Strategies for Staying in Care

ENHANCING ENGAGEMENT AND IMPROVING TREATMENT RETENTION

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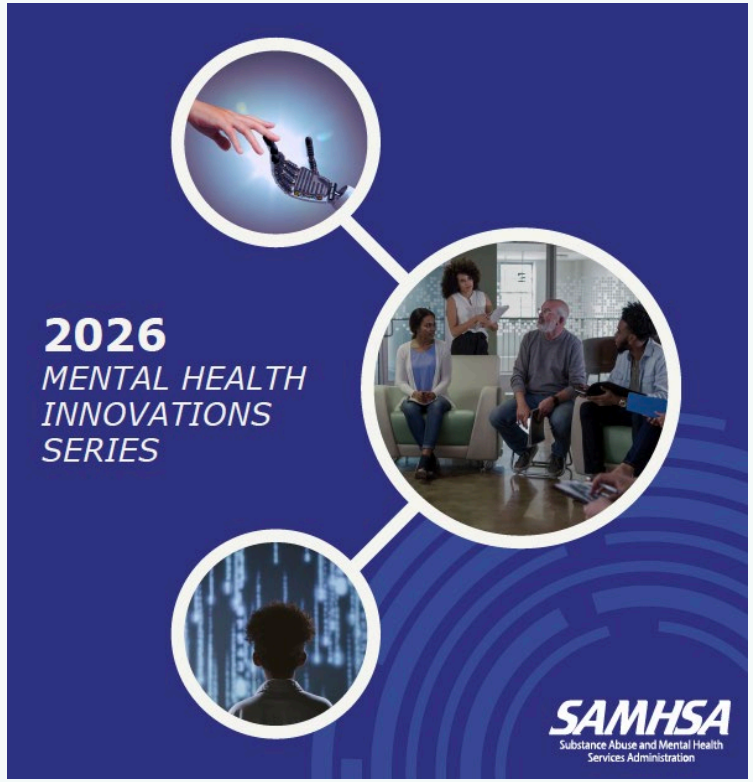

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Artificial Intelligence tools were used to assist in developing the slides for this presentation.

The Scope of the Problem

Treatment disengagement is common, costly, and system-wide.

20–50%

Dropout rate range for individuals with serious mental illness

60%

Individuals with schizophrenia do not show up for their first appointment after hospitalization

1/3

Of individuals who start mental health treatment ultimately disengage from it

Falling out of care has real consequences

- Disproportionate homelessness and housing insecurity
- Disproportionate incarceration or justice involvement
- Cycling in and out of hospitals, jails, and the ED
- Loss of resources for basic needs, deepening instability

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Defining the Terms

Engagement

Active, collaborative participation in treatment — an ongoing healing connection.

Adherence

Consistent follow-through with identified treatment goals and plans.

Non-adherence

States, without judgment, that a person is not following treatment recommendations.

Disengagement

Wholly withdrawing active participation in care.

Retention

Ongoing participation in care sustained across a period of time.

Non-compliance

Reserved for contexts with a power dynamic, e.g. a court's lawful order.

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What Drives Motivation

Both intrinsic and extrinsic motivation can be diminished in serious mental illness, linked to amotivation and anhedonia.

Intrinsic Motivation

- Comes from within the individual
- Internal, goal-directed behaviors
- Examples include aligning treatment with one's own goals — feeling better, reaching milestones
- Fostered by approaches like CT-R that build positive self-views

Extrinsic Motivation

- Comes from outside the individual
- External rewards or avoidance of punishment
- Examples include avoiding hospitalization, family pressure, court mandates, financial incentives
- Common and influential in real-world treatment settings

Motivational interviewing shows promise for substance use disorders and, in combination with CBT, for negative symptoms in schizophrenia.

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Insight and Treatment Engagement

Insight is not all-or-nothing — it sits on a continuum shaped by internal and external factors.

- CATIE/EUFEST studies combined 1,200 patients with schizophrenia found impaired insight correlated to reduced adherence to treatment
- Greater insight correlated to better treatment adherence in a study of Veterans with bipolar disorder
- Cognitive insight may complement clinical insight in improving medication adherence

Key takeaway

Insight correlates with adherence in multiple studies, but it is not the only driver — substance use, side effects, and negative symptoms matter too. Recovery-oriented approaches show success even without insight, and anosognosia should not be conflated with insight.

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Perceived Coercion

The subjective sense of being forced into care — distinct from formal or informal coercion.

16–90%

range of perceived-coercion prevalence across studies

- Greater perceived coercion is linked to worse psychosocial functioning, weaker therapeutic relationships, and lower willingness to remain in care.
- Perceptions of coercion during involuntary hospitalization are shaped more by procedural justice (fairness, voice, respect, trustworthiness) than by legal status alone.
- In outpatient treatment courts, how judges and case managers demonstrate procedural justice can shift participants' perceptions and influence long-term program outcomes.

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Understanding Non-Adherence

Non-adherence is not one thing — it exists on several overlapping spectrums.

1

Partial → Total

Missing a single dose or appointment differs from missing nearly all of them. Clarify what "clinically meaningful adherence" means for that person.

2

Temporary → Long-term

A missed day differs from years away from care. Treatment history matters, especially for restarting medications like clozapine safely.

3

Deliberate, Accidental, or Unavoidable

Side effects, stigma, lack of insight, or religious objections (deliberate); disorganization (accidental); lost prescriptions, incarceration, transportation (unavoidable).

A key first step: recommendations must be clear and feasible before any gap can fairly be called non-adherence.

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The Therapeutic Alliance

A positive bond between provider and person served can be built — or broken — from the very first encounter.

Bond

The relational connection and trust between provider and person served.

Goals

Shared agreement on what treatment is working toward.

Tasks

Shared understanding of the activities that make up treatment.

What the research shows

- Therapeutic alliance significantly predicts medication adherence — even after controlling for insight and symptom severity.
- Greater adherence correlates with higher insight, stronger alliance, and lower perceived trauma from prior psychiatric care.
- Acknowledging a patient's potentially traumatic experience with treatment helps build the alliance and drives engagement.

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Models for Fostering Engagement

Person-Centered Care

Shared and supported decision-making; control over decisions strengthens alliance.

Warm Hand-offs

Retention across care transitions where dropout risk is highest.

Trauma- & Grief-Informed

Recognizes histories of trauma and loss that shape trust and willingness to engage.

ACT

Interdisciplinary teams that meet the person where they are; also used in forensic settings.

MISSION Model

Case management plus peer support and CTI for co-occurring conditions and transitions.

Early Intervention

Extending first-episode psychosis services beyond 2–3 years may further reduce disengagement.

CT-R

Model for strengthening positive beliefs to foster engagement.

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Engaging and Retaining Individuals in Care: Spotlight on Recovery-Oriented Cognitive Therapy or CT-R:

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BECK INSTITUTE | COGNITIVE BEHAVIOR THERAPY

About Beck Institute

Beck Institute is a 501(c)3 nonprofit organization with the mission of *improving lives worldwide through excellence in CT-R and CBT.* We offer training and dissemination of Recovery-Oriented Cognitive Therapy and Cognitive Behavior Therapy to health and mental health professionals and paraprofessionals around the world.

Dedication

“There’s nobody in the world that doesn’t have aspirations, that doesn’t like to think of making their life better. People come in discouraged, demoralized, and apathetic, and they are offered a new life, and they’re able to go on and live the lives they’ve always wanted to, and that’s what we have to offer.”

-Aaron T. Beck

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Agenda

- How CT-R helps providers engineer contacts to inspire individuals to
  - Show up
  - Keep showing up
- What this looks like in the Community

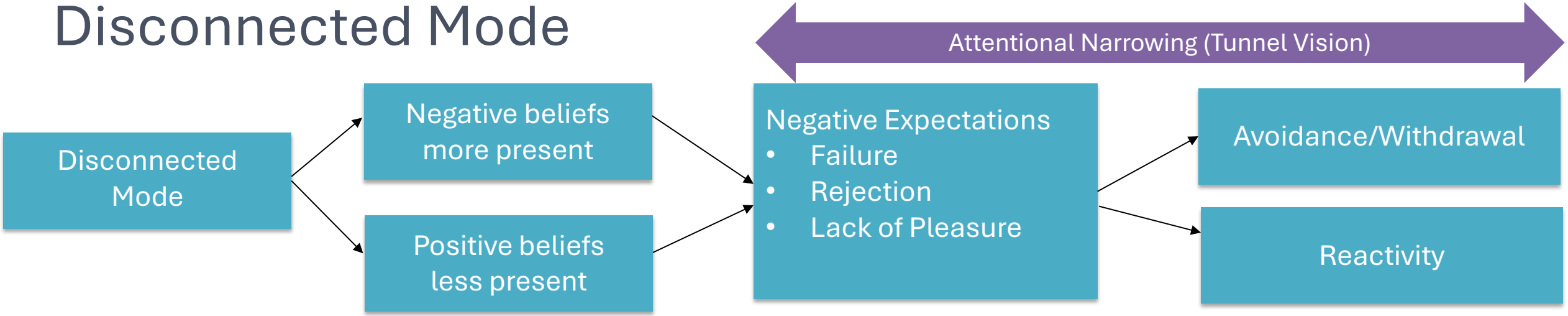
What is Recovery-Oriented Cognitive Therapy (CT-R)?

CT-R is a broadly-applicable, strengths-based, person-centered framework to understand how people can get stuck in challenges and how they can flourish

CT-R is:

- Collaborative
- User-friendly
- Flexible: fits into brief interactions, individual or group therapy
- Versatile: can be used in inpatient, outpatient, and telehealth contexts

Understanding Non-engagement and Disengagement: Disconnected Mode



- Moments when a person doesn't feel like themselves
- "Fast" thinking (pressured/inflexible)
- Challenging behaviors are present (e.g., self-injury, aggression, internal focus, social withdrawal)
- Not participating in interests or with other people

"I am worthless"

"Others will judge me"

"My future is hopeless"

The Impact: Adverse Events

The Takeaways

- Adverse Childhood Events are common:
  - U.S. adults: 64% *at least one*
  - *Four or greater:* Depression, substance use, suicide attempt, psychosis, incarceration
- Trauma also common
  - 80%+ community mental health
  - Higher: justice and unhoused settings
- Both have a significant and global impact on how we see ourselves and others

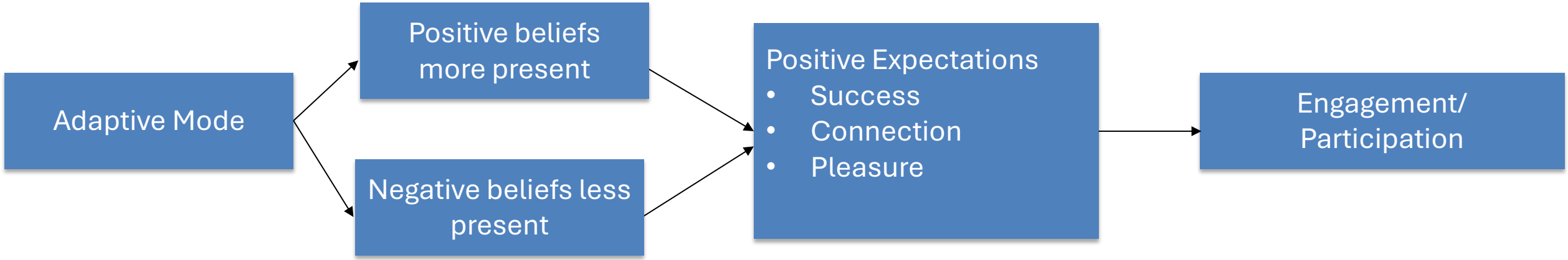
Self	*Others*	*Future*
It must have been my fault	People can't be trusted	The world is unsafe
I am unsafe	Others will take advantage of me	There is no hope for the future
I should have _____	Others don't understand	I can't do the things I want to do
I am worthless	Others are dangerous	There is no point in trying
I am weak		I can't do it anyways

Centers for Disease Control and Prevention (2023). Data and Statistics on Children's Mental Health. National Center on Birth Defects and Developmental Disabilities. Retrieved April, 2023, from https://www.cdc.gov/childrensmentalhealth/data.html
Varses, F. (2012) Childhood Adversities increase risk of psychosis: A meta-analysis of patient control prospective and cross-sectional cohort studies. Schizophrenia Bulletin.38 (4). 661-671

Disconnected Mode: Stigma

How people are perceived by others	• Attitudes of the general public (people look at you like you are crazy)
Experiences people can have	• Verbal or physical discrimination • “You are crazy” ,“I don’t want you near me or my kids”
Anticipated stigma	• Expecting prejudice • “They will judge me as crazy and look down on me” ,“I shouldn’t go out”
Self-stigma	• Person’s beliefs agree with stigma (“I am crazy” “I am broken”)

Life First: Adaptive Mode



- Moments when a person feels most like themselves or "at their best"
- Engaged in things that are important, enjoyable, meaningful
- "Slow" thinking (more flexible)
- Seem happy, confident, or less stressed, feel a sense of purpose
- Challenges fade to the background

"I have value"

"My future is hopeful"

"Others like to be around me"

Thinking Beyond Typical Treatment Models

These are key ingredients that **all people** want in their lives that also have a positive impact on physical and mental health, and overall wellbeing

- Connecting with others
- Having a purpose (e.g., contribution)
- Empowerment
- Sense of identity

Consider these our key CT-R targets!

CT-R and Risk Mitigation

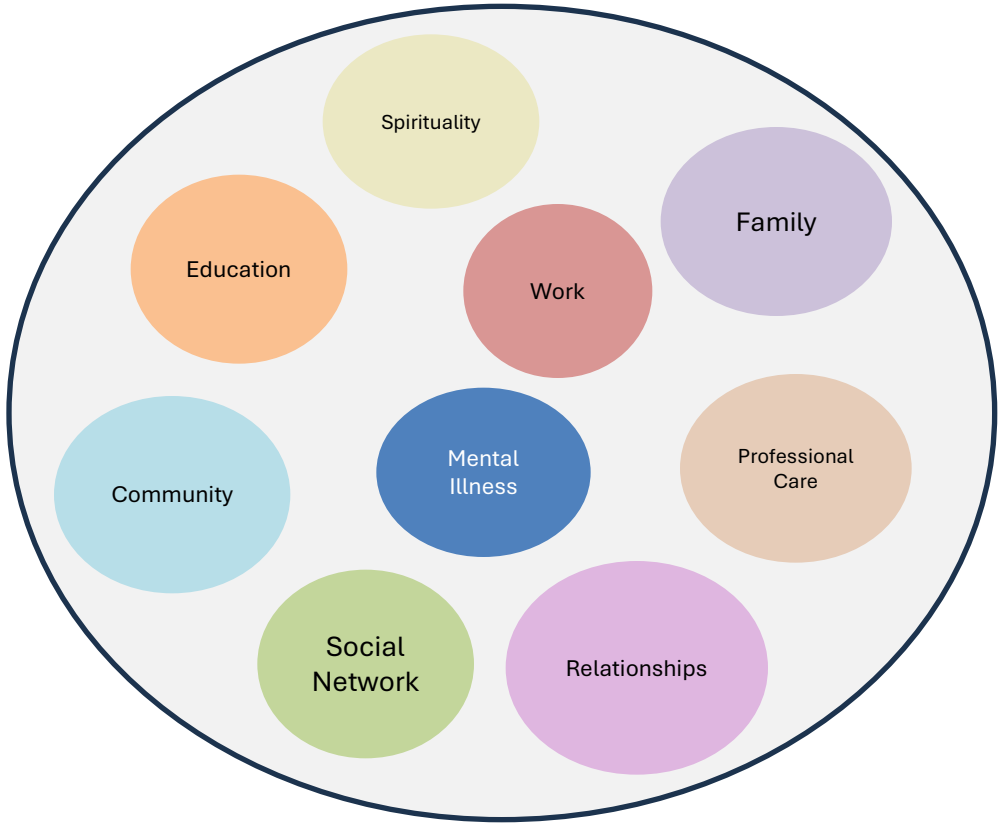
"Big Eight" Risk Factors
Criminal History
Antisocial Personality Pattern
Antisocial Cognitions
Criminal Companions
Substance Abuse
Poor family/marital relationships
Poor educational/vocational achievement
Lack of prosocial leisure activities

Bonta, J., & Andrews, D. A. (2007). Risk-need-responsivity model for offender assessment and rehabilitation. *Rehabilitation*, *6*, 1-22.

WHAT CT-R LOOKS LIKE ON THE GROUND IN THE COMMUNITY

A Different Way to Look at Treatment

Person with lived experience:
Perception of Treatment



Person with lived experience:
Preferred Focus

The Adaptive Mode & Best Self

- Talk about what people are like at their best and frame discussion in the context of their beliefs
  - Consider interests, hobbies, passions, skills, areas of expertise, favorite activities
  - Ask about *why* people enjoy these things ("what's the best part of doing ____?")

How to frame this?

Example: "Today we will be focusing on what we are like at our best. These are moments when we feel most like ourselves. This is something we all can experience – even if it has been a while since we felt that way."

Key Ingredients of Activating Activity

Prime individuals to connect with providers and others around their own interests/skills/pockets of knowledge

- You may have to come with a preplanned activity: **consider something completely unrelated to what brought them to care** (e.g., group trivia, a group puzzle, etc.)

The Why?

Builds trust, connection, & rapport amongst individuals who might otherwise not be treatment seeking

People may spend a **significant amount of time in their disconnected mode** so likely may come into a meeting with negative beliefs & expectations

This intentionally activates positive beliefs without completely changing a treatment approach

Adaptive Mode: Brief Interactions

1. **Activate** adaptive mode through discussing interests, doing an activity together, or putting individual in the expert role

2. **Ask questions** to notice key beliefs activated during the experience (e.g., connection, capability, control) or about how they can expand upon interests

3. **Complete** *any paperwork, case management, treatment plans, or other approaches*

4. **Set a plan**

Role: outreach, case management, paperwork, spiritual support, treatment/skills, med check

The CT-R portion can be very quick, but helps establish predictability of meeting and person-centered approach

The Adaptive Mode in Group Therapy

Inquire about group members best selves

Provide opportunities at the beginning of each group to engage in common interests/aspects of their identity outside of what brought them to treatment

Use roles in group to offer predictable ways the person can activate positive beliefs about themselves (e.g., “I can help others, I belong”)

Advantages

- Gets group members feeling connected, energized, focused, and at their best
- Gives people a chance to tap into their positive beliefs (adaptive mode)
- Increases participation/engagement in rest of group session

Focusing on the Future

Aspirations: significant and personally meaningful desire for how the person wants to live their life

Bringing Aspirations into Interactions

Advantages

1. Helps people consider **why it's important to try something new**

   (E.g., Connects the dots of less desirable elements of care to living the life they want)

2. Gets people feeling **hopeful & excited**

   (This can set the tone to talk about difficult things or plan for discharge)

How do we do it?

- "What are some things you'd like to do more of in the future?"
- "If everything were the way you wanted it to be, what would that look like?"

If the person isn't sure, use what you know about their interests and build from there!

- "You and I talk a lot about cooking and recipes. Is that something you see yourself doing more of in the future?"

Action Steps Towards Aspirations

Take action towards identified aspirations

Break aspirations down into small achievable steps (set up for success!)

Do one thing each day that gets a person closer to their aspirations (no matter how small!)

Help people notice how new steps and existing activities get the person closer to aspirations

Take action towards meaning underlying aspirations (especially important when in higher levels of care!)

Confirm your understanding of the meaning underlying aspirations

Explore additional activities that tap into similar themes

Plan frequent and predictable action towards meaning

Life First: Aspirations and Steps

Meaning of Aspiration
I am capable, successful
I can feel accomplished each day
I am a part of something/a team Others care about me
I have value/worth
I can have a meaningful future
My future is hopeful
People will see I overcame a lot

CT-R How-To: Planned Brief Interactions

1. Activate adaptive mode through discussing interests, doing an activity together, or putting individual in the expert role

2. Check-in on or ask questions to learn about aspirations

3. Ask questions to notice key beliefs activated during the experience (e.g., connection, capability, control) or about potential continued action

4. Complete any paperwork, housing planning, case management, or other approaches.

Your role: case management, paperwork, spiritual support, or other treatment/skills approach, med management

"What are you most looking forward when things feel more settled?"

"What will be the best part about that?"

"What do you want more of in your life?"

"How will working on some of this stuff get you closer to the things you want?"

Key Ingredients to Approach Challenges

Challenge: anything that might get in the way of a person working towards or living their aspiration(s)

The key: if the person doesn't see it as a challenge or a problem, we don't want to spend time focusing on it – ***the person's life becomes our guide to collaborating on problems***

Examples could include:

- Substance use
- Focus on voices, feeling persecuted
- Current or past relationships
- Navigating system responsibilities
- Taking a risk or putting yourself out there (e.g., a job interview) and it doesn't go your way

CT-R Approach to Challenges

When someone is having a hard time, re-experiencing challenging behavior, or isn't engaging as much as before…

1. What might be going on for that person that could have led to this challenge?
2. What ***negative beliefs*** might they be feeling about themselves, others, or the world that are contributing to what we see?

Let the beliefs guide your response

- Are there things you can do together to jumpstart ***positive beliefs***?
- Are there opportunities they can experience these positive beliefs throughout the week/day?

Systems of CT-R

Individuals Empowerment	Go from feeling defeated to thriving, from being disengaged to participating in the community, taking action towards a life of their choosing, developing resiliency in the face of challenges
Staff Self-Efficacy	Build upon their understanding, experience, skill, and knowledge. Enhance collaboration, teamwork, innovation and problem solving.
Organizations Culture Change	Community-based, residential, inpatient and justice-based programs create and sustain environments in which everyone has a hand promoting recovery and resilience
Systems Enhanced Care	Systems operationalize recovery, resiliency, and promote continuity of care as a person increases their involvement in the community

Thank you!!!

Feel free to reach out with questions, to learn more, to share

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Roundtable Discussion

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