Current Psychiatry

Web audio at CurrentPsychiatry.com
Dr. Fluent: Addressing patient resistance to a self-management model of care

How best to engage patients in their psychiatric care

© ANDREY POPOV

Thomas E. Fluent, MD
Clinical Assistant Professor
Medical Director for Ambulatory Psychiatry

Julie Kuebler, MS, APRN, BC
Psychiatric-Mental Health Nurse Practitioner

D. Edward Deneke, MD
Clinical Instructor
Ambulatory Collaborative Lead

Joseph A. Himle, PhD
Associate Professor
Director of Curtis Research Center
Department of Psychiatry and Social Work

....

University of Michigan
Ann Arbor, Michigan

Optimal care is best achieved through a partnership between patient and provider

Providing patients and their families with information and education about their psychiatric illness is a central tenet of mental health care. Discussions about diagnostic impressions, treatment options, and the risks and benefits of interventions are customary. Additionally, patients and families often receive written material or referral to other information sources, including self-help books and a growing number of online resources. Although patient education remains a useful and expected element of good care, there is evidence that, alone, it is insufficient to change health behaviors.[1]

A growing body of literature and clinical experience suggests that self-management strategies complement patient education and improve treatment outcomes for patients with chronic illnesses, including psychiatric conditions.[2,3] The Cochrane Collaboration describes patient education as "teaching or training of patients concerning their own health needs," and self-management as "the individual's ability to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a long-term disorder."[4]

In this article, we review:

- principles of self-management and the role of self-efficacy
- characteristics of long-term care models
- literature supporting the benefits of self-management programs
- clinical initiatives illustrating important elements of self-management support
- opportunities and challenges faced by clinicians, pa-

Disclosure
The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Table 1

Five key self-management skills

Skill	What does it mean?
Problem-solving	Defining and implementing possible solutions to self-care problems
Decision-making	Utilizing accurate clinical information and making sound self-care decisions in the day-to-day self-management of chronic illness
Resource-utilization	Finding and using available resources that support good self-care and contribute to relapse prevention
Partnering patient and provider	Establishing a relationship with health care providers that involves effective and efficient communication with each other
Taking action	Utilizing tailored plans that involve activities a patient feels confident that they can achieve

Source: Reference 7

tients, families, clinics, and healthcare systems implementing self-management programs.

Principles of self-management

Self-management evolved from Albert Bandura's work on social learning theory, and details the activities patients must master to maximize their health and well-being when living with a chronic condition. Self-management support is one of the six core elements of the Chronic Care Model; the others are community, health system, delivery system design, decision support, and clinical information systems.[5] To treat chronic conditions effectively, patients need a deeper understanding of their illness and the tools and confidence to manage their condition over time.

Chronic care models must account for conditions in which the clinical course can be variable, that are not amenable to a cure, and that demand long-term treatment. Optimal health outcomes rely on patients accurately monitoring, reporting, and responding to their symptoms, while engaging in critical health-related behaviors. In addition, clinicians must teach, partner with, and motivate patients to engage in crucial disease-management activities. Although typically not considered in this light, we believe most psychiatric disorders are best approached through a long-term care model, and benefit from self-management principles.

Basics of self-management include:

- patients actively participate in their treatment, and are primarily responsible for monitoring and managing their illness with a strong focus on health, wellness, and personal engagement
- patients must formulate goals and learn skills relevant to their disease
- problems are patient-selected and targeted with individualized, flexible treatment plans.

Corbin and Strauss believe effective "self-managers" achieve competency in three areas:

- **medical or behavioral management,** which might include adherence to prescribed medications, psychotherapy homework, exercise, and dietary recommendations, and abstinence from substance use, if applicable
- **role management,** which entails healthy adjustments to changes in role responsibilities, expectations, and self-identity
- **emotional management,** which often is particularly challenging in psychiatric conditions because of the emotional disruption inherent in living with a psychiatric illness.[6]

Proficiency in these three "self-manager" domains is enhanced by mastering five key self-management skills outlined in ***Table 1***.[7]

Successful intervention programs vary widely with regard to individual vs group formats, communication interface, and involved health professionals. However, evidence indicates that problem solving, decision making, and action planning are key components.[7] Successful planning includes:

- selection by the patient of behav-

Clinical Point

Clinicians must teach, partner with, and motivate patients to engage in crucial disease-management activities

Discuss this article at www.facebook.com/CurrentPsychiatry

Self-management

Box 1

Michigan Depression Outreach and Collaborative Care

This disease-management program enrolls patients with depression from psychiatry and primary care clinics. Care managers support patients through regular monitoring of scheduled on-line outcome measures. They provide phone-based, individual self-management support and education about their psychiatric diagnosis, medications, therapy options, and health behavior change; develop individualized treatment plans for enrolled patients with follow-up monitoring of outcomes and goal-setting activities; and alert care providers and facilitate linkage with care when indicated.

Clinical Point

Motivational interviewing is collaborative and nonjudgmental, and helps patients resolve ambivalence about behavioral change

iors to change with a high probability of success

- detailed descriptions of what, how, when, and where the activity will be accomplished
- assessment of patient confidence and adjustment of plans if confidence is limited
- continuous monitoring and self-tailoring of plans through collaborative discussions with providers, fostering a spirit of partnership and ownership.

For a ***Table*** illustrating elements of successful action plans in our Action Planning Worksheet, see this article at CurrentPsychiatry.com. Adapted from the work of Scharzer,[8] Prochaska,[9] and Clark,[10] we developed this self-management tool for individual and group treatment settings. It serves as a vehicle for collaborative patient-provider discussion and planning. The nuts-and-bolts nature of the discussions inevitably leads to learning new, important, and often unexpected information about our patients' daily lives and the challenges they face as they share their dominant priorities, fears, and insecurities.

Patients provide consistently positive feedback about action planning, and clinicians often find that the process reveals fruitful areas for further psychotherapeutic intervention. Examples include identifying a range of negative automatic thoughts or catastrophic thinking impeding initiation of important activation, and exposure activities for depressed or anxious patients.

Knowing what to do is different than actually doing it. Changing behavior is difficult in the best circumstances, let alone with the strain of a chronic illness. It is critical to recognize that the presence of depressive symptoms significantly reduces the likelihood that patients will employ self-management practices.[11] When combined with anxiety and the impairment of motivation and executive functioning that is common in psychiatric conditions, it is not surprising that patients with a mental health condition struggle to embrace ownership of their illness and engage in critical health behaviors—which may include adhering to medication regimens; maintaining a healthy sleep cycle, nutrition, and exercise routines; vigilant symptom surveillance; and carrying out an agreed-upon action plan.

Interventions

Motivational interviewing has been shown to enhance patient engagement in self-management and to improve patient participation and outcomes across a variety of conditions.[12] Motivational interviewing is collaborative, person-centered, and nonjudgmental, helping patients explore and resolve ambivalence about behavioral change by improving awareness of the consequences of changing or not. It is particularly helpful in one-on-one settings and facilitates patients' ownership of change.

Professionally-guided "light-touch" interventions and technology-assisted self-management interventions also can improve patient engagement in activities through individual encounters, group forums, and technology-mediated exchanges, including telephone, email, text message, telehealth, and web-based interventions.[13] The DE-STRESS (Delivery of Self Training and Education for Stressful Situations) model illustrates these principles. This 8-week program combines elements of face-to-face, email, telephone, and web-based assignments and exchanges, and demonstrates a decline in posttraumatic stress disorder, depression, and anxiety scores.[14] Our Michigan Depression Outreach and Collaborative Care program is another example of a self-management intervention (***Box 1***).

See this article at CurrentPsychiatry.com to download an action planning worksheet

Box 2

Examples of self-management initiatives for patients with psychiatric illness

M-Strides Outcome Measurement System
M-Strides utilizes a computer interface connected to our department's intake database that allows patients to sign in to a patient portal and complete on-line metrics or outcome measures. New patients complete a standard packet of instruments at intake addressing mood, anxiety, sleep, substance use, and functional impairment. More specific instruments are assigned based on the clinical presentation. Results are reviewed with the provider during the initial assessment and patients are sent regularly scheduled reminders to complete assigned outcome measures from home or in the clinic, which are reviewed by phone or at the next appointment. Results for completed measures are instantly available to patients and clinicians and can be graphically displayed over time. Patients enjoy reviewing the measures, asking questions about the implications of the results, and seeing "tangible" evidence of progress. Patients become active participants in their care, and the metrics provide a platform for assisting patients with monitoring their treatment progress, and patient-provider collaboration and/or interdisciplinary team discussions addressing clinical trends. This contributes to active problem solving, decision making, and planning.

Web-based resources, including the "Stress Gym"
All of our patients are directed to our department-created web sites (www.depressiontoolkit.org, www.campusmindworks.org). These web sites provide access to basic education regarding depression and other diagnoses; the importance of sleep hygiene, nutrition, physical exercise, and stress management on illness activity; and a range of evidence-based strategies to manage their illness. "Stress Gym" is an innovative technology-assisted self-management intervention targeting stress reduction that is embedded within the site. It is an online, cognitive-behavioral therapy-based intervention consisting of nine modules that have been shown to reduce stress. Modules most cited as helpful include stress and emotionality, reacting to stress, sleep, and balance.[16]

We emphasize that the information on these web sites is not meant to replace, but to support and augment, material covered in sessions between a patient and clinician. The information provided reinforces the concepts that depression and other diagnoses should be viewed as chronic but manageable illnesses, and that patient involvement in their care leads to the best outcomes.

Meds Plus Clinic
The clinic utilizes group medical visits to provide care to patients with serious and persistent mental illness, who are relatively stable, and unable to transfer back to their primary care physician for ongoing care. The primary focus is on long-term management of recurrent illness, with an emphasis on assisting patients to learn effective self-management strategies and coping skills for managing their disease. The clinic is staffed by a team, which includes nurse practitioners, social workers, and registered nurses, with back up from a psychiatrist. Medication management is offered during the group visit; a patient can be seen individually if necessary. No appointment is needed; the clinic meets one afternoon a week; and patients are invited to come as often as needed during specified clinic hours.

Bipolar Wellness Clinic
This clinic is designed for stable adult patients who have been given a diagnosis of bipolar disorder. Patients are on a stable medication regimen and no longer require frequent medication management or psychotherapy. We focus on helping patients learn self-management strategies needed to live with bipolar disorder and to manage the illness so that relapse is minimized. The clinic offers an alternative to routine medication management visits for stable patients. Instead of a routine 10- to 20-minute visit with a provider, a patient attends a group visit that provides medication management, self-management educational topics, and peer group support. This has been a popular clinic among our patients with bipolar disorder who appreciate the ability to meet other patients and learn from providers and one another strategies for managing their illness.

Metabolic Wellness Group
This group was designed to help patients learn about the metabolic side effects of psychotropics. This group utilizes self-management education and support to assist patients with developing healthy behaviors that will help minimize the risks associated with metabolic changes observed with some psychiatric medications.

These interventions intend, at least partially, to increase patient understanding of their illness and impart self-management skills with a goal of increasing patients' confidence that they can perform the tasks necessary to manage their illness. This self-belief is termed *self-efficacy* and positively correlates with health behaviors and outcomes.[15] Practices demonstrated to enhance self-efficacy include:

- mastery of skills through accomplishing specific action plans
- modeling and social persuasion through having patients observe and en-

continued on page 35

Current Psychiatry
CurrentPsychiatry.com

Clinical Point

Effective care for long-term illness necessitates that the patient become an expert on his (her) illness

continued from page 25

gage others as they struggle to overcome similar obstacles

• re-interpretation of symptoms aimed at fostering the belief that symptoms generally are multi-determined with several potential explanations, and vary with daily routines.

Helping patients understand when common symptoms such as impaired concentration or dizziness should be "watched"—rather than responded to aggressively—is crucial for effective long-term management.

Example initiatives. Representative self-management initiatives targeting a range of mental health conditions are described in *Box 2, page 25*. Some of these programs were developed within our department at the University of Michigan; all utilize important self-management principles. We have implemented a number of measures in our clinics to help ourselves and our patients move progressively towards self-management. These initiatives include systems to measure clinical progress, a range of innovative group models, innovative care management resources, and collaborative care programs with primary care providers.

Challenges

Health care delivery and medical educational models have been slow to embrace this change to long-term care models because doing so involves what might be uncomfortable shifts in roles and responsibilities. Effective care for long-term illness necessitates that the patient become an expert on his (her) illness, and be an active participant and partner in their treatment. Preparing health professionals for this new role as teacher, mentor, and collaborator presents a challenge to health care systems and educational programs across disciplines.

Evidence is strong that collaborative care models can improve mental and physical outcomes for psychiatric patients in a variety of settings.[17] Care providers must learn to collaborate with patients, families, and interdisciplinary teams consisting of other medical specialists and allied health professionals such as medical assistants, nurses, nurse practitioners, physician assistants, social workers, psychologists, and pharmacists. This can be challenging when team members do not know one another, do not share a common medical record, or do not work in the same department or system. This complexity increases the possibility of giving patients mixed messages and places a greater burden on the patient, highlighting the need for them to be the primary "manager" of their own care and emphasizing the need for communication and coordination among team members. The optimal make-up of team responsibilities will vary by patient population, clinic, and health system resources, ideally with early clarification of what patients can expect from each member of the care team.

continued

Related Resources

- Improving Chronic Illness Care. www.improvingchroniccare.org.
- Chronic disease self-management program (Better Choices, Better Health workshop). Stanford School of Medicine. http://patienteducation.stanford.edu/programs/cdsmp.html.

Current Psychiatry
CurrentPsychiatry.com

Clinical Point

Preparing health professionals for this new role as teacher, mentor, and collaborator presents a challenge to health care systems

Bottom Line

Emerging care models demand that health care providers become teachers and motivators to help patients develop and implement patterns of health surveillance and intervention that will optimize their well-being and functionality. As active collaborators in their care, patients form a partnership with their care teams, allowing for regular, reciprocal exchange of information and shared decision-making. This shift to a partnership creates new, exciting roles and responsibilities for all parties.

Self-management

When trying to facilitate effective patient-provider partnerships, it is important to recognize the variability in patient preference for what and how information is shared, how decisions are made, and the role patients are asked to play in their care. Patients differ in their desire for an active or collaborative shared-decision model; some prefer more directive provider communication and a passive role.[18] Preferences are influenced by variables such as age, sex, race, anxiety level, and education.[19] Open discussion of these matters between caregivers and patients is important; studies have shown that failure to address these issues of "fit" can impede communication, healthy behavior, and positive outcomes.

Clinical Point

Patients differ in their desire for an active or collaborative shared-decision model

References

1. Bodenheimer T, Lorig K, Holman H, et al. Patient self-management of chronic disease in primary care. JAMA. 2002;288(19):2469-2475.
2. Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, part 2. JAMA. 2002;288(15):1909-1914.
3. Druss BG, Zhao L, von Esenwein SA, et al. The Health and Recovery Peer (HARP) Program: a peer-led intervention to improve medical self-management for persons with serious mental illness. Schizophr Res. 2010;118(1-3):264-270.
4. Tomkins S, Collins A. Promoting optimal self-care: consultation techniques that improve quality of life for patients and clinicians. London, United Kingdom: National Health Service; 2005.
5. Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. Milbank Q. 1996;74(4):511-544.
6. Corbin JM, Strauss AL. Unending work and care : managing chronic illness at home. 1st ed. San Francisco, CA: Jossey-Bass Publishers; 1988.
7. Lorig KR, Holman H. Self-management education: history, definition, outcomes, and mechanisms. Ann Behav Med. 2003;26(1):1-7.
8. Schwarzer R. Social-cognitive factors in changing health-related behaviors. Current Directions in Psychological Science. 2001;10(2):47-51.
9. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: Applications to addictive behaviors. Am Psycholt. 1992;47(9):1102-1114.
10. Clark NM, Gong M, Kaciroti N. A model of self-regulation for control of chronic disease. Health Educ Behav. 2001;28(6):769-782.
11. Hibbard JH, Mahoney ER, Stock R, et al. Do increases in patient activation result in improved self-management behaviors? Health Serv Res. 2007;42(4):1443-1463.
12. Lundahl B, Burke BL. The effectiveness and applicability of motivational interviewing: a practice-friendly review of four meta-analyses. J Clin Psychol. 2009;65(11):1232-1245.
13. Tumur I, Kaltenthaler E, Ferriter M, et al. Computerised cognitive behaviour therapy for obsessive-compulsive disorder: a systematic review. Psychother Psychosom. 2007;76(4):196-202.
14. Litz BT, Engel CC, Bryant RA, et al. A randomized, controlled proof-of-concept trial of an Internet-based, therapist-assisted self-management treatment for posttraumatic stress disorder. Am J Psychiatry. 2007;164(11):1676-1683.
15. Holman H, Lorig K. Patient self-management: a key to effectiveness and efficiency in care of chronic disease. Public Health Rep. 2004;119(3):239-243.
16. Williams A, Hagerty BM, Brasington SJ, et al. Stress Gym: feasibility of deploying a web-enhanced behavioral self-management program for stress in a military setting. Mil Med. 2010;175(7):487-493.
17. Woltmann E, Grogan-Kaylor A, Perron B, et al. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. Am J Psychiatry. 2012;169(8):790-804.
18. Davison BJ, Breckon E. Factors influencing treatment decision making and information preferences of prostate cancer patients on active surveillance. Patient Educ Couns. 2012;87(3):369-374.
19. Chewning B, Bylund CL, Shah B, et al. Patient preferences for shared decisions: a systematic review. Patient Educ Couns. 2012;86(1):9-18.

Was this article useful to you?

For insights on a related topic from Current Psychiatry, read:

Postpartum depression: Help patients find the right treatment

Authors Marlene P. Freeman, MD, Hadine Joffe, MD, MSc, and Lee S. Cohen, MD, advise that:

"Patient preferences strongly influence postpartum depression treatment decisions… [and women]… may find it challenging to engage in treatment. On-site childcare, home visits, internet communication, and other accommodations that may facilitate treatment should be considered…"

Find it in the November 2012 issue and the Archive at CurrentPsychiatry.com.

Table 2

Action planning worksheet

Target area for change: *Example: Need to exercise more often*

Current behavior:

What am I doing now? *Am I happy with this?* *What problems is this causing?*

Desired new behavior:

How would this be beneficial? *How would this make a difference in my life?*

Set a short realistic goal: (Choose an **attainable** goal.) *Example: Walk 10 minutes 3 times a week*

How do you plan to meet your goal? *Example: Find a partner to walk with, wake up 15 minutes early every day*

1.

2.

Ask yourself:

How confident am I that I will meet this goal?

What outcome would I like to see?

What might be barriers to meeting this goal?

How will I confront these barriers to ensure that I am successful?

I will implement this plan on ______________________. *(Set a date and time)*

I will re-evaluate my progress on _______________________. *(Set a date and time)*

Assess whether or not I am following my plan.

Assess whether or not I am meeting my goal.

Assess the need for changes in my plan. (Do I need to readjust my goal? Are there changes needed in my plan? Are there other resources I need to obtain to meet my goal?)

Current Psychiatry

CurrentPsychiatry.com