Should I Stay or Should I Go? The Ethics of Engagement

Christine Powers, LICSW, MLADC

1

Workshop Objectives

How much and how long do you attempt to engage an individual when they are seemingly ambivalent about working with you or your team?

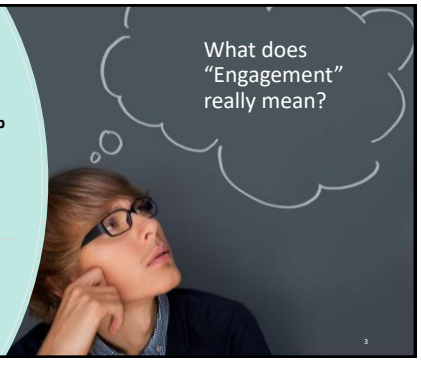
Objectives:

- Participants will be able to define engagement, as well as the barriers to engagement.
- Participants will be able to identify and differentiate between implicit and explicit client motivation related to engagement.
- Participants will be able to work through ethical decisions related to choosing diverse and effective engagement and outreach strategies and/or termination plans.
- Participants will leave with tools, creative approaches, and information regarding engagement and termination.

2

Is it part of our job to keep people engaged?

Why or why not?



3

What is Engagement?

- **"Engagement is the strengths-based process through which individuals with mental health conditions form a healing connection with people that support their recovery and wellness within the context of family, culture and community"** (NAMI, 2016).
- "*Compliance*" is a term more used than "*Engagement*," unfortunately.
- Engagement involves the participation of people who both deliver and seek services.
- When care is respectful, compassionate and centered on an individual's life goals, the likelihood of recovery is sharply increased.

- NAMI, 2016

4

Client Reasons for Disengagement:

What do you think?

Poor Provider Relationship - low Therapeutic Alliance	Stage of treatment not matching stage of change	Previous negative experiences in MH services (distrust)	STIGMA
Logistical inconveniences: time, location, etc.	Not tending to immediate needs (i.e., hierarchy of needs, like housing)	Forgetting / no reminders provided / cognitive challenges	Neurological (anosognosia – unaware of illness)
Integral to the symptoms / substance use	Lack of representation / connection / cultural insensitivity	Provider not strengths-based but deficit-based	Therapy can be HARD!

(Moser & Powers, 2024)

Barriers to Engagement

- Inability or unwillingness to use creative & innovative approaches to engagement
- Inability to work effectively within and across diverse cultures
- Rigid adherence to program rules and regulations
- Lack of respect for individuals and families
- Inability to convey a sense of hope for recovery and achieving life goals
- Ineffective treatment approaches

(NAMI, 2016)

6

Engaging individuals in a challenging the climate…

"*One participant described how, in her first experience with involuntary hospitalization, her personal items were taken away. They took away her clothes, schoolbooks and notes. She was essentially stripped of everything and anything familiar, of anything that would keep her calm. The hospital focused on rigid rules and procedures rather than on her needs and what she was experiencing as a terrified young woman. There was no attempt to engage her in care*" (NAMI).

How might this young woman feel about mental health care after this experience?

7

Why do we persist?

Because research shows evidence-based mental health services works!

- "*Most people who receive psychotherapy experience symptom relief and are better able to function in their lives. About 75 percent of people who enter psychotherapy show some benefit from it*" (Bhatia, 2023).
- We know clinical evidence-based practices (EBPs) work, as there is scientific studies with proven results.
- What EBPs do you use?

8

Why do we persist?

Because people are at higher risk when they disengage.

- Those that do not attend appointments are at "*risk of further deterioration, relapse, and hospital readmission*" (Mitchell & Selmes, 2018).
- In a meta-analysis of 40 randomized control trials, *"27.2% of individuals w/co-occurring SPMI and substance use disorder dropped out of services"* (Bouchard, et al., 2022).
- "*Clients in mental health care drop out of services at almost twice the rate compared to other medical specialties*" (Mitchell & Selmes, 2018).
- "*70% that drop out do so after their first or second visit*" (Olfson, et al., 2009).

9

Why do we persist?

Because people can and do recover!

*"Our job is not to judge who will and who will not recover. Our job is to establish strong, supportive relationships in order to **maximize** chance of recovery…People need to have the **dignity of risk** and the **right to fail**."*

- Patricia Deegan

Service retention is important! We can't help people move into (and keep) an apartment, get a job, girlfriend, cat, recreational hobby, address legal charges, etc. if they drop out of services (prematurely) [Moser, 2024].

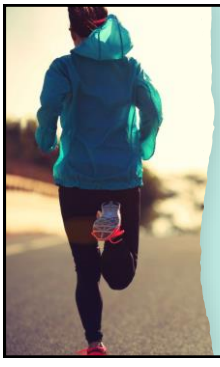
10

Engagement & Outreach Culture

- Portray hope
- Natural supports are essential
- Use a strengths-based approach
- Shape services on unique goals
- Meet people where they are at
- Educate staff about natural supports & peer importance
- Embrace respect and dignity
- Consider community and diversity
- Include individuals with lived experience
- Used shared decision-making
- Promote collaboration among a wide range of systems

(NAMI, 2016)

11



Engagement & Outreach Culture:

Therapeutic rapport is a marathon, not a sprint

- Take your time with engagement when you have the time to engage.
- Having time to engage depends on knowing individuals, their histories, margin for risk, etc.
- How will you remember what you have done and have not done if engagement takes time?
- How will you know what has worked and has not worked over time?

(Moser, 2023)

Engagement & Outreach Culture

- Having a **TANGIBLE written tool** with outreach & engagement strategies helps.
- Review clients who need outreach on a *regular* basis during team/consult meetings.
- Clients should not be removed from services solely due to disengagement.

13

Engagement & Outreach:

What are some creative strategies you might use to engage or outreach individuals?

14

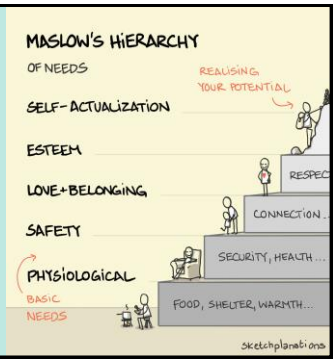
Engagement & Outreach: Individualized Care Components

- Understanding what the person wants help with & allowing them to be the expert
- Person-centered & recovery-based care
- Are we cancelling appointments?
- Engaging in an activity of their choice
- Understanding the person's culture / our bias
- Providing interventions that match the person's stage of change

15

Engagement & Outreach: Practical Needs

- Helping their basic needs get met: Food, shelter, & safety
- Helping with benefits, finances, or budgeting struggles
- Having needed medical care / medication
- Addressing SUD struggles (i.e., harm reduction)



Engagement & Outreach: Logistical Approaches

- Knowing their preferences re: logistics of treatment
- Providing environment comfortable and sensitive to their cultural needs
- Addressing transportation challenges
- Knowing preferences regarding home-based vs office vs virtual services
- Understanding preferences around technology and communication (letters, email, text, phone, tele)
- Respecting preferences on scheduled time/day

Engagement & Outreach: Team-Based Approaches

- Utilizing a team member that has great rapport
- Trying coordinated visits
- Having everyone from the team try to engage / meet the person
- Ensuring the person understands each team member's role and how each can be helpful to that person specifically, as it relates to their unique recovery goal(s)
- Ensuring understanding around agency policies around attendance

Engagement & Outreach: Outside Resources

- Engaging the person's natural supports
- Contacting their emergency contact
- If allowed, involving their employer, guardian, payee, and/or landlord, etc.
- Coordinating care with other providers (medical, psychiatry, SUD, etc.)
- Connecting with the previous provider?
- Providing contact info / referrals for outside resources useful for the person

19

Engagement & Outreach: Evidence-Based Practices (EBPs)

When we get medical care, we expect providers use treatment they know works. We should do the same – Use EBPs!

- Does the EBP have evidence for the symptoms present?
- Some common EBPs that have high evidence:
  - Motivational Interviewing
  - Peer Support Services / Recovery Support Services
  - Integrated Dual Disorder Treatment (IDDT / ITCOD)
  - Group Services
  - Cognitive Behavioral Treatment

20

Engagement & Outreach: Assertive & Legal Strategies (last resort!)

- Show up at their home or known spots
- Multiple outreaches – Calls, emails, texts, letters
- Creative messaging (i.e., SS check pick up is in person, providing a request they've asked before, offering to do a non-clinical activity they enjoy, etc.)
- Contact emergency contact / person in their residence
- Contact police, shelters, hospitals, jails, rehabs, etc.
- Initiate a legal crisis response (i.e., involuntary emergency admission, revocation of conditional discharge)
- Call in a wellness check

Engagement & Outreach: More Creative Techniques

Take out to coffee	Don't mention meds	Educate self on / take interest in..?	Drop off Gatorade and brief note
Show up on time	Strategically use peer specialist	Help fight legal charges	Take them to store
Help find housing	Listen more than talk	Show humility	Psych Advance Directive

Engagement & Outreach: Moving into the Ethics*

How do you balance self determination versus abandonment/neglect?

(Moser, 2024)

* Based on NASW Code of Ethics. Please check your pertinent professional licensing ethical guidelines!

23

The Ethics of Engagement: Self Determination

What does "self determination" mean?

Ethical Responsibilities to Clients:

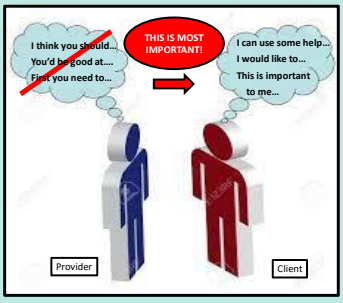
1.02 Self-Determination: "Respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others" (NASW Code of Ethics).

24

Self-Determination: Building on Intrinsic Motivation

FIRST THING'S FIRST…

What does the person want to accomplish while working with you?



Self-Determination: Building on Intrinsic Motivation

Collaborative, motivational interventions that build on the person's recovery goals.

What does THE PERSON want in their life? What can you do to build on/toward that?

Based upon promoting self-determination and independence, and instilling autonomy.

This should be the primary method for engaging people, having a thoughtful process and reasoning for shifting to more assertive options.

(Moser & Powers, 2024)

Self Determination: Using Extrinsic Motivation Sparingly

(Use very thoughtfully and limited capacity!)

Resort to these strategies when collaborative approaches have failed, and risks are increasing – avoid clinical negligence

Invoking position of power out of care and concern

Risk of harm to self and/or others (including grave disability / self-neglect)

This involves using some power and control – only use when lack of treatment is clearly going to result in potential harm or more restrictive outcomes

(Moser, 2024)

Self Determination: Using Extrinsic Motivation Sparingly

(Use very thoughtfully and limited capacity!)

Keep in mind… Some mental health treatment has been criticized for being coercive and paternalistic for good reason!

Create a system to identify those *not* engaged and identify who really needs services

Track approaches being used – effective or not?

Eye towards reducing use of regulatory interventions that can be experienced as coercive

Use team meetings to track, assess, and plan

Use periodic clinical reviews and other team members

(Moser, 2024)

What's the Top Secret to Self Determination & Engagement?

"People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others."

—Blaise Pascal

29

The Ethics of Termination

Typically happens when:

- Goals are reached / interventions are no longer necessary
- Specified time for services has arrived
- Clinician ends services for own reasons
- Client ends services for their own reasons / stops attending

1.17 Termination of Services: "Terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests" (NASW Code of Ethics).

What do you think of the word "Termination?"

30

The Ethics of Termination

- The close of the clinical process & working relationship between clinician and client
- An organized process for transitioning out of services or to new services
- Termination should include:
  - A step-wise approach
  - Evaluating progress and further needs
  - Working through emotions related to ending
  - Anticipating challenges and creating relapse prevention plan
  - Identifying local resources
  - Clarifying plan to re-enter services, if requested in the future
  - Sometimes referral(s) to new services

31

Termination: Common Clinician Explanations

Here are some common reasons clinicians terminate before treatment is complete:

- Client has needs that are beyond the clinician's area of expertise ("competence")
  - 1.04 Competence: "provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience" (NASW Code of Ethics).
  - 1.05 Cultural Competence: "demonstrate awareness and cultural humility by engaging in critical self-reflection (understanding their own bias and engaging in self-correction), recognizing clients as experts of their own culture…" (NASW Code of Ethics).

Termination: Common Clinician Explanations

- Client fails to make adequate progress toward goal(s) or doesn't agree with treatment recommendations
- Client fails to participate in therapy (e.g., no shows, cancellations)
- Lack of communication/contact from the client
- The clinician ends services due to threat/harm to clinician
- The clinician ends services due to non-payment

Termination: Common Clinician Explanations

- The therapist provided client ample notice with a timeline of ending services for good reason (i.e., retirement, moving to new job)
- A conflict of interest is identified after treatment begins
  - 1.06 Conflicts of Interest: "be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment…inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests…protecting clients' interests may require termination of the professional relationship with proper referral of the client" (NASW Code of Ethics).

Termination: WHEN?

Consider: Do you have a written policy in place and in the informed consent where cases are routinely closed after a certain amount of time without any contact from a client?

A great way to establish that timeframe is to think about how long you want to be the provider of record w/out seeing a client.

"*If I do not hear from you for a period of xxxx days, I will assume that you no longer intend to remain active in this therapeutic relationship and your case will be closed. You can request to return to therapy in the future if you decide to continue treatment*."

(Felton & Polowy, 2015)

Termination: WHEN?

Consider: Does the person really need services?

If refusing, is it due to symptoms? e.g., anosognosia, paranoia, severe depression. Is it representing *informed decision*? When were they last assessed?

What are the consequences of not receiving services? Historical information is critical. How bad does bad get and how quickly? Is suicidality or homicidality possible?

What are the consequences of using assertive engagement? Potential for total service drop-out (lose opportunity to refer out)? Potential harm to staff?

Termination: WHEN?

Consider: Are services are being terminated due to non-payment?

Keep in mind the ethics of payment; is your rate reasonable? 1.13 Payment for Services: "ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay" (NASW Code of Ethics).

Before ending services, are these components met (1.17c Termination of Services, NASW Code of Ethics)?
- Financial obligations clear & agreed in writing
- Client does not pose a risk of harm / not in crisis
- Clinical consequences of non-payment discussed/documented prior

Termination: HOW?

Consider: Does the person have limited decision making capacity? Can they make informed decisions?

Does their refusal appear to be due to symptoms of the illness itself? e.g., anosognosia, paranoia, severe depression, significant impairments in insight. Is it representing informed decision?

1.14 Clients Who Lack Decision Making Capability: "When (you) act on behalf of clients who lack capacity to make informed decisions…take reasonable steps to safeguard interests and rights of those clients" (NASW).

Termination: HOW?

Consider: Might you have to disclose confidential information in the process of termination?

1.07 Privacy & Confidentiality: If there's a "plan to disclose confidential info…(when feasible and to the extent possible) inform clients about the disclosure & potential consequences prior to disclosing... This applies whether (you) disclose confidential information on the basis of a legal requirement or client consent" (NASW).

Try to get disclosure permission prior. If permission isn't given, inform after w/reasoning. The only reason you shouldn't inform is due to potential harm to self or others. Document!

Termination: HOW?

Consider: Does the person have services to transition to if they need/want continued treatment?

1.15 Interruption of Services: "make reasonable efforts to ensure continuity of services in the event that services are interrupted" (NASW Code of Ethics).

1.16 Referral for Services: "refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when (you) believe that they are not being effective or making reasonable progress with clients and that other services are required" (NASW Code of Ethics).

Termination: HOW?

Consider: Have you sought out consultation from peers if this is not a straightforward termination?

2.05 Consultation: "seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients…only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject …disclose the least amount of information necessary" (NASW Code of Ethics).

If seeking consultation, be sure to seek consult from at least 2 professionals who have experience with the consult question. If their opinions differ, seek further consult from additional professionals!

Termination: HOW?

More tips for termination…

- Termination should be discussed as soon as you know it's possible to provide time for transition
- Ensure the clients understands when, why, and how termination will happen
- Offer face-to-face termination session(s), rather than via a text or email
- If continued services are needed, offer multiple referral sources (three should be the minimum) and help the person weigh the options
- Formalize termination with a letter and discharge progress note
- Document all of the above!

(Felton & Polowy, 2003)

Termination: HOW?

Provide a formal and confidential **Termination Letter** to the client to provide clarity, closure, and documentation.

The termination letter should include:

- Client name
- Dates treatment began and ended
- Reason(s) for termination
- Summary of treatment
- Prognosis and referrals made
- In-person at last session or certified mail

(Felton & Polowy, 2003)

Ethical Decision-Making Regarding Termination ACTIVITY

Please go into groups of 3 to 4 people for this activity.

When Termination = Abandonment & Negligence

- 1.17 Termination of Services: "take reasonable steps to avoid abandoning clients who are still in need of services…withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects…assist in making appropriate arrangements for continuation of services when necessary" (NASW Code of Ethics).

- Providers "who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences" (NASW Code of Ethics).

Abandonment & Negligence

Abandonment (or other ethical complaint) might be considered if you terminate:

- When client is a risk of harm to self or others or is in a current crisis
- To pursue social, financial, or an intimate relationship with the client
- When you anticipated termination but did not promptly inform the client and prepare for continuation of services elsewhere
- Without making arrangements for continuation of services, when necessary
- Without providing client information on the options with the associated risks and benefits when planning for a transition
- Without taking detailed consideration and care in termination process to avoid adverse effects

46

Abandonment & Negligence

Abandonment (or other ethical complaint) might be considered if you terminate:

- Without spending time on ensuring client understands the reason(s) for termination
- Without involving others if the client has limited decision making capacity
- While breaching confidentiality in a negligent manner
- Solely due to non-payment where policies were not in writing & understood prior
- Without assessing client within a reasonable time prior to discharge
- After providing services for an extended time in an area outside your competence
- While engaging in assertive & legal engagement mechanisms that weren't necessary
- While inflicting shame, aggression, and/or personal attack of character

47

Engagement & Termination: Documentation

Why is it important to document engagement and outreach efforts, as well as discussions and plans around termination?

- Have a written document that outlines the various engagement and outreach options & includes records on what you've tried (i.e., Engagement & Outreach Tool)
- Include the first discussion you had w/client re: termination, even if informal
- Document the transition plans that includes shared-decision making with your client
- Include a written crisis / relapse prevention plan if deemed appropriate
- Include a copy of the Termination Letter
- Include notes w/collaterals and/or consultations, w/specific info that supports plan
- *If it's not documented – It didn't happen!*

Engagement & Outreach Tool

An Engagement & Outreach Tool can be a critical mechanism for ensuring a team has considered and attempted all avenues of engaging a person in services prior to considering discharge from the team. The tool can be completed by hand, electronically or be incorporated into an electronic medical record.

Client / ID Number:
Date of Last In-Person Contact:
Possible reasons for disengagement / unknown location to consider:

If person can be located but not engaging:

Method Attempted	Date	Team Member(s)	Response / Outcome
Do we understand person's viewpoint, and address goals THEY want to work on?			
Have we helped by tending to basic or practical needs? ☐ Benefits, finances, or budgeting ☐ Shopping / groceries ☐ Medication administration / delivery ☐ Housing challenges ☐ Medical needs / appointments			
Have we visited their home and known spots?			
Have we considered person's preference re: logistical approaches? ☐ Meeting in a comfortable place ☐ Transportation ☐ Visiting their home / homeless shelter ☐ Using technology (email, text, etc.) ☐ Time of day appointments are scheduled			
Have we considered the following if the person has a substance use disorder? ☐ Harm reduction (i.e. clean needle exchange, Narcan, etc.) ☐ Rides to CDD groups ☐ Referrals / rides to self-help groups ☐ Sensitive to SOC			
Have we reviewed with the person how they can get in touch with the team?			

49

Have 3 or more different team members attempted to engage the person, including team leader & PSS?			
Have we tried coordinated team member visits?			
Engage in an activity of their choice (hobby, etc.)			
Have we reviewed each staff's role with the person and how each staff can be helpful with person's individual goals?			
Are there cultural differences that need to be addressed?			
Does stages of treatment match with person's SOC for each behavior / goal?			
Have we consulted with the person's informal and formal supports that have an active release of information? Document name and contact information below: Emergency Contact: Guardian / Payee: **If an informal support was contacted, don't forget to track this. Support #1: Landlord: Support #2: Previous Provider: Support #3: Probation/Parole Officer: Employer: Medical provider:			
Has the team enlisted the previous provider to encourage engagement in services?			
If applicable, has the team has attempted a crisis intervention?			
Have staff been cancelling appointments? If so, have we addressed this with person?			
Is termination based on missed appointments or fixed time limits?			
Have we utilized the following evidence-based practices? ☐ Motivational Interviewing ☐ Peer Support Services ☐ Dual Disorder Approach ☐ Group Services			
Assessed need for and initiated additional legal mechanisms (as a last resort): ☐ Involuntary Emergency Admission ☐ Revocation of CD ☐ Guardianship or Payee-ship ☐ Probation / Parole			
Other steps taken based on team discussion process:			

50

References

- https://nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Engagement-A-New-Standard-for-Mental-Health-Care
- Bhatia, R. (2023). What is psychotherapy? American Psychiatric Association website.
- Bijkerk, L. E., Oenema, A., Geschwind, N., & Spigt, M. (2023). Measuring engagement with mental health and behavior change interventions: an integrative review of methods and instruments. International Journal of Behavioral Medicine, 30(2), 155-166.
- Bouchard M, Lecomte T, Cloutier B, Herrera-Roberge J, Potvin S. Dropout Rates in Psychosocial Interventions for People With Both Severe Mental Illness and Substance Misuse: A Systematic Review and Meta-Analysis. Front Psychiatry. 2022 May 12;13:842329. doi: 10.3389/fpsyt.2022.842329. PMID: 35633799; PMCID: PMC9133375.
- Dixon LB, Holoshitz Y, Nossel I. Treatment engagement of individuals experiencing mental illness: review and update. World Psychiatry. 2016 Feb;15(1):13-20. doi: 10.1002/wps.20306. Erratum in: World Psychiatry. 2016 Jun;15(2):189. PMID: 26833597; PMCID: PMC4780300.
- Felton, E. M., & Polowy, C. I. (2015). Termination: Ending the therapeutic relationship—Avoiding abandonment. *National Association of Social Workers*.
- Mitchell, A., & Selmes, T. (2007). Why don't patients attend their appointments? Maintaining engagement with psychiatric services. Advances in Psychiatric Treatmengt, 13(6), 423-434. doi:10.1192/apt.bp.106.003202
- Moser, L., & Powers, C. (2023) "Being assertive or not being assertive enough: Navigating an important but challenging space within ACT" PowerPoint. Lecture, National ACT Virtual Meeting, February 5, 2023.
- NAMI Engagement: A new standard of care 2016
- Olfson, M.D., M.P.H., Ramin Mojtabai, M.D., Ph.D., Nancy A. Sampson, B.A., Irving Hwang, M.A., and Ronald C. Kessler, Ph.D. Psychiatric Services, 2009 Jul; 60(7): 898–907. Patrick Corrigan, Benjamin Druss, Deborah Perlick. Psychological Science in the Public Interest, Oct 2014, vol. 15 no. 2: 37–70.
- Powers, C. & McDonnell, K. (2023). "Assertive engagement and outreach" PowerPoint. Lecture, EBP Basic Trainings and several consults, 2019 – 2023.

51