ARTICLE

Patient Education: Powerful Tool for Program Success

RSI Recovery Systems Institute
RECOVERY PROGRAMS

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Programs that thoroughly educate their clients about addiction and recovery generally have superior outcomes. While those that don't... let's just say it's a shame to waste the opportunity.

Three Goals for patient education

Generally, the idea is to accomplish several aims.

First, **increase the knowledge and skill base for recovery**. Your patients may know a great deal about being sick, but have startling gaps in their knowledge when it comes to how to get well. A publisher asked me why I didn't write a book aimed at the drinking alcoholic instead of the family. "Because the drinking alcoholic wants a book titled 'Keep Drinking and Tell Everybody To Go Jump in the Lake'", I explained. Alcoholism is a threatening topic to an active alcoholic. They avoid much in the way of research.

Second, education should **help motivate continued treatment**. Think of the treatment experience as a window in denial. To keep the window open, we need to facilitate real change in the patient's attitudes and beliefs. Good education is a nonconfrontive way to impress upon the reluctant patient the importance of sticking with a program of recovery. In the language of motivation enhancement, we use it to avoid argument while developing discrepancy and supporting self-efficacy.

Third, education should **promote further education**. It's a chronic disease, right? No need to stop learning when you graduate from a treatment program. In fact, it's a bad idea if you do.

Four Steps to Designing and/or Modifying a Patient Education Program

Step One: Analyze the population you treat.

Look at areas that shout for your attention -- cultural traits, for instance, or demographic characteristics such as age and gender, or the presence of mental health codisorders, or history of prior treatment failure, and so forth. The goal is to design an education component that successfully meets the needs of the broad middle. More specialized needs can be addressed separately.

To increase the chances that the audience will remember fundamentals, present them in lay terminology

Here's an example from two clinics located within about five miles of one another:

Outpatient Clinic X

Average age 36, males representing 70%. The majority of patients are indigent or severely underemployed. About one in three has been incarcerated at some point. Drugs of preference include 50% opioid, 20% cocaine, 25% poly-drug users. Few patients have intact families and 36% meet criteria for an Axis 1 mental health disorder (mostly mood and anxiety disorders). Relapse is common; two in three have been treated before, often multiple times.

Outpatient Clinic Y

Here, the average age is 27, and females constitute nearly 40%. Four in five are currently or recently employed; 70% are involved with the Courts, mostly DWI for the men and Family Court for the women with children. Some 75% list alcohol as their only drug of abuse, with cocaine and marijuana predominant among the rest. 40% have a prior outpatient treatment experience.

Now these are very different programs that would benefit from different patient education components. Clinic X patients should get some informational sessions on employment skills and community employment programs, as well as specific information on opioid therapies. Clients of Clinic Y would no doubt benefit from special sessions on parenting and family issues.

The aim is to allocate limited treatment time where it can have the most benefit.

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Now an exercise:

Outpatient Clinic Z

The average age is 44, and the clinic population is 60% male. Drugs of choice include alcohol 70%, prescription opioids 40%, other prescriptions drugs 20%, marijuana 20%. 30% have mental health issues, mostly depression. 30% report chronic medical issues (diabetes, hypertension, pain management) requiring ongoing treatment.

Anything jump out at you?

Step Two: Identify outcomes you'd like to achieve via patient education.

For example, in our "exercise" Clinic Z, we start with the two fundamentals:

- Improve the client's knowledge of addiction and prepare him for recovery, and
- Improve motivation for continued treatment.

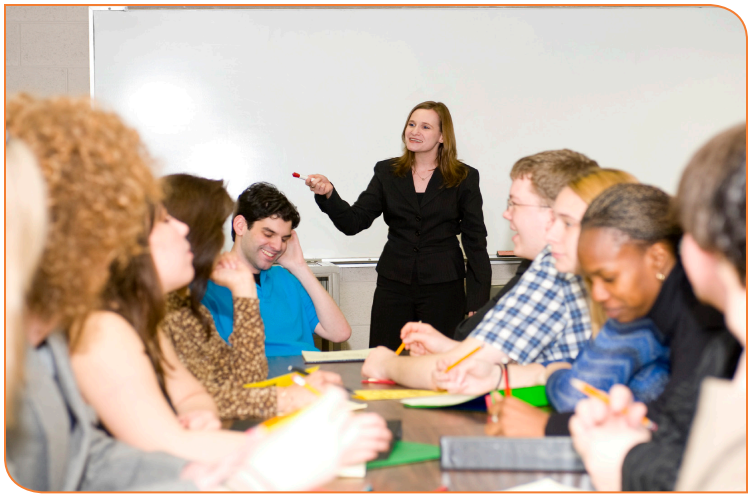
But we want to add information about:

- Managing chronic disease (diabetes, hypertension);
- Non-addictive treatment alternatives for pain; and
- Managing co-occurring mental health disorders

A patient education program both informs and motivates. A lecture or interactive educational presentation might be best for conveying essential information, while a group activity might be most effective at increasing skills. A dramatic film or guest lecture might be more valuable in terms of motivational impact.

Clinic Z decided to integrate the following into their education component:

- Lectures and materials on disease management, medication use, healthy nutrition, and smoking cessation;
- Daily journaling for selected patients on health-related behaviors; and
- Special resource materials on finding medical and mental health care in the community.



Of course, Clinic Z also supported its patient education goals by providing training for staff on working with the medically compromised or chronic pain patient.

Some comments on educational activities:

1. Sessions shouldn't be longer than an hour. Feel free to mix media -- a short educational piece, followed by a topic discussion, or perhaps an exercise using the material.
2. Groups should be homogeneous by problem -- meaning patients should have related disorders, or be facing similar challenges. That facilitates productive use of time.

Step Three: Develop simple outcome measures for the education component.

The two most common are pre/post-testing of knowledge, and progression through the stages of change. Pre/post tests can be done either at the end of each activity, weekly, or at the beginning and end of the treatment course. Movement through stages of change is generally a slower process, best measured at monthly intervals, or longer. Then collate your data and analyze. The point isn't to measure the individual's progress, but to measure the overall effectiveness of your patient education component.

Step Four: Periodically revise and update

Most programs rely on a Continuous Quality/Performance Improvement process for this purpose. That involves periodic review and analysis of outcomes, and changes to improve them.

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Five common flaws found in patient education programming:

Lacks relevance. Even otherwise good information can be of little value to a certain class of patients. One expert tells a story of his early days as a counselor, delivering a lecture to people in detox on Maslow's Heirarchy of Needs. You have to picture an audience in johnny gowns and various stages of sedation. One finally asked the question: "what does this have to do with not drinking alcohol?" And of course, at that stage in recovery, not very darn much.

The bar is set too low. Some programs skimp on patient education because they underestimate the newly recovering person's capacity to absorb information. So he doesn't recall the details; that doesn't mean he can't grasp and make use of core concepts. Even barriers like low literacy do not imply low intelligence. Other methods of learning are available. We should take advantage of them.

The bar is set too high. Clinicians with a background in science sometimes want to communicate the latest and most advanced concepts to patients. Commendable, but what's needed are fundamentals.

And to increase the chances that the audience will remember those fundamentals: Present them in lay terminology; emphasize key points of information; repeat those key points at beginning and end; and test the student on them (not on the rest of the information).

It fails to motivate. Much of the history of addictions education was devoted to scaring the heck out of the audience. Research suggests that's not terribly effective. It's still popular in some circles, however.

There's a legend about a speaker who would pick a distinguished-looking matron from his audience and demand to know if she had ever had sex with him. Before she could reply, he would quickly ask if she'd ever had an alcoholic blackout. If she admitted she had, he'd demand to know how she could be sure, one way or the other.

Our advice: don't do stuff like that.

The principles of motivation enhancement are fairly straightforward: express empathy, develop discrepancy, avoid argument, roll with resistance, etc. Use them to develop education that actually increases the patient's desire to succeed.

Lost in philosophy. There are a number of models of alcoholism and addiction: chronic disease, but also psychodynamic, family systems, adaptive learning, etc. If you try to introduce psychoanalytic principles into a program based on the notion that addiction is a chronic illness, you'll probably just confuse people. Better to be reasonably consistent in your approach.

Where can I find supplemental materials for patient education?

Search the SAMHSA website and TIP series for relevant publications. There are also a number of commercially-produced educational products that reflect a 12 Step or family systems approach, or motivation enhancement, or cognitive-behavioral therapies for common problems like craving reduction, anger management, and relapse prevention. All are fairly general in scope and so are relatively easy to adapt to most treatment settings.

Of course, you or your staff can develop your own, too. It's often a good, creative project for a team of professionals, one that also helps further customize treatment to your unique setting.

Chandler Scott McMillin, Principal of Recovery Systems Institute, has created and operated successful addiction treatment programs for more than thirty years. He has written countless articles and co-authored seven books on addiction treatment and helped hundreds of families with successful interventions.