BEHAVIORAL ACTIVATION FOR CHAMP TREATMENT MANUAL

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Behavioral Activation (BA) for CHAMP Treatment Manual

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Behavioral Activation (BA) for CHAMP Treatment Manual

Preamble, or really, an invitation to make CHAMP BA your own: The contents of this manual are meant to provide care managers and their teams with a comprehensive overview of the CHAMP Behavioral Activation (BA) treatment approach for addressing co-occurring mental health (MH) and opioid use disorder (OUD) concerns with their CHAMP patients. We offer the manual in the spirit of an invitation; an invitation to first become familiar with BA philosophy and strategies, to then identify the aspects of the treatment you think will be helpful to your patients in your clinical context, and finally to try them out with your patients and make them your own and theirs. We do not at all expect that any care manager will use the manual as a locked-in, step-by-step guide where every single suggestion is used with every patient or even with any single patient.

Additionally, you will almost certainly have patients who opt not to engage in formal BA, and this is fine. You can still use the principles and ideas in this manual to help your patients get where they want to go since BA is organic enough to not need to be talked about as "therapy" or even as a way to achieve one's "goals." The idea is to meet each patient where they are and to help them get to where they want to be in their lives using a solid behavioral framework that can either be completely in the background or, if it is useful, explicitly shared.

BA is inherently flexible and there is plenty of room for you as a care manager, along with your patients and the rest of the collaborative care team, to get creative in applying the principles to help your patients reengage (or engage) with life activities they care about and deem important to their well-being. An overview of the basic BA concepts and goals is offered immediately below, but the foundational idea underlying BA may be summed up as follows: **BA is about helping people move towards living lives they feel good about through engagement with activities that give them a sense of mastery and enjoyment**. As long as you keep the focus of treatment trained on this basic goal, you cannot go wrong.

We hope that the BA material provided in this manual will give you ideas and options to use in the service of this life enhancing, and even lifesaving, goal.

BEFORE YOU GET STARTED

Finding Free and Low-Cost Activities for Your Area

Because BA relies heavily on helping patients get active and engaged in things they find enjoyable and that fit with their values, having a list of free and low cost activities tailored to your geographic area is really helpful. Eventually most patients will become adept at coming up with their own ideas, but at the beginning of treatment, they will often need help coming up with things to do and to try.

Before you see your first CHAMP BA with patients, please start adding local activities to the **BA Activity template in Appendix A**. The template has some entries that are generic for all areas but we also list some that are relevant for the Seattle area to give you ideas (you'll remove these from your list ☺).

This is intended to be a "living document" that you can add to over time as you, your colleagues, and your patients discover new, cool things to add.

A. BA Basics

1. CHAMP BA Heuristic Model (**Appendix B**)

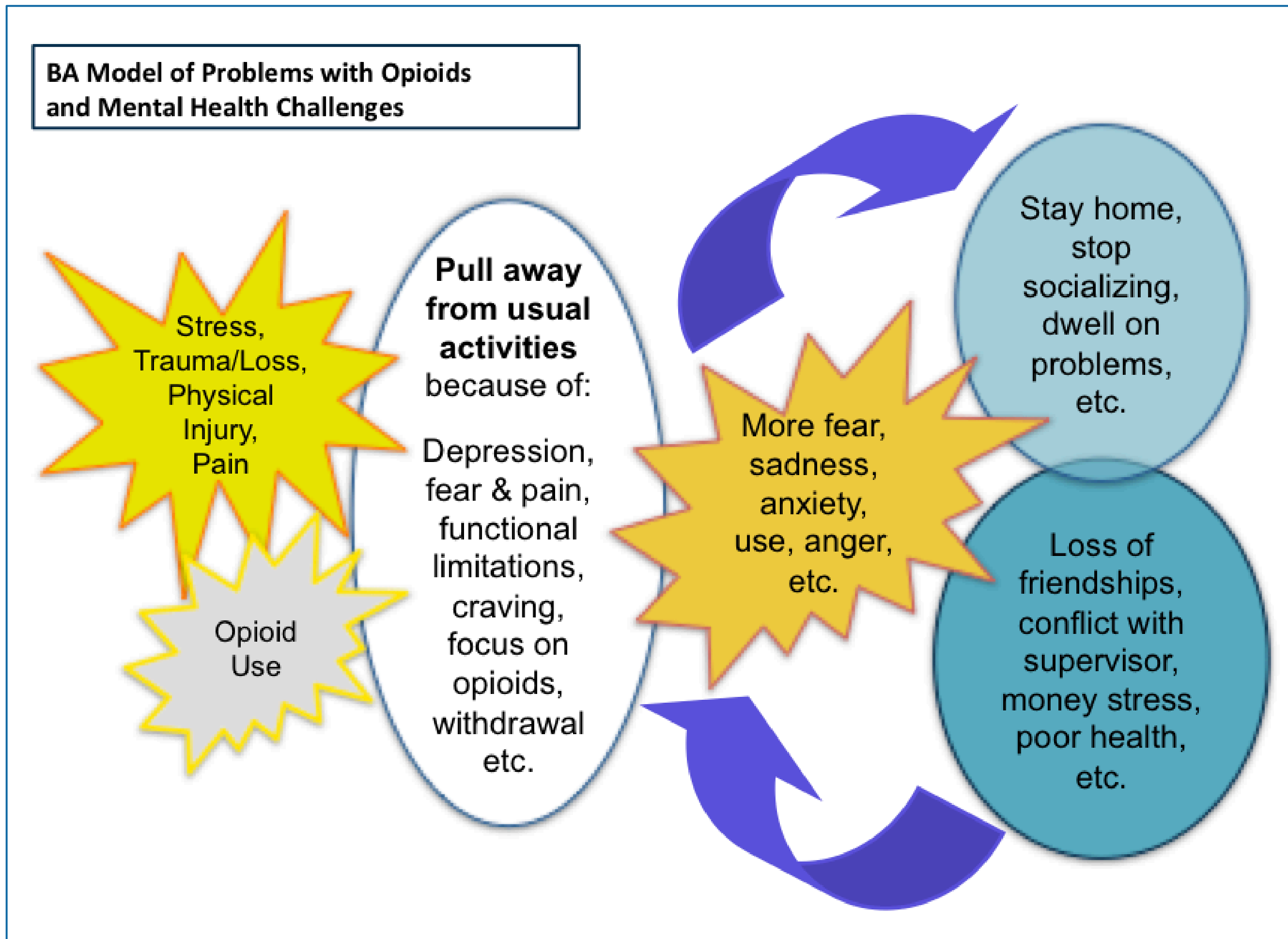

Figure Description: Loss (death, relationship, job), significant change in routine (job lob, moving), biological factors (illness, pain) can reduce pleasurable/reinforcing activities and lead to low mood. This can lead to avoidance, which can lead to a less fulfilling life, and further low mood. Substances can be used to "treat" these low moods and contribute to them through the avoidance/abandoning of previously fulfilling activities in order to use, recover, and find more substances.

2. Overview of BA history, concepts, and goals
    a. **BA was developed to treat depression** and has been adapted for use in the settings of PTSD, anxiety (Chen et al., 2013), SUD (Daughters et al., 2018), and chronic pain (Plagge et al., 2017)
    b. OUD and MH issues often contribute to withdrawal from life activities associated with responsibilities, mastery, and pleasure
        i. Essentially, people can get caught in vicious cycles where low mood, anxiety, and/or a focus on substances leads to lack of engagement with other people and activities that could be reinforcing, which in turn worsens mood and exacerbates stress and increases desires to avoid
        ii. BA aims to interrupt this cycle

c. BA is an **<u>"outside in" therapy</u>** where the idea is that changing one's life circumstances will lead to improved mood
d. BA is unlike many other therapies in that it is **not about processing the past or changing how one feels before acting**
    i. The idea of "waiting until I feel better" to make a move is an anathema to BA
    ii. BA is present-centered and uses reinforcement principles to gradually build confidence and improve mood through active engagement with one's life
    iii. The process of identifying treatment targets and goals is usually iterative, informed by patient input, in-session functional or behavioral analyses, and measurement-based care
e. Solid BA is by nature, patient centered
    i. It relies on eliciting from patients what is important to them and where and how it makes sense to start
f. Essentially, BA is designed to help people re-establish the activities and roles that make life meaningful to them

B. BA and Meeting Patients Where They Are At

1. Is BA a good fit for this patient at this time?
    a. BA is always a good fit with the following exception: active SI/HI, or grave disability requiring hospitalization
    b. Remember, everyone has something they are working on and if they are not amenable to doing formal BA, whatever you and the patient agree to do to help them get where they want to go doesn't need to be called "therapy" and what they are working towards does not need to be framed as a "goal" or "goals"
    c. Remember it isn't necessary to call it "BA"
        i. use the patient's words
        ii. and keep the focus on helping the patient get back to their life

2. BA can be applied along a spectrum of intensity to meet people where they are at.
    a. Low intensity BA
        i. Target group: for those "not interested" in "therapy" for various reasons
        ii. Potential BA targets: med adherence, making it to appointments, using substances safer, maintaining their current quality of life
        iii. Therapeutic approach: more motivational interviewing, less structure
    b. Moderate Intensity BA
        i. Target group: interested in therapy, motivated to make change
        ii. Potential BA targets: making small steps towards a life they feel good about
        iii. Therapeutic approach: some MI needed to enhance motivation, more structure in sessions
    c. High Intensity BA
        i. Target group: highly motivated to make change, comes prepared with a list of goals
        ii. Potential BA targets: larger goals requiring multiple steps to accomplish
        iii. Therapeutic approach: more structured sessions, more problem solving around barriers

C. BA Treatment Trajectory and the Care Manager's Role

<table>
<tr><th colspan="2">OUD Treatment and BA</th></tr>
<tr><th>MOUD Induction and Stabilization

(first several weeks)</th><th>MOUD Stabilization and Maintenance

(once stable through return to usual primary care)</th></tr>
<tr><td><u>BA Phase 1: BA for OUD/MHD Stabilization</u>

Support medication management of OUD
Safety Plan
Get to know patient and their values
ID potential treatment interfering factors
Establish therapeutic relationship
Informal case formulation</td><td><u>BA Phase 2: BA for OUD/MHD Recovery</u>

Reassess MH symptoms
Identify values, priorities and set goals
Collaborate with patient to pursue goals
Reassess MH symptoms and progress towards goals
Formal case formulation
Recovery support planning</td></tr>
</table>

This is an approximation of how BA treatment will align with a person's medication treatment for OUD. Some people may be ready for Phase 2 sooner than others. Here are some indicators a person is ready for Phase 2:

- ✓ Buprenorphine dose is stable
- ✓ Consistent attendance
- ✓ Not presenting intoxicated to clinic

1. Phase I of BA; BA for OUD/MHD Stabilization
    - **a.** Begin to **<u>identify potential BA targets</u>**
        - i. Both formally (e.g., results of standard assessments)
        - ii. And informally (e.g., comments shared by patients during rapport building)
        - iii. BA targets also include patient's behaviors regarding engagement with CHAMP
            1. Taking medications (for OUD and mental health issues) AND coming to appointments are great examples of behavioral activation in service of patient's well-being and life goals. Similarly, being on time for appointments and calling ahead to cancel, when need be, are ways of building mastery.
                - a. Medication adherence goals should include taking it daily at the prescribed dose
                - b. Pointing out these fundamental practices and reinforcing them periodically is a good idea
                - c. The goal is to help patients get comfortable and confident with their medication and treatment regimens
            2. Inconsistent OUD medication use or decline of medications for OUD
                - a. Not all patients will want to take medications for their OUD because they view medications for OUD inconsistent with their goal of "being off opioids" or because they do not want to stop opioid use
                - b. Non-linear trajectories for recovery are to be expected and care managers can support their patients through the rough spots by providing
                    - i. low barriers for engagement (e.g., better late than never)
                    - ii. and lots of reinforcement for showing up and/or responsible actions around appointment cancellations or even calling after the fact

        iii. Although counterintuitive, patients pursuing abstinence not on medications for OUD are at high risk for a lethal overdose and need clear harm reduction (HR) instructions
            1. **See Section D.5 for a further overview of HR approaches**

b. **Getting to know the Person and what matters to them** supports rapport, engagement, and helps identify treatment targets
    i. This is essentially the start of **Case Formulation**, which in Phase I of BA will be informal (i.e., basic information gathering and some synthesis) while in Phase II of BA will entail formal exercises aimed at articulating how the patient's substance use, psychiatric concerns, life circumstances, coping resources, and supports (or lack thereof) are all involved in how they are functioning to provide clues as to what sort of treatment targets will likely be most helpful.
    ii. There is often a lot going on at the beginning of a treatment episode with a new patient so the following are just suggestions for things CMs may want to pay attention to get to know their new patients and to start looking for likely BA treatment targets.
        1. **What is the big picture for this person?**
            a. Where are they in their lives – developmentally, relationally, vis a vie work and financial stability/instability?
            b. What is going well?
            c. What is not going so well?
        2. **What is bringing this person into treatment now and how do they feel about it?**
            a. Does the patient want to stop or change their substance use?
            b. Do they want to change the trajectory of their life and live healthier?
            c. Is there concern that they could lose important relationships?
            d. Are they trying to avoid losing their job, home, or health?
            e. Do they want to feel better – mentally and/or physically?
                i. For all of the above, it's helpful to listen for and/or actively elicit the "whys" behind whether they want to make changes in a given life area as this will give you clues to their motivations and potential targets for behavioral activation intervention.
                ii. Additionally, for people with OUD, concerns about overdose may be prominent because they've experienced one or more, know someone who has, or it's simply a realistic worry. Understanding how this life or death issue fits into their motivations for change can be helpful in rapport building and case formulation.
        3. **What is your patient struggling with?**
            a. Lack of mastery? (i.e., a sense of proficiency or solid feeling that one is able to accomplish what one needs or wants to do)
            b. Lack of pleasure or enjoyment?
            c. Lack of engagement with and support from others?
            d. Over-reliance on avoidance?
            e. Some combination of a, b, c, and d?

4. **What is hindering or supporting your patients' sense of mastery, pleasure, and enjoyment?**
    a. The answers to this question will come iteratively throughout the first third or so of treatment, but it can be helpful to be listening for clues about this early on.
    b. It may also be helpful to note complex situations where not only is a particular hindrance associated with important support (e.g., people who are members of an oppressed minority group can be stressed by the discrimination and obstacles they encounter and they may also have a sense of solidarity and support from others in that group and allies), but also when hindrances have led to growth, resilience, and strengths the person likely wouldn't have otherwise gained.
    c. Hindrance: Is chronic pain part of the picture? (see **Appendix C** for more on opioids and pain)
        i. Did the opioid use (and/or other substance use) stem from attempts to treat pain?
        ii. Are there functional limitations related to injury and/or pain that interfere with quality of life?
        iii. What is the person's relationship to their pain?
            1. Searching for cures or fixes?
            2. Resigned?
            3. Resentful and angry?
            4. Accepting and working to make the best of it?
        iv. Do they accept they have an opioid use disorder?
    d. Hindrance: What losses or changes might have contributed to increased stress and/or low mood?
        i. When did these things occur (i.e., are they fresh hurts or old wounds that are still tender?)
        ii. What has the person done in the past to try and cope with them?
    e. Hindrance and/or Support: Has your patient had to contend with oppressive systems or challenges related to who they are? Is their minority identity (or identities) perhaps also a source of strength and support?
        i. Are they a member of a racial or ethnic minority group?
        ii. Are they an LGBTQ person?
        iii. Do they have low SES status?
        iv. Are they an older person?
        v. Are they disabled in some way – apparent or not apparent?
    f. Hindrance and/or Support: What is the quality of their social support? Do they have people in their lives they can turn to? Feel understood and cared for by?
        i. Are these relationships mostly supportive or are they ambivalent or perhaps unhealthy but all the person has?
        ii. Is your patient caring for children? If so, what is this like for them and what kind of balance between mastery/non-mastery, pleasure/non-pleasure is generally present?

g. <u>Supports: What are your patient's strengths and interests, what has kept them going?</u>
    i. Your patient will have an opportunity to formally share their values with you in Phase II of BA, but it is helpful to be on the lookout for their strengths and personal assets early on both to get a fuller picture of their personhood and to be able to start helping them build on their strengths.
        1. Is the person creative or musical?
        2. Do they love animals or being outdoors?
        3. Are they personable and great with people?
        4. What did they do in the past that they enjoyed and might want to get back to?

> ***Remember:*** Some of these aspects of your patients' situations, including their identities, will be front and center for them and for you in the work that you do together and other aspects won't even be tiny blips, but at the beginning of the therapy relationship you don't know which is which and it <u>helps to keep an open mind and to not assume you "get this person" right away</u>

c. A critical goal, particularly early on in treatment, is to not be reactive to the crisis of the week but rather to **<u>see crises through the lens of the developing case formulation</u>** and to keep the focus on addressing whatever their core struggles are with BA principles and strategies
d. Other important <u>Phase 1 BA tasks</u>
    i. Address **safety issues pertaining to use** (e.g., risk of overdose, using drug of unknown quality/potency, using with unsafe others, not using clean needles, illegal activity to support use, no access to Narcan, etc.)
    ii. Address any **other safety issues** that may be relevant (e.g., concerns about domestic violence, child or elder endangerment, adequacy of food and shelter, engagement in sex work or exchanging sex for drugs, anger dis-control and violence outside of the home, etc.)
    iii. Provide **corrective experiences** for those who have had negative interactions with healthcare providers (e.g., they've felt stigmatized, invalidated, or alienated in the past)
e. This really is the beginning of therapy and the start of establishing a solid therapeutic alliance with your patient.

2. **Phase II of BA; BA for OUD/MHD Recovery is likely to start around session 5** and is slated to continue for about 8 more sessions but this number is flexible depending on patient needs.

    <u>Note 1:</u> Periodic consultation with the Psychiatric Consultant on treatment tapering and stopping decisions is a key aspect of Collaborative Care.

    <u>Note 2:</u> This section is intended to provide a high-level summary of the CM's role in ongoing CHAMP BA; See Section H, page 26 for a detailed overview of Phase 2: BA for OUD/MHD Recovery

a. Once patients' OUD is stabilized (e.g., taking MOUD at an adequate dose, abstinent, mostly abstinent, meeting harm reduction goals consistently, or impacts of use are reduced enough that attention can safely turn to encompass additional goals)….
   i. CM will carefully reassess their patient's mental health challenges using both formal measurement-based care tools (assessments completed before each appointment) and informal observation once MOUD is in place
      1. For many patients, their pain, depression, and anxiety may be appreciably improved once MOUD is well established
      2. Others may still struggle with their original mental health and/or pain issues or new concerns may become apparent once life chaos around drug seeking/use is diminished
   ii. BA session content will be guided by the assessment of patients' current functioning along with what the patient indicates is important to them on **The Values and Priorities List** (Linehan, 2014) and their personalized **Goals List** (Lejuez et al., 2011) both of which are to be administered at the outset of Phase II of BA or BA for OUD/MHD Recovery Phase (see **Appendix D** for these materials).
   iii. Revise (or reaffirm) the case formulation to help guide treatment approach
      1. How are the patient's substance use, psychiatric concerns, life circumstances, coping resources, and supports (or lack thereof) involved in how they are functioning?
      2. What clues does this provide as to what sort of treatment targets will be most helpful?
   iv. Work together to bridge the gap between where they are and where they want to be.
      1. Note: some patients will prefer to keep the paperwork to a minimum. If so, it is perfectly fine for them to simply articulate their goals or what they want to work on orally rather than going through the **Values and Priority List** or writing out their goals on the **Goals List**.
      2. In this case, the CM will want to record patient's goals so they are easy to refer back to over the course of treatment.

b. BA session content will generally come after checking in about medication adherence and any medical concerns patients want conveyed to the team

> ***In fact…*** it will remain important throughout BA to use both taking medications (for OUD and mental health issues) **AND** coming to appointments as examples of behavioral activation in service of patient's well-being and life goals. Similarly, being on time for appointments and calling ahead to cancel, when need be, will continue to be ways of building mastery.
>
> The goal is to help patients maintain (or establish) comfort with and confidence in their medication and treatment regimens.

c. BA will be supported by **ongoing assessment** via both brief symptom focused measures collected at each session (depression, anxiety, PTSD, opiate use and consequences) and self- and in-session-monitoring of activities and progress

D. Ingredients for Successfully Establishing and Maintaining Rapport

1. **A metaphor** that may be useful in conveying the patient-centered nature of BA is the idea that **patients are driving and providers are acting as guides**
    a. Patients are in the driver's seat and have control over the steering wheel, the gas pedal, and the brake. Note: This is figuratively and literally true and it's helpful to be clear about this for both the patient's sake and the CM's sake.
    b. CMs are in the passenger seat and have a map (not THE map) with handy information. They also have the equivalent of a first aid kit, tire jack, and ice scraper to help trouble shoot issues that come up along the way. In addition, CMs act as cheerleaders and provide ample reinforcement.
    c. This basic relational framing should be maintained even in situations where patients feel they have (and/or objectively have) driven themselves into proverbial ditches.
        i. The idea is not to leave them alone to figure out solo how to get out of the ditch and correct course, but rather to provide coaching and guidance while working to help them establish autonomy and solid self-management.
        ii. Both CM and their patient need to remember that the CM can't take over and be 'the driver' in the patients' life – this isn't a situation where you can trade off driving when the patient gets tired – the patient is always the one in the driver's seat.
        iii. CMs need to remember that they have little, if any, familiarity with the terrain of their patients' lives or what their patients' journeys have been like thus far. Being a curious and interested passenger can help fill in some of the blanks.

2. **Motivational interviewing principles and techniques** can be useful in keeping the focus on the patients' concerns and goals and may help providers in
    a. coming along side (i.e., joining in a friendly "we will figure this out together" way rather than in either a "I know best" directive way or a "let me drive" take-over way)
    b. letting go of specific outcomes/expectations to better discern and focus on what patients want for themselves
    c. working constructively with ambivalence
        i. about opiate use
        ii. other substance use that may be causing difficulties
        iii. behavioral patterns that may be maintaining substance use and/or emotional/relational/functional difficulties
            1. by understanding that ambivalence is normal (i.e., it isn't a sign of pathology)
            2. and that it can be influenced (by drawing out motivation for change and not insisting on a specific path for change)
    d. settling into listening (rather than telling) mode
    e. cultivating the skillful use of reflections and summaries that help patients clarify for themselves what is most important to them and what next steps they want or need to take
    f. rolling with resistance by validating feelings or concerns rather than arguing, confronting, or challenging the patient

3. Attention to patients' recognition of their problems, language, and stigma
    a. As noted above in Section C.1, some patients coming into CHAMP will be clear that their substance use and mental health issues are interfering significantly with their quality of life while others may not have such clarity.

i. Some may be confused or puzzled about why their lives aren't going so well
ii. Some may not recognize (or fully recognize) that things are as bad as they are, perhaps because they've grown accustomed to functioning this way or because those around them are perhaps doing similarly or worse
iii. Some may be adamant that others are to blame for their problems and their own substance use or mental health issues are not causal
iv. Some may be open to exploring what they, themselves, are bringing to the table and some will have a tough time with this and might initially refuse

b. Using motivational interviewing strategies and attending to language can help reduce defensiveness and keep things constructive and positive (or get things back on course)

c. It will be helpful to recognize that often patients are facing both **external and <u>internal</u> sources of stigma and alienation**
   i. Shame and embarrassment can make trust hard to establish
      1. these feelings can lead to guarded, slow to warm up presentations, and sometimes to prickly, defensive or resistant ways of interacting
      2. though it's not uncommon for some patients to be overly trusting and to have difficulty setting healthy boundaries
   ii. Stigma and alienation can lead to a sense that one's self is not worth working or fighting for
      1. for many, this poor sense of self is associated with hesitation about wanting anything or trying for anything because it feels too risky
      2. or there's just no sense that one could realistically have anything better
   iii. Because it is such a common experience for patients to experience stigma in their interactions with medical providers, it is important to ask about this.
      1. Have they felt judged by providers for their use?
      2. Have they felt they were given poor or substandard care because providers judged them or their use?
   iv. Coming alongside the person and helping them identify ways they've felt disrespected or harmed in the past by medical providers can help build trust and rapport.

d. **Stigmatizing language can inadvertently reinforce negative messages and lose patients**. When striving for non-pejorative language it is important to gauge where your patient is at in terms of their understanding and acceptance of their substance use and mental health issues as some will be ok with having either or both type of diagnosis and others will not.
   i. Person-first language
      1. Stigmatizing: "addict" / "junkie" / "drug abuse" /"mentally ill"
      2. Helpful: "person with opiate use disorder" / "person who sometimes has difficulties with opioids" / "person in long-term recovery" / "addiction survivor" / "experiencing depressed mood"
   ii. Behavioral descriptors
      1. Stigmatizing: "dirty UA" / "clean UA" / "substance abuse" / "disengaged"
      2. Helpful: "negative or positive UA" / "harmful substance use" / "substance use disorder" / "chronic brain disease" / "psychiatric or emotional challenges"
   iii. More descriptors
      1. Stigmatizing: "wasted" / "strung out" / "high" / "relapse" / "stuck" / "treatment resistant"
      2. Helpful: "intoxicated" / "return to use" / "unsure how to proceed" / "ambivalent about change"

e. Note: Even when patients use the more stigmatizing words or phrases, providers should stick with the more helpful options and model the use of objective, respectful, non-pejorative language.

4. General tips for goal setting that will enhance rapport, collaboration, and success
    a. With or without the **Goals List**, a useful way into goal setting is to ask a question like: "*What would you like to see happen for yourself during this treatment?*"
    b. Break one of those goals down into **baby steps or mole-hill sized steps**
        i. It's best to aim for **explicit, concrete goals** because they….
            1. are useful for benchmarking and measuring progress
            2. are easier to trouble-shoot and figure out what went wrong, where (it's tough to pin these things down with less concrete goals)
            3. offer patients an intrinsic sense of accomplishment that they can point to and feel good about
        ii. Examples of **concrete goals** include spending time every day reading to your kid(s), completing and submitting at least four job applications every week, walking for half an hour five times a week, reading a book for enjoyment, taking medications as prescribed, attending all appointments or canceling ahead if need be
        iii. Examples of **goals that are not concrete** (and therefore not easily benchmarked or measured) include feeling better, being less angry, feeling less pain
            1. Should patients have difficulty identifying specific, concrete goals, referring back to **The Values and Priorities List** along with what you learned about them during the intake process can be helpful
            2. **It's critical, though, that patients choose their own goals**
    c. **Again, no goal is too small**
        i. Rebuilding (or building) one's life can feel really daunting and it can feel like there is a lot of pressure to get it done yesterday, so it may be tempting to set ambitious goals to move things along more quickly
        ii. However, when goals are too big, failure is more likely and patients can get dejected and have trouble maintaining motivation for treatment
        iii. **We are looking for "mole hill" goals** to build up confidence and a sense of mastery and may even want to encourage people to consider that whatever they come up with, they may want to make at least half as big
            1. Plus, people are likely to get a lot more pleasure from the activities they choose to work on if these activities are actually **doable for them now**
            2. Some coaching and reassurance may be needed if patients used to have higher levels of functioning and need to start smaller than they would like

5. Substance use goal setting and harm reduction principles
    a. In addition to setting goals for increasing activity geared toward mastery and pleasure, it is important early on in treatment that patients identify a goal or goals for their substance use. In the context of polysubstance use, goals may differ across substances.
    b. As noted above, the following question can help patients generate goals around their substance use since it can help them clarify where they want to head: "*What would you like to see happen for yourself during this treatment?*"
    c. Identifying substance use **goals that are explicit and concrete** facilitates:
        i. benchmarking and measuring progress

ii. maintaining a consistent focus on substance use
iii. opportunities to talk about past treatment episodes
    1. What was and wasn't helpful?
    2. Any past success with abstaining or moderating use, and if so, what was helpful about it and what led to this most recent recurrence of problematic use?
iv. understanding of how substance use goals are related to life goals and values, which are often one and the same

d. Although abstinence from opiates and other substances is the safest route to recovery, **CHAMP is also supportive of harm reduction goals**
    i. It can be helpful to recognize that harm reduction is inherent to virtually all mental health interventions and to many health interventions (e.g., goals for diabetes and hypertension management are rarely for perfect control of these issues)
        1. With regard to mental health, we are generally in the business of helping people *reduce* the behaviors and habits that keep them stuck with depression, anxiety, PTSD, etc. and to *increase* behaviors and habits that will support more positive feelings, including enjoyment and a sense of mastery
        2. This is rarely an all/none process and it's usually iterative in that people need to try things out and refine as needed to get where they want to be in their lives
        3. We aren't expecting perfection or going for a "cure" or forever symptom-free life for our patients when we are addressing mental health concerns and we likewise shouldn't have such expectations for making changes in problematic substance use
    ii. With regard to substance use, sometimes patients will have abstinence goals for one substance and reduced use or harm reduction goals for other substances

> ***Harm reduction*** requires us to radically partner with our clients to support the goals they have around their own substance use recognizing that patients have many reasons to continue to use and that their goals may change over time as they build more mastery and get greater enjoyment out of non-substance use activities

        1. **Insisting on abstinence goals can be counterproductive in the following ways:**
            a. May lead to treatment drop-out
            b. Patients may not be honest about their use which can undermine treatment efforts
        2. Goals may differ across substances
        3. Within the harm reduction framework, **patients with abstinence goals are supported in their goals**
            a. It is usually helpful to explicitly clarify that the recurrence of use is part of the pattern of recovery, and it may take many attempts to be successful with abstinence
            b. Harm reduction principles can help mitigate shame and embarrassment about any return to use so that people can more readily get back on track with their goals
            c. Harm reduction ideas and strategies may be suggested to help support safety while someone is working toward abstinence
    iii. **Solid harm reduction substance use goals** include attention to the following:

1. What is the maximum number of days per week (or times per day) person plans to engage in use?
2. If amounts of the substance are readily identified (e.g., number of pills, amount of alcohol, grams or milligrams, etc.) what is the maximum amount of drug/alcohol plan to use? If amount is hard to gauge, how much money is your patient ok with spending on substance(s) per day/week or how much time are they going to spend engaged in substance-related activity?
3. Which reasons for use feel safe and fit within the person's goals for themselves (e.g., to socialize, to relax) and which do not (e.g., to avoid responsibilities, to cope with negative feelings, etc.)?
4. Under what conditions is it safe/acceptable to use (e.g., people, places, times, circumstances)?
5. What routes of administration and/or combinations of drugs/alcohol are consistent with harm reduction goals?
    a. Example 1: A patient who typically uses oxycontin and alcohol at the same time could set the goal of only using one or the other substance on a given day.
    b. Example 2: A patient who injects $30 worth of heroin every day when no one is home could set the goal of cutting the amount used in half and making sure that their partner is home (and telling the partner what is going on if this conversation needs to happen) and knows how to use Narcan.

iv. Even if patients are ambivalent about decreasing the amount or frequency of their use, they can make changes in <u>how</u> they use substances that will increase their safety. The following are **examples of potential concrete goals**:
1. Smoking or eating drugs instead of injecting
2. Not sharing needles; not using dirty needles
3. Not using drugs from unknown/untrustworthy sources
4. Not using multiple substances at a time
5. Not using drugs alone
6. Not using drugs with unknown/untrustworthy others

v. Consider providing patients with the **<u>HaRRT Safer Use of Depressants (Opioids)</u>** handout (**Appendix E**)

vi. Narcan should be prescribed
1. Have patients get and carry Narcan whether their goals are for reduced use or abstinence
2. Teach (or see StopOverdose.org) patient how to use it and have patient teach their family/friends how to use it

vii. The following are examples of substance use **goals that are not concrete** or measurable and are to be avoided (see Section F.1.e.i for ideas about how to help patients shore up mushy goals):
1. Cut back on opiate use
2. Use less often than usual
3. Use more safely (without specifying what this means)

e. Urine drug screens are for information but are not meant to be punitive or to necessarily inform care (definitely not dictate care)

6. How the whole Collaborative Care team can support BA and the therapeutic relationship
    a. All team members will have access to this manual and will have participated in some BA training so there should be shared understanding of BA principles and strategies
    b. The entire team can help reinforce progress and support goals (e.g., when checking on MOUD, PCP can ask about patients' non-SUD oriented goals and reinforce progress)
    c. When the CM is feeling stuck with a particular patient….
        i. because that person's situation is especially challenging or they have particular barriers that are interfering with goal attainment, **consultation** with the Psych Consultant and/or **brainstorming** with the team can be helpful
        ii. because a patient is challenging in some way or evokes negative thoughts/reactions on the part of the CM, the Psych Consultant or other team members may **provide support**, **advice** about how to set boundaries or shape behavior if necessary, or they may offer **another perspective** that allows the CM to have more empathy for the patient

E. BA Targets and Basic Strategies

1. **Mastery** generally refers to the idea that someone is capable of doing certain things well or proficiently. It can be a somewhat loaded or even intimidating word because it sounds fairly lofty and as though someone needs to be an expert or really, really good at something to claim they have "mastery" of that thing or activity.
    a. <u>In BA, mastery refers to patients' ability to do things well enough that they feel a sense of accomplishment and effectiveness</u>.
    b. We are looking for 'good enough' not perfection
    c. Additionally, for mastery or solid ability to be positively meaningful to the patient, it needs to fit in their current value system
        i. Someone may have gotten really good a various illegal behaviors to survive or to have enough money for drugs but that sort of mastery is likely no longer valued (or there's some ambivalence about it) and so other opportunities for mastery may need to be cultivated or tapped
            1. both to increase positive feelings like self-worth, confidence, and pride
            2. and to reduce the risk of resorting to behaviors that are likely to be harmful or consequential
        ii. Someone may very much value certain activities that could help them be better parents or workers or friends (etc.) but they may need help figuring out how to get the requisite skills down
    d. In life and as conceptualized by BA, **loss of mastery (or lack of mastery)** can cause, maintain, and/or exacerbate depression (PTSD, SUD, anxiety)
    e. When people feel overwhelmed and ineffective, or as though all they know how to do well is illegal, it's demoralizing and can be paralyzing
        i. If people have past experiences that include a reasonable sense of mastery and competence, it may be enough to have them recall such situations and to look for current parallels where they could engage or re-engage in ways that are meaningful to them
        ii. If people have relatively little experience with mastery or with mastery around currently valued activities, they may need more help breaking goals down into small steps to build confidence from the ground up. Doing so in service of goals that are important to the person will likely help this process go more smoothly given the inherent motivation boost.
        iii. As noted above, it is usually preferable to start with very small ("molehill-sized") steps towards goals to start building mastery right away to minimize patients feeling demoralized or ashamed of not completing agreed upon tasks since this can lead to disengagement and premature treatment termination.
            1. Note: In this context, there really isn't a situation where someone is choosing steps that are "too small" – any step is valuable, including coming to appointments, taking meds, feeding themselves, and so forth.
        iv. For everyone, it will be important to **ascertain whether opioid use was/is interfering with mastery** or was/is perceived to help with mastery
            1. With regard to the latter possibility, someone may, for example, have the strongly held belief that they are a better poet or creative thinker when they are high. This may or may not be true, but if their substance use is concerning to them (or their loved ones whose opinions they value) and they value their creative output, it will

be important to experiment with strategies to maintain or build creativity in sober contexts.

f. **Loss of pleasure (lack of pleasure)** can lead to a sense of drudgery or even alienation, both of which can be depressing and may leave people more vulnerable to continued substance use or recurrences as well as to persistent depression and anhedonia.
   i. **Losses** like those referenced above (e.g., death of loved one, break up of a relationship, loss of a job) can lead to lifestyle changes and limits that make pleasures harder to come by whether because of loss of companionship or financial resources
   ii. **Changes in routine** (e.g., a move in location, retirement, additional responsibilities) can take people away from their "go-to" pleasures and/or crowd out pleasure
   iii. **Poor health or pain** can result in people's lives becoming appreciably smaller and more constrained, sometimes to the point where they feel there is little point in trying to do much of anything

OUD and Anhedonia

- Moderate to severe anhedonia is common in OUD (21-48%)
- Anhedonia may worsen opioid cravings
- Calibrating expectations around levels of pleasure from BA goals may be needed
- Easily tracked in PHQ9 question #1

   iv. **Inability to feel pleasure (anhedonia) and/or cope socially without substance**
   v. Some people may rely on substances to **boost positive feelings** or to feel much of anything
   vi. Some may **really like how they think or feel when under the influence of the substance**(s)
      1. A lack of alternative activities associated with pleasure and feeling good can leave people vulnerable to substance over-use
      2. As noted earlier, often "regular" activities lack the rush and immediate pleasure that substances are able to deliver, necessitating……
         a. a re-scaling of expectations
         b. patience
         c. and re-learning (or learning) how to enjoy activities without substance use
   vii. Some may use **substances to facilitate social engagement and connection**. If social anxiety is a factor, patients may have come to rely on substances to be able to talk with/socialize with others or to "feel normal" in social situations.
      1. If patients' values/goals include working on relationships and sociability without substances or with moderated use, identify easier (mole-hill sized) social situations to begin practicing on
      2. Encourage patients to identify supportive people with whom the patient can socialize without use or over use
      3. Encourage and role play negotiations with family and friends who also use to support reductions and not use in patient's presence
      4. Teach use refusal skills (practice likely scenarios in sessions)
   viii. Some may use substances because they have more energy or feel less pain so they can get things done, because they feel more powerful and invincible, or because they just want to feel "normal"

1. For those with extensive histories of use and pronounced withdrawal symptoms, having the substance(s) on board can indeed lead to greater energy, clearer thinking, and the ability to get things done.
    a. However, it's often hard to calibrate use so that it stays in this ok zone
    b. Over time more is needed more frequently to maintain the ever shorter ok zone (e.g., "chasing the pain")
    c. It's expensive and risky to only be able to feel ok when under the influence
2. MOUD should help address some of these concerns and can be supported by
    a. Education about use/withdrawal cycles and the time it takes for peoples' systems to reset so that they can feel and think ok when not high (i.e., assuring that this is normal and will eventually pass or resolve)
    b. Education about how substance use can lead to greater pain sensitization
    c. Identifying relatively simple, but valued, activities to pursue when not under the influence to get practice and provide the opportunity to relearn how to function sober

g. It's important to **assess which of the above are driving the lack of pleasure**

h. From there, the BA **case formulation and treatment plan will need to take this into account** centering what the person thinks might (or would) bring them pleasure other than through substance use and without the aid of substances (see Section F.1.d for an overview of the Case Formulation elements and **Appendix F** for template to guide Case Formulation).

2. The overarching goal of BA is to help patients <u>increase their adaptive *approach* behaviors</u>, it is important to understand the opposite behavior, avoidance.
    a. Avoidance is key to understanding depression and similarly is critical to understanding PTSD, anxiety, substance misuse, chronic pain, and their co-occurrence
    b. **Avoidance** of situations that are stressful, uncomfortable, exacerbate pain, feel shaming or anxiety-provoking **is understandable (we all do it!)**, but can be limiting and can lead to lives that are impoverished and not very rewarding
        i. It's critical to understand what is driving avoidance
            1. Fear of failure, unsure how to be effective in challenging situations
            2. Don't want to feel feelings (including boredom)
            3. Don't want to risk returning to substance use
            4. Physical pain or worries about making it worse
            5. Mood (depression, anxiety, PTSD)
                a. The idea that one can wait and do a valued activity once one feels better (less depressed, less anxious, less fatigued, less pain) is appealing but it keeps people stuck
                b. Concern about trauma triggers and reactions to them
                    i. Panic
                    ii. Anger, rage responses
                    iii. Worry might freeze and be unable to cope
    c. **Substance use can serve a variety of avoidance functions** that may be more or less prominent for each patient at different times and in different contexts
        i. **Self-medication to avoid discomfort and withdrawal**

1. Emotional triggers (feelings, moods, thoughts) to include feeling uncomfortable in social situations, having down time and feeling bored, attempting to control one's anger or depression
2. Physical pain, which is a critical factor for many with OUD
    a. Poor pain tolerance
    b. Expectation that one should be pain-free
    c. Less stamina and strength from physical deconditioning
3. To avoid physical (and psychological) withdrawal
    a. Fear that withdrawal will be overwhelming or unmanageable
    b. Poor discomfort tolerance
4. When substances are used in response to discomfort
    a. **Use is often initially reinforced** because it does take the edge off of discomfort and pain
        i. Pharmacologic effects
        ii. Distraction
            1. From current emotional/physical state
            2. For some, living on the edge or in chaos/crisis mode is attention grabbing
    b. Over time, though, even poorer pain (physical and emotional) tolerance may develop and people can get into a **vicious cycle** where they are using substances to chase their pain and creating more pain or different sorts in the process
5. Identifying how patients avoid activities will be important for setting achievable treatment goals

3. Building distress tolerance and shifting expectations about discomfort and pain to combat avoidance-oriented substance use
    a. Often when patients have strong motivation to re-engage with their lives they find they are willing to tolerate more discomfort (emotional and physical) without using substances in service of valued activities
        i. Patients may need to learn when what feels like too much really is too much vs. when it makes sense to push through
        ii. Learning how to pace activities can help
        iii. Tolerance of discomfort often needs to be built incrementally

It's important to clarify that learning to tolerate distress doesn't usually lead to feeling better in the moment

Tolerating distress does, however….

- ✓ help keep one from doing things that aren't in line with one's values
- ✓ help one do things that are in line with one's values
- ✓ help one get through whatever is distressing (i.e., '*this too shall pass*' if we let it)

   b. Re-setting expectations and re-learning or learning what emotional discomfort/chronic pain does and does not mean is key and this can be facilitated by
      i. conducting behavioral experiments in the service of challenging valued activities to see that discomfort is tolerable
      ii. the experience of seeing over time as behavioral activation increases that old beliefs about discomfort/pain aren't necessarily true and that discomfort/pain doesn't have to impose life-curtailing limits

4. Functional avoidance in the context of SUD and mental health challenges
   a. It's important that CMs, the CoCM team, and patients recognize that **sometimes avoidance is exactly the right strategy**
   b. Here, it will be important that patients identify the people, places, times, and situations that are associated with problematic use or other problematic dynamics in their lives and either avoid them or learn how to handle them adaptively
      i. Some triggers for use or problematic dynamics will be critical to avoid
         1. The doctor that over-prescribed medications
         2. The dealer or friend who supplied drugs
         3. The liquor/wine/beer area of the grocery store
         4. The "friend" who always manages to get you to shoplift for them
      ii. Some triggers can't be avoided or would mean big life changes
         1. Pay day
         2. Trauma anniversaries
         3. One's partner who uses (or other family members)
         4. Social gatherings involving substances
      iii. Thoughts, feelings (including feeling stressed), and cravings can all be triggers and while they can't generally be avoided successfully (and trying to do so often makes matter worse), identifying ways to cope with them could include engaging in something constructive or in healthy distractions (puzzles, coloring, funny movies, walks, talking with a friend, cooking, etc.)

F. How BA works – Nuts and Bolts

1. **BA focuses on increasing activities consistent with a person's values, goals, and priorities** by working with patients to identify what they truly care about (ideally across multiple life areas so as to avoid putting all of one's eggs in one basket)
    a. Use the **<u>Values and Priorities List</u>** and the **<u>Goals List</u>** to help identify what patients care about OR simply have patients reflect on what is important to them and what they want to work on if they would prefer not to use the forms (See **Appendix D** for copies of these materials)
        i. Flexible application of BA is key
        ii. Patient preference should drive how BA is rolled out
    b. **Identify a couple of big goals to work towards** – wish list or if one had a magic wand
    c. Note: It's important to recognize that **identifying goals may be difficult** for those who have lost a great deal or feel they have a very deep hole to climb out of. Also, some patients may have difficulty translating their values and priorities into goals and will need assistance with this.
        i. Offer a few ideas
        ii. See if these jog patient's ideas
        iii. Help patient select and articulate 2-4 goals
        iv. Get creative and practical
        v. Remember to help the patient set out concrete, measurable goals
    d. Big questions that will help **frame the goal setting and case formulation**:
        i. What sort of increased mastery would the person like to have?
        ii. What would bring them more (non-substance related) pleasure and enjoyment?
        iii. What would help them counteract avoidance tendencies?
        iv. As introduced earlier, the question "*What would you like to see happen for yourself during this treatment?*" can be a great way to elicit patient's own goals.
            1. Again, it's important to be on the look out for less than ideal types of goals that aren't easily measured or tracked
                a. "Feel less depressed" could become: "do 3 things this week that I enjoy; take a walk, watch a show I like with my daughter, call my friend Steve"
                b. "Use less heroin" could become: "instead of using four times per day, use half the amount two times per day and make plans to be out of the house at the other times I would usually be using"
                c. "Cope better" could become: "when I feel overwhelmed, I'll take two or three deep breaths and take a minute to assess the situation"
    e. Break one of those goals down into **baby steps or mole-hill sized steps** (you can find more ideas about goal setting in the Goal Setting Tips in the Engagement and Rapport section above)

> When it comes to goals, ***less is usually more…..***
>
> ✓ likely to keep patients engaged
> ✓ likely to give patients opportunity for early mastery experiences
> ✓ likely to help sort out skills deficits patients might have

        i. **Get concrete:** What needs to happen first? Second?
            1. This is often where the CM is super helpful
                a. Patients maybe be tempted to skip steps or may not have a good grasp of the steps needed, which can be a set up for failure

            b. CM's assistance to patients in getting practical and concrete is critical

   ii. Start as small as needed to work together to come up with a plan to address the first or first couple of steps in reach one of the goals
   iii. The **<u>Weekly Activity Schedule</u>** may be useful to map out an approach (with plenty of reassurances that it can be done flexibly, i.e., if patient was aiming to do X on Wednesday but didn't, perhaps it could be done another day or some other thing could be done that will help move them towards their goal) (see **Appendix G** for the WAS)
      1. What day? What time?
      2. What is needed to carry it out?
         a. Answers might indicate the need to back it up even further (e.g., if the patient needs bus fare to go downtown to do X – the plan needs to start with securing bus fare)
         b. Who might be helpful here?
      3. What might get in the way?
         a. Trouble-shoot that
         b. Who can lend support?
      4. Emphasize the need for repeated practice

2. Focus is on what patient can do in the present
   a. Can't undo the past
   b. But can learn from it (using behavioral analysis)
   c. Can make changes now to head in more positive directions
   d. Note: Here, it may be particularly helpful to know that BA has been found to be helpful in addressing PTSD (Wagner et al., 2019) without relying on a past trauma focus.
      i. BA in this clinical context keeps the same emphasis on here and now, inside → out strategies, geared towards helping patients re-engage actively with their lives while managing the discomfort and distress that may be stemming from their PTSD.

3. It is important to be clear that increasing activity is NOT the following:
   a. Staying busy to stay busy
   b. Focusing solely on what other people think you should be doing
      i. Some patients may have developed patterns over time where they spend disproportionate amounts of their time and energy trying to appease or please others or they derive most of their sense of worth from doing for others
         1. This may make it difficult for them to identify what is important to them
         2. It may also be challenging to prioritize one's own needs and desires
            a. It will be helpful to be explicit about the patterns
               i. But not to "psychoanalyze" or try to get to the root causes
               ii. Rather, the goal is to actively address them in the here and now
            b. There may be extra work needed to help build communication skills around assertiveness and boundary setting
            c. It will be important to factor these concerns into goal setting
      ii. ***<u>However, if a patient is facing certain external contingencies, they will need to be considered</u>***
         1. Legal mandates

2. Threat of loss of valued relationships or situations (i.e., work, living arrangements) if certain behavior continues
3. Valued relationships or situations have already been lost and there is a desire to regain them

iii. It will be important to help patients frame taking care of these sorts of external issues as part of their journey towards mastery and the freedom to pursue healthy pleasure

1. It's hard to feel good about what one is doing and where one is heading if there are big things hanging over one's head that aren't being addressed

c. Just physical activity for the sake of physical activity. For some, this can contribute to mastery and pleasure, but it's not for everyone.

4. The **Activity and Mood Monitoring Form** may be used to track activities, mood, cravings, use, and medication adherence on a daily basis (see **Appendix H** for the AMMF)
    a. The goal is for patients to see how changes in activity are associated with changes in mood and substance use patterns (and how changes in substance use patterns are associated with changes in other activities)
        i. Activities may include coming to appointments, calling ahead to cancel as needed, and taking medications
        ii. "Activity" also includes things patient may be refraining from such as reducing or abstaining from substance use
    b. Over time, information can be used to see patterns and to identify when treatment is going well or it seems stuck or things are going in the wrong direction

5. It is also important to be aware that when anxiety or PTSD are the predominant mental health concerns, mood may not improve right away when engaging with the initial steps in the plan (and it might even worsen some)
    a. Both the CM and the patient need to know that it can be stressful, anxiety provoking, and may lead to some anger when starting work in earnest on things that are important
        i. This is not a sign that patients are doing something wrong
        ii. It will likely resolve as confidence is regained or gained and positives start kicking in
        iii. If there are **concerns about increased anger**
            1. Assess whether the patient has ever engaged in aggression or violence when triggered
            2. If so, work on building tolerance for uncertainty and for dealing with people sometimes (frequently) being aggravating
    b. It is helpful to **distinguish between mood and satisfaction**
        i. One can be stressed (or anxious or angry) and feel satisfaction at having gotten started on something or accomplishing it
        ii. Learning the **"both and" nature of emotions and behavior** can be very helpful

6. BA uses **two main tools** to facilitate helping people get back in touch with activities and relationships that give them a sense of mastery and that are rewarding and valuable to them; **Behavioral Analysis** and a specific way of **Working with Rumination and Worry**.
    a. **Behavioral Analysis** – helps both CM and patient understand what is driving problematic behaviors and keeping desired behaviors from happening (Note: Behavioral Analysis in BA is very similar to Behavioral Analysis in CBT but in BA there is more emphasis on actions and inactions than on

cognitions/thoughts, beliefs, and appraisals; the **CHAMP BA Behavioral Analysis Worksheet** is a helpful guide; see **Appendix I** for this worksheet)

i. Entails a step-by-step assessment of the situational context, antecedents, person (i.e., their behaviors, feelings, thoughts), and consequent factors that are directly related to the maintenance of a behavior (or that are interfering with the occurrence of a desired behavior)

ii. An understanding of the problematic behavior (or lack of constructive behavior) is developed by focusing on recent, concrete examples (one at a time)

1. Tell the story of what happened – who, when, where, what, how
   a. What set this off?
   b. What happened next? And next? And next?
   c. Who was with you?
   d. Where were you?
   e. What time of day was this? (day of week? etc.)
   f. How did you feel?
   g. Does any of this point to the need to back up the analysis even further in time (i.e., are there things even earlier in the sequence that are important to consider?)?
2. The goal is to understand the nitty-gritty details of the situation that gave rise to the problematic behavior, how it unfolded, and what happened afterwards
3. Repeated behavioral analyses are often needed
   a. Looking for patterns
   b. When/where in the chain interventions might happen to lead to a different outcome

b. **Attention to rumination and worry as behavior**

i. **Rumination** is when people repeatedly focus on unpleasant **past** events

1. Losses, being treated unfairly
2. Situations where they let themselves or others down

ii. **Worry** is when people are anxious about what could happen in the **future**

1. Failure, inability to handle situations
2. Rejection, betrayal

iii. In BA, the goal is not to change the content of such thoughts, but rather to

1. focus on the context in which the thoughts occur
   a. *Behavioral analysis* can help pinpoint when and where such thoughts show up
   b. and help uncover the function of such thoughts
      i. Rumination and worry can feel like problem-solving even though they aren't effective problem-solving tools
      ii. These thought patterns can so preoccupy (and paralyze) people that they keep themselves from engaging in valued activities
2. and to determine whether they foster or maintain avoidance (see above)

iv. In BA, the primary strategy for addressing rumination and worry is fostering attention to present/current experience through

1. teaching grounding strategies
   a. Focus on here/now sensory details (sights, smells, temperature, surface qualities, sounds, etc.)

        b. Identify ways to incorporate grounding in daily life and when it could be especially useful
            i. Anticipated stressful or boring situations
            ii. When <u>need</u> to do activities that aren't especially pleasant
    2. facilitating increased comfort with being present
        a. The present is the context in which people can act and make changes
        b. The present has vital information about what is needed and what constraints or supports might be in place
        c. There really is no time like the present ☺
    3. **The goal is to help the person get active and doing rather than stuck in worry/rumination**

7. The **<u>CHAMP BA Case Formulation Worksheet</u> (Appendix F**) may be used to help pull together information from your patient to provide a synthesis of where they are in their lives, where they want to head, and initial ideas for how they might get there. **The following will inform the Case Formulation**:
    a. Patient demographic characteristics
    b. Initial and post-MOUD stabilization mental health, SUD diagnoses and severity levels, and pain ratings
    c. Motives for use
    d. Stressors, strengths, supports
    e. Patient's goals for treatment
    f. Barriers and facilitators

Reminders for Optimizing CHAMP BA

Using the patients' language and terminology regarding what they want for themselves and how they are willing to engage, will help with rapport and engagement

Throughout treatment it is critical to periodically reassess progress

2. If things are progressing well, your patient is improving, and getting back to their lives, there's no need to change course
3. If things are not progressing well, it can be helpful to
    a. Validate their attendance at appointments and other positive steps they've taken
    b. Reassess goals; perhaps break goals into smaller steps or identify a new goal

G. Summary of the First Phase II BA Session

Note 1: The Collaborative Care materials will address the mechanics of MOUD Stabilization Phase sessions with Phase I BA material incorporated.

Note 2: Time estimates are for a 45-minute session and may need to be adjusted to fit the available session duration.

Note 3: Some of the tasks noted here may already have been accomplished in Phase I and if so, it's fine to just touch on them briefly to remind your patient of them. Also, if need be, the tasks in this first Phase II BA session can be completed over several sessions if there are more pressing treatment topics to attend to.

1. Preview the session agenda (2-3 minutes)
    a. Review the agenda and check to see if your patient wants to add anything
    b. Let the patient know that CM will be doing more talking than usual to orient to the treatment approach, but questions and observations are welcome

2. Orientation to **logistical aspects of BA** (10 minutes)
    a. Eight to twelve 30-45 minute sessions
        i. BA is a time-limited therapy even if overall CoCM treatment lasts longer
        ii. As patients improve the CM will work to help them continue to use BA skills but there may not need to be formal sessions for whole course of Collaborative Care.
    b. Initially sessions will generally be scheduled every two weeks, going to monthly when patient is stable and meeting their goals consistently
        i. Sessions can be spaced out strategically to allow time for practice and for meeting goals
    c. Each session, patient and CM will identify activities for the patient to engage in that are consistent with their values and priorities
    d. Progress is supported by measurement-based care
        i. Brief mental health, craving, and use monitoring before each session
        ii. Brief activity and mood monitoring between sessions
    e. As patient improves, CM and patient will work together on a plan to continue to use skills over the long term (laying the groundwork for Recovery Support Plan)

3. Orientation to CHAMP BA treatment targets and how CM and patient will work together (5 minutes)
    a. CHAMP BA provides an opportunity to address both mental health (depression, anxiety, PTSD) and physical health (pain, chronic diseases), and OUD
        i. Supports medication adherence for OUD and for MH concerns
        ii. Supports and facilitates regaining mastery and pleasure in one's life and re-engaging in important and valued life activities
        iii. Focus is on the present rather than the past
        iv. Explain that it's an outside-in therapy – emphasizes building back in activities and reducing avoidance to help improve mood and self-confidence
    b. Orientation to **how patient and CM will work together**
        i. Patient-centered philosophy with CM as guide or coach
        ii. Patients identify their values and priorities and CM helps them work towards them

4. Review results from mental health, craving, and use screens (5 minutes)
    a. Patient asked to share which of the signs/symptoms are bothering them the most or that they struggle with the most
    b. Patient asked about when symptoms tend to be worst? Best?
        i. What avoiding?
        ii. What not avoiding?
        iii. How feel when mostly staying home?
        iv. How do other people factor in?

5. Identifying overarching values, priorities, and goals (10 minutes)
    a. "*What would you like to see happen for yourself during this treatment?*"
    b. Patient may complete **The Values and Priorities List** and uses it to inform
    c. Personalized **Goals List**
        i. Remember: use of the forms is encouraged but optional depending on patient preference
    d. CM assists as needed
    e. Probe about the selected goals
        i. Why are they important?
        ii. When, if ever, was patient actively engaged with them? What was this like?
        iii. Essentially the idea is that both CM and patient are seeking to get a good understanding of patient's motivations and historical success at achieving them

6. Briefly explain **how BA works** (5 minutes)
    a. Use the heuristic ***Model of Problems with Opioids and Mental Health Challenges*** to help illustrate how issues can lead to a negative cycle of withdrawal (avoidance) and poor mood/functioning
    b. Explain that BA works to interrupt the withdrawal/avoidance and help people get back engaged with life
        i. **Focus needs to be on the right-hand side of the model rather than "fixing" the left-hand side**

7. Identifying goal(s) and activities for upcoming two weeks (8 minutes)
    a. Patient chooses the goal they wish to focus on first
        i. Patient and CM break down the goal into manageable, ordered steps
        ii. Using the **Weekly Activity Schedule**, plan out when it makes sense for patient to work through some or all of the steps
            1. Again, remember that use of the form is encouraged but optional depending on patient preference
    b. Patient chooses one value-consistent enjoyable activity to do every day (or a couple to rotate)
        i. This is intentionally planned and included on the **Weekly Activity Schedule** or in their personal calendar (phone calendars are fine
    c. Review the **Activity and Mood Monitoring Form** again and orient to daily completion

H. Overview of a generic BA OUD/MHD Phase II "Regular" Session

Note 1: CM may need to make adjustments to the suggested times depending on the appointment time available and please see **Appendix J for a "Cheat Sheet"** regarding the elements of a regular BA session

Before the appointment: patient completes mental health and OUD measures

1. **Set/review the session agenda** and **Review of measures** mental health symptoms, medication compliance, opioid cravings and any use (5-7 minutes)
    a. Note any symptoms or concerns that are contributing to de-activation
    b. be ready to use this information when reviewing the past week's work and
    c. to address it when planning the next week's goals and activities

2. **Review of Activity and Mood Monitoring Form and Weekly Schedule** or a verbal review of planned activities and progress (10-15 minutes)
    a. Praise/reinforce any and all progress including coming to the appointment
        i. Check in as to how things went and how it felt doing the activities and/or refraining from or moderating use
        ii. Listen for any hesitations or concerns that may need further attention
        iii. Also listen for any hints that things went really well or were easier than anticipated and perhaps reflect this back
        iv. Assess whether there was an unexpected risk for returning to substance use that needs to be rethought?
            1. For example, if the goal was to get a package mailed to a family member but the route to the post office takes the person by an old dealer's house, they might have chosen to not do the task or put themselves at risk for using again by going ahead and doing it without modification.
            2. For example, if the goal was to do the family grocery shopping but going past the liquor aisle (beer case, etc.) was triggering, how could they navigate this more comfortably/safely?
    b. Identify any frustrations or things the patient wanted to accomplish but didn't
        i. What got in the way?
            1. Especially be on the look out for avoidance
            2. Also note if worry/rumination seems to be a factor
                a. If either or both are present (worry/rumination can function as avoidance), consider using strategies described above to help the person get unstuck
            3. Any opioid or other substance use?
        ii. Was the goal too ambitious?
        iii. Was there an unanticipated relapse risk that needs to be rethought? (see above examples)
        iv. Does the person need to enlist someone's help?
        v. If it's still a desired/valued goal, rework the plan.
    c. Here is where ***Behavioral Analysis*** can come in handy (see pg. 26) for unpacking what happened (or didn't happen) and where there might have been options for different choices.
    d. Help the patient recognize any patterns that may be emerging regarding how their activities and moods go together

3. **If the <u>Weekly Activity Schedule</u> and/or the <u>Activity and Mood Monitoring Sheet</u> were not completed** (or if opting not to use the forms, brainstorm alternative ways of tracking activity, use, and mood)
    a. Explore why not completed
        i. If the person can track activities and/or use and cravings, but not mood, go through a brief exercise to have them focus on here-and-now sensory details as well as their mood
    b. Come up with a plan for doing the form or an alternative way of keeping track of activities, use, craving, and mood during the coming week
    c. Do it together in session for the past week

4. Planning Activities (10-15 minutes)
    a. Identify short-term goals for the week (be sure to keep them consistent with overarching short- and long-term goals and the patient's values)
    b. Make a plan for accomplishing two or three (or one, depending on the patient's needs) short-term goals
        i. Be mindful of potential risks for returning to substance use (or engaging in unsafe use if patient has harm reduction goals) and help the patient address them
        ii. Keep recovery goals front and center as additional life goals are identified and strategies for meeting them are worked out
    c. Write down when the person plans to do them in the **<u>Weekly Activity Schedule</u>** (or in patient's calendar, phone notes, etc. – may need to get creative!)
        i. If the person is attending any self-help/12-step meetings or other recovery functions, be sure to include these on the Weekly Schedule
        ii. Also include any family or work obligations that are out of the ordinary or that will help provide some structure and a sense that the person is engaging in their lives
    d. If there are any skills deficits apparent, provide brief coaching
        i. Communication (assertiveness vs. passive or aggressive)
        ii. Problem-solving (breaking things down so they are manageable, brainstorming)
        iii. If rumination and worry are issues, provide coaching on present focused grounding

5. Discussion of Homework (5 minutes)

<u>Note:</u> When you arrive at the patient's **next to last session** of FORMAL BA be sure to do the following:

a. Inform/remind patient that next session will be the final one (this should not come as a surprise as the end of treatment should be forecasted several sessions out)
b. Encourage patient to review their initial goals and their sense of the progress they've made
c. Encourage patient to think about what this treatment has been like, what changes they have seen, what has been helpful and not-so-helpful
d. Encourage patient to consider whether he/she would like to continue with therapy or group with another provider and you can discuss options next time

I. When Lapses or Breaks in Treatment Occur

1. It's relatively rare that patients with OUD and mental health concerns will sail through a course of treatment with no hitches, always attending sessions as scheduled and keeping a consistent focus on recovery

2. As has been emphasized throughout this manual, both Collaborative Care and BA are inherently patient centered and flexible so it's really ok if a patient steps away (disappears) from treatment for a period of time and then re-presents
    a. However, it's important to remember that one of the key ingredients of Collaborative Care is assertive outreach and not just passively waiting for a patient to return
    b. Taking responsibility and self-determination are important priorities in CoCM and BA, but sometimes patients will need some sturdy scaffolding from their CoCM team to get there

3. Should a patient be away from treatment unplanned for more than a couple of weeks the following can be helpful with re-engagement
    a. Lots of reinforcement for coming back
    b. Take time to find out what led to the missed sessions
        i. Were there life disruptions?
        ii. Lack of support for treatment from family/friends?
        iii. Something off-putting or stressful about the treatment itself?
    c. Explore whether patients' concerns have changed
    d. Evaluate whether goals/values have changed
        i. Problem-solve barriers to treatment and staying in contact
            1. Communication skills?
            2. Time management?
            3. Assertiveness and boundary setting?
    e. Review the rationale for BA as a refresher and to provide a reset

J. Overview of Final Session (Recovery Support Plan)

Note 1: See *Ending Treatment in CHAMP* below to determine readiness for transition back to treatment as usual.

Note 2: The final BA session may need to be about 20 minutes longer than usual to accommodate the development of finalization of the ***Recovery Support Plan***, though this could take less time if the Plan is incrementally developed over the last few BA sessions instead of all at once at the end.

Before the appointment, CM prepares a simple graph of MH symptoms, days per week of opioid use (and other substance use, if applicable), and craving over time; these can be separate charts since the scales are not the same

1. At outset of session, **set agenda** and **Review of measures** from past week regarding mental health symptoms, medication compliance, opioid cravings and any use (3-5minutes)

2. Review of activities, use, and mood since last week (5-7 minutes)
    a. Since this is the final week, the participant should work through this process as independently as possible with therapist prompting only as needed
    b. CM references ways patient has progressed throughout the treatment
    c. CM can begin to highlight/ask about activities patient will work towards in the future

3. Review of treatment course (10 minutes)
    a. Solicit **patient's impressions of the changes they've made**
    b. Solicit **patient's opinions** about how treatment went for them
        i. What has doing this work been like for them?
        ii. What changes have they noticed in their life? In their families?
        iii. What was helpful? Not so helpful?
    c. **Solicit patient's current understanding** of their mental health symptoms, use, craving and how this treatment was designed to help with these issues
        i. Listen for understanding of the links between engaging in valued activities and mental health and substance use recovery
        ii. Reinforce and clarify as needed
        iii. CM provides own views on this topic (either integrated into each question or presented separately, after the participant has provided his/her views
            1. Be sure to emphasize gains and strengths you've seen, in addition to highlighting areas for future work.
            2. Highlight differences in current functioning from functioning at the beginning of treatment.
            3. Concretely describe changes in activity level and types of activities in which patient is now engaging.
    d. As part of the review of progress, CM and patient review the original **<u>Values and Priorities List</u>** and graphs of the mental health symptoms, use, and craving over time
    e. If patient has made very few gains in treatment, CM shares views on the reasons for this and suggest options for additional care (e.g., *It seems like you've had so much going on for you that it's been very difficult to put a lot of these ideas into practice…this treatment was designed as a first step for treatment and many people benefit from additional and/or different treatment after completion of this program…*etc.)

4. Identify areas for future growth (3-5 minutes)
    a. Inquire what patient sees as **next steps** for them in building their life
    b. **Revisit the original values and priorities identified** and see what remains to be addressed
        i. Remind patient that this work is lifelong
        ii. Goals may be met but living in ways that are consistent with one's values is ongoing and never "finished" or "completed"
    c. **Review strategies** for identifying and meeting goals consistent with CHAMP BA

5. Develop a Recovery Support Plan
    a. Use the **Recovery Support Plan Worksheet** to record the plan. BA can be helpful to frame this discussion. Engaging in routine follow up is an important behavioral to reinforce. Note: the **Bolded** headings below correspond directly to the worksheet and information you and your patient will want to include in the plan. The rest of the text is meant to help contextualize the discussion and to trigger additional problem-solving as needed.
        i. **Plan for ongoing use of OUD and MH medications**
            1. What is the plan?
                a. Identify any possible barriers to getting prescriptions filled
                b. Identify any possible barriers to taking medications as prescribed (including temptations to use substances and "spontaneous" lapses in taking meds)
                c. Forecast temptations to "test" oneself regarding either use or discontinuing medications
                    i. Make a plan for the possibility patient will in the future want to attempt to d/c some or all of their medications so they can do it safely and with support
                    ii. Make sure patient knows who to contact with questions and to ask for assistance regarding medications
        ii. **Additional treatment**
            1. If patient needs it and is interested in additional treatment, help connect them with such services or arrange for periodic appointments to touch base, for example, when patient comes in for medication management appointments
        iii. **Personal warning signs/Triggers to avoid** resuming problematic substance use
            1. What are the warning signs that things are starting to head in the wrong direction for your patient?
                a. Reverting to old behavior patterns (staying in bed, avoiding friends, cutting out enjoyable activities, falling down on responsibilities, etc.)
                b. Feeling stuck in negative emotion and/or thought cycles (increased depression, anxiety, PTSD symptoms, feeling irritable and angry, difficulty controlling temper, poor sleep, etc.)
                c. Cravings for substances are increasing and finding oneself re-engaging with old people, places, patterns that were associated with use
            2. What sorts of situations have historically led to poor mood, increased craving, increased use or return to use?
                a. When might those happen in the future?
                b. What about surprise stressors? How has your patient dealt with these in the past?

3. Ideas for maintaining awareness of mental health, triggers for cravings, craving, use patterns
    a. Encourage patients to keep an eye on themselves over the long haul
    b. Brainstorm ways to build this into patient's lives over time
        i. Pick a day of the week to reflect on how doing
        ii. Find someone in life to check in with regularly

iv. **Things that help patients feel better** and remain engaged in their lives
1. Generate a list of activities that help your patient feel better
2. Make a plan for bringing in more of what helps patient feel better
    a. What strategies (including focus on values/priorities) can your patient use and fall back on to get through tough times?
    b. See how the plan is working
    c. Be willing to flex as needed
3. Helpful to include a reminder that they may need to keep going with activities (or restart them) even when mood is low or cravings are high, etc.
4. Some patients will benefit from reminders to advocate for themselves and to request feedback and support from their family and friends
5. Remind patients they will likely need to prioritize self-care to support their long-term recovery
    a. People with addiction and mental health challenges often aren't able to get by with less sleep, exercise, nutrition, down-time (etc.) in the same ways others around them might seem to be
    b. Setting boundaries around time and self-care may need to be negotiated with close others, but it's key that this happen
6. Suggest that patients ask their people to speak up if they notice that they are getting less active or mood is worsening
    a. Normalize and encourage patients to ask for support, assistance engaging or re-engaging with activities as needed
7. Remind patients that it's helpful to keep enjoyment and mastery in mind when choosing how to get active
8. Encourage being kind to oneself and letting go of perfection

v. It's helpful to anticipate and normalize that patients are likely to have uneven progress over time, including worsening mood, possibly returning to use
1. Many people have difficulty maintaining progress consistently
    a. It's not a sign of failure
        i. We can't anticipate everything; sometimes life throws us curves that are hard to manage
        ii. For various reasons we also may let up on the routines and self-care that help us cope
    b. One can get back on track

Developing a strong recovery support plan can help both the providers and patients feel reassured during this transition. This is important as there is almost always more that can be done AND there are more patients knocking at the door that makes completing an episode of care important as part of your role to support the entire population served in your clinic.

K. Disposition in CHAMP

1. Often in Collaborative Care settings there is a tension between wanting to provide ongoing support for one's patients and the need to have space for new folks
    a. Thus, an important function of the CoCM team is to make these sorts of treatment disposition decisions together
    b. After approximately 6-8 sessions of BA, it can be helpful for the CoCM team to reflect on the following questions:
        i. Has the patient had some success setting and achieving goals?
            - ✓ **Consistent abstinence from opioids**
            - ✓ **Consistent attendance**
            - ✓ **Stable improvements on symptom measures**
            - ✓ **Achievement of BA goals**
        ii. Does the patient have a basic understanding of BA principles, such as BA being an outside in (rather than inside out) therapy and the importance of staying engaged and active in one's life (as opposed to relying heavily on avoidance for coping)?
        iii. Do they have some useful coping tools they know how and when to use?
        iv. Are they stable with their MOUD and psychiatric medications?
            1. When the answers are "yes", patients are likely ready to transition back to ongoing care with their PCP
            2. When the answers are mixed and patients remain engaged with treatment, the team can develop a plan to help patients get the last bits under their belts
            3. When the answers are "no" or it's apparent the patient is struggling and would benefit from more intensive treatment, there are several steps that should be taken.
                a. Reassess for changes or additional MHD or SUDs
                b. Reassess for other complicating factors that could be affecting treatment (i.e. social determinants of health)
                c. Alter treatment to better address destabilizing factors and look for ways to intensify treatment within CHAMP for a brief period of time.
                    i. More regular visits with PCP or CM
                    ii. Shorter prescription timeframes
                    iii. Link treatment goals to contingencies (less frequent visits, longer prescriptions, less frequent urine drug screens-make it explicit)
                    iv. Consider referral to specialty mental health care
            4. When the answers are "no" or it's apparent the patient is struggling **but the patient has made it clear they will not attend more intensive treatment**, the CoCM team needs to develop a plan for helping the patient get more traction in treatment and also set some realistic benchmarks so that CMs know when it may be time to pull back on session frequency or end care even if the patient is still struggling or has not reached optimal end goals
                a. It is quite uncommon that CM's and Psychiatric Consultants will decide that a patient needs to be discharged from care even if a patient is not in remission and refuses a higher (more appropriate) level of care

b. When this does occur, it is usually because the patient has a personality disorder that is interfering with them being able to benefit from care.
    i. There is no support for Collaborative Care being an effective intervention for people with pronounced personality disorders and when it is clear that a solid effort was made to help the patient and things are at an impasse, it's ok to set boundaries and establish a more minimal treatment plan (e.g., ongoing prescription of MOUD and monthly check-ins with the CM)
c. The CM and Psychiatric Consultant will need to have discussed the issues surrounding such patients and to have explicitly given the patient a chance to come on board with using the offered treatment productively well ahead of a significant reduction in the treatment plan.

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Appendix 1. BA Activity Template

CHAMP BA Free and Low Cost Ideas for the XX Area
[TEMPLATE ~ remove this line]
Last Updated: ________

[Guidance: This is a template that is already partially populated with ideas you can share with your CHAMP BA patients. To make it much more useful and appealing, we encourage you to add in options for your local area, including things that you and your colleagues know of or that your patients come across. Basically, it's great to see this as a living document that can be added to and pruned over time. It is organized thematically, but you should feel free to rearrange the themes, add or delete them as you see fit.

In the time of covid-19, you may want to organize the categories and items within them to lead with those activities that can be done from home or that offer opportunities for safe social distancing.]

[Note: Be sure to remove everything set off by brackets and that is in turquoise font.]

Nature and Outdoor Activities

Ideas:

- Take a nature walk at _____ [list local parks or nature areas]
- Go star gazing on a clear night- use a book to identify stars
- Pick blackberries, blueberries, or raspberries and make a cobbler or a pie
- Plant a garden or grow flowers
- Take a scenic drive
- Visit a garden and identity flowers from a flower guide
- Go bird watching at a park and identify different birds with a book
- Go to a local farmers market
- Go swimming at a local beach
- Find free botanical or specimen gardens in your area [list for area]

Local Trails

[These are examples from the Seattle area to provide a sense of the details needed here and in other categories below.]

Burke- Gilman Trail- Seattle to Kenmore

- 14 miles, paved trail begins at Gas Works Park on Lake Union and follows the ship canal north along lake Washington
- Access areas: Gas works park, Matthews beach park, and Tracy Owen Station Park
- Questions? (206) 684-4075

Sammamish River Trail-Bothell-Redmond

- 10 miles of paved trail begins at Blythe park in Bothell and extends to Marymoor park in Redmond.
- Horseback riding permitted on a separate equestrian trail from northeast 175th St. in Woodinville to Marymoor Park
- Questions? (206) 296-4232

Snoqualmie Valley Trail- Duvall, Carnation, Snoqualmie, North Bend

- Crushed rock surface, 36 miles trail on former rail route
- Access points: McCormick Park near Duvall, Rattlesnake Lake Recreation area near North Bend, Loutsis Park near Carnation and Northeast 4th S. and Ballarat Ave in North Bend.
- Questions? (206) 296-4232

Gardens

Arboretum Japanese Garden-Seattle

- Traditional Japanese garden includes a pond with koi, a tea house, and a waterfall
- West side of lake Washington blvd, north of the east Madison street entrance to the Washington park arboretum in Seattle
- (206) 684-4725, call for open hours
- Admission: adults $5, children and seniors $3
- Www.ciseattle.wa.us/parks/parkspaces/gardens.html

Kubota Gardens- Seattle

- 20 acres Japanese-American garden with northwest influence
- 55th Ave S. and Renton Ave S., open dawn to dusk daily; Admission is free.
- Questions: (206) 684-4584, for guided tours: (206) 725-5060
- Guided tours: every 4th Saturday of the month at 10am; or if you have 8+ people

Outdoor Clubs

Outdoors for All

- Outdoors for All offers a variety of recreational activities for children and adults with disabilities.
- 6344 NE 74th St, Suite 102, Seattle, WA 98115, (206) 838.6030 x200
- Email: info at www.outdoorsforall.org

OutVentures- Seattle

- Gay and lesbian outdoor adventure club with inline skating, day and overnight hikes, scuba diving, field seminars, canoeing, kayaking, snow sports, biking, and social activities
- Membership dues $20 individual, $30 couple at same address
- www.outventures.org

Exercise

Ideas for low cost exercise:

- Go for a bike ride on a local trail, or see the trail listings for ideas
- Fly a kite or throw a Frisbee

- Roller skate or roller blade at a park in a local skating ring
- Wash the car
- Put your favorite music on and dance with a partner or around the house by yourself
- Play a game of tennis, basketball, soccer, racquetball, etc., outdoors or at your local YMCA
- Climb the stairs instead of using an elevator
- Go swimming at your local community pool or the beach
- Take a walking tour of downtown
- Park your car in the last space and walk to your destination
- Do sit ups during commercials while watching TV
- Walk the dog
- Gardening, chopping wood, pulling weeds, yard work with your favorite music
- Canoeing with a friend
- Painting the house/garage, or volunteer to help with a painting project
- Mall walking

Animals

Kelsy Creek Farm- City of Bellevue Parks and Recreation

- Non-operating farm with self-guided tours, animals available for viewing 9:30am-3:30pm
- 410 130th Pl SE Bellevue, WA, (425) 452-7688
- Admission is free

Washington Serpentarium- 1 mile east of Monroe Hwy 2

- Reptiles and snakes and the world's largest spiders and centipedes
- Daily 10-6pm
- (360) 805-5300, or www.reptileman.com
- Admission is $6 per adult, $5 per child

The Arts

Ideas for low cost arts and crafts:

- Design your own stationary with stamps, colored pencils, stickers etc.
- Create a collage with magazines or positive affirmation
- Make a sandcastle at the beach
- Pick flowers and dry them by hanging them upside down
- Embroider something- jeans, t-shirt, pillowcase
- Tie-dye a t-shirt, pillowcase etc.
- Make a patchwork quilt with old scraps
- Make greeting cards by ironing little flowers between wax paper
- Decorate cutout cookies
- Press flowers between the pages of a heavy book from dried flowers and make cards or pictures
- Make bead necklaces, earrings, or bracelets
- Make wax candles: pour ice cubes in paper milk cartons, melt crayons and wax in an old pan, then pour over the ice cubes and dangle a string into the carton for a wick and let it cool
- Paint or refinish old furniture

Art and Craft resources

The creation station- Lynwood

- Buy a variety of low cost arts and craft materials (fabric, spools, stickers, etc)
- Creation station will supply space and materials for classes, field trips, or birthday parties
- 19511 64th Ave W., Lynwood, (425) 775-7959

Circle of Friends for Mental Health

- Non-profit organization that offers classes in visual arts, music, writing, drama, and photography to people with mental health illness
- Carolyn Hale, (206) 325-6386
- www.cofmentalhealth.org
-

Museums

EMP- Experience Music Project- Seattle

- 323 5th Ave N
- Empsfm.org
- Admission is free the 1st Thursday of the month, 5-8pm

Animation USA- Seattle

- Filled with contemporary and vintage animation art
- 409 1st Ave S. & pioneer square, (206) 625-0347
- Admission is free

Center of Contemporary Art- Seattle

- 3091 1st Ave., (206) 621-1693, call for daily hours
- www.cocaseattle.org
- Admission is free

Theatre

Bainbridge Performing Arts

- plays, music performances, uplifting comedy, innovative theatre school, community and children's productions in a small, low cost community theatre
- Box Office hours: 1:00pm to 4:00pm, Wednesday - Friday, or one hour prior to performance -(206) 842-8569 or available online
- www.bainbridgeperformingarts.org

The Intiman Theatre-Seattle

- 201 Mercer St'; (206) 269-1900 or www.intiman.org
- Call for visit the website for show times and dates
- First Thursday showing of each event "pay as you can" with a $5 suggested donation

Tickets

Ticket Ticket
Offers half price, day of show tickets for local theatre, comedy, music, dance, and other special event performance
Locations:

- Downtown Seattle, 1st and pike at the entrance to pike place market. Hours: Tuesday-Sunday 12-6pm, (206)342-2744
- Capitol Hill, 401 Broadway east inside the Broadway markets', 2nd level. Hours of operation: Tuesday-Sat: 12-6pm (206)324-2744
- Bellevue, Myedenbauer Center 11100 NE 6th st., hours of operation: Tue-Sun 12-6 (425)637-1020

VetTix
Deeply discounted event tickets for Veterans
http://www.vettix.org/

Movies

[List local movie theaters and outdoor movie options that have reduced ticket prices.]

Music

Free Concerts/Seasonal
Chittenden Locks-Seattle

- 3015 NM 54th St.
- Free music Saturdays and or Sundays June to September
- Call for scheduled events (206) 783-2059

Bellevue Botanical Gardens-Bellevue

- 12001 Main St., (425) 451-3755 or www.bellevuebotanical.com
- Free concerts all summer long
- Call or check the website for more information

Social Activities

- Go to a free sporting event
- Walk through local open air market and listen to street musicians
- Tour a bakery and munch the free samples
- Put a photo album or scrapbook together
- Cook a special meal
- Visit the international district and sample food

Resources To Check Out At The Library

Books

- Seattle Best Place: By Nancy Leson & Stephanie Irving
- Nature Walks In & Around Seattle : By Shephen R. Witney
- Mr. Cheap Eats: By Robinson & Irving
- The Seattle Super Shopper 8th Edition: By Vicki Koeplin

Computer Access

- Search the web
- Explore community resources online
- Set up an email account

Resources to check out and take home

- Movies
- Books
- Tapes and CDs

Story Times

- Call (206) 621-8646 for information about local story telling events
- Call (206) 386-4656 for storyline and hear a story told over the phone

The Answer Line

- Answers questions regarding local resources and general information
- Call (425) 426-9600 or 1(800) 462-9600
- Monday-Thursday 8am-9pm, Friday 8am-6pm, weekend 1pm-5pm

Coupons

City Pass

- Adult $59 and children (4-12) is $ 39
- Includes admission to 6 Seattle attractions: Seattle Aquarium, Space needle, Pacific Science center, EMP museum, Argosy Cruises- Seattle Harbor Tours, Woodland Zoo OR The Museum of Flight

Seattle Mayor's Flash Card

- give cardholders discounts for events, goods and services at businesses and organizations throughout King County
- Available at The Mayor's Office for Senior Citizens, Community Services for the Blind and Partially Sighted, and the Special Technology Access Resources (STAR) Center
- For more info or directions –(206) 684-0500

Valupak.com

- Plug in your zip code and get discount coupons for eating out, recreation and more!

Web Resources

NWSource.com

- Great online recreation guides including: hiking, dog parks, farmers markets, dining out etc

Seattleinsider.com

- Check out Friday's "weekend Best Bets" for great ideas to plan your weekend!

www.Seattle.gov

- The community calendar lists paid and free events in the local community

Newspaper

Check out the Friday newspaper. Every Friday our local papers have weekend planning guides that list free fairs, festivals, and events, movie times for your local theaters, upcoming theatre and concert events, and restaurant reviews- including prices. Find something to do that day, weekend or plan ahead. The Thursday paper includes *The Northwest Weekend* which also has great ideas for getting out and having fun.

The Seattle Times
Look for "The Ticket"

The Eastside Journal
Look for "What's Happening"

The Seattle Weekly
Free publication with event listings

Educational Resources

Discover U

- Offers quality educational and recreational program for professional and personal development
- 2150 N 107th St., suite B52, (206) 365-0400
- www.discoveru.org
- Mon-Thurs: 9-7pm; Fri: 9-6pm; Sat 9-1pm

P.C.C (Puget Consumer Cooperative)

- Food works programs offers variety of classes at various store locations
- Call (206) 545-7112 for more information or pick up a class brochure at any PCC store
- Classes offered at Greenlake, Issaquah, W. Seattle
- 400 classes per year, 3 seasons, spring summer/winter/fall
- Health classes/wellness
- Italian, Thai - 60% of classes are vegetarian
- You can also use the website to learn more www.pccnaturalmarkets.com

Additional Ideas for Taking a Class

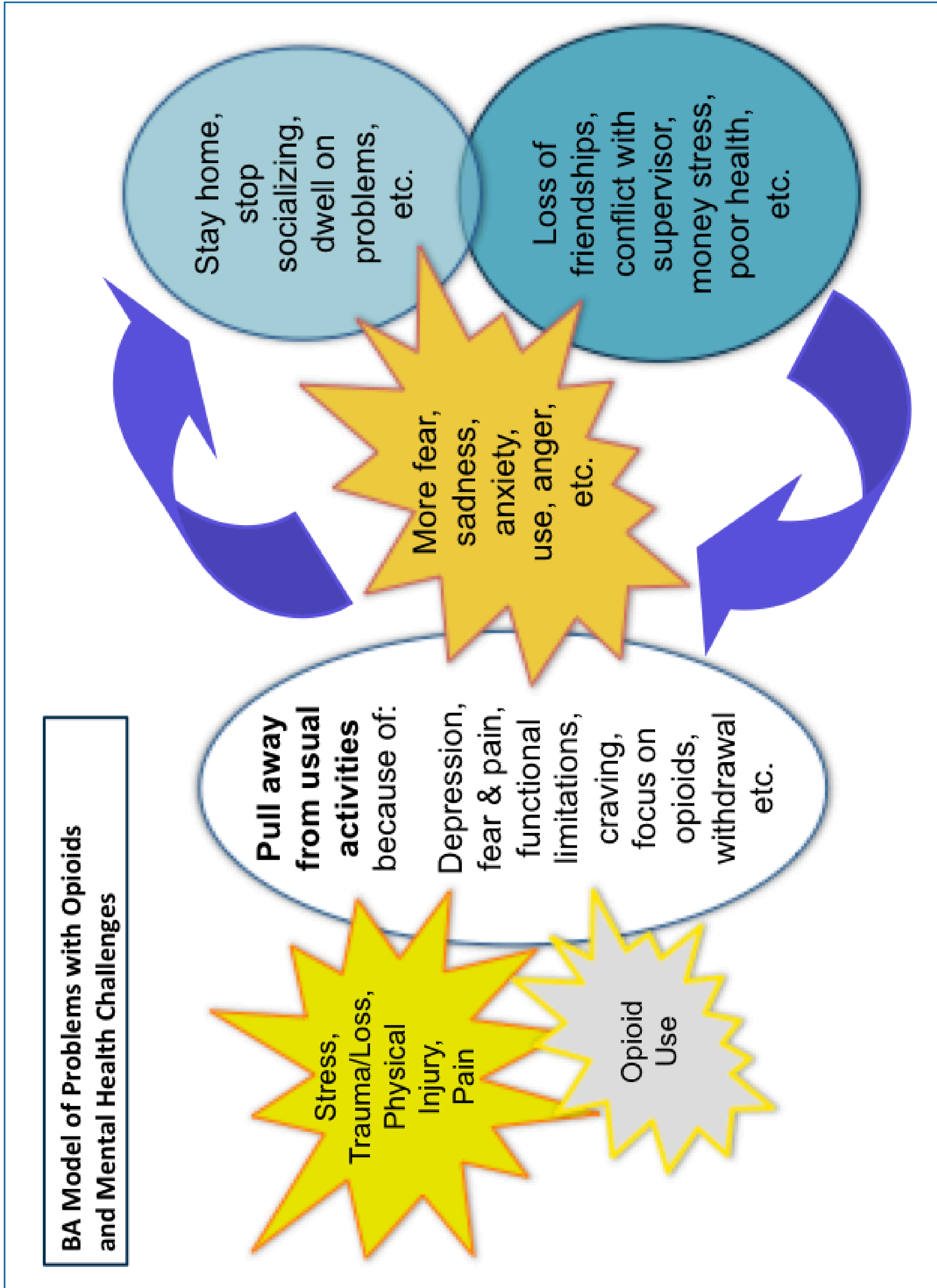
- Check out the library for free or low cost classes
- Check out local university or community colleges
- Community centers
- Park and recreation departments
- Look for local options for veterans
- Look for local options based on interests

Volunteer

Volunteer Match- www.volunteermatch.org

This is a national listing of volunteer opportunities. You can plug in your interests and zip code and find opportunities near you

Appendix B. BA Heuristic Model



Appendix C. OUD, Chronic Pain, and Mental Health

Chronic Pain, OUD, and MHD

1. **Chronic pain**
    a. Chronic pain is a common pathway that can lead people to develop problems with opioids and other substances
    b. Half or more of people with OUD have current non-cancer-related chronic pain (Dahlman et al., 2017; Dhingra et al., 2014; see Voon et al., 2018)
    c. Some patients who struggle with both pain and overuse of opioids (with and without other substance use issues) feel doubly stigmatized
        i. They may feel they have to "prove" they are tough by pushing themselves to do things that exacerbate their pain
        ii. Their substance use may be partially to help them cope with such intermittent increases in pain (Dassieu et al., 2020)
    d. Those contending with chronic pain may feel that their pain is poorly controlled and that their relationships with healthcare providers are not optimal or are even adversarial (Dassieu et al., 2020; Voon et al., 2018)
        i. Patients may feel their providers don't respect their understanding of their unique pain and how it is best managed
        ii. Patients may feel judged by providers, that their providers think they are addicts or junkies
        iii. Patients may feel as though they have no say in what their care looks like
        iv. Patients may desire to use non-drug options for pain control but they are too expensive or not available
        v. Patients may feel their providers have focused on one or the other issue – opioid use OR pain (usually the former) – rather than dealing with them in tandem (Speed et al., 2018)
    e. Factors that have been found to build provider/patient relationships in the setting of chronic pain and opioid use include (Marchand et al., 2020)
        i. Feeling valued and supported by providers helps facilitate **"opening up"**. Asking for and reflecting their pain story can help with this.
        ii. **"Being part of care"** is facilitated when
            1. patients feel it's safe to ask for what they need
            2. patients are explicitly asked to collaborate in treatment planning, which leads to better engagement and treatment satisfaction
        iii. Providers treating patients with chronic pain and opioid use issues report that treatment relationships are stronger and treatment is supported when they (see Beitel et al., 2017)
            1. themselves are more empathetic with their patients
            2. pay good attention to small signs of progress
            3. engage in their own self-reflection about their responses to their patients and how treatment is going
                a. Utilizing support from other members of the Collaborative Care team or other CMs in the clinic is likely to be helpful to CMs as well
    f. Buprenorphine is often an effective treatment for both OUD and for chronic pain (see reviews

by Aiyer et al., 2018; Eilender et al., 2016)

g. BA is a natural fit for people whose lives have been impacted by chronic pain
    i. BA emphasizes building mastery and engaging in enjoyable activities that are values based
    ii. Behavioral goals are developed to be manageable
        1. Barriers (including avoidance) are anticipated and contingencies are developed
        2. Facilitators are actively brought to bear
    iii. In the setting of chronic pain, the following are potential behavioral activation targets:
        1. Improved sleep hygiene
        2. Physical activity (with thoughtful pacing)
        3. Chronic pain education – it is an illness in itself
        4. Diaphragmatic breathing
        5. Progressive muscle relaxation/visual imagery

Appendix D. Values Checklist & Goal Identification

Day/Date___________

VALUES AND PRIORITIES LIST

Below is a list of values and priorities. Consider which areas are important to you at this point in time. This may be the same or different than your priorities and values before you struggled with OUD. Do take care to indicate which areas are important to you, not just which you think are possible for you (what may seem possible can be influenced by substance use, anxiety, depression, and PTSD). *Check the overall values headings and any of the individual priorities that may apply.*

____ **A. Attend to Relationships:**
1. Repair old relationships
2. Reach out for new relationships
3. Work on current relationships
4. End destructive relationships
5. OTHER: ____

____ **B. Be Part of a Group:**
6. Have close and satisfying relationships with others
7. Feel a sense of belonging
8. Receive affection and love
9. Be involved and intimate with others, have and keep close friends
10. Have a family and stay close and spend time with them
11. Have people to do things with
12. OTHER: ____

____ **C. Be Powerful and Able to Influence Others:**
13. Have the authority to approve or disapprove of what people do, to control how resources are used
14. Be a leader
15. Make a great deal of money
16. Be respected by others
17. Be seen by others as successful. To become well known. To obtain recognition and status.
18. Compete successfully with others
19. Be popular and accepted
20. OTHER: ____

____ **D. Achieve Things in Life:**
21. Achieve significant goals. Be involved in undertakings I believe personally are significant
22. Be productive
23. Work towards goals; work hard
24. Be ambitious
25. OTHER: ____

____ **E. Live a Life of Pleasure and Satisfaction:**
26. Have a good time
27. Seek fun and things that give pleasure
28. Have free time
29. Enjoy the work I do
30. OTHER: ____

____ **F. Keep Life Full of Stimulating Events, Relationships and Things:**
31. Try new and different things in life
32. Be daring and seek adventures
33. Have an exciting life
34. OTHER: ____

____ **G. Behave Respectfully:**
35. Be humble and modest, do not draw attention
36. Follow traditions and customs, behave properly
37. Do what I am told and follow rules
38. OTHER: ____

____ **H. Be Self-Directed:**
39. Follow my own path in life
40. Be innovative, think new ideas and be creative
41. Make own decisions and be free
42. Be independent and take care of myself and those I am responsible for
43. Have freedom of thought and action. Be able to act in terms of my own priorities
44. OTHER: ____

____ **I. Be a Spiritual Person:**
45. Make room in life for spirituality; live life according to spiritual principles
46. Practice a religion or faith
47. Grow in understanding myself, my personal calling and life's real purpose
48. Discern and do the will of God (greater power) and find lasting meaning in life
49. OTHER: ____

____ **J. Be Secure:**
50. Live in secure and safe surroundings
51. Be physically healthy and fit
52. Have a steady income that meets my own and my family's basic needs
53. OTHER: ____

____ **K. Recognize the universal good of all things:**
54. Be fair, treat people equally and provide equal opportunities
55. Understand different people, be open-minded
56. Care for nature and environment
57. OTHER: ____

____ **L. Contribute to the Larger Community:**

58. Help people and those in need; care for others' well-being, improve society
59. Be loyal to friends and devoted to close people; be committed to a group that shares my beliefs, values, and ethical principles
60. Be committed to a cause or to a group that has a larger purpose beyond my own
61. Make sacrifices for others
62. OTHER: ____

____ **M. Work at Self-Development:**

63. Develop a personal philosophy of life
64. Learn and do challenging things that help me grow and mature as a human being
65. OTHER: ____

____ **N. Have Integrity**

66. Be honest and acknowledge and stand up for my personal beliefs
67. Be a responsible person, keep my word to others
68. Be courageous in facing and living life
69. Be accepting of myself, others and life as it is, living without resentment
70. OTHER: ____

From: Linehan, M. M. (2014). *DBT Skills training handouts and worksheets*. Guilford Publications. NY:NY.

Day/Date___________

Goals List

Using the more specific values-oriented ideas you identified on the “Values and Priorities List” as a guide, please think about 2-5 broad or long-term goals you’d like to address in treatment. These should be things that are very important to you and should include a few of the different areas you identified as being important.

Don’t worry about making the goals specific right now. We’ll make short-term goals in the next session.

For example: If you chose “(A) Attend to Relationships: work on current relationships” you might make a long-term goal of “Be more involved with my children.” If you chose “(E) Live a Life of Pleasure and Satisfaction: seek fun and things that give me pleasure” a long-term goal you could make is “Pick up a new hobby I enjoy.”

1. ____

2. ____

3. ____

4. ____

5. ____

Modeled after: Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten Year Revision of the Brief Behavioral Activation Treatment for Depression: Revised Treatment Manual. *Behavior Modification*, *35*(2), 111–161. https://doi.org/10.1177/0145445510390929

Appendix E. Safer-Use Strategies - HaRRT

Safer-use Strategies: Downers/Depressants

Depressants are "downers" and include opioids, benzos, and barbiturates. They can be prescribed like Oxy, Vicodin, and Xanax, or street drugs like heroin. Here are some tips to help you stay safer and healthier no matter how you choose to change your use. Using more safely does not mean that you remove all risks, including death, but it can help you reduce your drug-related harm. You are worth it!

Group	Strategy	Why? / How?
Ways to be safer and healthier without changing use	Carry rescue drugs	• **Why?** Opioids like heroin, fentanyl and Oxys can lead to overdose. • **How?** Carry naloxone (Narcan) with you and give it to your family and friends who are near you when you use. Naloxone is a drug that may be inhaled through your nose or injected to reverse an opioid overdose. Use the buddy system when you use opioids so your friend can administer naloxone. Check out www.stopoverdose.org.
	Test your drugs	• **Why?** You can be more aware if your drugs are cut with other drugs (like fentanyl) or fillers (like levamisole) that could harm you. Note: Current methods are not failsafe. • **How?** Talk to providers about getting a urine drug testing kit and testing liquids before you shoot them. For pills and powders, check out https://dancesafe.org for testing kits.
	Nuture your body	• **Why?** Some depressants can dull your appetite, and used in larger quantities, depressants can take their toll on your body. • **How?** Try to eat nutritious foods before you use, pack healthy snacks and water on the go. **For people who <u>don't</u> get strung out:** Let you body rest for at least a day before using again, and try to take just as many days off as you used for.
	Take care of your veins	• **Why?** If you are shooting drugs, you can take care of your veins. • **How?** Drink water to keep yourself hydrated, rotate your injection sites, and learn about techniques that could help you stay safer and healthier when you use (e.g., http://harmreduction.org/issues/drugs-drug-users/drug-information/straight-dope-education-series/).
Ways to use more safely	Choose safer ways of using	• **Why?** Some ways of using drugs are less risky to your health. • **How?** Taking drugs by mouth is safer than snorting or smoking which is safer than shooting. Snorting opioids has a greater risk of overdose than smoking them. You can get clean works at the People's Harm Reduction Alliance or the King County Needle Exchange.
	Shoot safer	• **Why?** Avoid overdose, bloodborne illness (HIV and hepatitis C), bacterial infections. • **How?** Pace yourself until you know the strength of your stash. Shooting into veins in your arms or hands is safer than hitting blind into your groin or into your neck. Rotate sites and shoot downstream if possible. Using new, clean needles and works can help prevent bloodborne illnesses, like HIV and hepatitis C, and other infections.
	Avoid mixing drugs	• **Why?** Using different drugs at the same time can have unexpected effects, put stress on your heart, and lead to overdose. • **How?** Try to stick to one drug at a time, especially when you are unsure of its strength or content.
	Use with safe people in a safe place	• **Why?** Use of depressants can cause sleepiness, make you confused, and lower your inhibitions. People can take advantage of you when you're high. • **How?** Avoid using with people you don't know or trust. Use where you feel safe and in control of the surroundings. Do not drive or ride your bike when you are high.
Ways to change how much you use	Less is more	• **Why?** You can avoid overdosing or experiencing drugs' toxic effects. • **How?** You can decide how you want to limit your use. You could choose to buy only a certain amount or set a spending limit. Leave the rest of your money at home or in a safe place. You might ask a trusted friend to remind you of your limit.
	Choose not to use	• **Why?** Not using--even for a few hours or days--gives your body a rest and may help you to avoid your body or mind becoming dependent on depressants. • **How? If you are <u>not</u> yet dependent and don't get strung out**, you should not use for long periods of time and take days off from use every week to avoid getting hooked. Check in with a provider if you want to stop altogether.
	Talk to a provider about withdrawal	• **Why?** If you are highly dependent, alcohol and benzo withdrawal can be life-threatening. Other depressants may have uncomfortable withdrawal symptoms. These can be particularly harmful to unborn babies and people with HIV or other illnesses. • **How?** Talk to your provider if you are cutting down or stopping. They may be able to help. Also, there are some effective medications to help with opioid dependence.

For more information, contact the Harm Reduction Research and Treatment Center at 1 (855) 320-1004 or at harrtlab@uw.edu.

Appendix F. CHAMP Case Formulation Guide

CHAMP BA *Formal* Case Formulation Guide

Patient Initials: _______ / CM Initials: ________ / Date: ______________

1. Patient characteristics and stressors

Age: _______ Gender: _______________

Race/Ethnicity: ____________________

Sexual orientation: _________________

Relationship status: ____________________

Living situation: _______________________

Employment status: _______________________

Educational attainment: ____________________

Do they have children? If so, describe: ______________________________

Any other noteworthy characteristic(s): _____________________________

Prominent Stressors: ____

2. Mental Health, Substance Use, and Pain Information

Mental Health and SUD Diagnoses and severity <u>at entry</u> to Collaborative Care:

Diagnosis	Measure	Score

Chronic pain <u>at entry</u> to Collaborative Care:

Nature of their substance use <u>at entry</u> to Collaborative Care (comments could include types of substances used, routes of administration, level of harm or severity of consequences associated with use):

Primary motives for substance use:

Primary concerns regarding mental health issues and/or substance use:

Mental Health Diagnoses once OUD is stable:

Chronic pain once OUD is stable:

3. Mastery and Pleasure

Mastery Considerations

Current (and/or past) Strengths and Abilities:

Pleasure/Enjoyment Considerations

What does (or did) your patient find Enjoyable or Pleasurable?

4. Social Support

What is the nature of your patient's social support? (e.g., Who in their life can they turn to? Do they have people they can do things with? Are there relationships that are strained?, etc.)

5. BA Goals

What is your patient's answer(s) to the question: "What would you like to see happen for yourself during this treatment?"

What are their goals for their substance use?

What goals are they working on to bring more mastery and pleasure into their lives?

6. Barriers and Facilitators of Goal Attainment

What are likely mental health, substance use, and contextual circumstances that could pose challenges for you patient in addressing or meeting their goals?

What strengths and supports does your patient have that could facilitate them addressing or meeting their goals?

Appendix G. Weekly Schedule for CHAMP

Weekly Schedule for CHAMP

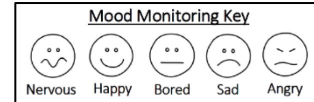
Create a schedule of things you have been avoiding. If you are feeling depressed or anxious, you may find it difficult to accomplish big tasks. We can work toward this! If you feel this way now, start with simple goals and work your way up. Be sure to include a list of people you could do some of these activities with, if that would help you to ensure you can do them!

Day	Morning	Afternoon	Evening
Example	• Meet with walking buddy • Coffee at coffee shop	• Email to nephew • Play guitar	• Grocery shopping for the week • Dinner with neighbor
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Appendix H. BA Activity Monitoring Form

Daily Activity and Mood Monitoring

Start Date: ______________________



Use the form to chart your activities each day, including whether you took your opioid medication. After you list an activity, rate your mood or moods. Use the ***Mood Monitoring Key*** if it's helpful or write about moods/feelings in the Notes section. At the end of each day, record the strongest degree of cravings for substances you experienced (if any), and whether your substance use was within your goal or wasn't within your goal.

	Activity Record activities you engaged in each day	Mood Rate mood after each activity	Craving and Use
Sunday	1. Took Medications? Yes ____ No ____ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	1. 2. 3. 4. 5.	Craving |----------------------------| None Lots Was your substance use within your goal? Y ___ N ___
	Notes:		
Monday	1. Took Medications? Yes ____ No ____ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	1. 2. 3. 4. 5.	Craving |----------------------------| None Lots Was your substance use within your goal? Y ___ N ___
	Notes:		
Tuesday	1. Took Medications? Yes ____ No ____ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	1. 2. 3. 4. 5.	Craving |----------------------------| None Lots Was your substance use within your goal? Y ___ N___
	Notes:		

	Activity	Mood	Craving and Use
Wednesday	1. Took Medications? Yes ____ No ____ 2. ________________ 3. ________________ 4. ________________ 5. ________________	1. 2. 3. 4. 5.	Craving |---------------------------| None Lots Was your substance use within your goal? Y ___ N___
	Notes:		Mood Monitoring Key Nervous Happy Bored Sad Angry
Thursday	1. Took Medications? Yes ____ No ____ 2. ________________ 3. ________________ 4. ________________ 5. ________________	1. 2. 3. 4. 5.	Craving |---------------------------| None Lots Was your substance use within your goal? Y ___ N___
	Notes:		
Friday	1. Took Medications? Yes ____ No ____ 2. ________________ 3. ________________ 4. ________________ 5. ________________	1. 2. 3. 4. 5.	Craving |---------------------------| None Lots Was your substance use within your goal? Y ___ N___
	Notes:		
Saturday	1. Took Medications? Yes ____ No ____ 2. ________________ 3. ________________ 4. ________________ 5. ________________	1. 2. 3. 4. 5.	Craving |---------------------------| None Lots Was your substance use within your goal? Y ___ N___
	Notes:		

Appendix I. CHAMP BA Behavioral Analysis Worksheet

Step 1: Describe the action or inaction that needs to be unpacked:	
What happened or didn't happen?	
When and **Where** did it take place?	
Who was present?	
Anything else that helps to set the stage?	

Step 2: What led up to the incident…..	
A. What happened just before this?	
B. And just before A?	
C. And just before B?	
D. And just before C?	
Keep going back in time until it seems likely that the root cause has been identified	

Step 3: What are the take-aways from Step 2? What could be done differently next time or in similar situations?	
1.	4.
2.	5.
3.	6.

Additional notes:

Appendix J. BA Generic Session Cheat Sheet

CHAMP BA "Cheat Sheet" for Regular Sessions

	Task Elements	Suggested Time Allotment	Handy Reminders
✓	**Review Assessments of:** o Mental health symptoms o Medication Compliance o Opiate craving/use	5 – 7 minutes	**Anything contributing to de-activation?** o If so, use the information when reviewing the past week's work o Address it when planning the next week's goals and activities
✓	**Review Daily Monitoring Form and Weekly Schedule** o How did things go? o How felt doing activities? o Any unexpected use risks? o Anything wanted to do but didn't?	15 minutes	**What to listen for and perhaps comment on:** o Any hesitations or concerns that may need further attention o Anything that went well or was easier than anticipated?
	Trouble-shoot as needed o What got in the way? o Was the goal too ambitious? o Is it still a desired goal? o Recurrence of use?		**Look-out for:** o Avoidance and/or Rumination/worry o If yes to either, is it related to the "trouble-shoot issues" or is it something else? o If it's either a Recurrence of Use or something else, drill down to understand it with a ***functional analysis***
	If the Forms weren't completed/no monitoring was done…. o Do them in session OR use preferred alternative o Come up with a plan for success for next week OR problem-solve an alternative way of tracking	(15 minutes)	**Explore barriers:** o What got in the way of tracking? o If necessary, use a ***functional analysis*** to understand the issues o If identifying moods was an issue, use the ***here/now sensory exercise*** and work out a plan for using it in day-to-day life
✓	**Planning Activities** o Identify goals for the week o Make detailed plan for 2-3 activities o Specify when plan to do activities in Weekly Schedule o Provide ***skills coaching*** as needed	15 minutes	**Tips for successful goal selection:** o Should be consistent with overarching long-term goals and values o Address potential use risks in planning o Keep recovery goals front and center o Get very specific regarding how goals/activities are to be accomplished o Could include family/work obligations for sense of mastery and/or structure
✓	**Discussion of Homework, Questions, and Feedback**	5 minutes	**End on a positive note:** o Find genuine things to reinforce and do so o Solicit feedback about how session felt, about how patient feels treatment is going o If indicated, ask what might improve the experience o Express optimism about their path forward