PCSS Medications for Opioid Use Disorders

Providers Clinical Support System

Creating Optimal Access for Opioid Use Disorder (OUD) Services Utilizing Stages of Change

September 4, 2025

Nick Szubiak, MSW, LCSW
NSI Strategies

Housekeeping

- Today's webinar is being recorded and all participants will be kept in listen only mode. There will be an opportunity to ask questions at the end of the webinar, so we encourage you to please submit your questions throughout the webinar in the Q&A box located at the bottom of your screen.
- The recording and slides will be made available on the PCSS-MOUD website within 2 weeks.
- Within 48 hours of today's session, you will receive an email from granteducation@aaap.org with evaluation and certificate claiming information.

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

Funder Information

- This event is brought to you by the Providers Clinical Support System – Medications for Opioid Use Disorders (PCSS-MOUD), a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Content and discussions during this event are prohibited from promoting or selling products or services that serve professional or financial interests of any kind.
- PCSS-MOUD aims to increase the knowledge and skills of healthcare and counseling professionals about available evidence-based treatment approaches for substance use disorder (SUD) with a particular focus on opioid use disorder (OUD). PCSS-MOUD provides free training and mentoring to practitioners on the use of medications for OUD (MOUD) and the integration of these services into mainstream health care.
- *Funding for this initiative was made possible by cooperative agreement no. 1H79TI086770 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.*

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Presenter(s), planner(s), reviewer(s), and all others involved in the planning or content development of this activity were required to disclose all financial relationships within the past 24 months

All disclosures have been reviewed, and there are no relevant financial relationships with ineligible companies to disclose.

All speakers have been advised that any recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in patient care. All scientific research referred to, reported, or used in the presentation must conform to the generally accepted standards of experimental design, data collection, and analysis.

Educational Objectives

- Discuss how the Stages of Change model applies to opioid use disorder (OUD) care.
- Identify barriers to accessing care and Medications for Opioid Use Disorder (MOUD) utilization as well as skills and opportunities to engage with clients for change at each stage.
- Explore practical strategies for creating stage-appropriate client engagement to care and MOUD.

Today's Speaker

Nick Szubiak, MSW, LCSW
Integrated Health Consultant and Principal,
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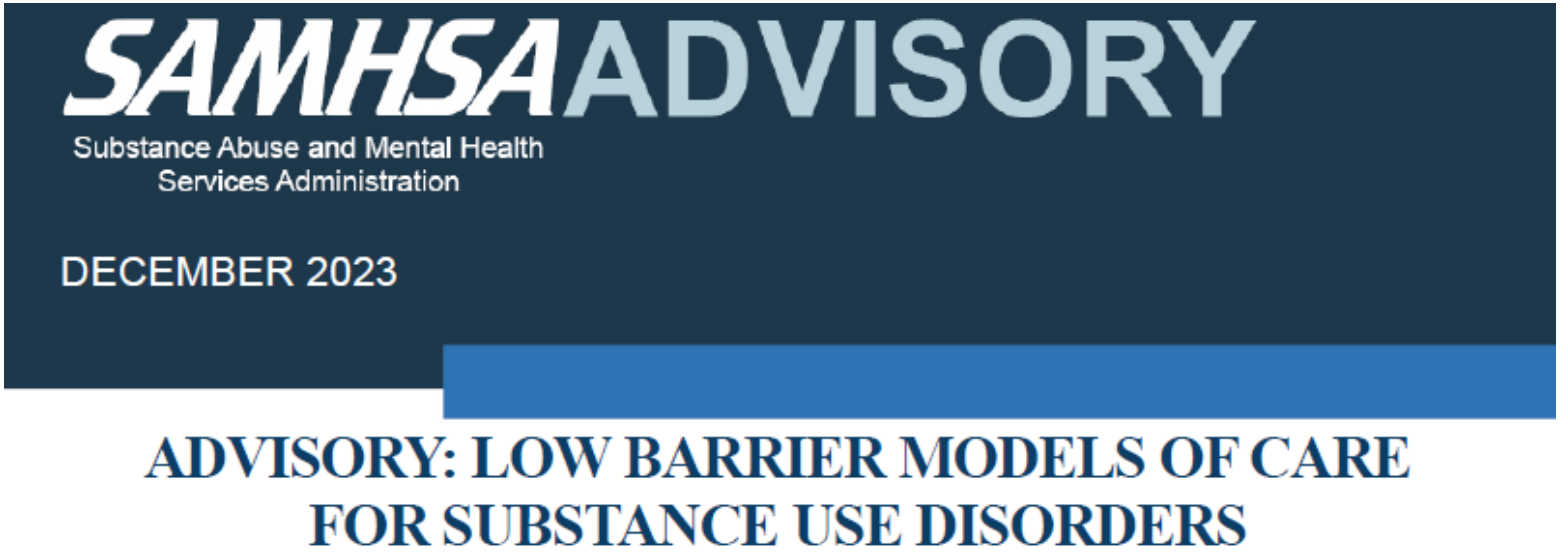
Transforming the Levels of Care

- Timely access to care
- Low-barrier access
- Care that the community wants to engage and stay engaged with
- Do our policies match the neuroscience of addiction?



Source: https://library.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf

Principles of Low Barrier Care

Person-centered care

Meeting the person where they are

Flexibility in service provision

Provision of comprehensive services

Recognize the impact of trauma

Image sources: PowerPoint, 2024

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Low Barrier and High Barrier Care

SAMHSA ADVISORY

Exhibit 1: A Comparison of Low-Barrier and High-Barrier Care

Barrier Level	Requirements and Approach [35,36,37,38,39,40]	Requirements and Approach (medication only)	Availability [41,42,43,44,45]
Low Barrier Care	• No service engagement conditions or preconditions. • Visit frequency based on clinical stability. • Ongoing substance use does not automatically result in treatment discontinuation. • Client's individual recovery goals prioritized. • Reduction in substance use and engaging in less risky substance use as acceptable goals.	• Medication at first visit. • Home initiation permitted. • Various medication formulations offered. • Individualized medication dosage. • Rapid re-initiation of medication after short-term disruption.	• Treatment available in non-specialty SUD settings. • Other clinical and non-clinical services incorporated into SUD treatment settings. • Same-day treatment availability, no appointment required. • Extended hours of operation. • Telehealth and in-person services available.
High Barrier Care	• Requirements for current or previous engagement with specific services. • Visit frequency based on a rigid, pre-determined schedule. • Treatment discontinuation due to ongoing substance abuse. • Treatment goals imposed. • Abstinence as the primary goal for all clients, all the time.	• Two or more visits before medication. • Clinic initiation required. • Limited medication formulation options. • Uniform maximum dosage. • Induction required to restart medication.	• Treatment only available at specialty SUD programs. • Non-integrated or limited-service offerings. • One or more day wait to initiate treatment, appointment required. • Traditional hours of operation. • Services only available in-person.

This table was adapted from a table developed by Jakubowski and Fox.[35]

Source: https://library.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf

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Provider Bias and Beliefs

What gets between you and patient care?

- What we think we know
- What we judge
- What we diagnose
- What we know can help
- What we know can change
- What we diagnose, assess, and our training to see pathology

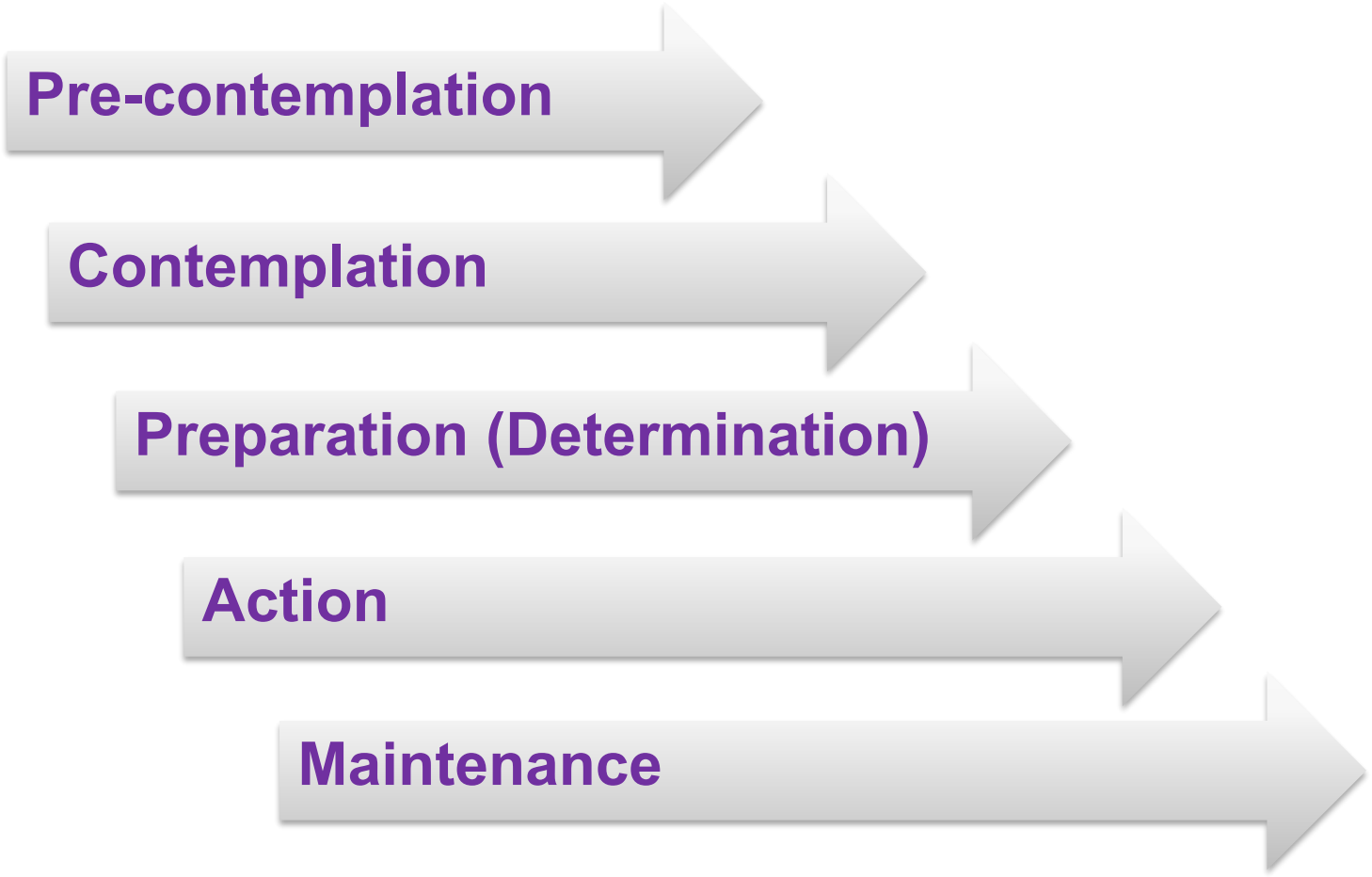
Removing:

- Resistance
- Non-compliance
- Not engaged

The way we think (stigma) impacts the way we behave.

Language matters.

Stages of Change



Source: https://smartrecovery.org/the-stages-of-change

The Stages of Change Explained

Pre-Contemplation

- Not ready for change (yet).
- Individuals do not intend to take action in the foreseeable future.
- Often unaware or in denial that their behavior is problematic or harmful.
- May defend their behavior or attribute issues to external factors

Image source: PowerPoint, 2024

Common Features

- Low insight or recognition of harm.
- Overemphasis on the costs of change.
- Minimization or rationalization of consequences.
- Avoidance of conversations about change.

Image source: PowerPoint, 2024

Contemplation

- Intending to start the healthy behavior in the foreseeable future.
- Recognizing that their behavior may be problematic, and considering pros and cons.
- Feeling ambivalent towards changing their behavior despite this recognition.

Image source: PowerPoint, 2024

Common Features

- Ambivalence is central: “I know this is hurting me, but I’m not sure I want to stop.”
- May be evaluating pros and cons of use (decisional balance).
- Can remain in this stage for months or even years.
- Often feels stuck, leading to emotional conflict and internal distress.
- May minimize risks or overestimate barriers to change.

Preparation (Determination)

- In this stage, people are ready to take action within the next 30 days.
- People start to take small steps toward the behavior change, and they believe changing their behavior can lead to a healthier life.

Image source: PowerPoint, 2024

Common Features

- Commitment to change has emerged.
- May have set a quit date or begun cutting back.
- Plans are forming: researching treatment options, talking to loved ones, or scheduling appointments.
- Still may experience some ambivalence, but motivation outweighs resistance.
- Confidence is growing but can still be fragile.

Action

- In this stage, people have recently changed their behavior (defined as within the last 6 months) and intend to keep moving forward with that behavior change.
- People may exhibit this by modifying their problem behavior or acquiring new healthy behaviors.

Image source: PowerPoint, 2024

Common Features

- Visible behavioral change is occurring (e.g., abstaining, reducing use, engaging in treatment).
- Person is using coping strategies, attending therapy or groups, and/or taking medication.
- High risk for relapse as new behaviors are still being learned.
- Requires effort, structure, and support.
- Individual begins to restructure their environment, habits, and relationships.

Maintenance

- In this stage, people have sustained their behavior change for a while (defined as more than 6 months) and intend to maintain the behavior change going forward.
- People in this stage work to prevent relapse to earlier stages.

Image source: PowerPoint, 2024

Common Features

- New, healthy behaviors are becoming part of daily routine.
- Increased stability in recovery, but vigilance is still needed.
- Focus shifts from stopping use to building a meaningful life in recovery.
- May experience plateaus, life stressors, or emotional triggers that challenge stability.
- Recovery identity may be emerging (e.g., “I’m in recovery,” “This is who I am now”).

Case Study: Background

- Marcus is a 34-year-old man who works seasonally in construction and lives with his older brother.
- He began using prescription opioids after a back injury three years ago and has since transitioned to using heroin, mostly by snorting, and occasionally by injection.
- He also reports occasional methamphetamine use, especially when trying to stay alert during long work shifts or to offset the sedating effects of opioids.

Case Study: Presenting Concern

- Marcus was identified as having OUD via SBIRT.
- He admits to using heroin "a few times a week," sometimes taking fentanyl-laced pills when heroin isn't available.
- He denies a history of overdose but notes, *"a couple of my friends didn't wake up."*
- He acknowledges that his substance use is affecting his health, relationships, and ability to maintain steady work.
- He's not ready to quit entirely but is thinking about making changes.
- He says, *"I know this isn't working, but I don't think I can just stop either. Maybe I need a different way."*

Case Study: Motivators and Barriers

Motivators:

- Concern about overdose risk
- Worsening physical health
- Conflict with family
- Desire to get back to consistent work

Barriers:

- Fear of withdrawal
- Dependence on substances to cope with stress
- Limited knowledge of treatment options
- Stigma
- Negative prior experiences with detox
- He also expresses uncertainty about stopping methamphetamine, which he feels helps him "get things done."

Stage of Change Poll

- **Based on the case study example, what stage of change would you say Marcus is currently in?**

  - Pre-Contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance

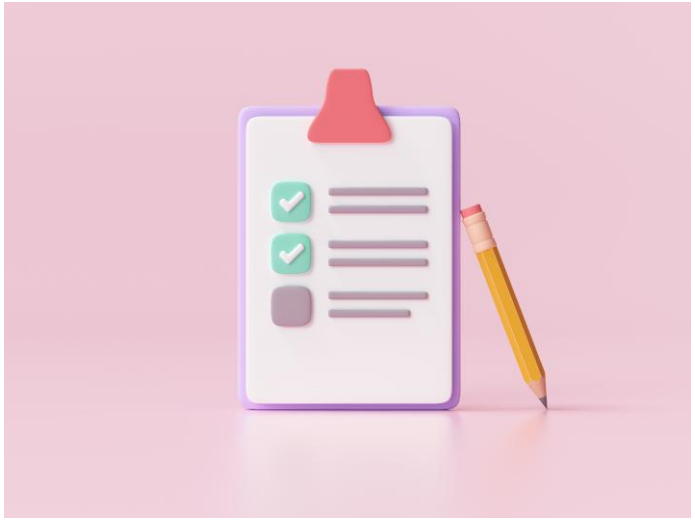


Image source: PowerPoint, 2024

Case Study Example

Stage of Change: **Contemplation stage**

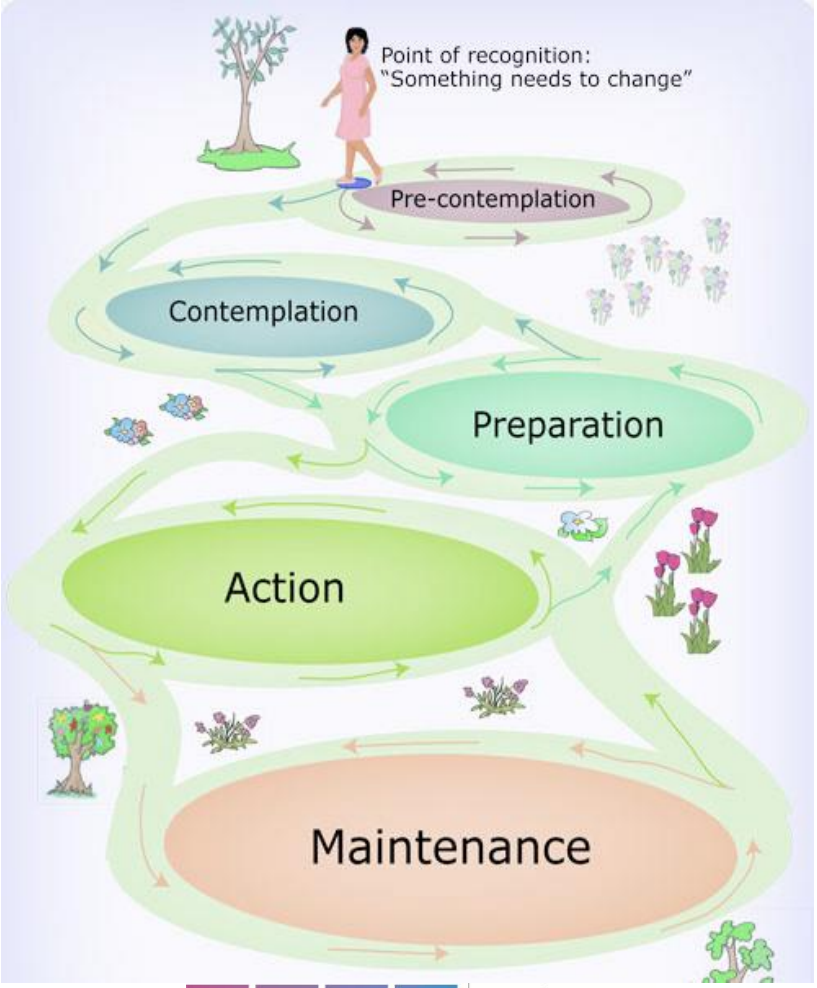
- He acknowledges that his substance use is affecting his health, relationships, and ability to maintain steady work.
- He's not ready to quit entirely but is thinking about making changes.
- *"I know this isn't working, but I don't think I can just stop either. Maybe I need a different way."*

Common Barriers and Needs

Stage	Common Barriers	Needs
Precontemplation	Stigma, lack of awareness, fear of treatment	Trust, overdose prevention, education
Contemplation	Ambivalence, conflicting priorities	Motivational Interviewing, peer support
Preparation	Logistical concerns, provider availability	Navigation, appointment access
Action	Financial, structural/systemic	MOUD, coordinated care
Maintenance	Housing, social support, relapse risk	Recovery support services

Fluidity and Complexity of the Stages of Change Model

- The key to utilizing the stages of change is alignment.
- Sometimes patients move back and forth between stages, *even within a sentence or two of conversation.*
  - It's okay to keep exploring!
- The focus should be to align with the patient's stage, ***not*** to "motivate" the client to move from one stage to the next.



What is Motivation?

- A person's state of readiness for change.
- Malleable – it is dynamic and fluctuating.
- Modifiable - it can be nurtured or hampered.
- Affected by external factors.
- Particularly sensitive to interpersonal interactions with people in our lives who we consider to be influential.

Image source: PowerPoint, 2024

What is Your View?

Deficit	Competence
❑ Insight & knowledge is lacking.	✓ Capacity to change is within.
❑ Telling	✓ Asking and listening

12 Roadblocks to Maintaining the Motivational Interviewing Spirit

1. Ordering, Directing
2. Warning, threatening
3. Giving advice, making suggestions, providing solutions
4. Persuading with logic, arguing, lecturing
5. Moralizing, preaching
6. Judging, criticizing, blaming
7. Agreeing, approving, praising
8. Reasoning, sympathizing
9. Questioning, probing
10. Withdrawing, distracting, humoring, changing the subject
11. Shaming, ridiculing, name-calling
12. Interpreting, analyzing

Source: Gordon Training International, 1957

Supporting the Relationship with Listening and Hearing

- Commitment
- A suspension of judgments, perceptions, thoughts, diagnosis, evaluation, formulation, and conclusion
- Can be self-sacrificing
- Takes energy
- Takes belief

Image source: PowerPoint, 2024

Point of Recognition

Image source: ESP, 2009

How Can We Elicit Change from Precontemplation?

Image sources: PowerPoint, 2024

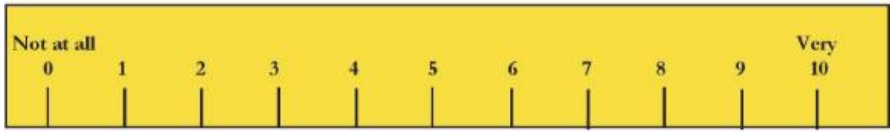
- Build trust and rapport without pressure.
- Use nonjudgmental curiosity to spark reflection.
- Introduce overdose prevention strategies and basic education.
- Explore values and life goals that don't directly confront behavior.
- Explain the benefits of MOUD using stage-appropriate language/framing.

Moving from Precontemplation to Contemplation

Readiness Ruler

Thinking About Change
What change(s) are you considering?
How important is it that you make this change?
How confident are you that you are able to make this change?
How ready are you to make this change?

Readiness Ruler



Ask the client to indicate a best answer on the ruler to the question:

- **"How important is it for you to change?"**
- **"How confident are you that you could change if you decided to?"**

Source: American Counseling Association, 2015

Contemplation:
Holding Space for Ambivalence

- **Ambivalence ≠ Resistance**
  The individual may feel **torn or uncertain**, not because they're uncooperative—but because change is complex and risky.
- **Feeling Stuck**
  A tension exists between the *desire for change* and the *comfort or protection of current behavior*.

Contemplation:
Tools for Exploration

- **Decisional Balance** – Weighing pros and cons to clarify values and internal conflict.
- **Cognitive Dissonance** – "I know using is hurting me… but I also need it to cope."
- **Emerging Awareness**
  As defenses drop, deeper truths surface—the real reasons behind the behavior. This may include **shame, guilt, fear, or grief**. *Reality bites—this is a tender, destabilizing time.*

Relationship is Paramount.

We **don't push** them—we **walk with them.**

Preparing for Discrepancies in Language and Powerful Reframing

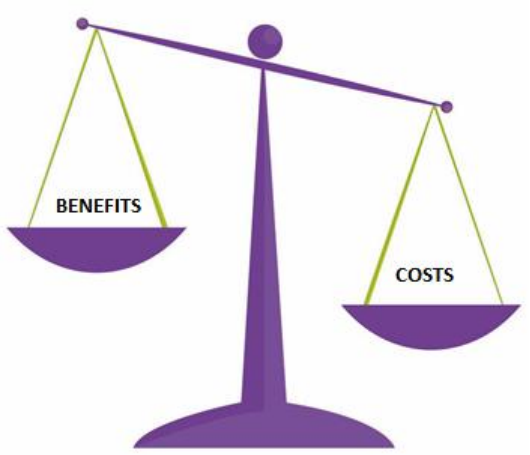
- ~~Non-Compliance.~~
- ~~Not engaged.~~
- ~~No Show.~~
- ~~Frequent flyer.~~

- Continued use despite harmful consequences.
- Loss of voluntary control.
- Shifting drivers and neuroadaptations.
- Emotional dysregulation.
- Cognitive impact.

Contemplation Strategies: Cost Benefit Analysis

What's the price of change vs price of maintaining the status quo?

Cost of doing…	Benefits of doing…
1.	1.
2.	2.
3.	3.



The relative weight people assign to the pros and cons of a behavior influences their decisions about behavior changes. (Janis & Mann)

Image source: Blogger, 2017

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Contemplation Exercises - New Language: New Approach

- "Why do you want to change at this time?"
- "What were the reasons for not changing?"
- "What would keep you from changing at this time?"
- "What are the barriers today that keep you from change?"
- "What might help you with that aspect?"
- "What things (people, places and behaviors) have helped in the past?"
- "What would help you at this time?"
- "What do you think you need to learn about changing?"

Preparation

S	Specific
M	Measurable
A	Achievable
R	Relevant
T	Time-based

- Decision is made, have a plan to start MOUD.
- Resolution of ambivalence.
- Readiness to embark on behavioral change.
- SMART Goals
- Praise the decision to change behavior – do not underestimate your sphere of influence!
- Identify and assist in problem solving re: obstacles, obstructions, potholes, roadblocks.
- Encourage small, initial steps.
- Assist identifying social supports.
- Time frame

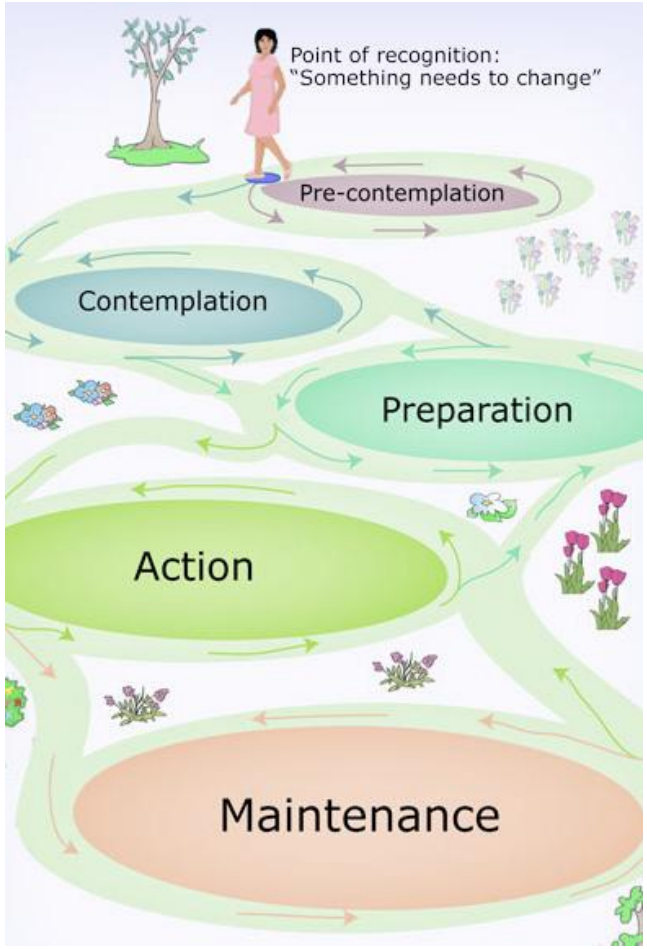
Image source: Youngwivesguide.com, N.D.; Indeed.com, N.D.

ACTION!

- Overt behavioral change.
- Usually means stopping or starting a behavior.
- Requires conscious work.
- The person is actively doing things to change or modify behavior.
- Integrating MOUD care in OUD treatment regimen.

Image source: PowerPoint, 2024

Maintenance



- Sustained behavior over time.
- Sustained MOUD use to prevent relapse and reduce risk of overdose.
- Alternatives established.
- Attention to relapse risk, triggers, cues, old patterns.
- In maintenance the person continues to maintain behavioral change [for at least six months] until it becomes permanent.

Image source: ESP, 2009

Stages of Change Model: Support

- The model is based on decades of empirical research and has been applied across numerous health behaviors (e.g., smoking cessation, substance use, exercise, diet).
- It provides a **structured, nonjudgmental way** to understand where someone is in their change process.
- Recognizes that ambivalence is a natural part of change — especially in early stages like **precontemplation** and **contemplation**.
- Integrates well with other frameworks.

Stages of Change Model: Critiques

- The model can be misapplied as a **linear sequence**, when in reality, change is often messy, and nonlinear.
  - *Clinicians need to understand client readiness to increase opportunities for successful MOUD treatment.*
- Human behavior change is complex and context-specific.
  - *Clinicians need to utilize effective strategies to encourage MOUD medication.*
- Categorizing people into just 5 or 6 stages can **oversimplify** motivation and ignore social, cultural, and systemic factors.

Critiques continued...

- Determining a person's stage can be **ambiguous** and inconsistent across providers.
  - *Providing clear and understandable psycho-education can support MOUD choices.*
- It focuses on individual decision-making, potentially **ignoring other external challenges** (e.g., poverty, access to care) that affect readiness or ability to change.
  - *Psycho education around MOUD may play a critical role with families, social supports, community supports and faith-based supports.*
- ***These factors can impact a person's choice to start MOUD and the duration they utilize MOUD.***

Questions?

Image source: PowerPoint, 2024

Thank You!!!

Nick Szubiak: nick@nsistrategies.com

PCSS-MOUD Mentoring Program

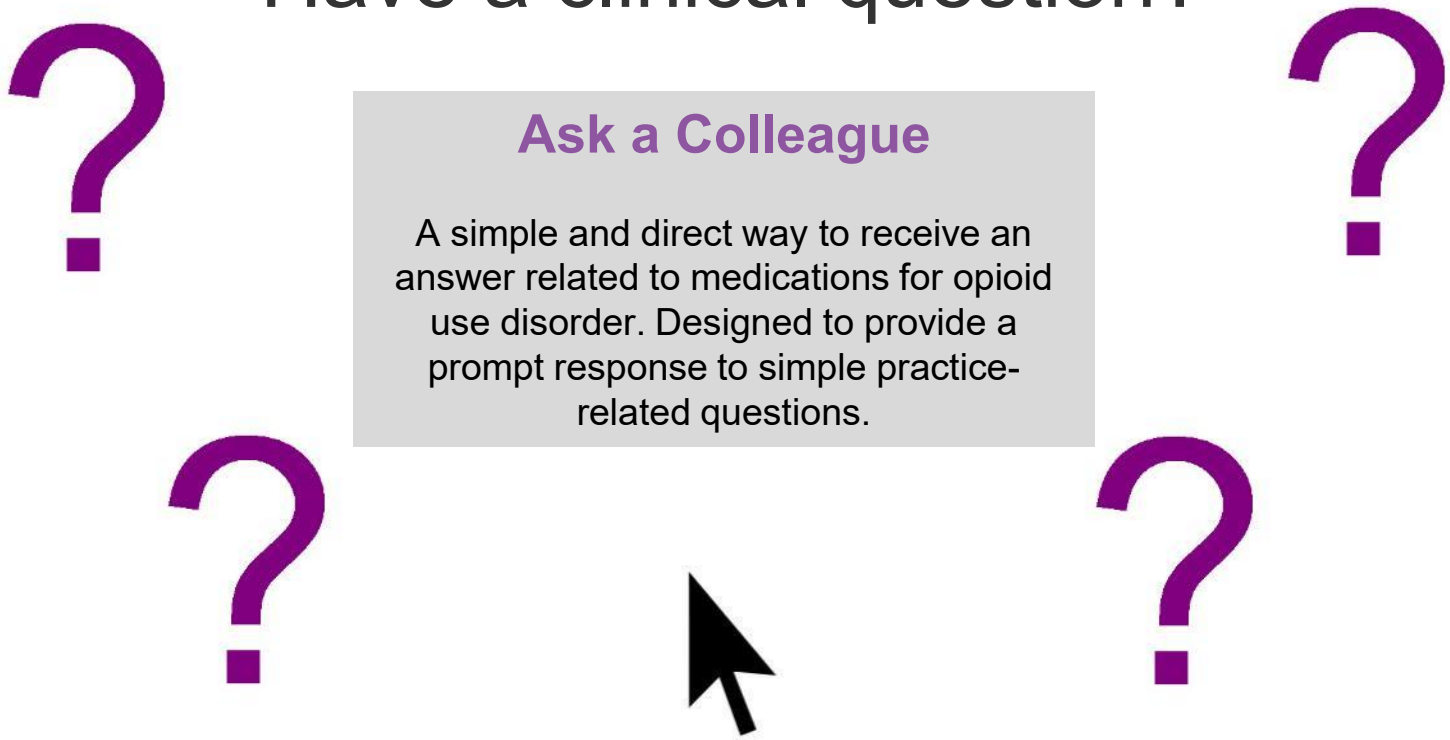
- PCSS-MOUD Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS-MOUD Mentors are a national network of providers with expertise in **addictions, pain, and evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

For more information visit:

https://pcssNOW.org/mentoring/

PCSS-MOUD Discussion Forum

Have a clinical question?



Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

http://pcss.invisionzone.com/register

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PCSS-MOUD is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

Addiction Policy Forum	American College of Emergency Physicians*
Addiction Technology Transfer Center*	American College of Medical Toxicology
African American Behavioral Health Center of Excellence	American Dental Association
All Rise	American Medical Association*
American Academy of Child and Adolescent Psychiatry	American Orthopedic Association
American Academy of Family Physicians	American Osteopathic Academy of Addiction Medicine*
American Academy of Neurology	American Psychiatric Association*
American Academy of Pain Medicine	American Psychiatric Nurses Association*
American Academy of Pediatrics*	American Society for Pain Management Nursing
American Association for the Treatment of Opioid Dependence	American Society of Addiction Medicine*
American Association of Nurse Practitioners	Association for Multidisciplinary Education and Research in Substance Use and Addiction*
American Association of Psychiatric Pharmacists	Black Faces Black Voices
American Chronic Pain Association	Coalition of Physician Education

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Columbia University, Department of Psychiatry*	Northwest Portland Area Indian Health Board
Council on Social Work Education*	Partnership to End Addiction
Faces and Voices of Recovery	Physician Assistant Education Association
Mobilize Recovery	Project Lazarus
NAADAC Association for Addiction Professionals*	Public Health Foundation (TRAIN Learning Network)
National Alliance for HIV Education and Workforce Development	Sickle Cell Adult Provider Network
National Association of Community Health Centers	Society for Academic Emergency Medicine*
National Association of Social Workers*	Society of General Internal Medicine
National Council for Mental Wellbeing*	The National Judicial College
National Council of State Boards of Nursing	Veterans Health Administration

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