Maslow's Hierarchy of Needs as it Relates to Mental Health and Substance Use in a Rural Setting

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Blending theories

- When assessing individuals for services we accumulate a lot of information and knowledge about that individual. As we assess we identify needs and wants that the consumer has that can be utilized to initiate growth. With the addition of the stages of change we have a plan of action that can aid us in moving individuals through their treatment in a smoother fashion and we can identify the changes that are needed in order to do this.
- By adding in the concept of Maslow's Hierarchy of needs we can gain greater understanding in how to motivate individuals through the stages to gain better perspective of the potential for growth and the basic drives that can help us increase the desire to change.

Integrated Treatment for Co-Occurring Disorders

Integrated treatment is defined as simply having the same treatment team or practitioner providing both mental health and substance use treatment concurrently.

Services are organized in an integrated fashion that treat both the mental health and substance use concerns at the same time.

Consumers are given a consistent message about substance use and mental health treatment so there is less room for misinformation.

Providers have comprehensive knowledge of both mental health and substance use symptoms which allows for an understanding of the overlap.

Traditional Models for Treatment

- How this differs from SUD and traditional mental health only approaches.
- Several approaches have been utilized in the past for substance use and mental health diagnosis.
- Sequential treatment: In this treatment approach a consumer with a dual diagnosis is not eligible for treatment by one program until the other issue is resolved.
- Parallel treatment: In this treatment approach both mental health and substance use are treatment are provided however it is normally by different providers and in some cases different agencies.

Rural Populations

- According to Missouri's Department of Health and Senior Services Biennial report from 2021, there are a total of 115 counties, in which 16 counties are urban and 99 are rural (Missouri Department of Health and Senior Services, 2021)
- DHSS in this report defines rural counties according to two qualifications:
  - There are less than 150 people per square mile
  - Does not contain any part of a central city in a Metropolitan Statistical area.

  Additionally, while the majority of the state is rural, approximately 66.3% of the population lives in the 16 urban counties. The DHSS also noted that the top 18 counties with the highest rates of poverty were all rural.

  Within this report, they also document that for populations under age 65, the highest uninsured rates are all rural counties.
- North Central Missouri Mental Health Center, where we are employed, serves 9 rural counties in the north central portion of the state.

Show me the numbers:

- NCMMHC Statistics

Clients by program and percentages (2022 Totals)
573 program (All Clients, including Doctor or therapy only): 1,212 (100%)
590 CPRC (focused on mental health only): 541 (45%)
ITCD 590: 200 (17%)
SUD (adult)(No mental health diagnosis): 7 (0.01%)

ITCD broken down into stages:

Stage of recovery	Homeless	%	Employed	%	On Probation/Parole	%
Pre-engagement	9	3%	34	10%	34	10%
Engagement	4	1%	37	11%	41	13%
Early Persuasion	3	1%	3	1%	5	2%
Persuasion	1	0%	22	7%	14	4%
Early Active	1	0%	38	12%	29	9%
Active	1	0%	21	6%	28	9%
Relapse Prevention	0	0%	4	1%	3	1%
Remission/Recovery/ Maintenance	2	1%	4	1%	0	0%
Totals	21	6%	163	50%	154	47%

Current Data

- Homeless rates: The National Alliance to End Homelessness currently reports approximately 5,883 individuals on a given night are homeless in the state of Missouri.
- Unemployment: The Department of Labor states that the current rate of unemployment in Missouri is 2.6%
- Substance use rates: The stage of Missouri Department of Mental Health reported in December of 2020 that “Approximately 368,000 Missouri residents have a substance use disorder, including 256,000 with an alcohol use disorder and 133,000 with a disorder stemming from illicit drug use.” (status report on Missouri’s substance use and mental health; twenty-sixth edition—2020)

Mental Health Disorders

- Depression
- Bi-polar Disorders
- Schizophrenia
- Generalized Anxiety Disorders
- Post-traumatic stress disorder
- Adjustment Disorders
- Personality Disorders

Examples of SUD

- Alcohol use disorder
- Cannabis use disorder
- Hallucinogens
- Inhalants
- Opioids
- Sedatives

STAGES OF TREATMENT

ENGAGEMENT: Lack of therapeutic relationship between consumers and treatment team.

- Goal: create a working alliance with consumer.

PERSUASION: consumer has regular contact with clinician and is not yet ready to reduce substance use.

- *Goal: develop consumers awareness of how substances effect their lives to increase motivation for change.*

ACTIVE TREATMENT: consumer is motivated to reduce substance use which is indicated by a reduction in use for at least one month.

- *Goal: Further reduction in use and is possible attain abstinence.*

RELAPSE PREVENTION: consumer has not experienced problems related to substance use for at least six months.

- *Goal: maintain an awareness of relapse and extend recovery to other areas of their life.*

Stages of Change Model

PRE-CONTEMPLATION: In this stage and individual may have been referred or encouraged by another entity to obtain treatment. They are unlikely to see a need for treatment and have not yet accepted the idea of change.

CONTEMPLATION: The consumer will have some awareness of the issue and may both consider and reject change.

PREPARATION: The consumer will have a readiness to change and there will be an opportunity to promote that change.

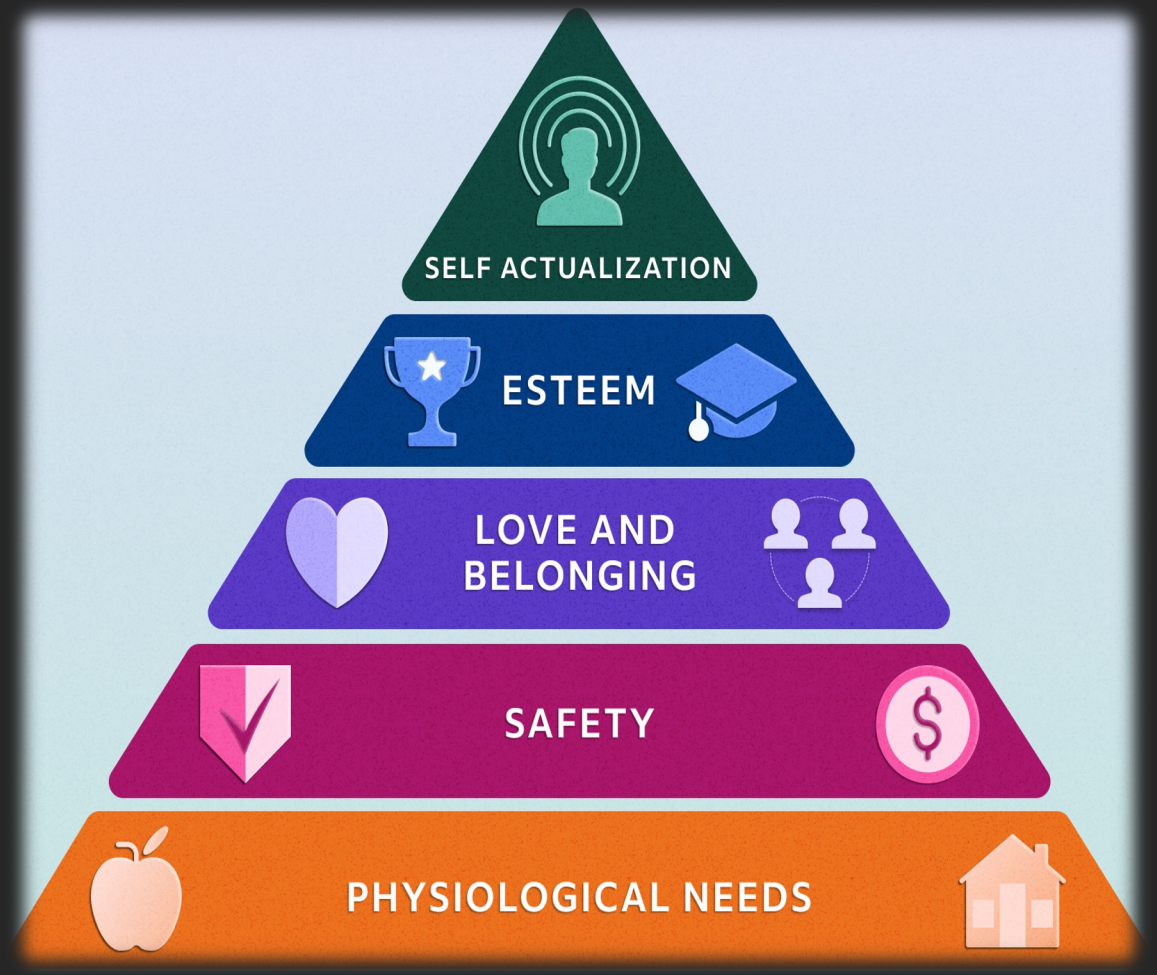
ACTION: The consumer will engage in actions intended to promote change.

MAINTENANCE: The consumer will implement strategies to maintain progress and reduce the likelihood of relapsing behaviors.

RELAPSE: The consumer may experience a “slip” or return to behaviors that are higher than acceptable.

Maslow's Hierarchy of Needs

- PHYSIOLOGICAL NEEDS: Oxygen, food, water, shelter, clothing, sleep
- SAFETY NEEDS: Health, employment, property, family and social ability.
- LOVE AND BELONGING: Friendship, family, intimacy, sense of connection
- ESTEEM NEEDS: Confidence, achievement, respect of others, the need to be a unique individual.
- SELF-ACTUALIZATION: Morality, creativity, spontaneity, acceptance, experience purpose, meaning and inner potential.



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Physiological Needs

- The physiological stage of Maslow's Hierarchy of needs is considered a deficiency need that can clearly be understood as a priority when consumers have entered into treatment. At this point many consumers do not have adequate housing, food, water, clothing, warmth, sex, and sleep.
- Many individuals can be lacking in this area due to untreated mental health or substance use needs which can make it difficult to retain the employment needed to address financial concerns of housing, water, and food. The symptoms that often goes along with untreated disorders can also led to isolation and trust concerns which make it difficult to form and maintain relationships, obtain resources, and make healthy choice.

How Physiological Needs Relate to Stage of Change

- Physiological needs at each stage:
- **Pre-Contemplation**: "I was kicked out of my family's home for using and I'm fine couch surfing because I'm used to it."
- **Contemplation**: "It would be nice to be able to live in my own apartment and not have to worry about where I'm going to sleep"
- **Preparation**: "I think I want to work with my caseworker to get food from my local food pantry"
- **Action**: "I'm applying for housing and jobs so I can live independently."
- **Maintenance**: "I have a stable place to live, and I have all of my basic needs met so I can survive."

Case study:

- Jason is a 43-year-old male who was referred to the ITCD program by his probation officer due to qualifying for an alcohol use disorder and schizoaffective disorder. Jason was living at a recovery center located on a plot of land outside of a small town of about 2,000 after moving to this center from Iowa. Jason was doing well in his recovery and starting to work with ITCD services, until suddenly the recovery center closed and he was given a notice that he had to find a place to live within 30 days. Client became panicked, he begun experiencing cravings, and his mental health symptoms increased in severity due to the uncertainty of his living situation. Client did not have any family members that would assist him, and he felt stranded with little to no resources in a place he was unfamiliar with.

Movement through the stages:

- How we address barriers to physiological resources in rural settings to assist clients in moving through the stages during treatment:

1. Pre-contemplation to contemplation: Develop rapport with client and use motivational interviewing to find what basic needs or resources they need. Discussing their readiness to obtain resources.
2. Contemplation to Preparation: Caseworker obtaining community resource applications, encouraging the client to utilize resources and motivate client to continue working on getting their basic needs met.
3. Preparation to Action: Caseworker working with client to fill out applications for income stability, housing, disability, etc. Encouraging client to fill out applications and provide appropriate documentation in order to be successful. Completing interviews or activities needed to secure resources.
4. Action to maintenance: Client has worked on applying for community resources and has become stable in their living situation, ability to obtain food, and all their basic needs are met.

Outcome

- Client worked with his caseworker to find community resources. He began working with local resources such as Offender Empowerment, a program that assist individuals on probation or parole with funding and resources that are otherwise difficult for this population to obtain. He worked with his caseworker to apply for a residential facility several towns over, in which he would be able to walk to the store and have more opportunities to stabilize his physiological needs on his own. He was able to receive funding assistance for the residential facility with federal/state funding through his mental health center due to meeting qualifications for the funding. Client now has his physiological needs stabilized, has a regular income after being approved for disability, and continues to do well in his recovery.

Safety Needs

- Individuals who are coping with substance use and mental health symptoms often have the inability to maintain personal safety. Safety needs include access to health care, financial stability, employment, and ability to engage in resources. Many individuals who have untreated mental health and substance use symptoms are not equipped to engage in obtaining these resources due to many reasons including trust of authority figures and concerns about judgement from others.

Safety Needs

- Safety needs at each stage:
- **Precontemplation**: “I can’t pay my bills so why should it matter”
- **Contemplation**: “It would be nice to have help but that’s never happened.”
- **Preparation**: “Maybe I would feel better if I saw a doctor.”
- **Action**: “I know I can get help if I keep my appointments and be honest”
- **Maintenance**: “I know how to talk to my doctor, and I have been able to work now so things have been better. “

Case study:

Della, a 19-year-old female was referred to the agency after being released from hospitalization. She had recent use of substances including crack, coke, PCP and methamphetamines which led to psychosis and delusions where she was manic and attempting to locate her parents who had passed away when she was an infant. Della had denied any current suicidal ideations or self-harm and was currently on medications provided by the hospital physician. Della reported a history of mental health treatment since the age of 14 with diagnosis of Generalized Anxiety Disorder, PTSD, depression and most recently bi-polar I disorder with psychosis. Della reported two long term treatments since age 14 including a juvenile detention center.

Della reported that she began utilizing pills, marijuana and alcohol at age 10 and progressed to methamphetamines and psychedelic drugs at age 15. By age 17 she was utilizing heroine and began utilizing cocaine by age 19. She reported past trauma of physical, emotional, verbal and sexual abuse. In addition, the consumer reported sexual assault and a history of intimate partner violence. Della had lost both of her parents when she was a toddler and had been raised by her paternal grandmother and paternal aunt.

Upon intake Della was unemployed and living with her grandmother and her aunt who was her legal guardian. She reported feeling that she was unable to accomplish anything and did not feel that she was able to maintain employment or care for herself as “I have never been able to keep that going.”

Movement through the stages:

- Precontemplation: lack of access to safe housing, financial instability, low levels of employment, decreased access and education on health services, and inability to engage in use of area resources.
- Contemplation: provide outreach to introduce education on area resources and health services, encourage engagement with IPS and other resources to obtain employment or address training and educational needs, instill budgeting techniques to address financial stability, and use of Motivational interviewing techniques to encourage engagement in all services and address limits of trust.
- Preparation: obtaining health care provider and scheduling appointments, developing plan of action to engage in services and identify the specific needs of the consumer, education on application processes and encouraging interaction with providers, instilling hope for future outcomes and confidence to ask for help.
- Action: attending scheduled appointments with health care agencies and discussing needs, completing applications for resources and following up on documentation, following plan for budgeting needs and engaging in employment, education, or training needs.
- Maintenance: attending and following up on scheduled appointments and treatments with health care providers, obtaining services and maintaining contact with providers as needed, learning to adjust budgets and follow financial plans on their own without assistance, and maintaining confident employment in a secure setting.

Outcome

- While working with the agency Della was able to sustain her SUD recovery and move through the stages. She began engaging in NA and was able to start her own group in the area. She engaged with her case manager, therapist and doctor to obtain medications, resources, and engage in grief and trauma work. Della continued to make progress slowly over the years and addressed her safety needs by engaging in part-time employment, working on her health and obtaining her own car.
- Della continued to progress and began the process to end her guardianship. At this time, she had begun a healthy relationship and moved to another city with her significant other. Della continued with services at the agency until she was transferred to a new agency. She continued to engage in her treatment and medication needs, attended the local NA, and obtained full time employment.

Love and Belonging

- Everyone needs to feel loved, cared for and needed in life. Maslow had the same thought and placed it in the third tier of hierarchy. Maslow's Definition states, "belongingness refers to a human emotional need for interpersonal relationships, affiliating, connectedness, and being part of a group".
- The client's we serve within ITCD struggle with having those connections. There can be family conflicts, barriers within interpersonal relationships and/or peer discord over mental health or past/present substance use.

Love and Belonging

- Love and Belonging at each stage:
- Per-contemplation: "I don’t need anyone. I can use and I'm not lonely".
- Contemplation: "It would be really nice to have people, but my friends that use get me".
- Preparation: "I really want a relationship with people that don't use, but I have to hide my use".
- Action: "I want the relationships and I'm working on gaining those connections through my substance use group".
- Maintenance: "I have a family (blood or not) and feel like I belong. I have the connection and acceptance I need. I don't need to use anymore".
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Case study:

An 18-year-old young man came into services struggling with **substance use and truancy** during his senior year. His juvenile officer and school officials said that he **struggles to have a good relationship with his peers, is not passing classes and uses marijuana and alcohol almost daily.** As you meet the young man during the first appointment; he is **loud** and uses **humor** often or attempts to treat everyone else like they are **beneath him**.

As appointments go on, you discover how he is currently living with his older sister, her partner and their kids. You also find out that his other sister lives with the oldest sister as well while client is sleeping on a couch. As you begin to develop rapport, client shares that his **mother** struggles with **severe substance use**, **father** is in **prison** and he struggles to **trust others** because of **past trauma**. He uses humor and creates barriers with people because of not trusting others and **believing he didn't need positive relationships to succeed**. He is using **substances** to **cope** with his depression, anger of feeling alone and blanketing his emotions. He has barriers with learning because of not being able to pay attention in class with others. He loves basketball but is not able to play because of the substance use or grades. He is using substances to "**deal with it all**" and doesn't know of any other ways to cope with his situation. The only friends he has "**do the same thing.**" When asked what he sees for himself in his **future** he states, "***probably in prison like my dad.***"

Movement through the stages:

The client continues to be in the pre-contemplation stage of change. In order to aid him with moving to the next stage, evoking hope through motivational interviewing, continuing to develop a trusting therapeutic relationship and guiding him to take the necessary steps to being successful and in recovery.

1. Pre-contemplation to contemplation: Develop rapport while encouraging client to assess what he wants in life while guiding client to see that he needs positive supports in his life. Giving education about what substance use does to the brain and body.
2. Contemplation to Preparation: Continuing positive relationship, using motivational interviewing while also using open ended questioning to assist client with understanding their emotions and feelings. Continuing to give education on the negative barriers that substance use creates.
3. Preparation to Action: Engaging in groups for support and to create healthy relationships. Client at this point is ideally not using substances and creating long lasting relationships or repairing the relationships affected by substance use. Could also be engaging in family interventions, counseling and doing more in the community. This is where you will see less barriers within their life, better view of their abilities and a better quality of life.
4. Action to maintenance: Has sustained healthy relationships, recovery and is continuing to create healthy supports in and out of the home. Client is probably continuing group engagement, counseling and or therapy with full integration into the community. The client at this time feels wanted, content and supported. This is where you begin lessening contact as a clinician since you have shown them that they can maintain this quality of life on their own.

Outcome

- As the client continued to move through the stages of change using Maslow's guide, he has gained peers that support him in making positive changes, engages in groups and has graduated school early. He has completed his substance use treatment but remains in the program to continue positive peer engagement as a leader. He has not used substances in over 2 years. The client now lives with his mother, who is also substance free, while having his own room and bed. Client has continued to make strides with his mental health, coping skills and utilizing his relapse prevention skills.
- The client has made many new relationships within his life, feels safe, loved and knows he is part of a family and community unit. He has plans on going to college and becoming a social worker himself.

Esteem

- Esteem is a prominent figure in not only engaging in treatment but maintaining the changes that an individual has made. Esteem needs incorporate respect, self esteem, status, recognition, strength and freedom. These needs are subject to mental health and substance use symptoms and in turn will affect an individual's behaviors in society, occupation, family life and will be the gauge to their feelings about status in society.

Esteem

- Esteem at each stage:
- **Precontemplation**: “ I am not good at anything, and I don’t need to try to do things. ”
- **Contemplation:** “I do have some things that I could do but I am not very good at them. ”
- **Preparation**: “Maybe if I try, I can do better at…”
- **Action:** “I am going to take a chance and try to ….”
- **Maintenance:** “ Things are getting better, and I am doing really well with my … maybe I can teach others now.”

Case Study:

- Katrina is a 34-year-old female who requested services due to mental health symptoms and use of opioids. Katrina was recently hospitalized for suicidal ideations and reported a past hospitalization approximately 4 years ago. She expressed a decrease in daily hygiene, lack of motivation for caring for herself or family, and struggled with family relationships and roles. She reported use of prescription opioids which led to past legal charges.
- Katrina expressed past trauma however she would not discuss this at the time of intake. She stated that there was a family history of behavioral health issues and stated that she “tries to stay away from them”. She expressed a decline in her relationship with her children and arguments with her spouse which has led to her isolation.
- At time of intake, she was living with her children and spouse in their family home. She was the main caretaker for the family and her ability to complete her daily tasks was diminishing due to her isolation and symptoms. Katrina felt that she could not care for her family and reported that she was not good enough to be with them at times. denied any current employment and stated that she did not work outside of the home.

Movement through the stages

- Precontemplation: lack of respect for self, community, and family partially due to negative consequence of substance use and low levels of education on mental health symptoms. Individuals may feel added guilt, and shame which can decrease their self-esteem and led to isolation from family, community, and society in order to cope with their emotions.
- Contemplation: beginning to become aware of the individual as a whole as opposed to the symptoms they are experiencing. Aiding the individual in identifying how their behaviors while utilizing substances or having an untreated mental health diagnosis has created an atmosphere of guilt and shame that may be disconnecting them from themselves.
- Preparation: Identifying triggers for guilt and shame and creating an action plan to aid in coping. Engaging healthy social and family relationships that can aid in uplifting the individual and helping them to notice their status in the lives of others.
- Action: engaging in family and social life using healthy communication, boundaries, and health activities. Aiding individuals to locate their strengths and providing the freedom to choose activities using skill building.
- Maintenance: establishing the individual's role in society, family, and community through the use of healthy activities, enjoyable work, and possibly volunteerism or sponsor roles.

Outcome

- Katrina had difficulty at times moving through stages and engaging with her family. She worked with the agency for three years and during this time she was able to begin Suboxone treatment for her opioid addiction and work on decreasing symptoms. Katrina engaged in therapy, case management and doctor services to aid in her treatment. She continued to work on engagement with her family and strived to build a healthy interactive relationship with them.
- Katrina was able to obtain medications that aided her in decreasing her depression symptoms. She engaged in trauma therapy, engaged in work on self-esteem and self-compassion and learned to ask for her needs. Katrina began working outside of the home and her isolation decreased. She engaged in her children's school and worked to develop trust within the family again.
- She began educating herself on becoming a Certified Peer Specialist and engaged in training for this goal. She began college courses in psychology and worked to obtain a bachelor's degree. As time went on Katrina was able to obtain employment as a CPS and through her care for others and drive, she continued to progress in her career and feel the recognition and status that she deserved.

Self-actualization

- Self-actualization is explained best as the realization of a person to fulfill their potential. This stage of the hierarchy is difficult to achieve and may only be experienced in moments. Self actualization incorporates the desire to become the most that one can be. This is difficult for individuals experiencing substance use or mental health symptoms as they often cannot see past the symptoms to have a concept of who they are and where they would like to be. Through the stages you may see this desire for self actualization expressed in the stage of change.

Self-actualization

- Self-actualization at each stage:
- **Precontemplation:** “Everything is worthless. Its all luck of the draw”
- **Contemplation**: “I don’t like where I am at in life, maybe I can find a better way”
- **Preparation:** “I need to make things better and focus on what I want to do with my life”
- **Action:** “I can use my skills and knowledge to have the life I want to have”
- **Maintenance**. “I have made the changes I needed to and have the life I want, and I am not going to stop now”

Case study:

Georgia is a 53-year-old female who was referred for services after an intensive inpatient stay. She had been provided a guardian and hospitalized after she had erratic behavior due to not taking her medications and utilizing alcohol to the point of psychosis. She had been taken to the hospital by the local police department due to her erratic behavior that included not caring for herself or her home. She was found outside of her home in minimal clothing in the cold winter months and had delusions of persecution which led to the hospitalization.

Georgia had prior treatment with the agency and had in the past had a guardian provided by the state however she had achieved stabilization to the point of being able to end this guardianship in the past. At time of intake her sister was her guardian and she had been in her current inpatient treatment for over a year.

Georgia had past trauma and a tumultuous relationship with her family. She had one past fiancé who she was estranged from, and she felt that he was causing her extra stress by talking to her providers when she did not want him to. Georgia was housed in a behavioral care unit in the area and was only allowed out with the aid of staff for appointments as she was still seen as a safety risk to self.

Movement through the stages:

- **Precontemplation**: individuals may identify things they do not like about their life however they do not feel that they are able to make changes.
- **Contemplation**: starting to identify what they want to do with their lives however they are not ready to, nor do they feel they have the ability to achieve their goals.
- **Preparation**: building trust in themselves and their abilities. Identifying their role in the life they have created and finding the desire to make changes. Engaging in education and planning to help them achieve the life they want to have.
- **Action**: engaging in self-help groups to obtain further education, and following their plan to create the life they want to have.
- **Maintenance**: Achieving the essence of the life they want and finding ways to continue to make changes and sustain growth so that they can enjoy the work they have put into their lives.

Outcome

Throughout her treatment Georgia had made gains in her recovery and she had ended her alcohol use when she had been hospitalized. After engaging in therapy Georgia was able to leave the behavioral care unit and return to her home. AT that time she was provided a case manager and began attending education groups for co-occurring disorders.

Georgia began to cultivate her relationship with his sister who was also other guardian and would engage with her parents weekly for lunches. She started repair work in her home which had not been cared for since she was hospitalized, and she was able to fix the items that had been broken when she was erratic.

Through her work in therapy and her engagement with her family Georgia began to identify how her behaviors were related to her alcohol use and her inability to maintain her medications. Georgia continued her regimen of medications without support or reminder. She began to work through her guilt and identified the life that she would enjoy which for her included her farm, family, and her animals. Georgia progressed to engaging in decreasing her tobacco use, learning technological skills in order to engage with providers and family, increasing her healthy nutrition and engaging in daily activity. IN addition to this she has been working on her hobbies of baking, and wood working to engage her creative side.

Georgia has recently discovered some changes she wanted to make to her communication skills as she felt hat her parents were having difficulty understanding her. She has begun to engage in work on listening skills and her diction to aid in working towards this goal.

Examples of Interventions

- Outreach: case managers, counselors, and on call and emergency staff can engage with consumers in the community to aid in providing education and assistance.
- Practical assistance: area and state resources for physiological interventions.
- Natural supports: Identifying and utilizing the consumers natural support systems including family, friends, educational staff, religious affiliations, etc. to engage in supporting the client through education on co-occurring disorder, family counseling, and establishing communication skills with the consumer.
- Counseling and Educational groups: provide peer support, education on mental health and SUD concerns, establish safe spaces to engage in processing feelings and encourage use of services.
- Certified Peer Specialists: CPS provides a valuable tool that can aid clients in feeling supported and understood as they are encouraged to move through the stages by individuals who have had similar experiences.

Resources our rural community uses daily.

As an ITCD team, we regularly help clients move through the stages of change and Maslow's Hierarchy through the following resources:

- Offender Empowerment Program
- Medicaid/Medicare
- Disability
- Food Stamps/SNAP
- Department of Family Services
- Churches within the community
- Food Banks (Second Harvest)
- United Methodist Store
- Medicaid Transportation
- Community Resource Center (homeless shelter)
- For many resources, we must outsource to different counties and/or cities since our resources are limited.

Let's do a full case study together!

CASE STUDY

- Joan is a 41-year-old female who began services with the agency in 2014. Upon requesting services with the agency Joan expressed symptoms of anxiety, depression, confusion and sleep deprivation. Joan states that she heard noises, had past suicidal ideations, obsessive-compulsive tendencies which included having to check her locks 4-5 times per night. She expressed racing thoughts, fidgeting, and memory concerns. In addition, Joan expressed feelings of guilt and grief due to the loss of her mother. Joan denied current suicidal ideations however she did report three past hospitalizations for suicidal ideations.
- Joan had been married twice in the past and had two children. She had a degree in nursing and had ended her last job several months prior to requesting treatment. She also had medical concerns related to a heart attack that she experienced when she was 31 and on-going heart concerns related to this. She was referred to doctor and therapy services.
- Joan had not yet expressed her use of substances and was in the pre-contemplation stage of change for her treatment with her basic physiological needs met.

Continued

- In 2016 Joan left her abusive significant other of the time and expressed that she felt safer and that she was “more independent” She had begun to engage in her health and was working with her PCP on weight loss to aid in decrease her heart disease symptoms. Joan obtained her disability and began to engage with her family.
- Joan reported use of nicotine products however she denied any other substance use at this time and had diagnosis for bi-polar disorder, agoraphobia, OCD, and panic disorder. She denied suicidal ideations and had not had any new hospitalizations since entering services.
- Joan was expressing that her safety needs were being met.

Change

- In 2016 Joan was ready to discuss her substance use. She expressed that she had utilized methamphetamines for three and a half years. Joan's daughter had recently stopped contacting her due to her use and she could no longer see her grand-child.
- She reported medical concerns of cardiac disease, diabetes II, and hypertension. Joan was utilizing methamphetamines consistently and was not able to end her use. Joan had requested aid on her own.

- She was now entering the preparation stage and showed deficits in Love and belonging.

Love and belonging

- In 2019 Joan entered in the ITCD program. She began attending educational groups and engaging with others. She still had difficulty leaving her home and she would sometimes shop to cope with her triggers. Joan continued to report mental health symptoms related to anxiety and agoraphobia and had relapses on methamphetamines during this time.
- Joan began to spend time in a new relationship which appeared to be healthy, and she began working with a therapist on communication skills and boundaries. Her relapses began to be fewer and farther between. She grew to be stabilized on her medications and became a consistent support for other group members.
- Joan displayed behaviors that placed her in the active stage of change, and she has begun to engage in expression of love and belonging.

Esteem

- As time went on Joan made plans to marry her significant other and had developed a relationship with her daughter. She was able to spend time with her grandchild and the family unit was increasingly closer. She had ended all substance use and was engaging in work on her physical health with focus on diet and exercise.
- Joan continued to report some symptoms of her bi-polar disorder and anxiety. Her OCD symptoms had dissipated, and she no longer reported any auditory hallucinations since ending her methamphetamine use. Joan was making plans to be in the work force as a nurse part time and felt hat she had the strength to give back to her community and help others.
- Joan was in the maintenance stage of change, and she was expressing that her esteem needs were being met.

Self-Actualization and outcome

- Joan's drive for treatment was to engage with her daughter and grandchildren and return to life as a nurse as this helped her to feel fulfilled. Joan was able to maintain her recovery for five years, had decreased her mental health symptoms to anxiety and some need at times for isolation in her room. Joan no longer expressed symptoms of agoraphobia and expressed happiness in her relationship with her family and the part time work she was able to obtain.
- Joan had lost weight and increased her healthy activities to the point of going on a vacation with her spouse which she had not been able to do in years due to her past agoraphobia symptoms. Joan ended her work with ITCD and continued to engage with doctor services and monthly therapy sessions to maintain progress and work on the remainder of her isolation behaviors.
- Joan had reached the maintenance stage of change and had now expressed self-actualization.

Agency Growth Since COVID

Clients by program and percentages (2019 Totals)
573 program (All Clients, including Doctor or therapy only): 932 (100%)
590 CPRC (focused on mental health only): 470 (50%)
ITCD 590: 50 (5%)
SUD (adult)(No mental health Diagnosis): 5 (0.05%)

Clients by program and percentages (2023 Totals)
573 program (All Clients, including Doctor or therapy only): 1,212 (100%)
590 CPRC (focused on mental health only): 541 (45%)
ITCD 590: 200 (17%)
SUD (adult)(No mental health Diagnosis): 7 (0.01%)

COVID Response: No Ride? No Problem!

"Rural Missouri experienced a higher COVID-19 mortality rate (94.2) than both statewide (87.3) and urban rates (83.2). " (Missouri Department of Health and Senior Services, 2021)

- Available use of modern resources and changes due to COVID response: Messaging applications, online work profiles, telehealth appointments, Zoom, Google Meets.
- How this effected the rural population: There was no pause on care. Clinicians were able to continue working with the client and family through the crisis. Groups were able to continue, and medications were able to be filled because of Tele-health appointments with physicians.
- When struggling with WIFI, we were able to call the client and be able to bill for it. This is one of the first time's our company was able to implement this.
- Issues with education on computers and technology: Many clinicians did walk throughs, demonstrations and aided the client past their technological advances.
- This also allowed clients to have quicker access to clinicians or services during one of the scariest experiences of our time.

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