What's Going on @SPNS

AN UPDATE FROM HRSA, HIV/AIDS BUREAU,
SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

JUNE 2010

Creating Change: Using Motivational Interviewing in SPNS Projects

Motivational interviewing (MI) is a "directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence."[1] Providers trained in MI use a specific approach to conversations with clients to help them develop the motivation to initiate and sustain behavioral change. First developed in connection with substance abuse treatment, MI is now used in a range of behavioral health applications, including smoking cessation, medication adherence, and weight management.

In HIV care, using MI to address risk behaviors may help people better manage their HIV and improve health outcomes. As a result, MI has been used in a variety of Health Resources and Services Administration, HIV/AIDS Bureau (HAB), Special Projects of National Significance (SPNS) demonstration projects. This issue of *What's Going on @ SPNS* highlights how a few SPNS grantees are using MI in various aspects of their interventions, from initial client assessment to ongoing case management, to retaining people in care.

Stages of Change

MI is designed to move people along the continuum of behavioral change stages outlined in the Transtheoretical Model of Change[2] (see the box on p. 2). It works primarily on the first three stages—precontemplation, contemplation, and preparation, during which the person moves from not seriously considering change to actively preparing for change.

MI is patient centered. The process focuses on identifying client strengths and helping the client "articulate and resolve his or her ambivalence."[1] Often, clients are conflicted between continuing their current unhealthy behavior and adopting more healthful behaviors. Both courses have positive and negative consequences. For example, a person living with HIV/AIDS may have trouble adhering to his or her medication regimen or not want to take HIV medications at all. On the one hand, adherence offers the potential for improved health, which in turn enables the person to live a fuller life. On the other hand, the medications may have unpleasant or disfiguring side effects that subject the person to feelings of illness and, sometimes, social stigma. The client sees both sides but will not start to improve adherence until the client resolves his or her ambivalence about taking HIV medications.

Another key to MI is the interaction of the care provider* with the client. Motivation for change must come from the client, and providers must avoid attempts at direct persuasion, coercion, and confrontation; they should be directive only insofar as such direction helps clients identify and resolve their conflicting feelings about changing the behavior in question.[1] Another tenet of MI is that "readiness to change is not a client trait but a fluctuating product of interpersonal interaction."[1] In other words, when providers encounter resistance to change, it is generally because the provider is pushing too hard. Successful MI depends on good rapport between the client and provider. Specific techniques for provider–client interaction are provided in the box on page 3.

Motivational Interviewing in SPNS Demonstration Models

Finding people living with HIV/AIDS (PLWHA) and keeping them in care is crucial to controlling the spread of the epidemic and associated infections that have public health implications (e.g., hepatitis B and C and tuberculosis). The circumstances of many people living with and at risk for the disease make engagement and retention in care a challenge. In working with this population, providers must address barriers to care, which may include poverty, lack of health care insurance, homelessness, drug and alcohol addiction, mental health issues, and

* This article uses the term *provider* to refer to clinicians, peer counselors, case managers, and other nonclinical staff and volunteers who work with people with HIV/AIDS.

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stigma of various kinds. It requires a significant level of provider engagement as well as approaches to patients that may differ from those in typical care settings.

Across several SPNS initiatives, providers are using creative approaches to bring patients into care and keep them there. SPNS grants give providers the opportunity to take approaches like MI, which have been used in other settings, and apply them in an HIV care setting. Because providers must tailor their work with each patient to meet that patient's unique care needs and overcome a unique set of barriers to care, MI is an excellent tool for this work.

SPNS Innovations in Oral Health Care Initiative

People living with or at risk for HIV/AIDS can develop the same oral health problems, such as cavities, gum disease, and sensitive teeth, as those who are HIV negative. They also may face many other oral health care issues, ranging from cost of services and limited access to care to physical and behavioral health factors. Some conditions, such as oral lesions from candidiasis (thrush), herpetic ulcers, and Kaposi's sarcoma, are seen almost exclusively in people who are HIV positive and often are among the first symptoms of HIV infection.[3] In addition, many medications, including antiretrovirals, may cause "dry mouth" (xerostomia), which predisposes people to caries, periodontal disease, and oral candidiasis.[4,5]

PLWHA often have co-occurring substance abuse issues, which can have a direct impact on oral hygiene. Moreover, tobacco use, particularly smokeless tobacco (dip, chew), increases the risk of developing oral cancers.

In response to increasing dental health care needs among people living with HIV/AIDS, HAB launched the SPNS HIV/AIDS Oral Health Care Initiative in 2006 to develop, implement, and evaluate innovative models of oral health care around the country. The 5-year, 15-site initiative focuses on urban and nonurban areas where oral health services for PLWHA do not exist or are inadequate to meet the demand.

East Texas Dental/Oral Care Services Program

One SPNS Oral Health Care Initiative grantee, the East Texas Dental/Oral Care Services (DOCS) Program at Special Health Resources for Texas (SHRT), in Longview, Texas, serves a 23-county, entirely rural service area. The program's clients are fairly evenly divided between African-American and White clients; few are Hispanic because of the program's location in northeast Texas, according to Program Director Nancy Young. Two-thirds are male.

Most of SHRT's patient population has a history of substance abuse, which interferes with engagement and retention in care as well as with treatment adherence. They tend to be of low socioeconomic status and have little or no prior dental care, low health literacy, and lack of self-efficacy navigating the health care system. Moreover, many clients use tobacco, particularly smokeless tobacco.

The program uses MI in many ways. Pennye Perry, the program's dental hygienist, says that she uses the technique to help patients improve their regular oral health care as well as help them move toward quitting smoking—not just because of its impact on oral health but because many patients have high blood pressure, which smoking makes harder to control. "Many patients say they don't use tobacco, but you can tell they do," she says. "I have to get past yes–no questions and dig deeper with them. . . . People think that [smokeless tobacco] is safer, but it's not. They are in denial about their addiction."

Perry uses MI to find out more about patients' oral health habits and help educate them. "I have to know what they are doing and how," she says, before she can teach them healthier alternatives. To her, MI "is talking to people, not having expectations . . . some people are very difficult and don't want to say anything more than yes or no. I have to make them comfortable." She says that patients tend to be more afraid of the doctor than of her, so they often open up more easily in dental consultations. The process starts when she takes the patient's history. On each subsequent visit, she

Stages of Change

The developers of the Transtheoretical Model of Change identified five stages of change:

1. *Precontemplation*: The client has no interest in change; he or she does not view the behavior in question as a problem.
2. *Contemplation:* The client is thinking about change: "I really should see a doctor about this problem." At this stage, people "are in the grips of ambivalence regarding their [behavior]. This ambivalence is the hallmark of contemplation."
3. *Preparation:* At this point, the client has decided to change. He or she wants to change, and the provider's job is to help create a workable plan based on the client's goals.
4. *Action:* In the action stage, clients implement a plan for change. The provider's job is to help the client stay on task by reaffirming his or her desire and motivations for change.
5. *Maintenance:* Clients in the maintenance stage have made the desired change in behavior. It is important for clients at this stage to monitor themselves and implement relapse prevention strategies. Relapse to the undesired behavior is not unusual in this stage.

Source: Tomlinson KM, Richardson H. *Motivational interviewing and stages of change: integrating best practices for substance abuse professionals.* Center City, MN: Hazelden; 2004: 14–16.

reviews the patient's file for any issues that came up in their previous conversation and checks in to see how the patient is doing.

Perry adds that she uses MI techniques because they "get people to open up to me, to be more honest than they might be otherwise. Many people are not very forthcoming, and . . . these techniques provide me with the tools to better communicate with them."

SHRT also uses MI in case management. Case Manager Ernesto Guevara's intake interview is rooted in MI techniques to address issues interfering with medication and appointment adherence. According to Young, Guevara's successes are in tracking down "lost to followup" cases and reengaging those patients in medical and dental care. She says that denial of their illness is at the heart of many patients' refusal of treatment or poor adherence. By accepting where patients are in the stages-of-change process and using MI to gently break through their denial, Guevara is able to engage them in care. Perry adds, "It's about making people responsible for and aware of their actions in a nonthreatening way."

Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative

In September 2007, the SPNS program created the Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative (Jails Initiative) to develop innovative methods for providing care and treatment to HIV-positive jail inmates who are reentering the community. The 10 demonstration projects are identifying and helping HIV-positive jail inmates with transitioning to community-based HIV primary care and social support services.

Many inmates leaving jail are homeless and jobless, and they need immediate food and shelter in addition to ongoing HIV/AIDS care. Another concern for many inmates upon release is substance abuse treatment: According to the Bureau of Justice Statistics, 68 percent of jail inmates reported experiencing substance dependence or abuse symptoms in the year before their admission to jail.[6]

South Carolina Linkage Program for Inmates

The South Carolina Linkage Program for Inmates in Columbia, South Carolina, offers voluntary rapid HIV testing to inmates in the holding dorm in the Alvin S. Glenn Detention Center, where they await release on bond or assignment to a bed in either the jail or another correctional facility. Inmates who test positive for HIV are invited to participate in the linkage program. According to Mark Sellers, linkage coordinator for the program, the participation rate is high. He has a caseload of 78 men and women, all of whom are HIV positive; only 12, however, are newly diagnosed. Women make up about 25 percent of the caseload.

Sellers uses MI in the context of strengths-based case management to bring recently released inmates into care and link them to services. It is a challenge, because the community has little in the way of support for HIV-positive people facing homelessness, unemployment, and addiction.

Inmates meet with Sellers over seven sessions. The first session focuses on allowing the client to express his or her feelings about the diagnosis and gives Sellers a chance to assess the client's barriers to care. He says that many of his clients first tested positive for HIV anywhere from 5 to 15 years ago but have not been in care for various reasons: "There is no one to help, they are in denial, homeless, hungry. They aren't thinking about treatment. Incarceration can provide a moment of clarity."

Sellers asks his clients, "What are your goals? What do you need?" He uses their responses to guide the intervention. "Treatment and care may not be number one on their agenda," he observes.

Even though the client's immediate goals may have no apparent connection with treatment, Sellers is often able to use the goal as motivation for the client to stay in care. For example, he tells the story of an 18-year-old client who only wanted "grills" (gold caps) for his teeth. When asked why, he said he "wanted to look fly" and not like he had HIV. Sellers asked, "Well, to be fly, don't you have to look healthy?" The client decided that he wanted good health so that he would "match his grills" and agreed to seek care.

Sellers uses MI throughout all seven client sessions. In the second session, he helps the client identify barriers to care and treatment and continues to emphasize their strengths. For example, with someone who is homeless, he might emphasize how much the client knows about the services that are available and the survival skills the client has developed. Sellers stresses that he uses a nontraditional case management approach and spends a fair amount of time giving rides and buying sandwiches for his clients and making the occasional home visit.

Seller's third through sixth sessions with clients focus on making and maintaining linkages to other services, such as substance abuse treatment, housing, mental health treatment, and employment. Always, he highlights the clients' strengths and lets them set their goals.

The last session is one of disengagement, where Sellers and the client finalize a long-term case management plan. He emphasizes, however, that the disengagement process begins with the first session. The client is always aware that Sellers' role is time limited. He tells clients that when their work together is done, "You will always have access to me, but I'll refer you to another case manager."

Sellers had many reasons for bringing MI techniques into his work in the Jails program. "It has been proven successful through studies," he notes, and he used it in a previous program that linked newly diagnosed PLWHA to treatment and care. He adds,"We used this technique to build a rapport with clients, encouraging them to 'drive their treatment process' with the case manager as the 'navigator.' Basically, it encouraged clients to buy into their

Motivational Interviewing Techniques

William Miller and Stephen Rollnick, developers of the MI process, emphasize the following communication techniques:

- *Open-ended questions:* Questions that cannot be answered with a simple yes or no, such as "How are you feeling today?" are open ended. According to Miller and Rollnick, this type of question "allows the client to create the impetus for forward movement."
- *Affirmations:* Statements that highlight the client's strengths are affirmations. They help clients recognize their successes and believe that they really can change. To a client who feels like a failure because he relapsed after a week of abstinence, the case manager might say, "You didn't use drugs for an entire week. That is an accomplishment in itself."
- *Reflective listening:* "Reflections" rephrase what the client has said, allowing him or her to feel heard. Miller and Rollnick say that reflective listening is "key to this work." Summarizing what clients have said tells providers what is working for the client and where they are in their process of change—the client will point it out if the provider misunderstands something. Providers should focus on the aspects of the client's statements that relate to change. In addition, they should attempt to dig below the surface and reflect some of client's emotions: "Your girlfriend left you because you aren't taking your meds, and she thinks you aren't interested in taking care of yourself. That must be painful for you." Drawing out the client's feelings can uncover strong motivators.
- *Rolling with resistance:* Miller and Rollnick say that this technique is vital to successful MI. Rather than directly confront the client's resistance, the provider accepts it ("rolls with it") and thereby helps defuse it. The client might say, "I'm not taking any HIV meds. I don't want the side effects, and I feel fine." In response, the provider might say, "Well, you might decide after our conversation that that's the way to go. Let me tell you a little more about the medications so you can make an educated decision."
- *Reframing:* Reframing is a way to give a client a new perspective on his or her situation. For example, if a client says that he or she feels like "a loser" for living on the street, the provider can highlight the client's survival skills and how far he or she has come just by being in the provider's office and talking about the situation.

Source: Motivational interviewing: Interaction techniques. 2003. Available at: http://motivationalinterview.org/clinical/interaction.html

treatment process through behavior change and the resolution of internal and external issues."

Sellers says that MI is "a beautiful process when it works. It's about the counselor helping the client resolve ambivalence." He points out that traditional case management involves telling clients what to do, whom to call, and when to be at a certain place, but it doesn't offer real engagement with the client. What MI does is create a process that is client driven and relationship based. "The objectives are identified by the client—how empowering!" he says.

Enhancing Access to and Retention in Quality HIV/AIDS Care for Women of Color Initiative

Although 74 percent of new HIV diagnoses each year are among men, Black women account for nearly two-thirds of new HIV infections among women.[7] A whopping 78 percent of new HIV infections among women in 2007 were among women of color.[8] The SPNS Enhancing Access to and Retention in Quality HIV/AIDS Care for Women of Color Initiative, a multisite demonstration and evaluation of HIV service delivery interventions, has funded 11 demonstration sites for up to 5 years to design, implement, and evaluate innovative methods for enhancing access to and retention in primary medical care and ancillary services for women of color. Interventions include community-based outreach, patient education, intensive case management, and patient navigation strategies that promote access to care. The grants were awarded in the fall of 2009, and all sites are getting underway with their work.

Peer Outreach Worker Entry and Retention Program

The Peer Outreach Worker Entry and Retention (POWER) Program is a peer-driven demonstration project of SUNY Downstate Medical Center (SUNY–DMC), which is also a Part D grantee. POWER's goals are to ensure timely entry into care for newly diagnosed women of color, increase retention rates of those already receiving care, and find women lost to followup and bring them back into care. The target population is predominantly Black women (including African, African-American, and Afro-Caribbean) and Latinas, with or without children, who are living with HIV in the Brooklyn, New York, area.

The program builds on an existing network of nine programs, all of which provide multidisciplinary services to assist children, adolescents, and their families in accessing comprehensive, coordinated, community-based HIV care. The network programs use a family-centered approach.

Five network clinic sites will use peer outreach workers and case managers to guide newly diagnosed women of color through the linkage process at network sites, mentor women transitioning from adolescent to adult care, and seek out and reengage

For More Information . . .

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HIV-positive women who have been lost to followup. Peers will also facilitate support groups at selected network sites.

According to Rachael Peters, POWER program coordinator, the peers will focus on engaging and retaining clients in care. As with the other projects described in this article, clients will pick their goals, and the peer outreach workers will use MI to help them achieve them. Peers will also play a role in linking clients to other care and service providers. Peters notes that "flexibility is part of the power" of MI, as is relationship building. "If the client isn't ready, that's okay—eventually, you will build a relationship and the peer will build trust."

When asked why her program chose to use MI rather than another approach, Peters responds, "MI has a proven track record, it has already been successful with our population, and it has been shown to be just as effective when peers use it as when master's-level or bachelor's-level staff use it. . . . The spirt of nonjudgment and empowering clients to make their own choices resonated well with our clients and our staff, especially the peer staff."

Past successful cases provided the incentive to use MI as well. Peters notes that Jeffrey Birnbaum, the project's principal investigator and physician, has been using it successfully with youth for years. "He tells them that they are in charge of their own life and that no one makes decisions for you, they might give you consequences for your decisions, but the decisions are yours," she says. This approach keeps the youth engaged.

MI can work slowly, Peters observes: "Sometimes you lay groundwork for years before the client is ready. [Dr. Birmbaum] might move a client from precontemplative to contemplative regarding taking medications and then not move them to preparation or action for a long time, but they stay connected because of the respect they have felt and the way they were engaged with at the clinic. Sometimes a client will come back after a year still remembering what you had talked about and now willing to start taking medication."

Many program staff have been trained in MI and have already incorporated MI into their daily work. The POWER program is finalizing its protocols and procedures; the peer outreach workers are being trained in MI and should have their first clients this spring.

Summary

MI techniques, such as active listening and open-ended questioning, which are common in many types of provider–client interactions, must be distinguished from MI itself, which has the specific objective of moving clients through the stages of change toward a particular behavioral goal. Rollnick and Miller warn,

> MI ought not be confused with brief interventions in general. We suggest that the word "motivational" be used only when there is a primary intentional focus on increasing readiness for change. Further, "motivational interviewing" should be used only when careful attention has been paid to [MI's] definition and characteristic spirit. . . . Put simply, if direct persuasion, appeals to professional authority, and directive advice-giving are part of the (brief) intervention, a description of the approach as "motivational interviewing" is inappropriate.[1]

The SPNS programs highlighted here, as well as many others, are using MI in its strictest sense, although many other programs use techniques associated with MI that are not MI per se. It seems clear that once a person is trained in MI, he or she would be hard pressed to not use some of those highly effective communications techniques in other realms.

All the SPNS programs described in this article are being evaluated; additional information on the efficacy of the various projects will be available following the conclusion of the grant period.

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