ENGAGING PATIENTS AND FORMING THERAPEUTIC RELATIONSHIPS

Interdisciplinary Strategies for Managing Maternal Opioid Use Disorder Workshop

Center for Interprofessional Education
University of Maryland, Baltimore
October 1, 2019

Katherine Fornili, DNP, MPH, RN, CARN, FIAAN
Assistant Professor, University of Maryland School of Nursing

UNIVERSITY of MARYLAND
SCHOOL OF NURSING

Problem Statement:

- Negative provider attitudes inhibit one's ability to provide adequate services to patients with SUDs (Goplerud, Hagle, McPherson, 2017)

- Stigma and mistrust of parents by healthcare professionals:
  - Increase parents' feelings of shame and incompetence;
  - Are counter-productive in the parents' recovery process; and
  - Impact adequate bonding between parents and babies.

Content

1. Recovery-oriented system-of-care (ROSC)
2. Non-stigmatizing, non-labeling language
3. Welcoming environments
4. Trauma-informed care
5. Resistance and motivational enhancement
6. Strengths-based and relationship-building approaches

Start with the Phenomenon of Recovery

WORKING DEFINITION: *(SAMHSA, 2011)*

- "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

CORE RECOVERY MEASURES: *(SAMHSA, 2014)*

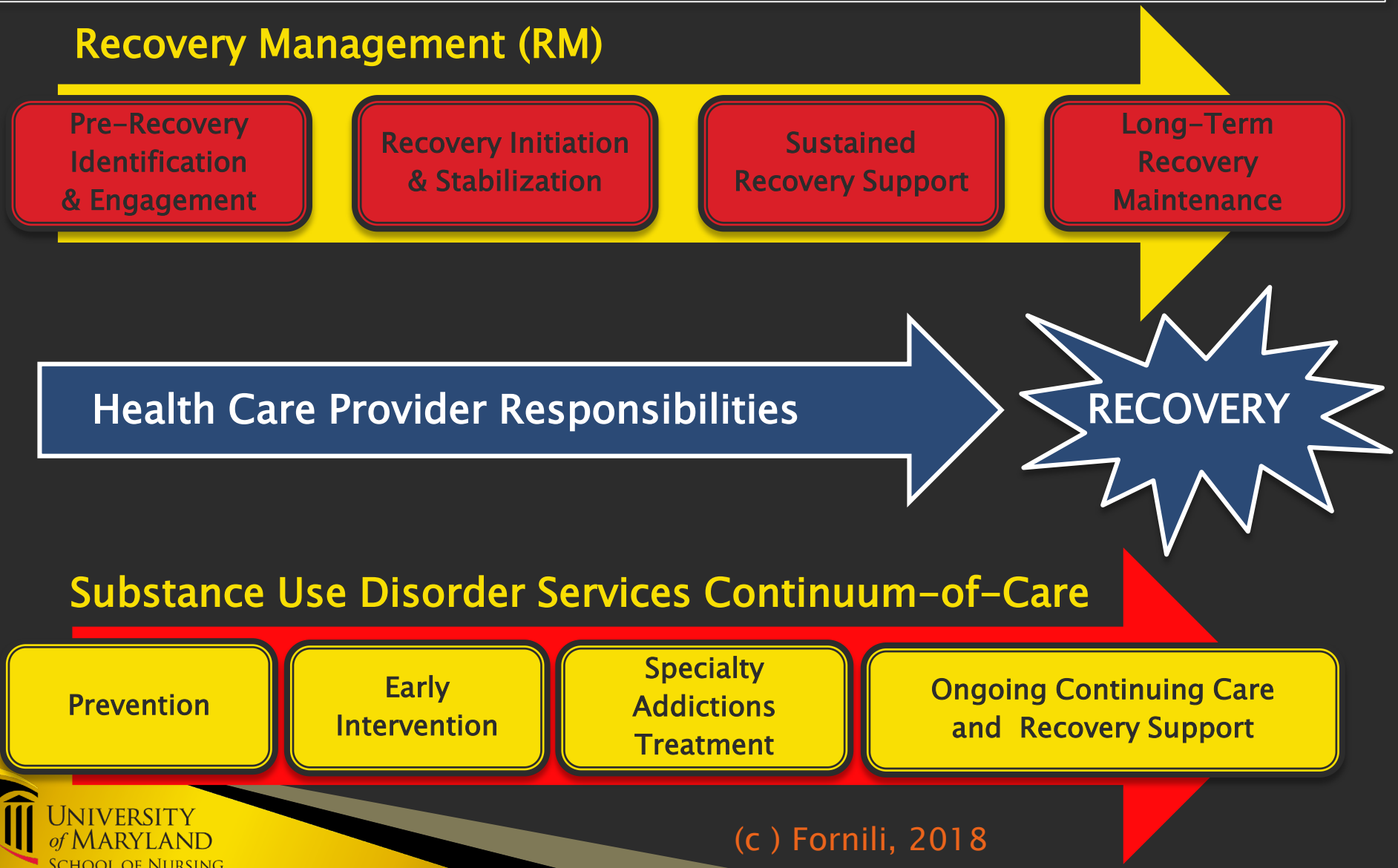
- **Health**—Overcoming or managing disease process; physical/emotional well-being;
- **Home**—Stable and safe place to live
- **Purpose**—Meaningful daily activities (job, school); and
- **Community**—relationships and social networks that provide support, friendship, love and hope.

OVERARCHING PRINCIPLES OF RECOVERY:

- Recovery is a reality for millions of people;
- There are many pathways and styles of recovery;
- Recovery is a voluntary process;
- Patients thrive in supportive communities;
- Recovery gives back what addiction and mental illness took away.

White & Davidson, 2006; System Transformation. Recovery: The Bridge to Integration? Behavioral Healthcare, 26(11), 22-25).

William White's Recovery Management Model and the Substance Use Disorders Continuum-of-Care



1. Recovery-Oriented Systems-of-Care:

Continued contact is the responsibility of the primary care provider and other service staff rather than the patient.

a) **Pre-Recovery Identification & Engagement:**
Dependent on a therapeutic alliance between the practitioner and the patient

- **Practitioner**: Awareness of a window of opportunity, and willingness to intervene
- **Patient**: Awareness that the healthcare provide is helpful and supportive, and willingness to trust the provider

b) **Recovery Initiation & Stabilization:** Failure to initiate and stabilize recovery is due to flaws in the service delivery system, not failures (non-compliance) of the individual (White, 2008)

c) **Sustained Recovery Support Services:** Full range of non-clinical services to reduce or eliminate environmental or personal barriers to recovery

- Child care
- Transportation
- Housing
- Life skills training
- Employment readiness
- Legal consultation
- Wellness checks
- Self-management support

d) **Long-term Recovery Management:**

- Shifts focus from the service environment to the client's natural environment;
- Requires provider commitment to extended post-treatment monitoring & support.

CONCEPTUAL FRAMEWORK:
Brofenbrenner's Ecologic Framework

PATIENT-CENTEREDNESS

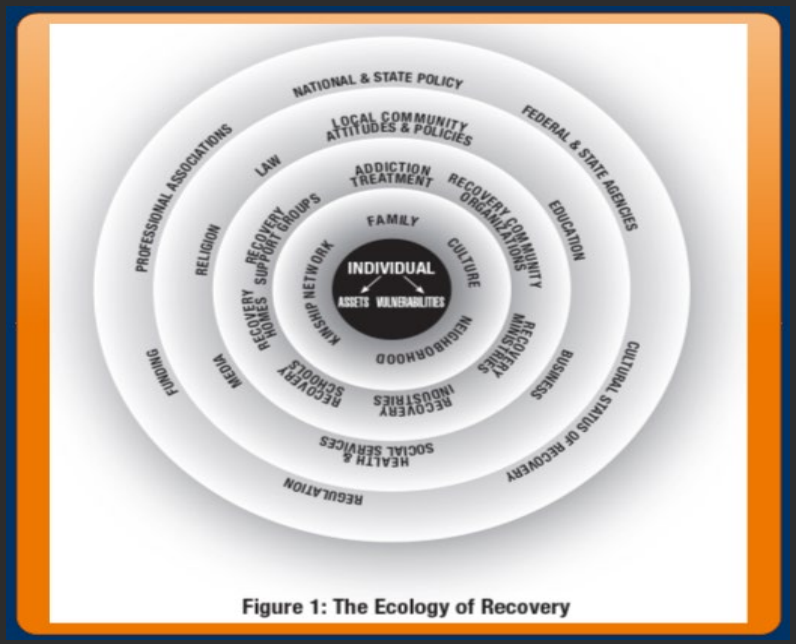


Figure 1: The Ecology of Recovery

"At the center of the ecological onion rests the individual and the internal vulnerabilities and assets that the individual brings to AOD (alcohol/drug) problem-resolution efforts"

White, W.L. (2008). Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices.

2. Words Matter!

Use non-stigmatizing, non-labeling language

- **Stigma: Disgrace associated with a particular circumstance, quality, or person** (www.dictionary.com)
  - Prompted by beliefs that the individual caused their situation intentionally
  - Terms like "substance abuser" and "addict" imply that the person willfully makes bad choices and has poor moral character
- **Cognitive Bias: Systematic error in thinking affecting decisions and judgments** (www.verywellmind.com)
  - Providers with negative attitudes and stereotypical beliefs towards people with substance use problems demonstrate significant blame and judgment; and use more punitive, pejorative language
- **Self-Stigmatization: Internalization of negative stereotypes (self-stigma)**
  - **Self-stigma** affects the patient's feelings of self-worth, self-value, and self-esteem
- **Words Matter!**
  - **Stigmatizing words**: Bring shame, dishonor, disgrace, and discrimination
  - **Positive words**: Directly impact a person's treatment success and recovery outcomes

(Burda, 2019)

3. Create Welcoming Environments and a Culture of Quality Improvement:

(Network for the Improvement of Addiction Treatment, NIATx) https://niatx.net

4 AIMS:

- Reduce waiting time between first request for service and first treatment session;
- Reduce no-shows by reducing the number of patients who do not keep an appointment;
- Increase admissions to treatment;
- Increase continuation from the first through the fourth treatment session.

3. Create Welcoming Environments and a Culture of Quality Improvement:

(Network for the Improvement of Addiction Treatment, NIATx) https://niatx.net

- **Purpose**: To increase family engagement intreatment for pregnant and parenting women in recovery (Results of 15 sites)
- **Relationship-based programs**: Beneficial for women in treatment
- **Family engagement:**
  - Is a fundamental element of treatment (Etheridge & Hubbard, 2000)
  - Predicts improved retention in treatment (Liddell, 2004)
  - Can lead to better outcomes (Copello et al., 2005).
- **Treatment agencies need to:**
  - Find effective ways to meaningfully engage family members or significant others (non-residential children and fathers/father figures);
  - Support family engagement (Copello, et al., 2009) and care for the affected family members.

Women, Children, and Family Treatment (WCFT) NIATx Collaborative Final Report (Madden & Zastowny, et al., 2011)

4. Trauma-Informed Care: Avoid Re-traumatization

Majority of women with addiction report having experienced:

- Sexual abuse (74%)
- Physical abuse (52%)
- Emotional abuse (72%)
- More instances of incest and rape
- More domestic violence
- Abuse by more perpetrators, more frequently, & for longer periods of time

(Covington & Cohen, 1984; Miller, Downs & Gondoli, 1989)

Compared to women that have EITHER a post-traumatic stress disorder (PTSD) OR a substance use disorder (SUD), women with BOTH suffer:

- More co-morbid mental disorders
- More medical problems
- More psychological symptoms
- More in-patient admissions
- More interpersonal problems
- Lower levels of functioning
- Poor compliance with aftercare and motivation for treatment
- More significant life problems (Homelessness, HIV, domestic violence)
- More loss of custody of children

(Covington, 2007; Najavits, Weiss & Shaw, 1997)

4. Trauma-Informed Care: Avoid Re-traumatization

- Outcomes for women with co-occurring substance and mental disorders and histories of abuse or trauma are improved when the provider has adopted a trauma-informed treatment philosophy
- Women may use substances to numb the pain of non-mutual, non-empathetic and violent relationships and to medicate anxiety or depression
- Trauma-informed environments are those that pay attention to boundaries (intrusion into personal spaces, the right to say no to hugs), use language that communicates empowerment, and avoid shaming and punitive approaches
- Female trauma survivors may need to receive treatment in women-only recovery groups.

(Herman, 1997; Covington, 2007)

5. Resistance and motivational enhancement:

DO NOT PUSH people into changing when they are not ready

- Most people are not completely ready for change!
- If people are not ready to change, we need to:
    - Help PREPARE them for CHANGE; and
    - Help move them to the NEXT LEVEL OF READINESS.

5. Resistance and motivational enhancement:

DO NOT PUSH people into changing when they are not ready

SIGNS OF PATIENT RESISTANCE include:

- Interrupting
- Denial
- Ignoring
- Arguing

- These are:
  - Signs that the patient is not feeling HEARD, RESPECTED, or TAKEN SERIOUSLY;
  - Clues to check our own behaviors, plans and expectations.

- Are we rushing ahead to action planning without first checking the patient's level of readiness?

- If so, we may be in a "CONFRONTATION-DENIAL TRAP", inducing the patient to argue, interrupt, deny the problem, or ignore us even more.

Problem Recognition, Readiness for Treatment and Motivation

People who show INSIGHT about:

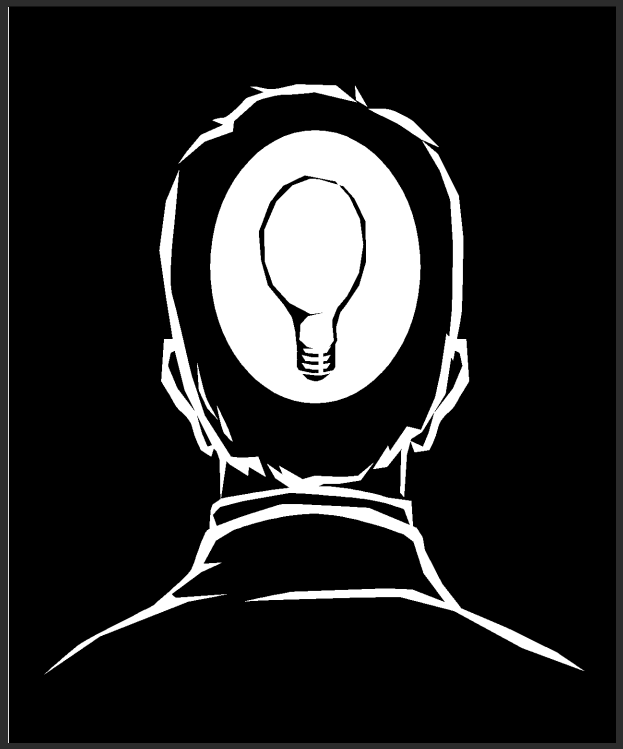
- The RELATIONSHIP between NEGATIVE CONSEQUENCES and
- Their USE of ALCOHOL AND OTHER DRUGS (AOD)

Will probably:

- BE RECEPTIVE to treatment, and
- DO WELL in treatment.

ADAPTED FROM: Ingersoll, K. and Wagner, C. "Motivational Enhancement Groups for the Virginia SATOE Model," Va. DMHMRSAS, 1977.

Problem Recognition, Readiness for Treatment and Motivation



People who:

- Are unable to RECOGNISE their problems,
- FAIL TO DISCLOSE that they have AOD problems, or
- Exhibit DENIAL and MISTRUST---

Will probably be:

- HARDER TO ENGAGE in treatment; and
- MORE LIKELY to "DROP OUT"

ADAPTED FROM: Ingersoll, K. and Wagner, C. "Motivational Enhancement Groups for the Virginia SATOE Model," Va. DMHMRSAS, 1977. © 2002, Va. DMHMRSAS

Problem Recognition, Readiness for Treatment, and Motivation

These persons need to be ASSESSED for TREATMENT READINESS and LEVEL of MOTIVATION

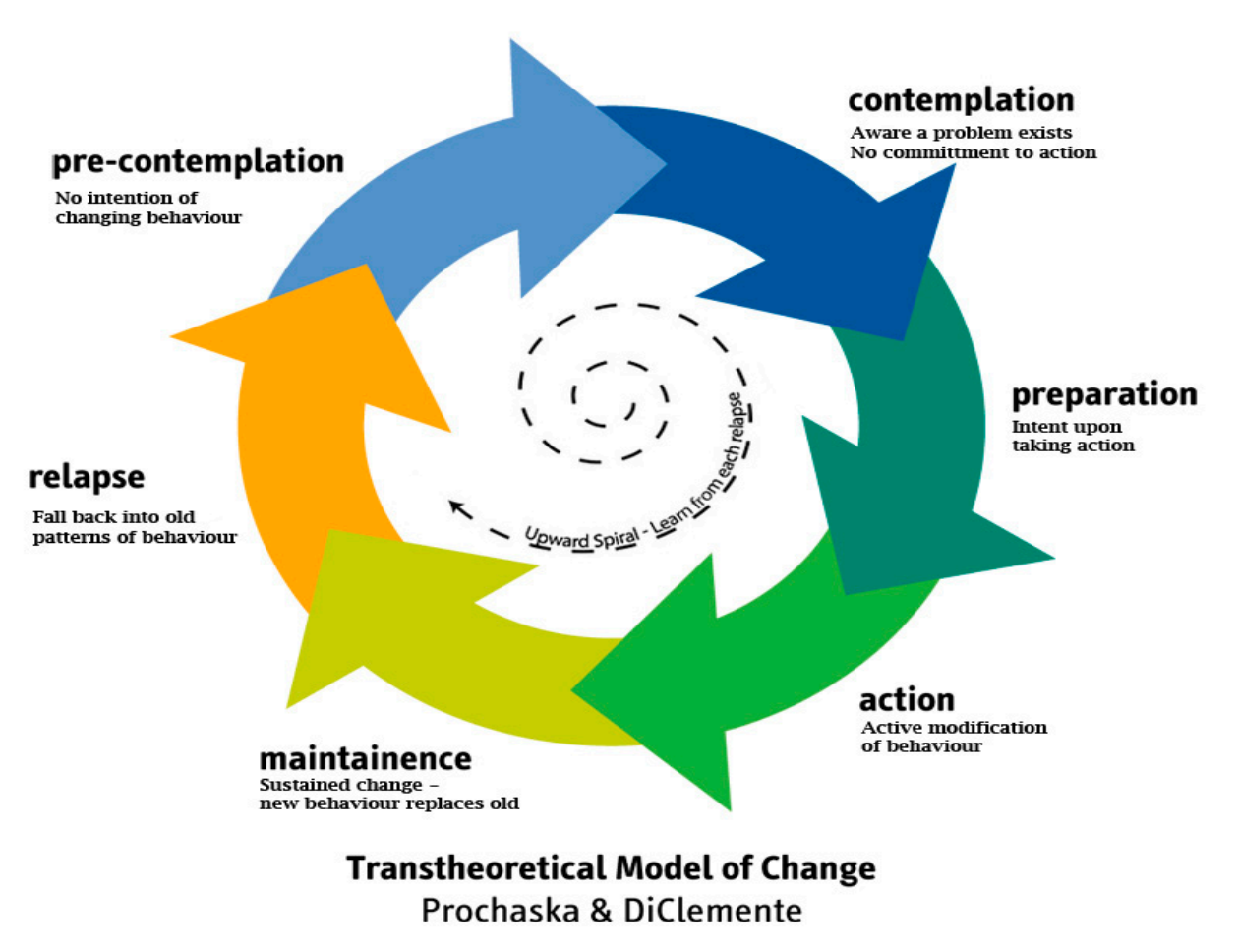
"MOTIVATIONAL ENHANCEMENT" will help improve the likelihood of success.

ADAPTED FROM: Ingersoll, K. and Wagner, C. "Motivational Enhancement Groups for the Virginia SATOE Model," Va. DMHMRSAS, 1977. © 2002, Va. DMHMRSAS

A Better Way of Communicating---

Focus is not on ABSTINENCE

Focus on helping patients move to the NEXT LEVEL OF READINESS



5 Principles of Motivational Enhancement

1. **Communicate RESPECT for Patients—LISTEN rather than TELL.**

2. **Help Patients Perceive a DISCREPANCY**—between where they ARE, and where they WANT TO BE

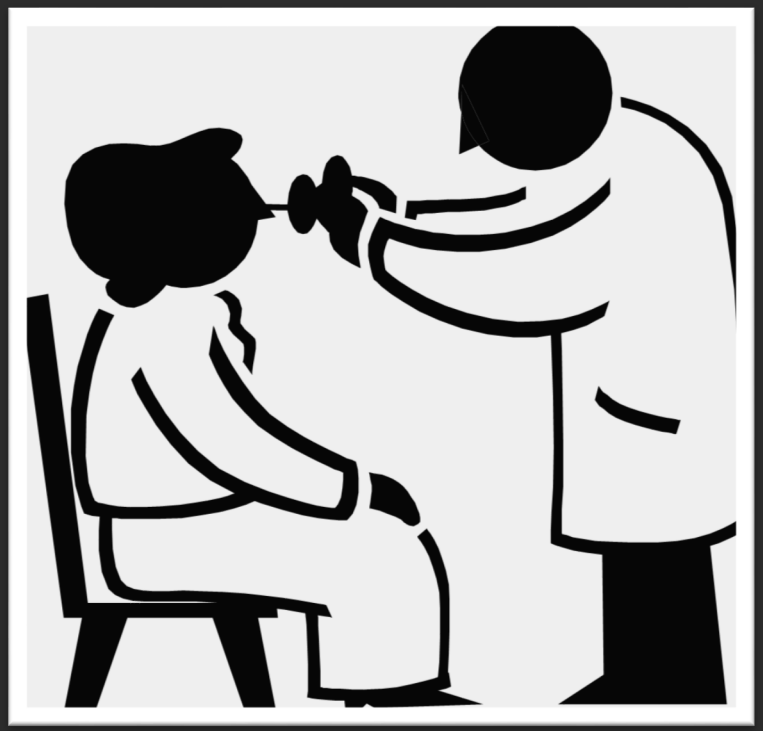
3. **Avoid ARGUMENTATION—in order to avoid RESISTANCE.**
   - Resistance is a **PATIENT'S REACTION** to what they perceive as a **THREATENING** interpersonal interaction.
   - Resistance is evoked by **DISRESPECT** or **THREATS to** SELF-ESTEEM.
   - Resistance is minimized by **enhancing SELF-ESTEEM** and **RESPECTING** the patient.

4. **Discuss AMBIVALENCE openly**—Seek the patient's opinions about POSSIBLE SOLUTIONS.

5. **Enhance SELF-EFFICACY**—the ABILITY to achieve goals.
   - People only move towards change when they perceive a CHANCE OF SUCCESS.
   - Help the patient BELIEVE she CAN change.

ADAPTED FROM: Ingersoll, K. and Wagner, C. "Motivational Enhancement Groups for the Virginia SATOE Model," Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services, 1997.

Incorporating Recovery Messages into the Context of General Health



The more we incorporate advice about substance use with general health concerns and consequences of continued use, the better our chances of success.

6. Strengths-based & relationship-building approaches:

COMMON FACTORS — Meta-analysis of 40 Years of Outcomes Research

Patient Factors---40%

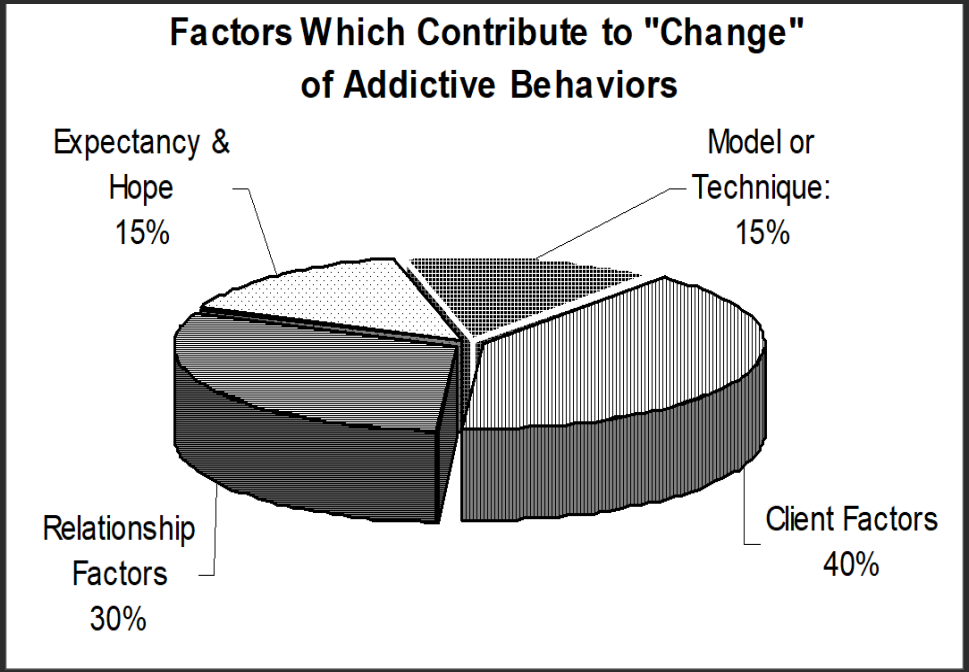
- Strengths: Talents, past problem-solving abilities, social supports, beliefs, resources, etc.

Relationship Factors---30%

- ALLIANCE between patients and staff;
- Patient perceptions of EMPATHY, ACCEPTANCE & HOPE

Expectancy & Hope---15%

- Extent to which the patient BELIEVES or EXPECTS the intervention will be beneficial
- Whether the counselor can convey the "POSSIBILITY OF CHANGE"
- HOPE, OPTIMISM and ENCOURAGEMENT improve outcomes



Model/Technique---15%

- Least Influential Contributors To Change:
  - What we do as helpers
  - Our strategies and techniques
- Instead of finding more "effective" models of treatment, we should elicit, amplify and reinforce the PATIENT and FAMILY FACTORS.

Mid-Atlantic Addiction Technology Center.
Addiction Exchange, Vol. 3, No. 8: Common Factors Research, May 15, 2001

University of Maryland School of Nursing

6. Strengths-based & relationship-building approaches:

COMMON FACTORS — Meta-analysis of 40 Years of Outcomes Research

- All treatment models can be equally effective
- Outcomes do not improve when we require patients to "fit" or "conform" to our favorite model or technique

- The biggest engine of change is the patient and family not "us" or our intervention models
- Outcomes improve when we instill hope and accommodate our patients

Mid-Atlantic Addiction Technology Center.
Addiction Exchange, Vol. 3, No. 8: Common Factors Research, May 15, 2001

For questions/comments, please contact:

Katherine Fornili, DNP, MPH, RN, CARN, FIAAN

Assistant Professor

University of Maryland School of Nursing

Department of Family & Community Health

655 W. Lombard Street, #545-D

Baltimore, MD 21234

Office: 410.706.5553

Cell (Preferred): 443.902.3622

Email: fornili@umaryland.edu

UNIVERSITY of MARYLAND SCHOOL OF NURSING