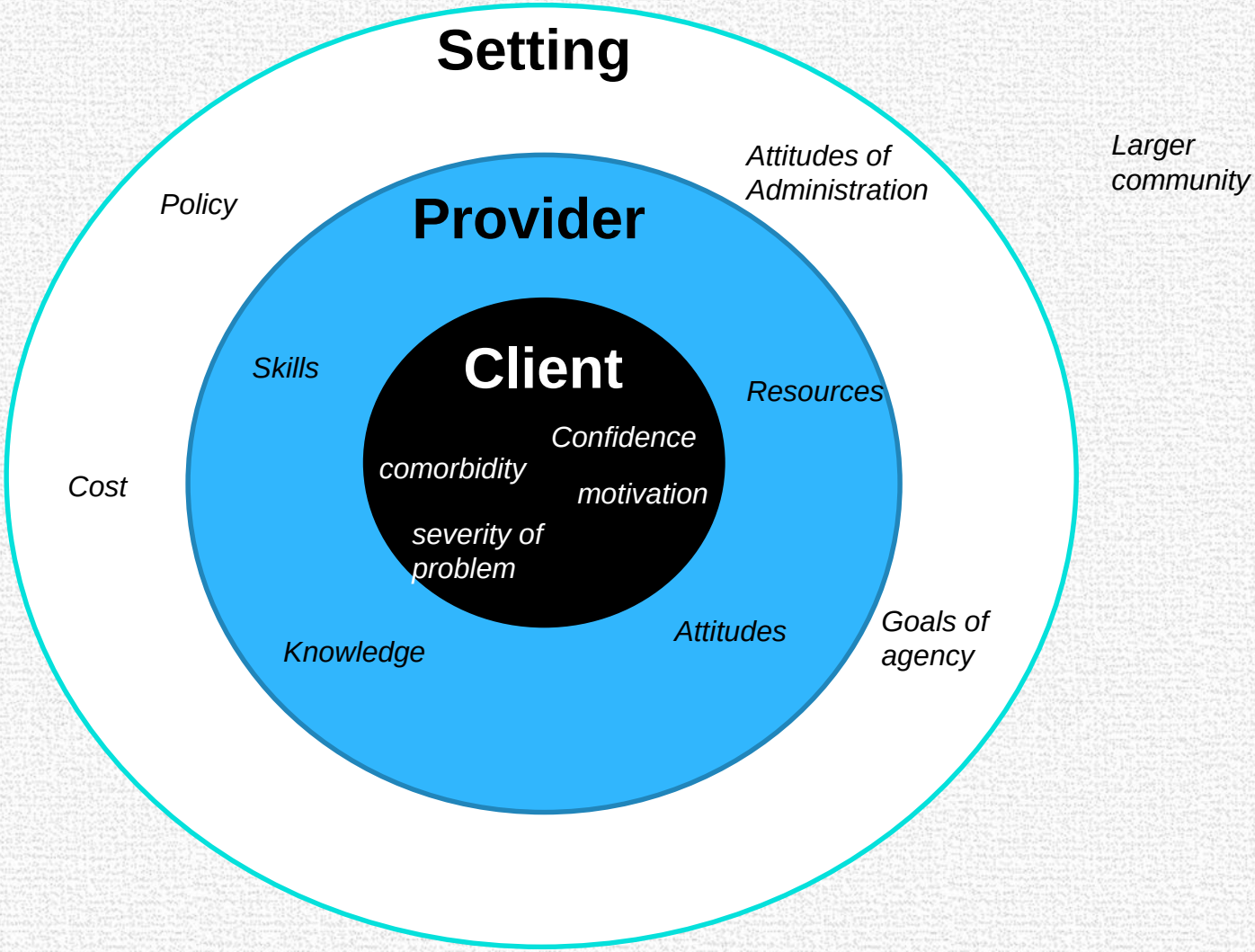
Integration in the New Health Care System

- Focus on Chronic Conditions which involve behavior change and psychological/emotional dimensions
- Empower the client to be in charge of the change
- Multidisciplinary – Medical, Pharmacological, Psychological, Behavioral, Environmental, Community, Systems Sciences must be blended together
- Collaboration in where services will be given and integration of information
- Use of new technologies to reach out and extend services to where patients are and meet them where they are at

How will your organization respond to new programs, new structures, new technology

How to move agency or organization through the process of change?

Multiple Levels of Factors Influence Clients



Organizational Change

- Similar to Personal Change Process
- Complicated by different groups of stakeholders
- Organizational framework and culture
- Who has to be motivated to change?
- What has to be changed?
- Implementation/Dissemination Science

Challenges of Dissemination and Implementation of Best Practices

- Outcomes of empirically based/supported interventions in clinical trials are reduced (sometimes dramatically) when evaluated in dissemination settings
- Workshop training is a weak method of implementation and dissemination
- Clinical settings differ dramatically in staff, organization and expertise:
  - "if you have seen one clinic, you have seen one clinic" (Boyle & Hrouda Ohio SAMI COE).
- Dissemination must be organizational, relational, collaborative, realistic, and focused on the process of change not simply the content of the best practice

New Models are Needed

- Dissemination must begin within an agency and involve the entire organizational structure since commitment, support and restructuring are needed for sustainability
- Implementation must be unique to each organization: what is essential and what can be adapted is a critical distinction for any EBP
- Organizational and individual culture must be part of the implementation model

Needs and Barriers for Patient Centered and Integrated Care

Needs

- A Process Model to guide decision making
- Interdisciplinary and multidisciplinary resources
- Time sensitive communication system
- Client oriented, empowerment approaches
- Flexible allocation of Resources

Barriers

- Lack of adequate actionable assessment
- Specialist Model of Care
- Lack of collaboration among providers and programs
- Lack of integrated medical record accessible to all healthcare providers
- Lack of incentives and lack of trust among providers

Some Solution Focused Suggestions

- Use a model that focus on patient needs and desires, motivation, and self-regulation
- Create systems of care not treatment programs
- Build Integrated Care training capacity not just learning about what other specialists do
- Create a system of communication among professionals
  - Focused on the client and
  - used to coordinate interventions and treatment (patient oriented medical record?)