Practical Approaches to Integrated Behavioral Health: Coping with Chronic Pain

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Disclosure

• The presenter has no financial arrangement related to the content of this continuing education activity.
Objectives

At the completion of this activity, participants will be able to:

• Describe models and approaches used to integrate behavioral health and primary care.
• Identify time-effective, evidence-based methods for helping patients improve their ability to cope with chronic pain.
• Identify specific considerations in planning, implementing or evaluating integrated behavioral health and primary care in community settings.
Definition of Integrated Care

The care that results from a practice team of primary care and behavioral health clinicians working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

(SAMHSA-HRSA Center for Integrated Health Solutions, 2016)

www.integration.samhsa.gov
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<thead>
<tr>
<th>COORDINATED</th>
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<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
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<thead>
<tr>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
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<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Onsite</td>
<td>Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/ Merged Integrated Practice</td>
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</table>

| Behavioral health, primary care and other healthcare providers work: |
| In separate facilities, where they: |
| In separate facilities, where they: |
| In same facility not necessarily same offices, where they: |
| In same space within the same facility, where they: |
| In same space within the same facility, sharing all practice space, where they: |

- Have separate systems
- Communicate about cases only rarely and under compelling circumstances
- Communicate, driven by provider need
- May never meet in person
- Have limited understanding of each other’s roles
- Have separate systems
- Communicate periodically about shared patients
- Communicate, driven by specific patient issues
- May meet as part of larger community
- Appreciate each other’s roles as resources
- Have separate systems
- Communicate regularly about shared patients, by phone or e-mail
- Collaborate, driven by need for each other’s services and more reliable referral
- Meet occasionally to discuss cases due to close proximity
- Feel part of a larger yet ill-defined team
- Share some systems, like scheduling or medical records
- Communicate in person as needed
- Collaborate, driven by need for consultation and coordinated plans for difficult patients
- Have regular face-to-face interactions about some patients
- Have a basic understanding of roles and culture
- Actively seek system solutions together or develop work-a-rounds
- Communicate frequently in person
- Collaborate, driven by desire to be a member of the care team
- Have regular team meetings to discuss overall patient care and specific patient issues
- Have an in-depth understanding of roles and culture
- Have resolved most or all system issues, functioning as one integrated system
- Communicate consistently at the system, team and individual levels
- Collaborate, driven by shared concept of team care
- Have formal and informal meetings to support integrated model of care
- Have roles and cultures that blur or blend

# Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Key Differentiator: Clinical Delivery</th>
<th>Key Differentiator: Patient Experience</th>
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<tbody>
<tr>
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<tr>
<td>Level 1</td>
<td>Basic Collaboration at a Distance</td>
<td>- Screening and assessment done according to separate practice models&lt;br&gt;- Separate treatment plans&lt;br&gt;- Evidenced-based practices (EBPs) implemented separately</td>
<td>- Patient physical and behavioral health needs are treated as separate issues&lt;br&gt;- Patient must negotiate separate practices and sites on their own with varying degrees of success</td>
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<tr>
<td>Level 2</td>
<td>Basic Collaboration Onsite</td>
<td>- Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges&lt;br&gt;- Separate treatment plans shared based on established relationships between specific providers&lt;br&gt;- Separate responsibility for care/EBPs</td>
<td>- Patient health needs are treated separately, but records are shared, promoting better provider knowledge&lt;br&gt;- Patients may be referred, but a variety of barriers prevent many patients from accessing care</td>
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<tr>
<td>Level 3</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>- May agree on a specific screening or other criteria for more effective in-house referral&lt;br&gt;- Separate service plans with some shared information that informs them&lt;br&gt;- Some shared knowledge of each other’s EBPs, especially for high utilizers</td>
<td>- Patient health needs are treated separately at the same location&lt;br&gt;- Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider</td>
</tr>
<tr>
<td>Level 4</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>- Agree on specific screening, based on ability to respond to results&lt;br&gt;- Collaborative treatment planning for specific patients&lt;br&gt;- Some EBPs and some training shared, focused on interest or specific population needs</td>
<td>- Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers&lt;br&gt;- Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services</td>
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<td><strong>INTEGRATED</strong></td>
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<tr>
<td>Level 5</td>
<td>Full Collaboration in a Transformed/ Merged Integrated Practice</td>
<td>- Consistent set of agreed upon screenings across disciplines, which guide treatment interventions&lt;br&gt;- Collaborative treatment planning for all shared patients&lt;br&gt;- EBPs shared across system with some joint monitoring of health conditions for some patients</td>
<td>- Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others&lt;br&gt;- Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop</td>
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<td>Level 6</td>
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<tr>
<td><strong>Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place&lt;br&gt;- One treatment plan for all patients&lt;br&gt;- EBPs are team selected, trained and implemented across disciplines as standard practice</strong></td>
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Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

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**Key Differentiator: Practice/Organization**

- No coordination or management of collaborative efforts
- Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow
- Some practice leadership and coordination, but often without a clear, systematic information sharing
- Some provider buy-in to collaboration and value placed on having needed information
- Organization leaders support integration, but often coordination is viewed as a project or program
- Provider buy-in to making referrals work and appreciation of onsite availability
- Organization leaders support integration through mutual problem-solving of some system barriers
- More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components
- Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced
- Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers
- Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development
- Integrated care and all components embraced by all providers and active involvement in practice change

**Key Differentiator: Business Model**

- Separate funding
- No sharing of resources
- Separate billing practices
- Separate funding
- May share resources for single projects
- Separate billing practices
- Separate funding
- May share facility expenses
- Separate billing practices
- Separate funding, but may share grants
- May share office expenses, staffing costs, or infrastructure
- Separate billing due to system barriers
- Blended funding based on contracts, grants or agreements
- Variety of ways to structure the sharing of all expenses
- Billing function combined or agreed upon process
- Integrated funding, based on multiple sources of revenue
- Resources shared and allocated across whole practice
- Billing maximized for integrated model and single billing structure

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**Advantages**

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<tr>
<td>Each practice can make timely and autonomous decisions about care</td>
<td>Maintains each practice’s basic operating structure, so change is not a disruptive factor</td>
<td>Colocation allows for more direct interaction and communication among professionals to impact patient care</td>
</tr>
<tr>
<td>Readily understood as a practice model by patients and providers</td>
<td>Provides some coordination and information-sharing that is helpful to both patients and providers</td>
<td>Referrals more successful due to proximity</td>
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**Weaknesses**

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<td>Services may overlap, be duplicated or even work against each other</td>
<td>Sharing of information may not be systematic enough to effect overall patient care</td>
<td>Proximity may not lead to greater collaboration, limiting value</td>
</tr>
<tr>
<td>Important aspects of care may not be addressed or take a long time to be diagnosed</td>
<td>No guarantee that information will change plans or strategy of each provider</td>
<td>System issues may limit collaboration</td>
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<tr>
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<td>Referrals may fail due to barriers, leading to patient and provider frustration</td>
<td>Potential for tension and conflicting agendas among providers as practice boundaries loosen</td>
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Behavioral health needs of the primary care population: What is your range of services?
Designing workflows that support treatment to target: Care planning, team functions, clinical systems

**Level of Complexity**

**Straightforward** situations: Typical protocols apply – usual care & decision-making, usual team functions & processes

**Complex** situations: Challenges to usual processes requiring unusual attention, non-standard care processes or team functions

**Clinical Presenting Problems**

**Behavioral Health** (MH or SUD) conditions commonly presenting in primary care, e.g. depression, anxiety, PTSD, or other depending on scope of services offered

**Medical** conditions with strong behavioral health component, even if patient doesn’t see self as having MH or SUD problem, e.g. diabetes, IBS, asthma, chronic pain

When planning and implementing integrated behavioral health in primary care, it is useful to consider:

A. Capacity to provide a range of services for a given population.
B. Workflows for straightforward vs. complex clinical situations.
C. Your organization’s current characteristics with respect to levels of integration.
D. All of the above.
Pain

A sensory and emotional experience associated with actual or potential tissue damage.

*International Association for the Study of Pain*
Chronic Pain

• Pain that continues to be intense or interfere with daily activities after the expected period of healing following overuse or injury
  – “Expected period of healing” may vary from weeks to months depending on the specific medical condition.

• Pain that is related to a progressive disease (such as arthritis or cancer)
  – May be cyclical or nonlinear in course
## Obstacles to Treatment of Pain

<table>
<thead>
<tr>
<th>Healthcare Professional Barriers</th>
<th>Healthcare System Barriers</th>
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<tbody>
<tr>
<td>• Inadequate knowledge</td>
<td>• Regulatory requirements</td>
</tr>
<tr>
<td>• Inaccurate evaluation of pain</td>
<td>• Restricted availability of controlled drugs</td>
</tr>
<tr>
<td>• Limited access to specialized pain clinics</td>
<td>• Pain management is a low priority</td>
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<tr>
<td>• Legal issues for controlled substances</td>
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<tr>
<td>• Competitive treatment priorities</td>
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<table>
<thead>
<tr>
<th>Patient Barriers</th>
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<td>• Under reporting pain</td>
<td>• Concerns about addiction</td>
</tr>
<tr>
<td>• Fears that disease is worsening</td>
<td>• Considered an “addict”</td>
</tr>
<tr>
<td>• Shifts focus from disease</td>
<td>• Poor treatment adherence</td>
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<td>• Concerns about addiction</td>
<td>• Under reporting pain</td>
<td>• Inadequate reimbursement for pain care/management</td>
</tr>
<tr>
<td>• Risk of respiratory depression</td>
<td>• Fears that disease is worsening</td>
<td></td>
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<tr>
<td>• Pharmacologic tolerance</td>
<td>• Shifts focus from disease</td>
<td></td>
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<tr>
<td>• Competing treatment priorities</td>
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Treatment of Pain

• Many layers of complexity for the field of medicine:
  – Not always the same answer for every patient
  – Pain is not like specific diagnoses that have specific tx protocols
  – Opioids create significant risks

• Complexities indicate the need to reframe pain treatment.
  – Treatment of pain does not always equal prescription for opioids.
  – Comprehensive, interdisciplinary approaches are most effective.
  – Behavioral and cognitive-behavioral interventions can reduce experienced pain, behavioral expression of pain, pain-related fear; and improve coping and functional abilities (Morley, Eccleston & Williams, 1999; Ahles et al., 2006; Von Korff et al., 2005).
Biopsychosocial perspective

- Useful for integrating assessment and treatment across medical, allied health, and behavioral health fields.
- Encompasses multiple domains of patient’s life that must be engaged for effective treatment and recovery:
  - Physical/biological
  - Psychological
  - Social/interpersonal
    - Culture and language
    - Economic/access to healthcare
    - Spiritual
    - Occupational
Recovery & Resilience Perspective

- Persons with chronic pain can have a fulfilling life within their family and community.
- Healthy coping is common; individual definitions of recovery vary.
- Functional abilities can increase even if symptoms are still present.
- Change may be nonlinear; pain and impairment may fluctuate in severity or partially remit.
- Change processes gain a positive trajectory when a person develops resilience:
  - Building upon strengths;
  - Creating access to supports;
  - Fostering a holistic approach to health and wellness.
Functional Assessment of Chronic Pain

• Caveats:
  – Behavioral assessment and intervention should always be in conjunction with medical evaluation.
  – Severe functional impairment indicates probable need for referral to specialty pain clinic or rehabilitation program.

• When assessing, consider local cultural context for expression of pain and distress. For instance some AI/AN patients may describe their experience of pain with reference to social or spiritual context and be less comfortable about rating pain on a scale from 1 to 10 (Jimenez, et al., 2012).

• Use a simple interview protocol to identify:
  – General description of individual’s pain;
  – Psychosocial and behavioral aspects;
  – Functional impacts;
  – Opportunities for change.
Interview for Psychosocial and Behavioral Assessment of Pain
(see handout)

- General description of pain -
  - Location in the body:
  - Quality/type:
  - Approximate date of onset:
  - Frequency and duration:
- On a scale from 1 – 10, 1 being mild pain and 10 being excruciating pain -
  - Pain level right now:
  - Typical worst pain level:
  - Typical best pain level:
- What can you do to decrease the pain?
- What makes the pain worse?
- Why do you think you are experiencing pain?
- What has your physician told you about the cause of the pain?

- Describe a typical day, including home, work, and leisure activities:
- How does the pain limit you, or what would you be doing differently if you didn’t have pain?
- How has the pain affected you emotionally? [Assess depression, anxiety, anger]
- How have others responded to the pain? [Family, friends, coworkers]
- How would you like others to respond?
- What have you done to help deal with the pain? [adaptive coping; medical treatments; self-management strategies; medication use; alcohol or drug abuse; excessive sleep or inactivity]
- In what other ways has pain affected your life?

Patient Education regarding pain

- Pain is not “either” physical “or” psychological (false dichotomy);
- Chronic pain is best understood as an interaction of numerous “biopsychosocial” factors. Many aspects of these factors can be addressed to help manage chronic pain conditions.
- Gate Control Model helps explain why we feel pain differently at different times/situations, and provides a way to think about the different approaches we can use to manage pain.

![Gate Control Model of Pain](image-url)
<table>
<thead>
<tr>
<th>Factor</th>
<th>What you can do to improve pain management</th>
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</table>
| Physical | • Keep muscles toned through physical activity.  
           • Take prescribed pain medication.  
           • Use relaxation techniques to relax muscles and control the stress response. |
| Emotional| • Use relaxation to control anxiety.  
           • Stay involved with relationships and enjoyable activities to protect against depression and other negative moods. |
| Cognitive| • Recognize unhealthy thinking patterns that interfere with adaptive coping with pain.  
           • Challenge faulty thinking and replace it with healthy thoughts. |
| Behavior | • Stay physically active.  
           • Pace your activities; avoid a cycle of over activity and underactivity.  
           • Adhere to medical recommendations (including medications and physical therapy). |
| Social   | • Discuss what you find helpful and not helpful with family and others who are close to you.  
           • Stay socially involved.  
           • Pursue activities that are meaningful to you. |
CBT and Chronic Pain

- Noticing most common “automatic thoughts” and not reacting to them; work to alter or disengage from them over time (see handouts).
- Catastrophizing, magnification & minimization:
  - “My pain is totally out of control.”
  - “Nothing has changed.”
- Behavioral activation and self-talk are also valuable tools.
- Use CBT to also address comorbid depression, and work with feelings of anger and loss.
Question:

Topics that can be included in patient education about chronic pain can include:

A. The false mind/body dichotomy.
B. The Gate Control Model.
C. The importance of pacing.
D. All of the above.
Behavioral Activation (1)

• Explain rationale for patient behavior change: “When we feel down or in pain, we sometimes stop doing many activities that we used to like to do. This can make depression and chronic pain worse. Research has shown that depression can be improved when we increase activities that provide enjoyment or sense of accomplishment; and that chronic pain improves with moderate, paced activity.”

• Acknowledge difficulty of depression and that sometimes no activities feel enjoyable. Strategically take small steady steps even if activities initially feel difficult or awkward instead of pleasurable. Words to describe this:
  – Act first, Feel later; “Outside-In”; Act according to plan/goal, not feeling; “Fake it ‘til you make it”

• With chronic pain, functional limitations can be seen as insurmountable barriers. The manner or extent of participation in previous activities may need to change due to functional limitations. Use problem-solving approaches and CBT to work with this.
Behavioral Activation (2)

• Select activities that:
  – Are likely to increase pleasure or sense of accomplishment;
  – They used to enjoy; or they already do but would like to do more often;
  – Include elements of physical exercise and social interaction, setting goals that are realistic for the individual.
  – Are realistic considering the person’s resources.

• Follow up may include:
  – Track and monitor to help them notice progress.
  – Use solution-focused strategies / problem-solving as needed to resolve barriers
  – Reinforce positive behavior change
  – Reset goals as needed
  – Strengthen or refine using stimulus control (cues/reminders and consequences/rewards)
  – Communication skills for engaging or being assertive with significant others
Relaxation training

• Most people with chronic pain will quickly make the connection that their pain gets worse when they are tense, anxious, or “stressed.”
• Coaching and encouragement may be needed to help them achieve proficiency with relaxation methods;
• Although immediate relief is not as great as medications, the effectiveness of relaxation tends to increase over time, compared to medication effectiveness which tends to decrease.
• Diaphragmatic breathing is a “building block skill” that supports other more potent relaxation methods (see handout).
  – Can also be used to introduce mindful breathing.
• Guided imagery or mindfulness-based sensory awareness are both good techniques to learn next.
• Relaxation methods focused on the body may be less helpful initially for persons with chronic pain, but progressive muscle relaxation techniques specifically target muscle tension, which often contributes significantly to pain.
• If there is comorbid anxiety disorder, spend some time connecting relaxation training to psychoeducation about anxiety.
Question: A good starting point for learning relaxation skills is:

A. Diaphragmatic Breathing.
B. Progressive Muscle Relaxation.
C. Clinical Hypnosis.
D. Both A and C.
Acceptance and Commitment Therapy - ACT

• A therapeutic approach based on acceptance and mindfulness that emphasizes:
  – Observing thoughts and feelings as they are, without trying to change them;
  – Increase awareness of personal values, which provide meaning and motivation to make the changes that are needed to get back on track in their life;
  – Behaving in ways consistent with valued goals and life directions.

• The basic premise of ACT as applied to chronic pain is that while pain hurts, it is the struggle with pain that causes suffering.

• Pain is seen as an inevitable part of living that can be accepted.

(Dahl, Luciano & Wilson, 2005; Hayes, Strosahl, & Wilson, 1999)
Take Back Your Life:

CHRONIC PAIN $\neq$ SUFFERING

does not necessarily equal

and suffering...is normal.
Acceptance and Commitment Therapy – ACT

• Suffering increases to the extent a person believes (“fuses with”) and acts in accordance with pain-related thoughts and emotions, e.g.,
  – “I can’t do anything useful or enjoyable because of my pain.”
  – “I have to get rid of my pain before I can do anything I value in life.”

• The aim of ACT is to help the client to develop greater psychological flexibility in the presence of thoughts, feelings, and behaviors associated with pain.

• The ACT model differs from traditional CBT by:
  – Being aware and nonreactive with respect to pain-related thoughts and feelings, rather than intentionally seeking to change them;
  – Focusing on moving toward a vital life rather than specifically on pain management.

(Dahl, Luciano & Wilson, 2005; Hayes, Strosahl, & Wilson, 1999)
Some individuals with severe chronic pain, comorbid mental health or medical conditions, opioid and polypharmacy issues may lack access to specialized care in rural or underserved communities, including:

- Neurosurgery and other medical specialties;
- Comprehensive pain clinic;
- Coordinated treatment for opioid dependence and chronic pain;
- Specialty mental health care.

The best option in complex situations with scarce resources may be to coordinate what resources you do have, in a team approach.

Develop special workflows for complex situations so team members know their roles and responsibilities and can respond effectively.

Include a team member whose role is advocacy for access to needed care.
Community and System Considerations (2)

- Literature finds evidence of poor patient/provider communication about pain management in AI/AN populations (Jimenez et al., 2011).
  - One role of BH provider can be to facilitate communication and coordinate goals of both patient and PCP regarding management of chronic pain.

- Community health workers/aides have the potential to provide education and support for coping with chronic pain, but one study in Alaska found that these workers express uncertainty and need for training in this area (Cueva et al., 2005).
  - BH and medical provider could team up to train and support community health staff.

- Consistent with the patient’s own values, always consider traditional or Native healing approaches as potentially beneficial in a comprehensive approach to pain management with AI/AN patients (Buchwald, Beals & Manson, 2000).
Client/Patient Resources


Clinician Resources


More Clinician Resources


