Self-Management: Supporting People with Mental Health & Physical Health Conditions

For the Mental Illness Fellowship Victoria
Melbourne, Victoria
May 2011
Assoc Prof Sharon Lawn  sharon.lawn@flinders.edu.au
08 84042321 / 0459 098 772
Workshop Outline

1) What is Self-Management?
2) What does Self-Management Support look like?
3) Behaviour Change
4) Physical Health & Mental Health – Issues for Self-Management & Providing Support
5) Break
6) Motivational Tools
   • Problems & Goals
   • Motivational Interviewing
   • Health Coaching
7) An Example Approach to Self-Management Support
Why don’t people do what they know is good for their health?

Why don’t people just do what workers tell them to do?
What are the characteristics of people who self-manage well?

What barriers might they experience?

**Self-care** – is a part of daily living. It is the care taken by individuals towards their own health and well being … whether in their homes, neighbourhoods, local communities, or elsewhere. Self-care includes the actions individuals take for themselves, to maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital (adapted from NHS, 2005, p.4).

**Self-management** - is what the person with a health condition does by taking action to cope with the impacts of their condition. It is a component of self-care that is informed by evidence-based health information.

**Self-management support** - is what others such as services, health & welfare professionals, family, friends and carers do to support the person to self-manage. They may do this by providing physical, social or emotional support to the person.
Kate Lorig (1993) states that self-management is about enabling the person to:

“Make informed choices, to adapt new perspectives and generic skills that can be applied to new problems as they arise, to practice new health behaviours, and to maintain or regain emotional stability”.

Definition of a Good Self-Manager
Principles of Self-Management

1. Know your condition

2. Be actively Involved with the workers to make decisions & navigate the system

3. Follow the Care Plan that is agreed upon with services (e.g. GP and other supports, including carers)

4. Monitor ‘symptoms’ associated with the condition(s) and Respond to, manage and cope with the symptoms
5. Manage the physical, emotional and social **Impact** of the condition(s) on your life

6. Live a healthy **Lifestyle**

7. Readily access **Support Services**

( KICMRILS )
Principles of Self-Management

Knowledge
Involvement
Care Plan
Monitor & Respond
Impact
Lifestyle
Support Services
Self-Management Partnership & Responsibility

Recognises that:

• Each person in the partnership brings with them expert knowledge & skills

• Each person in the partnership brings their own personal agenda, values & assumptions

• Partnership is a two-way process

• All parties in the partnership have responsibility
Characteristics of Successful Self-Management Support

1. Assessment of Self-Management
   (learn what the person knows, their actions, strengths and barriers)

2. Collaborative Problem Definition
   (between person and health professionals)

3. Targeting, Goal Setting & Planning
   (target the issues of greatest importance to the person, set realistic goals and develop a personalized care plan)

(Von Korff et al, 1997; Lawn & Battersby 2009)
Characteristics of Successful Self-Management Support

4. Self-Management Training and Support Services

(include instruction on condition management, behavioural support, & address physical & emotional demands of having a long-term condition)

5. Active and Sustained Follow-up

(reliable follow-up leads to better outcomes)

(Von Korff et al, 1997; Lawn & Battersby 2009)
How does your current management of chronic conditions support consumers to self-manage?

What would you like to change?
**Stages of Change**

**EXIT**: Long-term abstinence or moderation

**ENTER**: Particular behaviour problem (e.g. drinking, smoking, over-eating)

- **Pre-contemplation**
- **Contemplation**
- **Action**
- **Maintenance**

**Lapse**

(Prochaska & DiClemente, 1986)
Change – What are we asking people to do?

- Give up something, rewarding helpful and meaningful to them
- Resolve their ambivalence
- To move forward
- Find something else that is rewarding helpful & meaningful to them that will improve their health
The Importance of Thoughts, Feelings, Actions

- Self-esteem
- Self-efficacy / confidence
- Social Connection / Inclusion
- Health Beliefs
- Stigma & Hope

These things determine how people:

- Feel
- Behave
- Motivate themselves
- Think about their situation
Triggers for change

- An accepting empowering environment where the person feels safe
- Non judgemental assistance
- The client is respected & listened to
- Culture is respected
- A collaborative, curious approach
- When the change is intrinsic (of fundamental value to the person)

(Self-determination theory/autonomous motivation not external pressure - DECI & Ryan, 1985)
Core Skills for the Workforce:

Three sub-groups of capabilities:

– Person-Centred skills
– Behaviour Change support skills
– Organisational/System skills

(Lawn & Battersby, 2009)
General Person-Centred Skills

1. Health promotion approaches
2. Assessment of health risk factors
3. Communication skills
4. Assessment of self-management capacity (understanding strengths & barriers)
5. Collaborative care planning
6. Use of peer support
7. Cultural awareness
8. Psychosocial assessment & support skills
Behaviour Change Skills

9. Have knowledge of models of health behaviour change
10. Motivational Interviewing
11. Collaborative problem definition
12. Goal setting & goal achievement
13. Structured problem solving & action planning
Organisational/Systems Skills

14. Working in multidisciplinary teams / Inter-professional learning & practice
15. Information, assessment & communication management systems
16. Organisational change techniques
17. Evidence based knowledge
18. Conducting practice based research/ quality improvement framework
19. Awareness of community resources
Why Provide Person-Centred Care?

So that people can:

• Understand the factors influencing their health & wellbeing
• Respond effectively to minor self-limiting conditions & needs independently of support providers
• Select most appropriate forms of support in partnership with workers
• Monitor signs & effects for themselves
• Be aware of safety and other issues & report them
• Adopt health behaviours to prevent occurrence or recurrence of problems with health & wellbeing
• Be empowered to critique & feed back on quality & appropriateness of services and supports

(adapted from Coulter & Ellins, 2006)
“I started smoking to help me stop overeating. Then I started drinking to help me stop smoking. Then I started overeating to help me stop drinking.”
• How is MI Fellowship engaging consumers right now to address their physical health & wellbeing?

• What has worked & what hasn’t worked?

• How do you currently support self-efficacy?

• How do you show consumers, that you’re in it together…that we’re walking alongside them? Ie. How do you provide self-management support?
Barriers to Physical Health & Wellbeing

• More sedentary

• Less likely to eat fruit & vegetables

• Particularly likely to smoke…

• Less likely to engage with services early if at all

• Often experience compounded stresses

• Effects of long term use of medications!
More Real Barriers

• Cognitive & psychosocial problems - reduced accurate self-assessment of physical symptoms & relay to others

• Low uptake of advice due to co-morbid depression, social isolation, low self-efficacy, social determinants which render it irrelevant to needs

• Homelessness & itinerancy

• Avoidance or neglect of contact with GPs or health care services

• Stigma & discrimination, resulting in fear or reluctance to discuss physical symptoms, mistrust of health workers & advice they provide

• Unreported / masked physical symptoms, reduced pain sensitivity

• Negative symptoms or sedating effects of antipsychotic meds resulting in low levels of motivation & engagement
System Barriers

• Poor uptake of Best Practice Guidelines

• Lack of agreement over who is responsible for monitoring or screening

• Lack of continuity of care & follow up

• Capacity to provide physical health services or support (e.g., general health check-ups) often inadequate in mental health service systems

• Physical complaints may be regarded as symptoms of SMI

• Opportunistic physical health advice is not offered in MH settings

• Attention is often focused exclusively on mental health issues and ignores physical health
Each day is a different country!
...with constantly shifting landscapes
This Thing Called Health Literacy

- **Assumption 1**: That it will improve engagement by the person in their own healthcare.

- **Assumption 2**: That the person has the problem engaging with services & that greater health literacy on their part will improve this.

- ...So long as systems of care and the broader social circumstances in which people live their lives are also addressed so that we don’t create barriers for them.

- People have complex life histories that impact on health behaviour in spite of knowing what is ‘good for them’.

- Knowledge alone makes no difference to health outcomes. Supporting behaviour change by walking alongside people does.
“Emphasis was placed on rapport building with consumers over extended time periods to engender partnership with the consumer and to attain a better understanding of barriers and goals to include in individual plans. The outcome for some consumers was that they became confused about the relationship with staff ("paid friends") and at times staff and consumers were unsure what was being achieved in the support relationship…Although rapport building in the support relationship can be therapeutic it can also allow support to be reactive and crisis driven.”
The Flinders Program

Assess Self-Management + Problems and Goals

- Self-Management
- Medical Management
- Community / Carer Support
- Psychosocial Support

Care Plan
Agreed Issues
Agreed Interventions
Shared Responsibilities
Review & Measuring Process
EBM
...Principles of Self-Management

K  Knowledge
I  Involvement
C  Care Plan
M  Monitor & Respond
R  Impact
I  Lifestyle
S  Support Services
Person with Chronic Health Condition to Complete

Please circle the number that most closely fits for you

1. Overall, what I know about my health condition(s) is:

   0 1 2 3 4 5 6 7 8
   Very little      Something      A lot

2. Overall, what I know about the treatment, including medications of my health condition(s) is:

   0 1 2 3 4 5 6 7 8
   Very little      Something      A lot

3. I take medications or carry out the treatments asked by my doctor/health worker:

   0 1 2 3 4 5 6 7 8
   Never           Sometimes      Always
8. I take action when my early warning signs and symptoms get worse:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Sometimes</td>
<td>Always</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. I manage the effect of my health condition(s) on *my physical activity* (i.e. walking, household tasks):

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not very well</td>
<td>Fairly well</td>
<td>Very well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. I manage the effect of my health condition(s) on *how I feel* (i.e. my emotions and spiritual wellbeing):

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not very well</td>
<td>Fairly well</td>
<td>Very well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. I manage the effect of my health condition(s) on *my social life* (i.e. how I mix with other people):
<table>
<thead>
<tr>
<th>CUE QUESTIONS</th>
<th>Notes</th>
<th>HP's Score</th>
<th>Pt's Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>KNOWLEDGE OF CONDITION(S):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What do you know about your condition(s)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.g. causes, effects, symptoms?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What could happen to you with this condition?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What does your family/carer understand about your condition?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>KNOWLEDGE OF TREATMENT:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What can you tell me about your treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What have been the side effects of your treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What may happen if the treatment is stopped?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What other treatment options including alternative therapies do you know about?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What does your family/carer understand about your treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>MEDICATIONS AND TREATMENT MANAGEMENT:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What stops you from taking your medication as prescribed by your doctor/health worker? (e.g. consider lack of understanding, frequency, side effects, costs, other barriers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What other vitamins, supplements or social drugs do you take?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What stops you from carrying out your other treatments? (Consider knowing what to do and why: time, energy, physical, other barriers)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# PROBLEM AND GOALS ASSESSMENT

**Name:**

### OPEN-ENDED QUESTIONS

<table>
<thead>
<tr>
<th>THE PROBLEM</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you see as your main problem?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THE IMPACT</th>
<th>ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does this problem change the way you live?</td>
<td></td>
</tr>
<tr>
<td>Are there things that you do more or less of? (eat, exercise, go out, smoke, sit)</td>
<td></td>
</tr>
<tr>
<td>Are there things you don’t do at all?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THE FEELINGS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How does this problem make you feel? (angry, sad, lonely, worried, cross)</td>
<td></td>
</tr>
</tbody>
</table>

### CLIENT / PATIENT PROBLEM STATEMENT

(should include Problem, Impact and Feeling from above)

### MEDIUM-LONGTERM GOAL

<table>
<thead>
<tr>
<th>Specific Behaviour/Action:</th>
<th>My progress towards achieving this goal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What would you like to be able to do on a regular basis that the problem stops you from doing say in 6-9 months time?</td>
<td></td>
</tr>
<tr>
<td>Can someone observe it?</td>
<td></td>
</tr>
</tbody>
</table>

### Timeliness

<table>
<thead>
<tr>
<th>Where/when:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How long and how often:</td>
<td></td>
</tr>
</tbody>
</table>

### Conditions:

(i.e who with - alone, with friends)

<table>
<thead>
<tr>
<th>CLIENT / PATIENT GOAL STATEMENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Should be SMART - Specific, Measurable, Action-based, Realistic, Timely)</td>
<td></td>
</tr>
</tbody>
</table>

Name of Health Worker: ________________________________
<table>
<thead>
<tr>
<th>IDENTIFIED ISSUES [INCLUDING SELF MANAGEMENT]</th>
<th>MANAGEMENT AIMS</th>
<th>INTERVENTION</th>
<th>WHO IS RESPONSIBLE</th>
<th>DATE REVIEWED</th>
<th>PROGRESS (eg no progress, some progress, completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sign Off - Patient**
I ................................................................. (patient name) agree that the information contained within this care plan is true and correct and currently reflects my needs for the forthcoming year. Additionally, I consent to this information relevant to my care will be released to my health providers.

Signature: .................................................
Date: ................./

**Sign Off - Doctor**
I ................................................................. (GP name) agree that the services prescribed within this care plan are true and correct at the time of development but are subject to review based on the patient's needs and / or my professional opinion as the responsible Medical Practitioner.

Provider No: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Date: ................./

**Care Plan Review Date: ................./
Signature: .................................................
MBS ITEM: GP Prepared Community Care Plan 721 ☐ Team Care Arrangements - 723 ☐
Noarlunga Study

Aim:
To develop & trial a generic model of self-management based on assessment of self-management, peer support & collaboration between mental health workers & GPs, for people with both mental & physical illness living in the community.

- Enhanced Primary Care (EPC) GP Management Plan (GPMP) & Team Care Arrangements (TCA)
- 12 months Duration (2001-2002)
- Individualised self-management assessment & care planning using the Flinders program
- Stanford peer-led, self-management groups – 6 week course
- One-to-one peer support to promote goal achievement
- Across system collaboration
Results

- 38 consumer participants
- Multiple mental & physical health problems
- 25 psychotic illness
- Median age 42 (21-102)
- 5 people with First Episode Psychosis
Results: Cont.

- Improved PIH self-management (all scales significant)
- Problem 5.19 – 3.16 (0<0.001)
- Goal 5.35 – 3.55 (p<0.001)
- SF-12 – improved mental summary score (p<0.001)

That is…Overall Quality of Life, motivation & engagement in their own care improved.
Results: Cont

Hospital Admissions:

• 16 admissions (12 months pre project)
• 0 admissions (during project 12 months)
• 4 admissions (12 months post project)

18 had no change (pre & post). Of these, 13 had never been hospitalised
Qualitative findings

• The assessment process challenged mental health workers’ perceptions of clients’ potential to improve

• Structured assessment gave new information from the person’s perspective

• Peer workers’ emotional & physical health improved

• GPs learned more about mental health & became more comfortable in dealing with people with mental illness

• Collaboration across systems of support mattered.
3 parts to a problem statement

- The Problem
- What happens to the client because of the problem?
- How this makes the client feel?
Problem Measurement

Problem Statement
“Because I’m often short of breath I don’t go out much and I feel frustrated and angry”

Rating Scale
How much of a problem is this for me?

0 1 2 3 4 5 6 7 8
Not at Very little Somewhat a fair bit A lot all
Goal Measurement

Goal Statement

“I will catch the community bus to the local community centre, twice a week for the afternoon Craft Group”

Rating Scale

My progress towards achieving this goal is:

0 1 2 3 4 5 6 7 8

No progress 50% Complete success
Goal Statements

> Client goals (not the worker’s goals)
> Should be written positively + be a personal reward
> They are long / medium term & involve a degree of challenge (Locke, 1996)
> Can be clearly & simply evaluated using the 0 - 8 scale
> Can be maintenance goals for people effectively self-managing
Making Goals Motivational

Avoid

• “One off” goals and
• “I wanna’ be happier, skinnier, prettier, richer”
• Are not clinical interventions (e.g. referral or blood tests)

Goals expressed negatively (avoidance goals) lead to:

• Less satisfaction with progress & more negative feelings about progress
• Decreased self-esteem & sense of personal control
• Feeling less competent in relation to goal pursuits

I.e. Plans that contain ‘reduce, control, limit...’ can be counterproductive
# Problem and Goals Assessment

**Name:**

<table>
<thead>
<tr>
<th>Open-Ended Questions</th>
<th>Date:</th>
<th>ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Problem</strong></td>
<td>What do you see as your main problem?</td>
<td></td>
</tr>
<tr>
<td><strong>The Impact</strong> (What happens because of the problem?)</td>
<td>How does this problem change the way you live? Are there things that you do more or less of? (eat, exercise, go out, smoke, sit) Are there things you don’t do at all?</td>
<td></td>
</tr>
<tr>
<td><strong>The Feelings</strong></td>
<td>How does this problem make you feel? (angry, sad, lonely, worried, cross)</td>
<td></td>
</tr>
<tr>
<td><strong>Client/Patient Problem Statement</strong></td>
<td>(should include Problem, Impact and Feeling from above)</td>
<td>How much of a problem is this for me:</td>
</tr>
<tr>
<td><strong>Medium-Longterm Goal</strong> Specific Behaviour/Action:</td>
<td>What would you like to be able to do on a regular basis that the problem stops you from doing say in 6-9 months time?</td>
<td>0 1 2 3 4 5 6 7 S Not at all Very little somewhat a fair bit a lot</td>
</tr>
<tr>
<td><strong>Timeliness</strong></td>
<td>Can someone observe it?</td>
<td></td>
</tr>
<tr>
<td><strong>Conditions:</strong></td>
<td>Where/when: How long and how often:</td>
<td></td>
</tr>
<tr>
<td><strong>Client/Patient Goal Statement</strong></td>
<td>(i.e. who with - alone, with friends)</td>
<td>My progress towards achieving this goal:</td>
</tr>
<tr>
<td>(Should be SMART - Specific, Measurable, Action-based, Realistic, Timely)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of Health Worker: ________________________________
Motivational Interviewing & Self-M’t Support

1. Express empathy
2. Develop Discrepancy
3. Roll with resistance
4. Avoid argumentation
5. Support self-efficacy
Undertaking a Motivational Interview

1. Examine the good things about the target behaviour
2. Examine the less good things and compare the two
3. Systematically explore how much of a concern the negatives are
4. Ask the client: ‘How does this concern you?’ Look to the future. Is the good / not so good balance going to change?
5. Highlight any discrepancies
6. Ask the client to rate the importance of changing and their confidence in undertaking the change
7. Summarise
# Change your Mind to Change your Actions!

(ANTS – Automatic Negative Thoughts / PETS – Performance Enhancing Thoughts)

<table>
<thead>
<tr>
<th>Decision Point</th>
<th>Self Talk – ANTS</th>
<th>Consequences</th>
<th>Alternative Self Talk – PETS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(When can you intervene to change things?)</td>
<td>(Justifications and excuses you use BEFORE you decide not to do the healthy behaviour)</td>
<td>(What are the physical, behavioural, social and emotional consequences of these thoughts?)</td>
<td>(What could you say to yourself to make it more likely that you will achieve your goals at the decision point?)</td>
</tr>
</tbody>
</table>

Confidence in achieving your goal, given these ANTS /10

Confidence level, given your PETS / 10

Adapted from Health Coaching Australia
## Decisional balance Conversations

<table>
<thead>
<tr>
<th></th>
<th>Not changing</th>
<th>Changing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Good outcomes</strong></td>
<td><img src="image" alt="Arrow" /></td>
<td></td>
</tr>
<tr>
<td><strong>Not so good outcomes</strong></td>
<td><img src="image" alt="Arrow" /></td>
<td><img src="image" alt="Arrow" /></td>
</tr>
</tbody>
</table>
### Readiness/ Confidence to change rulers

- **How important to you is your physical health?**
  - ‘The Readiness Ruler’
  
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not important at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Extremely important</td>
</tr>
</tbody>
</table>

- **How confident are you about changing?**
  - ‘The Confidence Ruler’
  
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not confident at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Extremely confident</td>
</tr>
</tbody>
</table>

- Why did you score yourself so high/ low?
- What would help to move you higher on the scale?
- How high on the scale would you need to be to change?
John (45 yo) : A Case Example

Diagnosis
Paranoid schizophrenia, schizoaffective disorder, polysubstance abuse
Impaired cognition as a consequence of illness & lifestyle history.

Treatment
Fortnightly depot flupenthixol 200 mg, 4 mg biperidin daily (usually takes between 20 and 60 to get high)
Compulsory treatment orders (CTOs) sought annually since early 20s

Environment
Lives alone, public housing with dog
Hand-to-mouth, drug culture, regular police attendance in street, vulnerable

Service Response
Assumed to need MH Services for life, assumed to have no insight & no capacity for self-control, ongoing high risk issues, poor problem-solving & social skills. Standover towards GP for scripts to sell/trade, assumed Hep C+
What we did...

• What do you see as your main problem? "Tiredness and lack of physical strength".
• How does this problem change the way you live? "I sleep a lot and lack energy and use drugs to make me feel more alert. I sit around and smoke and don’t get motivated to do anything".
• How does this problem make you feel? "I feel weak and depressed".
• He rated it as 6 out of 8 on 0–8 Likert scale with 0 representing no problem and 8 representing severe problem.
What we did...

Main SMART goal "Use my weights to build up my muscle strength and feel fitter at least once a week at home on my own".

Sub-goal "To walk my dog three times per week for at least 30 minutes in the evening".

Progress towards achievement of these goals as 2 out of 8 (8 = full achievement & 0 = no progress towards achievement)
Two connected problems and goals

(1) Problem: "Feeling anxious and suicidal due to using too many drugs leads to problems with my memory, going out, keeping my cool around other people, and managing my money which makes me feel even more depressed like there’s no hope for the future".

Goal/Intervention: stop abusing biperidin (side effect medication) by sticking to withdrawal plan worked out with key worker over the next 2 months.

Harm minimisation approach
Gradual Reduction
Motivational face-to-face and phone contact – planned and regular
(2) Problem: "Being a smoker means that I’m poor all the time and other people are more able to book smokes up in my name at the deli and this make me more poor and annoyed that people keep thinking they can use me".

Goal/Intervention: together with key worker, visit the deli next week to talk to the deli owner about the problem and agree on a plan to manage cigarette purchases.
John’s Achievement…

• Went from 20–60 2mg biperidin per day to 2 tablets (the standard dose) over a 2-month period.
• Built a routine of walking his dog in the evenings at least three times per week but did not pursue the goal of using his weights regularly.
• Psychiatrist amazed by the progress, previously perceiving as having little self-control.
• Next goal set was to give up smoking and successfully quit smoking within 1 week of setting this goal.
• Has suggested to several "acquaintances" that they also quit smoking.
• Plans to follow a similar process with his addiction to stimulants.
• Now negotiates targets re CTO, discusses issues with workers
1. **Express empathy**

- Unconditional acceptance of the client’s position
- Skilful reflective listening
- View ambivalence & client’s perspective as normal & understandable
- Avoid labelling the person’s behaviour

(eg. threw out the assumptions & acknowledged the environment in which they live and cope day to day)
2. Develop Discrepancy

• Create & amplify the discrepancy between client’s current behaviour & their goals

• Clarify important goals & explore consequences of client’s present behaviour that conflict with those goals

(eg. Talked about how they feel about being used by others, reinforced belief in all the good things they do for others, their decency as a person, talked about the downside/aftermath of drug use –choosing the moments)
3. **Roll with resistance**

- Don’t push against the client’s views

- Client resistance is a signal to change your talk

  (eg. back to reflective listening to re-engage, build trust and belief that you are on their side & hold hope for change)
4. Avoid argumentation

- Arguments are counter productive
- Defending breeds defensiveness
- Assist the client to argue for their own change

(eg. became their advocate and called others to account, showed them this person, squashed all 3rd person conversations)
5. Support self-efficacy

- Build confidence that change is possible

- Express confirmation that the client can change

- Support belief that the client can achieve a goal

(eg. Just told them, small steps to build confidence and kept reminding them of each achievement along the way, just keep going, doing it together)
How Well does the Organisation do at Supporting Self-Management?

The PACIC & ACIC - Practical quality improvement tools to help organisations identify the strengths & weaknesses of their delivery of care for long-term conditions in the areas of:

- Organisation of Care
- Community Linkages
- Self-Management Support
- Decision Support
- Delivery System Design
- Information Systems


### Recovery Approaches Enhance Self-Management

*(Scottish Recovery Network, 2007)*

<table>
<thead>
<tr>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belief in self &amp; developing positive identity</td>
<td>Having friends and family who are supportive &amp; don’t undermine self-determination</td>
</tr>
<tr>
<td>Know that recovery is possible</td>
<td>Being told recovery is possible</td>
</tr>
<tr>
<td>Having meaningful activities in life</td>
<td>Having contributions recognised &amp; valued</td>
</tr>
<tr>
<td>Developing positive relationships with others and community</td>
<td>Having formal support that is responsive &amp; reflective of changing needs</td>
</tr>
<tr>
<td>Understanding illness, mental health &amp; general wellbeing</td>
<td>Living &amp; working in a community where others can see beyond the illness</td>
</tr>
<tr>
<td>Actively engaging in strategies to stay well &amp; manage setbacks</td>
<td>Having life choices accepted and validated</td>
</tr>
</tbody>
</table>
“You’ve seen his cubist period — this is his giving-up-smoking period.”
Good Luck and Thank You for listening!
References

http://www.health.org.uk/publications/research_reports/patientfocused.html


