Behavioral Health Integration in Pediatrics

FSU Center for Behavioral Health Integration

Part I: Professional Park Pediatrics

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Overview of Topics

1. Basic Models of Behavioral Health Integration
2. Overview of major psychiatric disorders in childhood and treatments
3. Use of screening tools and strategies in Pediatrics
4. Patient Engagement: Overview of Motivational Interviewing
5. Next steps

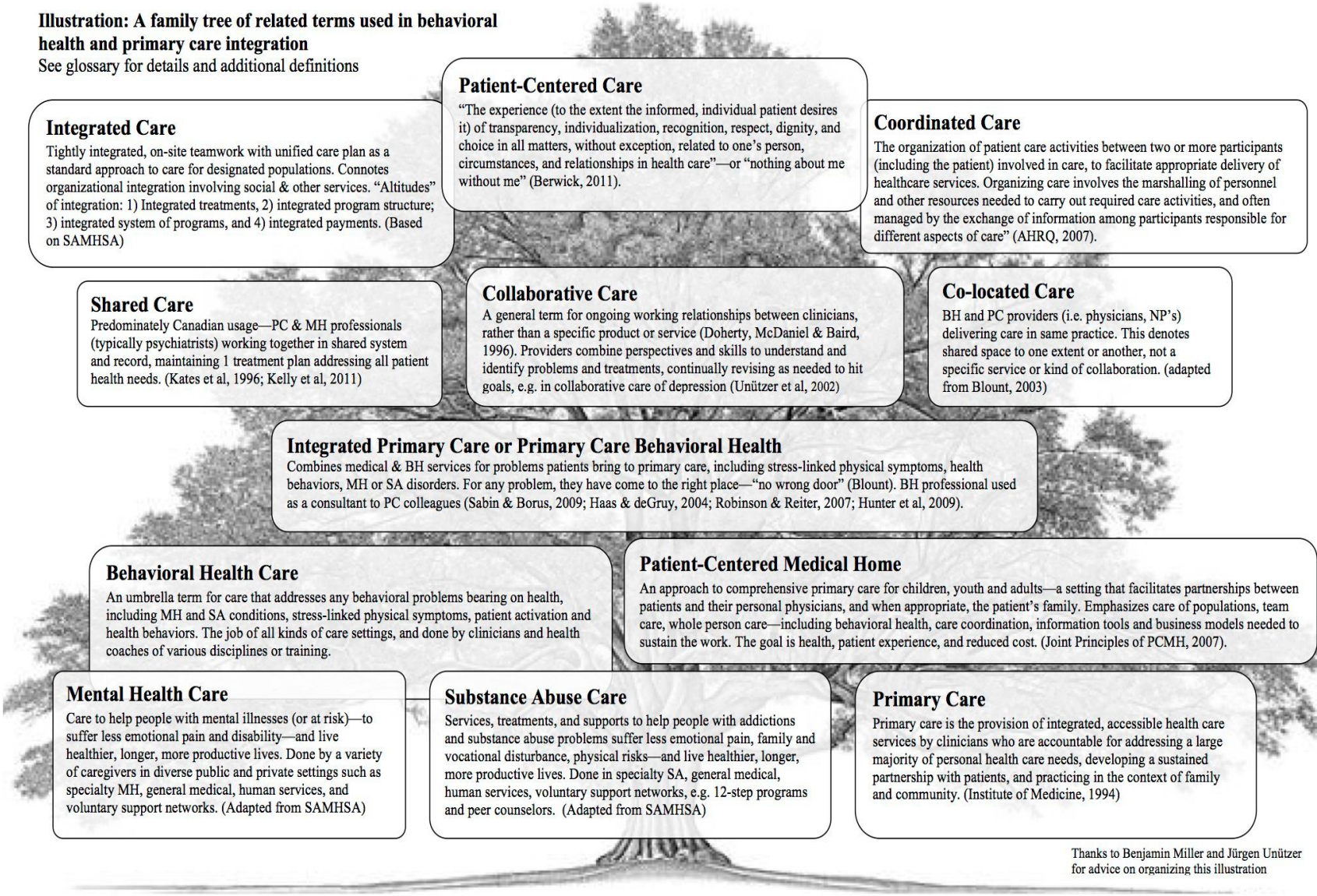
Basic Models of Behavioral Health Integration

Elements of successful depression treatment models in primary care

- **Integrated care**
  - Mental health providers are linked with primary care providers via co-location, common medical records, team meetings, etc.
- **Collaborative care**
  - Patient is cared for by a multidisciplinary team; each team member has a specific role
- **Stepped care**
  - Matches intensity of treatment and resources to severity and complexity of illness
- **Self care**
  - Actively engages patient in managing illness and maintaining health
- Meta-analysis[1] shows that these models improve
  - quality of care
  - patient and provider satisfaction
  - clinical outcomes

1. Neumayer-Gromen et al: Med Care 42:1211-1221, 2004

Illustration: A family tree of related terms used in behavioral health and primary care integration
See glossary for details and additional definitions



Integrated Care
Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Altitudes" of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

Patient-Centered Care
"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Berwick, 2011).

Coordinated Care
The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care" (AHRQ, 2007).

Shared Care
Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

Collaborative Care
A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

Co-located Care
BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

Integrated Primary Care or Primary Care Behavioral Health
Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

Behavioral Health Care
An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Patient-Centered Medical Home
An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

Mental Health Care
Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

Substance Abuse Care
Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

Primary Care
Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
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 (some shared space), 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

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

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

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

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Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
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 in more systematic information sharing ▸▸ Some provider buy-into collaboration and value placed on having needed information	▸▸ Organization leaders supportive but often co-location 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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Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

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Overview of major psychiatric disorders in childhood and treatments

ADHD

- Complex diagnostic process
  - Gold standard: Multi-method, Multi-informant
    - Standardized diagnostic interviewing
    - Thorough bio-psycho-social developmental history
    - Valid, reliable self- and other-report measures
    - Behavioral observations
      - Clinic
      - School
    - Parent, child, teacher, other
- Assess for common comorbid disorders
- Assess other common causes of similar sx

Treatment of ADHD

- Treatment Options
  - Medication (front line: mid childhood and beyond)
  - Behavior Therapy
    - Parent Training: structure, predictability, contingencies
    - Study skills, organization
  - Combination
- Take homes:
  - Both are effective; medication or combination best
  - Treatment gains typically don’t persist

Generalized Anxiety Disorder

- Excessive anxiety, worry
  - More days than not, >6 months
  - A number of topics

- Difficulty controlling worry
- Physical symptoms (1k/3a)
  - Restlessness/on edge
  - Easily fatigued
  - Difficulty concentrating /mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance

- Distress/Impairment?

- Evidence based treatment manuals
  - Coping Cat
- Evidence based treatment approach
  - Cognitive behavioral therapy
    - Identify & restructure cognitive distortions
    - Identify the likelihood of feared outcomes
    - Identify coping strategies if the worst occurs
    - Decrease safety/anxious behaviors that reinforce
- Medication: Duloxetine (Cymbalta); (Prozac?)
  - Not advised: benzodiazepines

Example of Mood Log for CBT work

time	Mood rating (1-10)	What are you doing?	What are you thinking about?	What makes mood better / worse
Morning				
Afternoon				
Evening				
Bedtime				

OCD Treatment

- Treatment Options
  - Exposure and Response (Ritual) Prevention
    - Gradually engage in feared behaviors WITHOUT engaging in behaviors to suppress/reduce threat
  - Medication
    - Clomipramine (Anafranil) 10+
    - Fluoxetine (Prozac) & fluvoxamine (Luvox) 8+
    - Sertraline (Zoloft)

MDD

- Depressed Mood (quick quiz: kids?)
- Decreased interest/pleasure
- Significant weight loss/gain (kids?)
- Insomnia or hypersomnia—near daily
- Observable psychomotor agitation/retardation
- Fatigue/loss of energy
- Worthlessness or excessive/inappropriate guilt
- Diminished concentration, indecisiveness
- Thoughts of death, suicidal ideation, attempt, plan

- Treatment Options for children/adolescents
  - Cognitive Behavior Therapy
  - Interpersonal Therapy
  - Behavior Activation
  - Medication
    - Fluoxetine (Prozac)
    - Escitalopram (Lexapro)

    - Not recommended by FDA: Paroxetine (Paxil)

- Treatment Options for children/adolescents
  - Cognitive Behavior Therapy
  - Interpersonal Therapy
  - Behavior Activation
  - Medication
    - Fluoxetine (Prozac)
    - Escitalopram (Lexapro)

    - Not recommended by FDA: Paroxetine (Paxil)

- 30% of children/adolescents who are clinically depressed attempt suicide by 17 years of age
  - 3rd leading cause of death in 10-14 year olds
- Among children/adolescents who kill themselves, odds of having major depression are 27x more than controls
- Ages 13-14: peak for first suicide attempt
- Attempts double in adolescence, but decline after 17-18
- Associated with numerous psychological disorders, not only MDD

- Multiple Attempter?
- Resolved Plans and Preparation?
- Suicidal Desire, Ideation, Intent?
- Other significant findings:
  - Mental illness, sleep disturbance, intoxication, hopelessness, helplessness, access to means

- Safety Planning

Self-harm behaviors

- Cutting, burning, choking
- Function
  - Decrease/release emotion
  - Experience emotion
- It's effective; it's dangerous
- Treatment options
  - DBT: emotion regulation; distress tolerance
    - TIP: temperature, intense exercise, progressive relaxation

Use of screening tools and strategies in Pediatrics

Monitoring and screening: Overview

- Most children come in contact with pediatricians annually, which provides a tremendous opportunity for detecting behavioral health issues

- American Academy of Pediatrics (AAP) recommends healthcare providers:
  - Monitor child's development at each visit
  - Implement universal, intermittent screening to identify emergent behavioral health needs
  - Ensure comprehensive follow-up measures are conducted if behavioral health issues are uncovered
    - (Monitoring and screening ≠ Diagnosis)

- Our job is to:
  - Provide education and feedback about effective, efficient screening practices
  - Help streamline screening/monitoring process
  - Trouble-shoot any work-flow or practice-related barriers to screening/monitoring

Why universal screening and monitoring?

- American Association of Pediatrics recommends universal screening at pediatric well-child visits for several measures of child wellbeing, including overall child development, Autism Spectrum Disorders, Depression, and Substance Use Disorders.
  - Maternal depression is also recommended as a universal screening objective in well-child visits during the first 6 months postpartum.

- Universal screening is key to early intervention for any at-risk patients, not simply the most severe cases

- Universal screening helps to protect against any implicit biases that we might have and helps to promote detection in all your patient subpopulations.
  - Some subpopulations (i.e., families from low SES backgrounds, traditionally medically underserved racial and ethnic backgrounds, parents with behavioral health concerns) might be less likely to disclose worrisome symptoms due to fear of stigma or other concerns.

Instruments for Universal Screening & Monitoring[1]

Recommended Visit	Target Screening Characteristic	AAP-Recommended Assessment Tool Options
- 1 month - 2 month - 4 month - 6 month	Maternal Depression	- Edinburgh Postpartum Depression Scale (EPDS) - PHQ-2, PHQ-9 - Survey of Well-being of Young Children (SWYC)
- 9 month - 18 month - 2 year	Child Development	- Ages & Stages (ASQ-3) - Parents' evaluation of developmental status (PEDS) - Survey of Well-being of Young Children (SWYC)
- 18 month - 2 year	Autism Spectrum Disorder	- Modified Checklist for Autism Spectrum Disorder with Follow-Up (M-CHAT-R/F) - Survey of Well-being of Young Children (SWYC)
- 11-21 years (annually)	Depression (beginning at age 12)	- PHQ-2, PHQ-A (ages 11-17), PHQ-9
- 11-21 years (annually)	Tobacco, Alcohol, Drug Use	- Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD) - Screening to Brief Intervention (S2BI) - Car, Relax, Along, Forget, Friends, Trouble (CRAFFT)

Detecting/tracking maternal depression

- 1 in 10 women will experience depression during the postpartum period, but only about half of these cases will be detected.
  - Children of mothers who experience postpartum depression are more likely to experience developmental delays and to have ongoing behavioral problems.

- Pediatricians often have greater access to new mothers than do their OBGYNs. Screening for maternal depression can be a key way to elevate familial health and wellbeing across the board.

- Can implement rapid screening to detect
  - i.e., PHQ-2, PHQ-9; EPDS

Detecting/tracking child development

- Key markers of childhood development:
  - Babbling by 12 months;
  - gesturing by 12 months;
  - Single words by 16 months;
  - Two-word spontaneous phrases by 24 months;
  - Loss of any language/ social skills at any age

- Screening should take place at all well-child visits from birth-school age, and further evaluation should take place if above mile markers are not met.

- Providers should prioritize implementing Ages and Stages/ Parents' Evaluations of Developmental Status over the Survey of Well-being in Young Children due to the measures' ability to appropriately detect developmental issues.

Detecting/tracking Autism Spectrum Disorders

- Many pediatricians are already screening for ASD among patients[2]
  - RCTs provide new support that screening and early intervention can improve outcomes including core deficits of ASD, IQ, language, and symptom severity[3, 4, 5].

- MCHAT, POSI, SWYC, and Denver Developmental Screening Test (DDST) tools exhibit low specificity[6, 7, 8]→ they could be identifying problems that don't exist (false positives)
  - Creates increased volume of follow-up

- American Academy of Neurology and the Child Neurology Society Recommend the following screeners: Ages and Stages; BRIGANCE Screens; Child Development Inventories; PEDS

- Screener for ASDs from FSU Autism Center: Infant-Toddler Checklist[9, 10]

Detecting/tracking pediatric depression

Can measure pediatric depressive symptoms using[1]:

- Rapid assessment: PHQ-2
- Follow-up: PHQ-A, PHQ-9
- Alternate screening tool: Mood Disorder Questionnaire for Parents of Adolescents (MODQ-A)

For addressing mild-moderate depression:

- AAP recommends active monitoring in primary care settings for 6-8 weeks for adolescents who screen positive & are diagnosed with MDD[11].
- Additional recommendations include contact every 1-2 weeks during symptom monitoring window for:
  - Psychoeducation
  - Supportive counseling
  - Facilitating parental and patient self-management
  - Refer for peer support
  - Regular monitoring of depressive symptoms and suicidality

For addressing moderate-severe depression[11]:

- AAP guidelines advise that primary care providers should (1) refer patients to specialty care & (2) collaborate to develop a care management plan

Detecting/tracking pediatric substance use

- Can begin discussion with open-ended questions

- 2 valid screening rapid assessment tools: BSTAD, S2BI[12]
  - BSTAD = n of days of use in past year
  - S2BI = gradient response (never, weekly, monthly, etc)
  - Both can be administered by the adolescent or by a healthcare provider
- CRAFFT was initially validated as a screening tool but is increasingly being used as a follow-up measure to probe for more detailed information.
- Like with children's/teens' mental health, consideration should be given regarding confidentiality and screening[13].

- Acute danger signs to look out for in pediatric patients using substances:
  - High, potentially lethal volume intake
  - Polysubstance use
  - Substance-related hospital visits or injuries
  - Risky sexual behaviors associated with substance use
  - Signs of addiction
  - Use of intravenous drugs

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The Basics of Motivational Interviewing: An evidence-based patient-centered engagement approach

Examples of Behavior Changes

- Medication adherence
- Diet / Exercise / Weight
- Managing Stress
- Substance Use
- Treatment / referral /
- Making and keeping a medical appointment
- Risk behaviors (HIV; pregnancy)

Motivational Interviewing (MI) is an Evidence-Based Approach to Facilitating Behavior Change

- MI can be effective for improving the outcomes of conversations about behavior change when a person is ambivalent (resistant / has mixed feelings) about making that change
- Can be used when provision of information is not all that is needed, but helping the person to address their ambivalence about the change
- MI is not necessarily needed when a patient is clearly motivated and committed to changing and all she needs is expert advice / information

Some basics of MI

- Can be used any time a conversation ventures into someone else's motivation for change
- Attitudes and behavior are represented in language
- Therefore, effective use of MI involves careful attention to language.
- People are more strongly persuaded by what they hear themselves say
- MI is not done "to" someone but "with" and "for" someone
- It is not a way to trick or make someone do something they do not want to do, but to draw out what they want

MI Integration in Health Care

- Behavior change is at the heart of most modern health care concerns (heart disease, obesity, depression, cancers, diabetes, liver disease, respiratory problems)

- Most health care practitioners have conversations / encounters regarding behavior change everyday

- More attention has been on providing information vs how to approach (style) and facilitate behavior change with the person

There are many ways to try to help someone make a change. Do you…….

- Explain what the person could do differently to improve their health?
- Advise / persuade / warn what will happen if they do not change?
- Counsel them about how to change?
- Refer to a specialist?
- Set goals for change?

There are several styles of interaction and communication skills within a helping context

Styles

- Guiding – “I can help you solve this for yourself”
- Directing – “ I know how you can solve this problem, I know what you should do”
- Following – I won’t push or change you, I trust your wisdom to do what is best for you

Skills

- Asking questions
- Listening
- Informing

Styles and Skills may be mixed and matched, but MI is mainly Guiding

MI Definition:

Motivational interviewing is a collaborative conversation to strengthen a person's own motivation for and commitment to change

(as opposed to you providing your motivation for them)

MI assumes that mixed feeling, or Ambivalence, about change is normal

Ambivalence:

- **“Yes, but….”**
- **is at the heart of motivation**

“It’s not a goal unless it’s a goal for the patient”

A persons own goals and motivation and much more powerful and sustainable than someone else’s – Therefore, MI emphasized drawing out versus imparting a person’s own motivation

MI is about practicing the skills to listen so people can talk, and to talk so people can listen.

Basic Role of the Helper

- Is to help the client become his / her own advocate for change
- Is to elicit rather than instill expertise on how to change
- “join with” a persons own intrinsic motivation to move towards more adaptive behavior (i.e. those that are in line with their values and goals)

Giving Information and Advice in a Patient-Centered Way

- **Get permission ("would it be ok if we talked about your diet?"**
- **Qualify, honoring autonomy (this is completely up to you, but I have some information that might be helpful)**
- **Ask – Provide – Ask**
- **For suggestions, offer several, not one (menu of options)**

Basic principles

1) Practitioners want to help! Leads to strong urge to correct behavior that is harmful – Righting reflex. But, it is a natural human tendency to resist persuasion - Resist
2) The patients own reasons for change are much more powerful than ours - Understand
3) The answers regarding behavior change come from the patient – Listen
4) Outcomes are better when patient takes and active role in deciding on outcomes - Empower

4 Fundamental Processes in MI

Engaging – The Relational Foundation

- Guiding – The Strategic Focus
- Evoking – The Transition to MI
- Planning – The Bridge to Change

Early strategies: OARS

- Open Ended Questions ("are you concerned about your health?" vs "to you, what are important reasons to take this medicine")
- Affirmations ("It really sounds like you have been committed to being the best father you can")
- Reflective listening
- Summary ("Let me try to pull together what we have been talking about, let me know if I missed something; it sounds like on one hand are worried about your health but on the other hand, you are not sure this medicine is the best choice because you can t tell that it is working")

Reflective Listening: Overview

- The essence is that it makes a guess as to what the speaker means
- Statements rather than questions
- “Continue the paragraph” – not just re-iteration
- It is an active process (you decide what to reflect or ignore, what to emphasize, preferentially reflects change talk)

Change Talk

- Change talk is any client speech that favors movement in the direction of change or is related to change
- Change talk is by definition linked to a particular behavior change target (related to Focusing process)