Stage-wise Treatment: Matching Treatment Intervention to Readiness for Change

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Center for Evidence-Based Practices

at Case Western Reserve University

The Center for Evidence-Based Practices at Case Western Reserve University is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices (EBPs) for the treatments and recovery of people diagnosed with mental illness or co-occurring mental illness and substance use disorders.

Our technical-assistance services include:

- Service-systems consultation
- Program Consultation
- Clinical Consultation
- Training and education
- Program evaluation (fidelity & outcomes)
- Professional peer-networks
- Research

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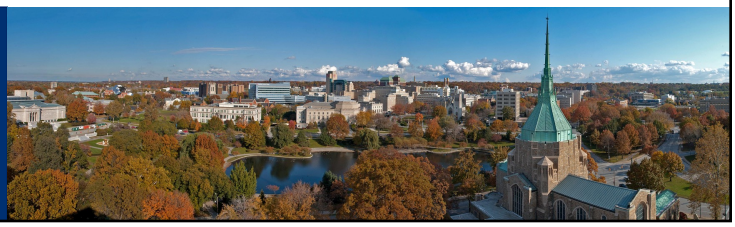

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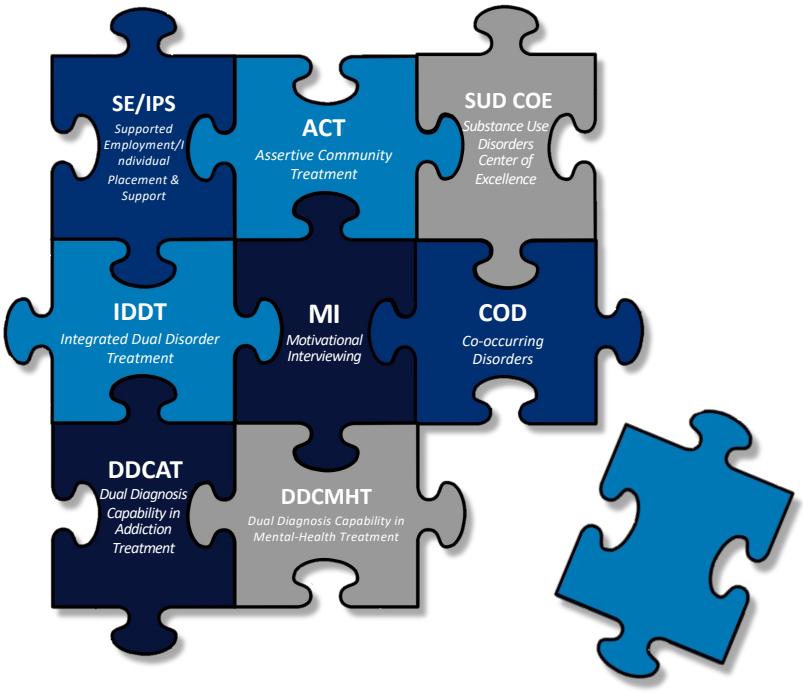
Service innovations for people with mental illness & substance use disorders



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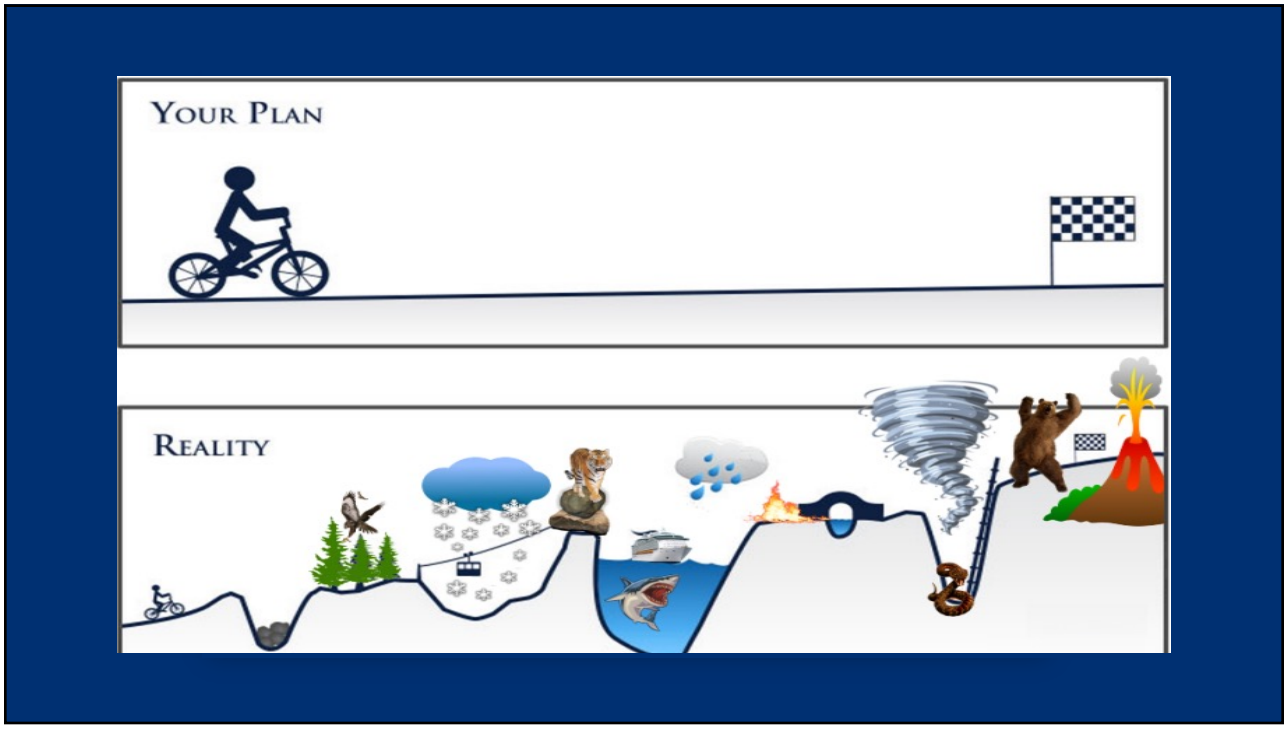

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First…Some Basics

- Treatment Works.
- Getting and Keeping People in Treatment is **necessary**.
- Rapport, Respect and Relationship are **cornerstones**!
- Stage-Wise and Motivational Implications should become **natural** considerations.

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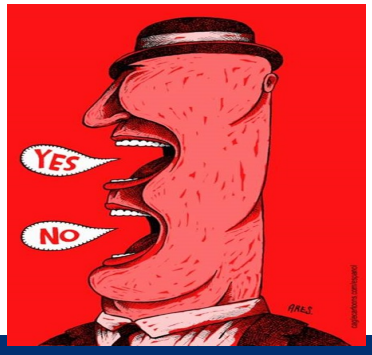
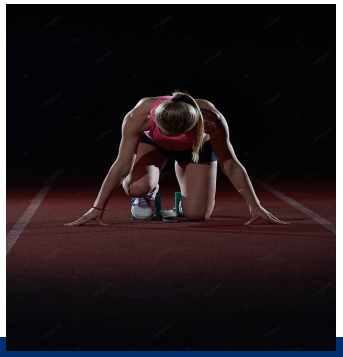
Components of Change Overview

Resistance **Ambivalence** **Motivation**





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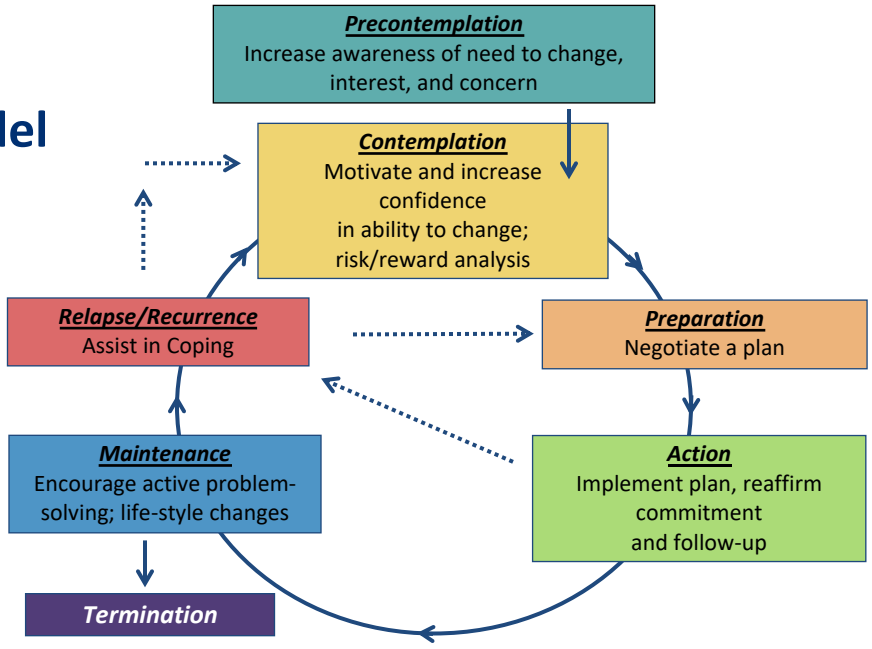
Stages of Change

- A way of thinking about where people are in regard to a particular change
- Motivation for change is not constant
- People may return to an earlier stage of change
- Returning to old behaviors is normal

Prochaska, Norcross & DiClemente (1994)

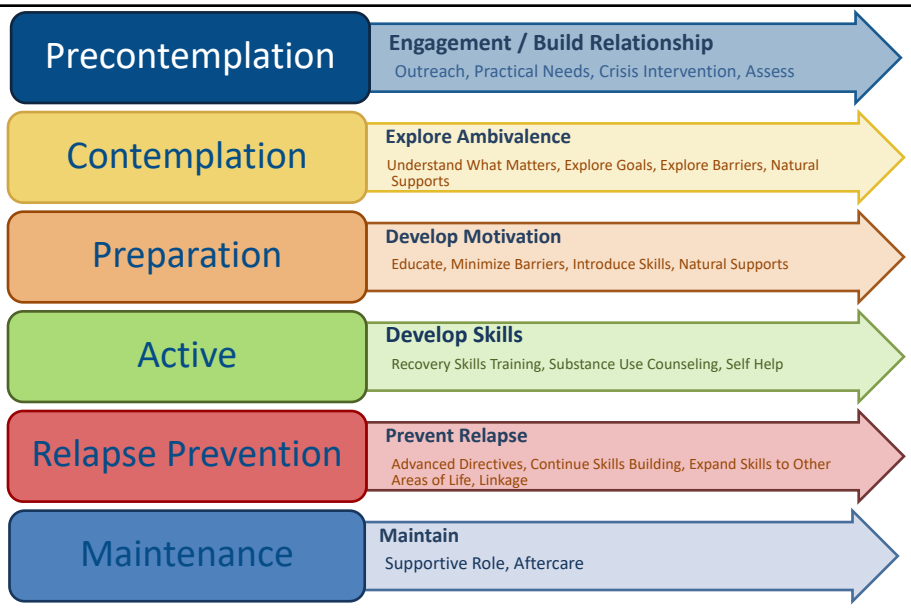
Stages of Change Model



Different services are helpful at different stages of treatment

- **Precontemplation (*Engagement*)**
  - Outreach, Practical help, Crisis intervention, Develop alliance, Assessment **(Build Relationship)**
- **Contemplation/Preparation (*Motivation*)**
  - Understand what matters to the person, Explore goals, Explore concerns and awareness of problem (motivational counseling), Family support, Peer support **(Explore Ambivalence & Motivation)**
- **Action (*Treatment*)**
  - Substance abuse counseling, Recovery skills training, Self help groups **(Develop Skills & Solidify Motivation)**
- **Relapse Prevention (*Planful Support*)**
  - Relapse prevention plan, continue skills building in active treatment, expand recovery to other areas of life **(Support Life Changes)**

Stages of Change and Focus of Intervention



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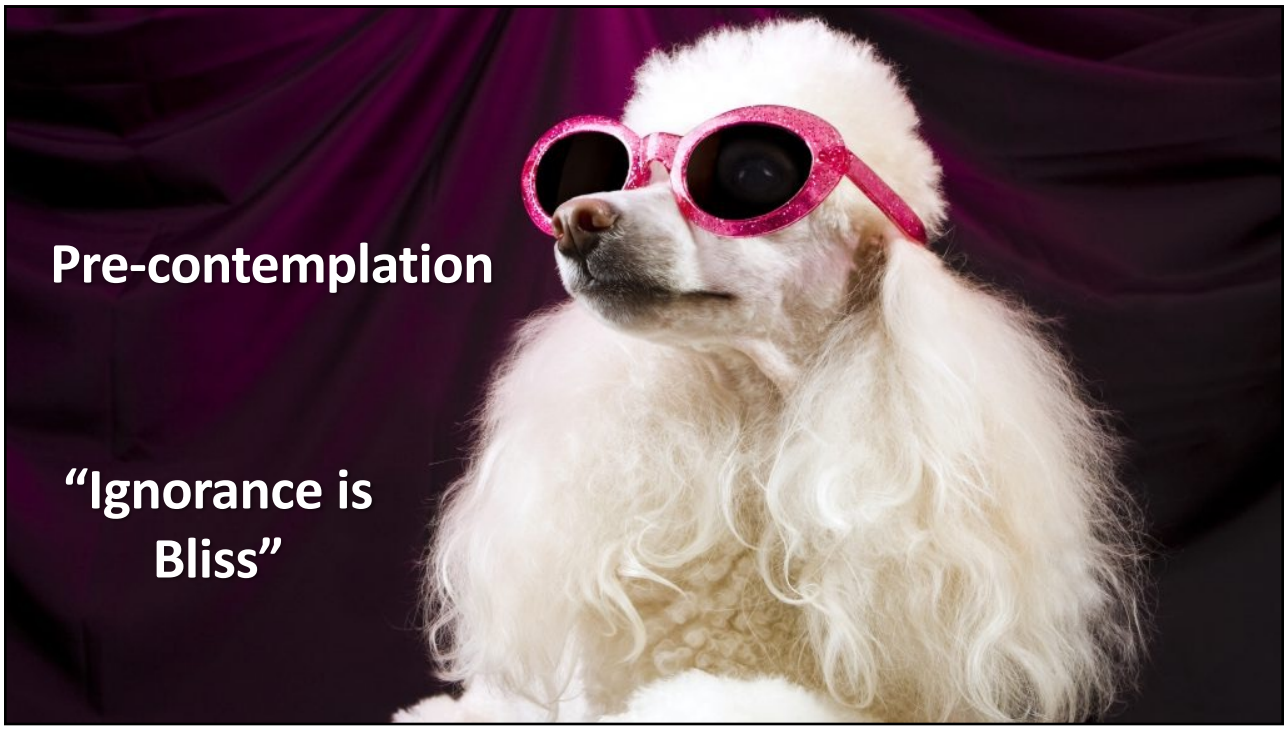

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Pre-contemplation
"Ignorance is Bliss"

- No intention to change behavior - may "wish" - "want to want to change"
- Unaware/lack awareness of problems
- Others are aware of problem
- Present for help under pressure
- May demonstrate change under pressure - though then return to behavior
- No expectation for change

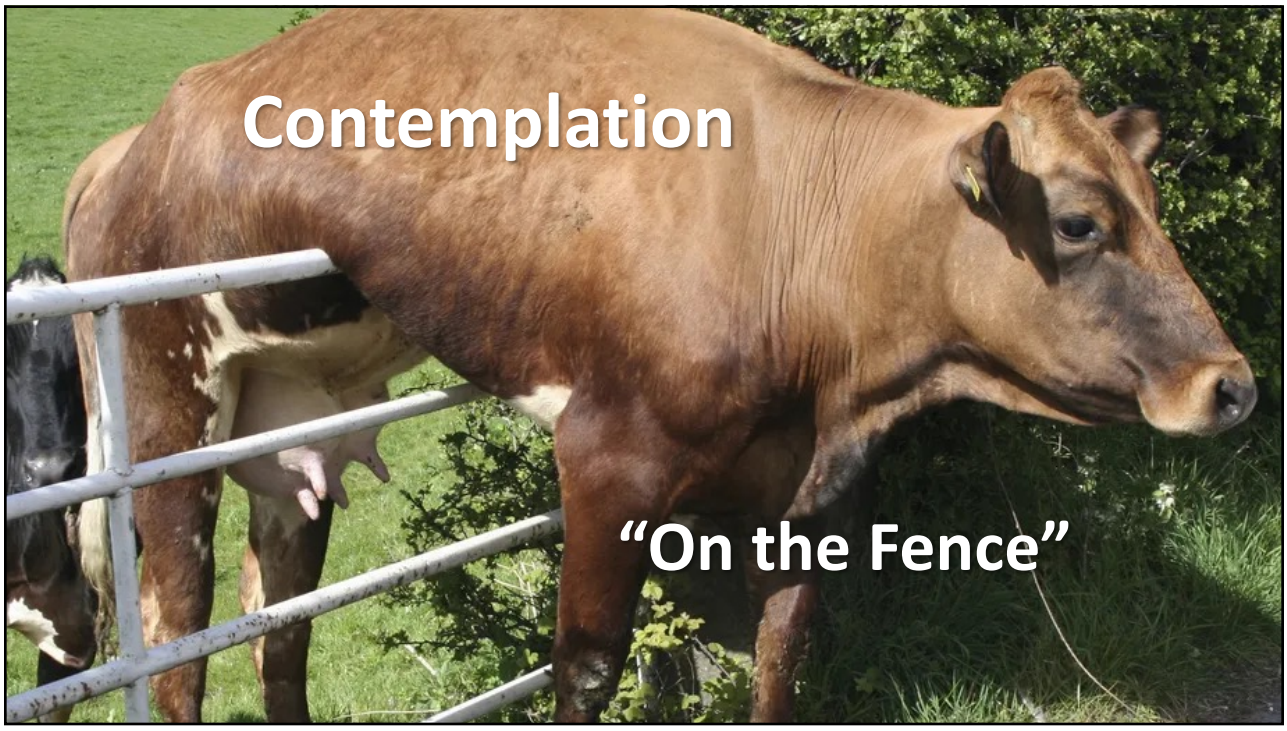
Hallmark = Not Interested / Resistant to change

Pre-contemplation
"Ignorance is Bliss"

- Build Alliance
- Outreach
- Practical Assistance / Basic Needs
- Crisis Intervention
- On-going Assessment
- Provide options/choices wherever possible
- Provide frequent contact
- Monitor environment
- Collaborate with other providers were appropriate

Engagement

- Create comfort with open honest discussion about substance use.
- Be consistent and kind
- Explore the person's goals
- Stay Curious



Contemplation
"On the Fence"

- Aware of problem & considering overcoming it
- No commitment to take action
- May remain "stuck" here for many years
- Knowing where one wants to go yet "not quite ready"
- Weighing pro's and con's of problem/solution
- Low expectation for change; high regard for participation and effort.

Hallmark = Ambivalence

Contemplation
"On the Fence"

- Avoid Resistance
- Explore for understanding of impact
- Provide education on areas of impact
- Provide opportunity for harm reduction
- Facilitate peer interaction
- Low expectation for change, but high support for participation, attendance, communication
- Provide optimism

Contemplation
"On the Fence"

Possible Stage-Appropriate Staff Tasks

- Provide options/choices wherever possible
- Goal setting
- Be aware of resident's own pros/cons for all aspects of life (medication, housing stability, employment, etc.)
- Engage person's support system where present and appropriate
- Continue frequent contact
- Continue to monitor environment
- Continue to collaborate with other providers

Preparation (Determination)
"Testing the Waters"

- Intend to take action soon (perhaps again), may have done so in the past
- Some reduction in problem behavior
- Have not yet reached criteria such as abstinence
- Decision-making stage
- Low expectation for change; high regard for participation and effort

Hallmark = Small steps toward action

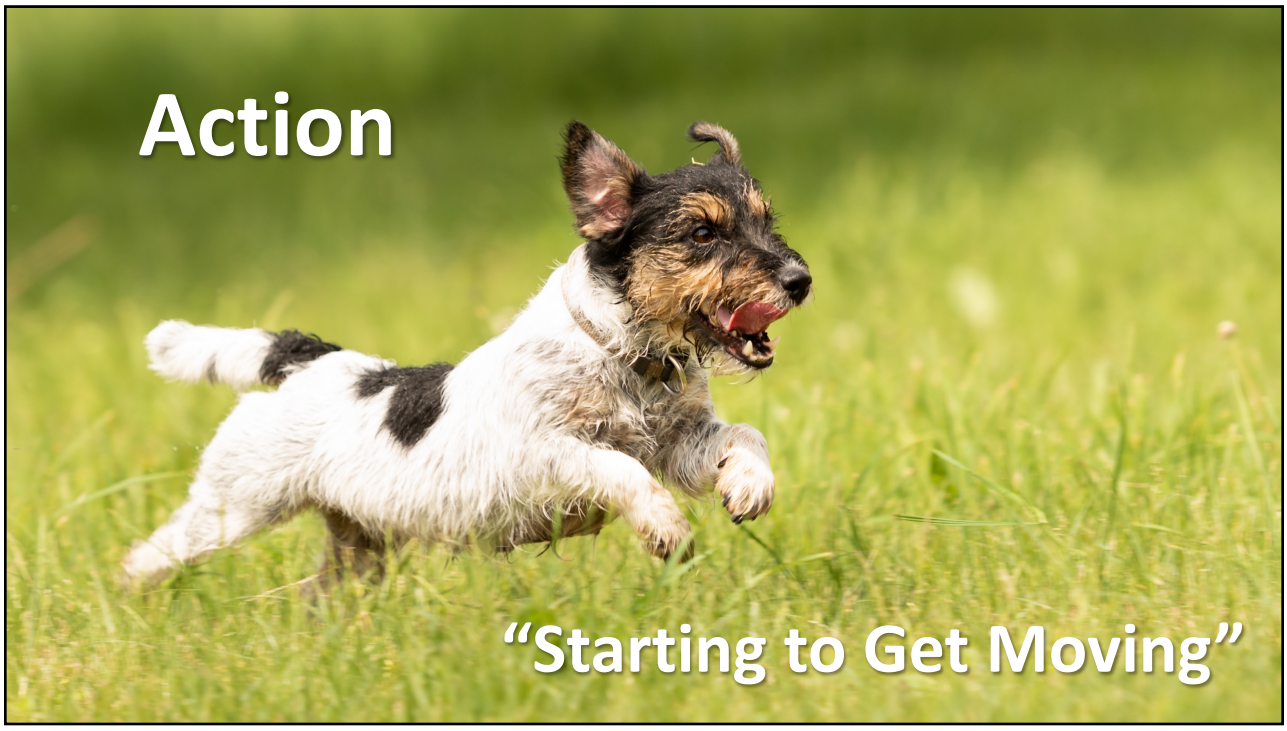
Preparation (Determination)
"Testing the Waters"

- Avoid resistance
- Minimize barriers
- Educate on "Next Steps"
- Provide opportunity for harm reduction
- Facilitate peer interaction
- Moderate expectation for change, but high support for participation, attendance, communication
- Provide optimism

Preparation (Determination)
"Testing the Waters"

Possible Stage-Appropriate Staff Tasks

- Educate, provide choices and resources & Support choices
- Discuss change in a realistic way
- Identify & problem solve barriers as the person sees them
- Motivational Approach and Motivational Interviewing
- Focus on developing small incremental steps towards goal
- Support & recognize small change efforts
- Help teach and model decision making
- Opportunities for Harm Reduction
- Continued collaboration with other providers



Action
"Starting to Get Moving"

- Regular Contact with the provider/team
- Individuals modify behavior, experiences, or environment to overcome problems
- Requires considerable commitment of time and energy
- Moderate expectation for Change
- Change is visible and recognized
- Action does not = change (6 months)

Action
"Starting to Get Moving"

- Once clients are motivated to manage their own illnesses, they need to develop skills and supports to control symptoms and to pursue an abstinent lifestyle.
- Effective programs provide some form of counseling that promotes cognitive-behavioral skills at this stage.
- Moderate to high expectation for change
- Provide optimism

Action
"Starting to Get Moving"

Possible Stage-Appropriate Staff Tasks

- Medication Monitoring and adherence strategies
- Mental Health/Substance Abuse Counseling
  - Individualized, EBP, Clear and measurable Action Plan
- Expand focus to other life skills/Skills training
- Link with Self Help
  - Be knowledgeable & respect client preference
- Provide close follow up.
- Family Treatment when appropriate
- Continued collaboration with other providers

Coping Skills and Social Skills Training

- **What skill deficits may result from addiction and/or mental illness?**
  - **Social Skills:** The opposite of addiction isn't sobriety, it's connection
  - **Routine Management:** Routine management is done through careful planning and the development of time management skills.
  - **Personal Skills:** This means learning to eat well, have better hygiene, budget, and do chores that improve your daily cleanliness.
  - **Professional/Vocational Help:** Give them the personal skills to better seek out professional work when they are done with recovery, so that they can get rooted in financial stability.
- **What skills training needs may need to be introduced into treatment groups?**

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Relapse Prevention/Maintenance

"Holding Steady"/"Revisiting the Past"

- Work to consolidate gains attained
- A continuation (not absence) of change
- From 6 months-indeterminate (lifetime?)
- Remains free of addictive/problem behavior

Hallmark = Stabilizing behavior change & avoiding relapse

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Relapse Prevention/Maintenance
"Holding Steady"/"Revisiting the Past"

- Focus moves towards sustaining life-style changes that support recovery
- Expanding recovery to other areas of life
- Continue skills training
- Self help
- Provide optimism

Relapse Prevention/Maintenance
"Holding Steady"/"Revisiting the Past"

Possible Stage-Appropriate Staff Tasks

- Similar to Active Treatment
- Focus on sustaining made changes
- Continue to develop life skills
- Expand recovery to other areas of life
- Link with Self Help
  - Be knowledgeable & respect client preference
- Relapse Prevention Plan/Advanced Directive
- Continued collaboration with other providers

Stage of Change	Characteristics	Strategies
Pre-contemplation	Person doesn't see the need for change	• Engage and build relationship • Explore person's own goals
Contemplation	Person open to discussing behavior and/or considering the possibility of change	• Explore discrepancy between person's goals and behavior • Explore pros/cons of change
Preparation	Exploring how change might occur, creating a plan for change, may take small steps towards change	• Build confidence • Weigh options • Develop change plan
Action	Taking steps to change, change is visible	• Skill building • Problem solve barriers • Relapse prevention planning • Monitor motivation
Maintenance	The change is part of the person's daily routine for an extended period of time	• Consider other life goals • Monitor for relapse potential
Relapse	Return to prior behaviors	• Reframe relapse as a learning opportunity • Re-engage motivation for change • Avoid shaming person

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Stage of Change	Characteristics - Issues	Strategies
Pre-contemplation *"Ignorance is Bliss"*	"Nothing needs to change"	• Relationship • Trust • Provide Information/Resources
Contemplation *"On the Fence"*	"I am considering change"	• Explore Ambivalence • Develop Discrepancy • Build External Recovery Capital
Preparation/Determination *"Testing the Waters"*	"I am figuring out HOW to change"	• Build Internal Recovery Capital • Explore Options and Barriers • Introduce Skills
Action *"Started Moving"*	"I'm making changes and taking steps."	• Develop Skills • Plan Reachable Goals • Monitor * Encourage
Relapse Prevention *"Revisiting the Past"*	"I've gone back to old behaviors. Have I lost everything I've worked for?"	• Normalize and Explore • Avoid Shaming or Blaming • Planful attempt again
Maintenance *"Holding Steady"*	"I've changed, now to just keep it up."	• Support Change • Re-visit Relapse Prevention Plan

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Staging Considerations/Errors

1. **Instrument Issues/Inconsistencies**
   - No staging tool used at all
   - No staging tool present while staging
   - Wrong staging tool used
   - Staging only completed by individual and not team

- Staging is team-based activity requiring multi-disciplinary input

- Use Stage of Treatment (SATS) to guide interventions

Staging Considerations/Errors

2. Frequency
   - Too Often
   - Irregular/Random

- Formally stage every 6 months, and/or discuss whenever clinically indicated

Staging Considerations/Errors

3. Documentation

- Staging is being done, but not reflected in clinical record
- Reinforces stage appropriate treatment
- Increases likelihood of communication among team members re: stage appropriate strategies

Staging Considerations/Errors

4. Lost in Translation

- Staff are not yet proficient at stage appropriate interventions (ex: have not yet learned MI, CBT, or lack engagement skills, etc.)
- Staging occurs, though subsequent interventions don't reflect appropriate strategies for the identified stage

- Train and supervise for full spectrum of skills appropriate to each stage

Supervision, Supervision, Supervision

Stage Based Decision Guidelines

(Review Document)

Engagement Stage	Is the client **in crisis**? • If so, what needs to be done to **manage the acute crisis?** • Intervene if person is an imminent danger to themselves or others • Decrease emotional distress by helping to reduce symptoms and/or crisis inducing circumstances	Is the client **accessing needed services**? • Are we planning and providing adequate **outreach** to ensure needed services are being delivered?	Does the client have **basic needs** addressed? • If not, what do we need to be doing to address those needs? • Have we learned what needs the client would like to address? (so as not to be forcing our own opinions about this upon them)	Do we have a **trusting relationship** with the client? • If not, what needs to be done so that we get one? • Begin to develop a rapport via regular contact with the person (use multiple team members if/when possible) • Be curious yet sensitive, find out about this person's story and perspective • Express Hope & Optimism	Have we gathered enough information in our **assessment** about the history and interactive course of disorders? • If not, what do we need to learn more about and how can we learn it? • Elicit description of a typical day

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Stage Based Decision Guidelines for ACT/IDDT					
Early Motivation Stage	Do we know **what matters** (values and goals) to the person? • If not, that's the conversation • If so, the conversation becomes "what's getting in the way of what matters to you and what helps you get what matters to you?" • Avoid Common Traps (Expert, Premature Focus, Arguing for Change, Labeling, Question/Answer, Blaming/Shaming) • Values Card Sort (For those who struggle to verbalize this)	Will the person **discuss** their use, mental health and/or other concerns with the team? • Elicit, listen to, and acknowledge the aspects of substance use or other issues that the person enjoys • Payoff Matrix • Explore willingness to develop a Crisis Plan	Do the team and the individual **agree on direction?** • Ask permission to address the topic of change • Listen for and learn the person's perceptions of the problem • Explore the meaning of the events that brought the person to treatment or the results of previous treatments • Normalize ambivalence	Can a **discussion of change occur?** • Provide encouragement and support; instill hope and a sense of possibility and to rebuild a positive self-image • Assesses readiness/ confidence in their ability to make positive changes • Invite the person to attend motivational groups that are non-threatening and which do not insist on commitment to change • Offer to engage individual's support network	Continue: • Outreach • Assistance w/ Basic Needs • Assessment • Non Judgmental interactions • Instilling Hope and Optimism • Compassion and Concern • Roll with resistance • OARS • Trauma sensitive interactions • Avoid directive interventions

Engagement		
Goals	Objectives	Interventions
To establish a working alliance with the person served through a therapeutic relationship	■ Minimum weekly in-person contacts with person served. ■ Regular, weekly, meetings with client indicating the beginning of a therapeutic relationship. ■ Ongoing Assessment of Needs (e.g., housing, vocational assistance, income support, social support systems, transportation, etc.) ■	■ Outreach to client when in a crisis or crisis setting. ■ Provide practical help with ADL's through outreach efforts ■ Assist client in obtaining entitlements and managing available funds. ■ Assist client in obtaining and maintaining stable housing. ■ Assist client in managing legal penalties through therapeutic services available. ■ Link, coordinate, assist client in securing food, clothing and transportation. ■ Assist client in therapeutic meetings with family and/or significant others ■ Assist client thru medication reminder prompts. ■ Multiple contacts per day/week with client to monitor functioning level and build a therapeutic relationship. ■ Assist client in securing vocational referrals and/or securing activities that are structured and meaningful to the client. ■ Assist client in accessing self-help and other social support networks in the community. ■ Assist client in stabilizing Mental Health and Drug/Alcohol symptoms. ■ Facilitate further development of daily living skills as identified by the individual and/or guardian. ■ Coordinate ISP, including: Services identified in the ISP; Assistance with accessing natural support systems and the community; and linkages to formal community services/systems. ■ Monitor Symptoms ■ Coordinate and/or assist in crisis management and stabilization as needed. ■ Advocate and Outreach the person served. ■ Help the person served develop coping skills and interpersonal skills to increase chances of successful recovery.

Persuasion/Motivation		
Goals	Objectives	Interventions
To Increase client awareness/motivation to see either substance use or symptoms of mental illness or both as interfering with their personal goals.	■ Weekly/Bi-Weekly attendance at Persuasion Groups. ■ Complete "Pay-Off Matrix" ■ Increase verbalizations/written statements about difference between clients goals and current behaviors. ■ Reduce amount(s) or frequency of substance use. ■ Reduce types of substances used. ■ Increase adherence to medication & treatment regime. ■ Weekly/Bi-Weekly attendance at Skills Training Groups. ■ Assist in achieving personal independence in managing basic needs as identified by the person served and/or Guardian. ■ Ongoing Assessment of Needs ■	■ Psychoeducation for the person served and/or their family/sig. other regarding substance use, mental illness and their combined effects. ■ Group treatment/psychoeduction to assist person served/family/sig other to recognize signs and symptoms of mental illness, substance use and their combined effects. ■ Assist person served to secure employment, vocational referrals, and/or securing activities that are structured and meaningful to the client. ■ Review with/educate person served on the negative consequences of their behavior (e.g., legal, relationships, job, health). ■ Assist person served to experience and express feelings concerning problem behavior and difficulty of change. ■ Review actual or potential consequences of behavior (e.g., car accident, health issues, friend or relative having difficulties as a result of similar behavior). ■ Assist person to examine how problem behavior affects society, community and relationships. ■ Assist person served to examine internal reasons for behavior & how life would be different (both positively and negatively) without the problem behavior. ■ - Examine how person served perceives and feels about problem behavior. ■ Assist person served to journal thoughts and feelings concerning problem behavior and change. ■ Assist person to choose a plan of action or date to terminate some problem behaviors. ■ Coordinate ISP, including: Services identified in the ISP; ■ - Assist with accessing natural support systems in the community; and linkages to formal community services/systems. ■ Monitor Symptoms ■ Coordinate and/or assist in crisis management and stabilization as needed. ■ Advocate and Outreach to the person served. ■ Help the person served to develop coping skills and interpersonal skills that increase chances of successful recovery. ■ Support attempts/efforts at changing problem behaviors. ■ Assist person served in "doing something different" in place of problem behavior (e.g., relaxation, positive self-statements, hobbies). ■ Assist person served to begin to remove reminders (i.e., cues, stimuli, triggers) of problem behavior. ■ Assist person to manage/avoid cues, triggers and urges associated with problem behavior. ■ Assist person in finding safe, affordable housing, including "damp" housing (I.e., tolerant of some abuse). ■ Facilitate further development of daily living skills as identified by the person served and/or guardian.

Adams, N. & Grieder, D. M. (2014).

Treatment Planning for Person-Centered Care: Shared Decision Making for Whole Health (2nd ed.).

San Diego, CA: Academic Press.

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