



Listen → Learn → Connect → Commit → Engage

The Psychological Patient Journey

*A Research-Supported Framework for
Behavioral Health Intake Conversations.*

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Why This Framework Exists

The behavioral health industry has borrowed its intake models from consumer marketing — buyer processes, sales funnels, conversion rates. These models work for commerce. They fail for care.

When someone calls for behavioral health help, they are not “shopping.” They are often in crisis, deeply ambivalent, ashamed, and making the hardest phone call of their life. The person who answers that call has minutes — sometimes seconds — to establish trust, understand the caller’s reality, and help them take the next step toward care.

The Psychological Patient Journey replaces the buyer decision model with a framework built on what actually happens during that call — grounded in Motivational Interviewing, the Transtheoretical Model (Stages of Change), the therapeutic alliance, commitment language science, trauma-informed care principles, and the research literature on help-seeking behavior, help negotiation, and treatment engagement.

This framework plays directly into the Access Axis of The Delta System™. If the Access Axis governs an organization’s ability to convert need into movement to care, The Psychological Patient Journey explains the human dynamics inside that moment — recognition, ambivalence, trust, commitment, and follow-through.

Behavioral health access takes place in a consumer environment — a phone call, a web inquiry, a scheduling workflow — but what the caller needs is not a retail experience. It is a patient experience: empathy, safety, trust, and guidance. HeadsUp helps Care Navigators deliver that patient experience in real time.

While these stages often overlap in live conversations, and callers may move back and forth between them, each stage reflects a distinct psychological task in the journey toward care.

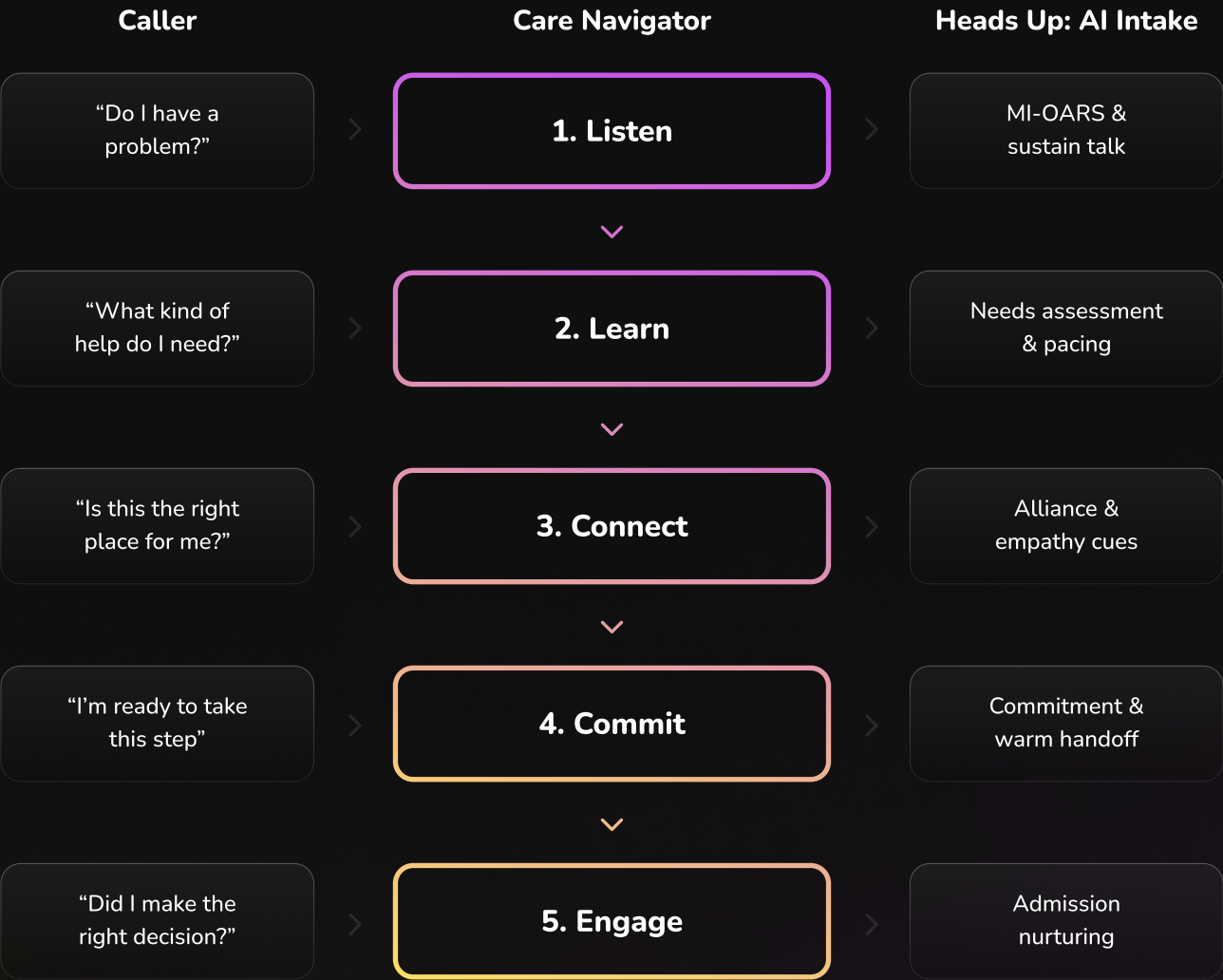
HeadsUp — AI-powered real-time conversation intelligence — is designed to support Care Navigators at each stage of this journey. It does not script the call. It does not replace the human. It helps the right person say the right thing at the right moment.



The Five Stages

Three Layers Aligned

Every stage of the journey aligns three perspectives: what the caller is asking themselves, what the Care Navigator must do, and how HeadsUp AI supports them in real time.





01 Listen

“Do I have a problem?”

Recognition, Ambivalence & Willingness

The Callers Reality

This is not rational “need recognition.” It is denial cracking, shame surfacing, the first terrifying admission that something is wrong. Stigma and fear are active barriers. The more distressed the caller, the less likely they may be to accept help.

Callers naturally oscillate between change talk (reasons to get help) and sustain talk (reasons to keep things as they are). A common mistake untrained staff make is arguing with sustain talk, which instantly entrenches the caller’s resistance.

Heads Up: AI Intake Capability

MI-OARS & Active Listening Cues

Surfaces real-time prompts grounded in **OARS** (open questions, affirmations, reflective listening, summaries). HeadsUp identifies sustain talk in real time and prompts the Care Navigator to roll with resistance rather than argue — until the caller naturally circles back to change talk.

Research Basis

The “help negation effect” (Rickwood et al.) documents a consistent pattern where higher distress correlates with lower help-seeking. Stigma, embarrassment, poor symptom recognition, and self-reliance are among the most consistently reported barriers to help-seeking (Gulliver et al., 2010). MI’s OARS micro-skills are foundational to engagement with ambivalent individuals (Miller & Rollnick, 2013; SAMHSA TIP 35). The therapist’s ability to evoke change talk while rolling with sustain talk is a primary mechanism of behavior change (Moyers et al., 2007).



02 Learn

Discovery & Understanding

“What kind of help do I need?”

The Callers Reality

Not comparison shopping. The caller is trying to understand whether help even exists for someone like them. The Care Navigator must explore four dimensions:

Solution vision — What does the caller think help looks like?

Clinical needs — What is actually going on clinically?

Financial reality — Can they access and afford care?

Motivation — How ready are they to act?

Missing any one of these dimensions can weaken the conversation and increase the risk of disengagement. Acute stress can narrow attention, reduce working memory, and make it harder to process complex logistical choices or dense insurance explanations all at once. This stage is also a safety assessment moment: risk cues, instability, and escalation concerns may surface here and must be recognized without overwhelming the caller.

Heads Up: AI Intake Capability

Four-Dimension Needs Assessment & Safety Cue Detection

Guides the Care Navigator through all four dimensions. The relationship-centered communication model cues the exchange so the caller feels oriented and respected, not interrogated.

The Psychological Patient Journey incorporates principles from Motivational Interviewing, trauma-informed communication, expectation-setting practices, therapeutic alliance research, and evidence-based approaches to engagement and trust-building.

HeadsUp helps the Care Navigator pace the delivery of information — ensuring it's provided in bite-sized, cognitively manageable pieces. It also surfaces early safety and risk cues in real time, helping discovery remain trauma-informed, clinically grounded, and responsive to escalation needs.

Research Basis

The help-seeking process model (Veroff, Kulka & Donovan, 1981) identifies problem recognition, decision to seek help, and service selection as distinct stages requiring different support. Cost and insurance barriers are documented across all populations (Andrade et al., WHO World Mental Health Surveys). The Transtheoretical Model (Prochaska & DiClemente) confirms that mismatching intervention to readiness stage leads to disengagement. Research on cognitive load in crisis states shows that executive function is significantly compromised under acute psychological distress.



03

Connect

*“Is this the right place for me?”**Therapeutic Alliance & Solution Fit***The Callers Reality**

Not a feature comparison. This is a **trust decision**: does this person on this call understand me? What is forming is a therapeutic alliance — the initial bond of trust, shared understanding, and mutual agreement on goals.

The foundations of this alliance can begin forming on the very first contact, and how the Care Navigator communicates can be as important as technique in shaping engagement and early follow-through. This is often the moment the caller begins to believe this may be the right place.

Heads Up: AI Intake Capability**Alliance-Building & Empathy Cues**

Prompts the Care Navigator with empathy cues, reflective statements, and rapport-building language that actively facilitate the therapeutic alliance on this first call. By reinforcing attunement and shared understanding, HeadsUp helps the Care Navigator strengthen one of the most important protective factors against early disengagement: trust.

Research Basis

A meta-analysis (Sharf, Primavera & Diener, 2010) found a moderately strong association between the therapeutic alliance and lower risk of dropout ($d = .55$). Broader alliance research (Norcross, 2011; Lambert & Barley, 2001) estimates the alliance accounts for a substantial portion of psychotherapy outcome variance. Up to 50% of clients discontinue therapy within the first three sessions, before a strong alliance has time to form. The foundation of the alliance is laid in the very first contact.



04 Commit

Commitment to Care

“I’m ready to take this step”

The Callers Reality

Not a purchase. An act of courage. The “yes” is fragile. How commitment is asked for matters as much as whether it is gained.

Research shows that the strength of commitment language during a conversation directly predicts follow-through. Stronger, more definitive statements of intent correlate with better outcomes. The Care Navigator must elicit the caller’s own words of commitment, not impose them.

But a caller won’t use commitment language unless they believe they are capable of actually entering treatment. The Care Navigator must actively validate the courage it took just to make the phone call — affirming this small victory builds the caller’s self-efficacy, bridging the psychological gap between wanting help and believing they can survive the intake process. Commitment is strongest when the next step feels co-created, not assigned — a plan the caller can see themselves carrying out.

Speed matters: average attrition is 45% between the initial call and clinical assessment, and another 32% between assessment and actual treatment enrollment.

Heads Up: AI Intake Capability

Commitment Language, Co-Creation, Self-Efficacy & Warm Handoff

Guides the Care Navigator to elicit commitment in the caller’s own words using MI planning techniques — evocative questions, confidence scaling, and first-person restatement. Prompts the Care Navigator to affirm the caller’s courage and capability, building the self-efficacy required for genuine commitment.

HeadsUp supports co-creation of the next step by helping the Care Navigator shape a plan with the caller, not for the caller. Then it streamlines the warm handoff with real-time context transfer — summarizing the emotional and clinical context for the receiving staff member so the caller is not forced to repeat their story. Protecting momentum. Preserving trust.

Research Basis

Commitment language strength during MI sessions predicts drug use outcomes; stronger commitment statements are associated with better outcomes (Amrhein, Miller, Yahne, Palmer & Fulcher, 2003). Self-efficacy — the belief in one’s own capability to succeed — is a prerequisite for genuine commitment language (Bandura, 1977). Average attrition: 45% between initial call and clinical assessment, 32% between assessment and enrollment (specialty addiction treatment review). Over 70% scheduled within 48 hours kept their appointment vs. 53% beyond (Stasiewicz & Stalker). Forcing patients to repeat their story after a handoff is a documented driver of early disengagement and alliance rupture.



05 Engage

Bridge to Arrival

“Did I make the right decision?”

The Callers Reality

Between saying yes and walking through the door, doubt returns. Shame, fear, and practical barriers begin to resurface. Internal turmoil and the help negation effect re-engage.

Research shows that two-thirds of those who drop out of residential treatment had been actively considering leaving since the day they committed. Admission nurturing is more than good customer service — it is a continuity intervention designed to protect fragile commitment before the patient even walks through the door.

Heads Up: AI Intake Capability

Admission Nurturing Workflows

Sustains active engagement through the gap — **personalized outreach, encouragement, barrier resolution** — maintaining continuity of the relationship built on the call. Bridges the emotional commitment to the physical arrival.

Research Basis

Approximately 30% drop out of SUD treatment overall (meta-analysis, 151 studies). In dual-diagnosis populations, 60% drop within the first month (Pennay et al., 2011). 66% of residential treatment dropouts had actively considered leaving for up to two months before doing so, with 69% of those contemplating it from day one (Ormbostad et al., 2021). Higher mental distress at intake = 48% increased dropout risk (Andersson et al., 2018).



The Foundation

Trauma-Informed Language

Every stage above rests on a single foundation. The Care Navigator never knows when or how trauma will surface — and the caller may not identify their experience as trauma. Trauma-informed language is not a technique applied at one stage. It is the operating system for the entire conversation.

Trauma-Informed Language

Foundation — Active Across All Stages

The Care Navigator never knows when or how trauma will surface — and the caller may not identify their experience as trauma. Trauma-informed language is not a technique applied at one stage. It is the **operating system for the entire conversation** — the lens that ensures every question, reflection, and response creates safety rather than re-traumatization.

How it Shows Up Across All Stages

Between saying yes and walking through the door, doubt returns. Shame, fear, and practical barriers begin to resurface. Internal turmoil and the help negation effect re-engage.

Listen — Prevents re-traumatizing in the first 60 seconds. The foundation beneath OARS.

Learn — Shapes how clinical needs are explored — safety first, not interrogation.

Connect — Creates the psychological safety that allows the therapeutic alliance to form.

Commit & Engage — Protects the fragile commitment. Trauma survivors are especially vulnerable to doubt and shame that drive dropout.

Heads Up: AI Intake Capability

HeadsUp embeds **trauma-informed language cues throughout every stage** — not as a separate module, but woven into every prompt the Care Navigator sees. Safety, choice, collaboration, trustworthiness, and empowerment are present in every interaction.

Few platforms are explicitly designed around the psychological experience of the person on the other end of the phone. The Psychological Patient Journey is the framework that makes HeadsUp fundamentally different — not another technology tool, but a clinical intelligence system built on how people actually reach care. It helps Care Navigators deliver a patient experience inside a consumer access environment.



The Impact

Across the behavioral health organizations I have worked with, the pattern is consistent. The differential between top and bottom quartile admissions staff is roughly 2:1. The bottom quartile converts qualified callers to care at about half the rate of the top. Same training. Same playbook. Same callers. Half the conversion. The variance is consistent enough to be structural — and it is invisible to most leadership teams until someone goes looking for it.

That variance has a cost. For the person on the phone, the outcome at the front door is too dependent on who happens to answer it. For the organization, the cost is buried inside the conversion rate.

HeadsUp raises the floor. It helps every Care Navigator — including the newest hires — meet the caller where they are in the Psychological Patient Journey and apply the evidence-based approaches described in this paper. It does not make the newer Care Navigator equal to the veteran. It lifts the bottom of the range.

The consequence is twofold. For the caller, the front door is no longer a coin flip. For the organization, even a 10% lift in conversion is not a 10% lift in revenue — in a duration-based model with high fixed costs, every additional admission flows through to contribution margin at a multiple. Clinical mission and economic engine, finally, move together.

That is the case for starting at the front door.

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“Better Conversations. More People Reaching Care.”

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