Brief Motivational Interviewing for persons with severe mental illness

Promoting physical health and wellness

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- I have no conflict of interest

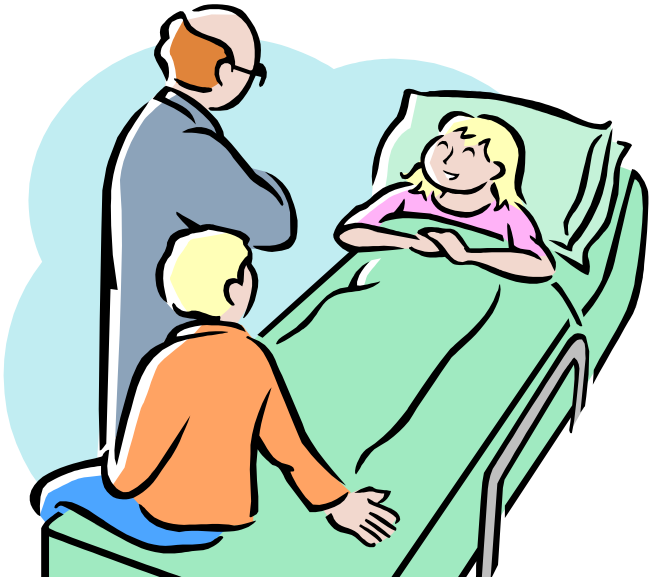
Objectives

- Knowledge:
  - Know the mortality rate of persons with severe mental illness
  - know the predictors of mortality for this group
  - Know 4 health behavior theories
  - Understand Brief Motivational Interviewing

- Skill:
  - Brief Motivational Interviewing
    - Reflective Listening
    - Elicit – Provide – Elicit
    - Readiness Rulers
    - Cost-Benefit Analysis (Simple decisional balance)
    - Payoff Matrix (Complex decisional balance)

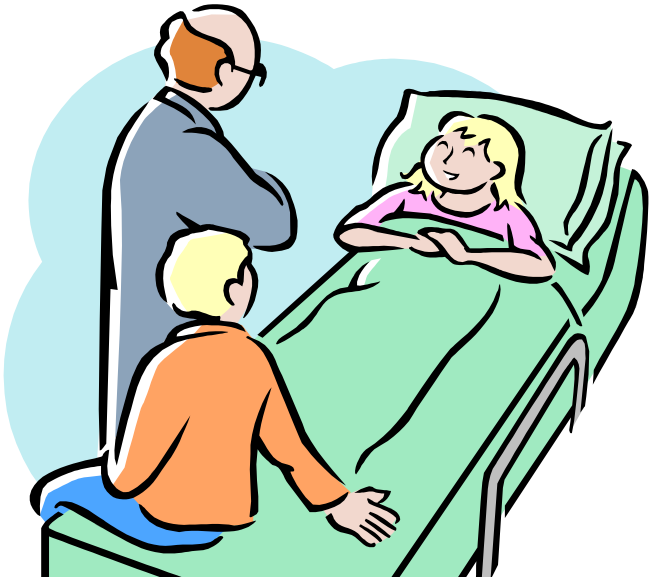
Health Disparity

People with serious mental illness served by our public mental health systems die, on average, at least ? years earlier than the general population.



Health Disparity

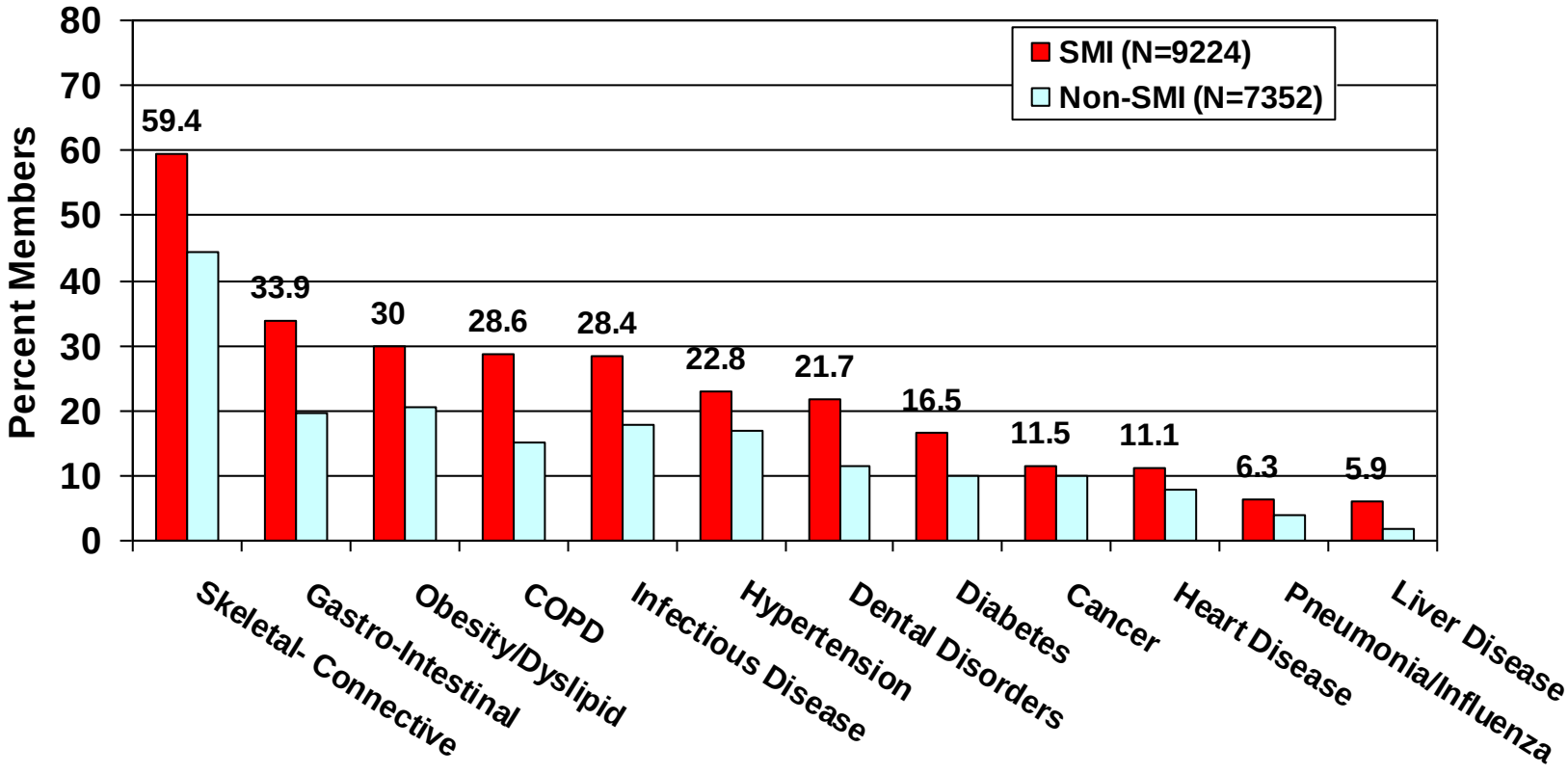
People with serious mental illness served by our public mental health systems die, on average, at least 25 years earlier than the general population.



Colton , & Manderscheid, 2006

Health Disparity

Maine Study Results: Comparison of Health Disorders Between SMI & Non-SMI Groups



Health Disparity

Measurement of Health Status for people with serious mental illness, NASMHPD (2008)

- Co-occurring health conditions should be considered an expectation
- 87% of years lost due to premature death are caused my medical illness
- Premature death is predominantly caused by chronic diseases (infectious, pulmonary, cardiovascular, and diabetes)
- Psychotropic medication can cause weight gain, dyslipidemia, and glucose metabolism
- Persons with mental illness have much higher rates of metabolic syndrome, liver diseases, hypertension, and dental disorders
- Persons with mental illness have higher rates of smoking, poor weight management and physical inactivity
- Persons with mental illness have very low rates of utilization of preventative medicine and self care

Causes of Health Disparity

- Higher rates of comormidity
- Higher rates of cardio-vascular disease
- Higher rates of obesity
- Higher rates of poor dietary habits
- Higher rates of Physical Inactivity

Colton & Manderscheid, 2006

- Higher rates of smoking and substance use

Mcginty, Baller, Azrin, Juliano-Bult, & Daumit, 2006

Health Behavior Theory

- Health belief model
- Theory of planned behavior
- Transtheoretical model
- Social cognitive theory

Health belief model

- Definition

  Health behaviors are shaped by a persons perceptions and beliefs about susceptibility, severity, benefits of change, barriers for change, and ability to take action

- Support for behavior change

  Promote awareness about risk, benefits, prompt and remind to engage in health behaviors, encouragement

Baranowski, Cullen, Nicklas, Thompson, & Baranowski, 2003

Theory of planned behavior

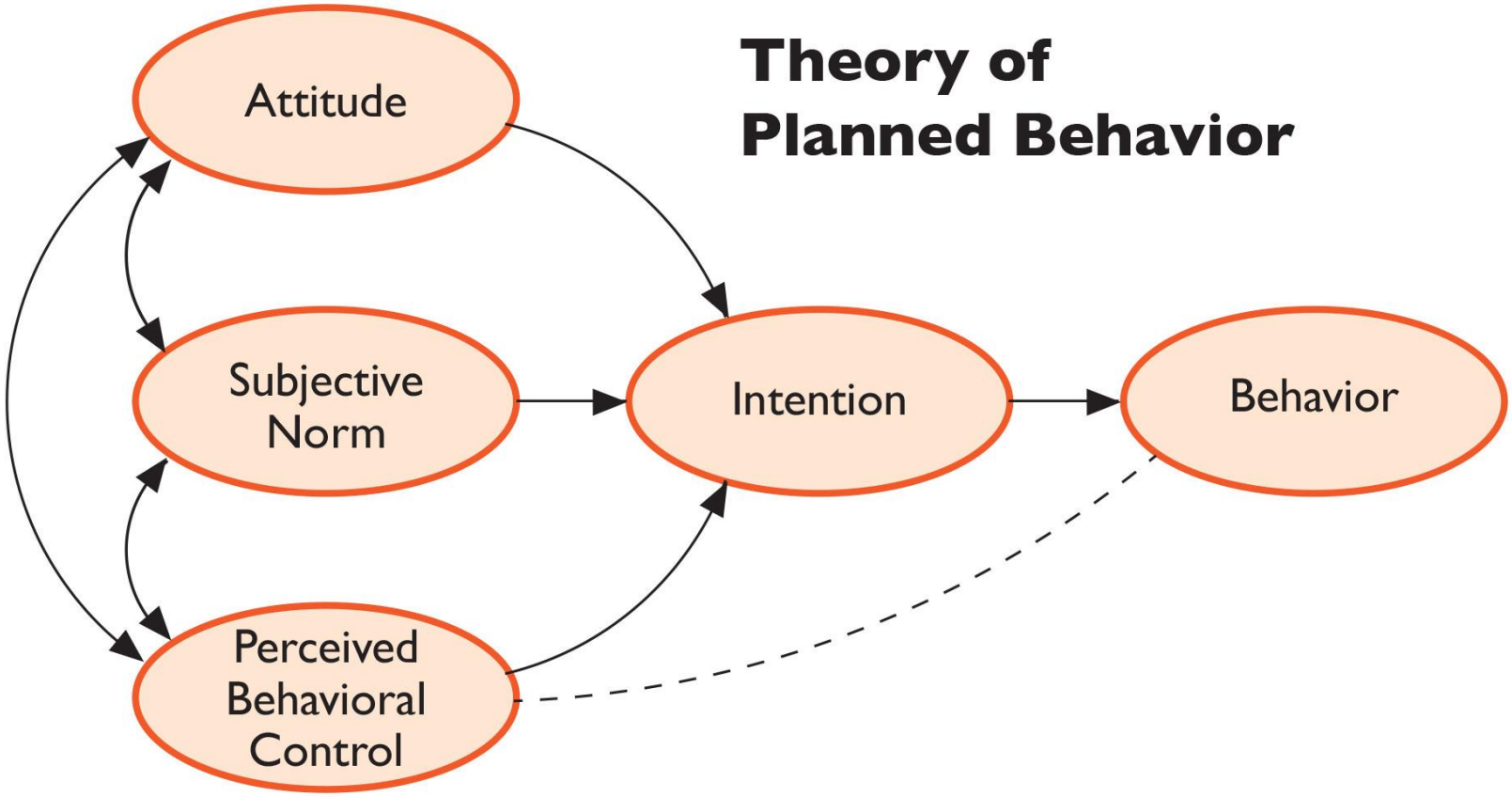
- Definition

  1) Perceived norms, beliefs about health, and perceived behavioral control predict a persons intent and motivation to engage in health behaviors. 2) Intent is predictive of health behaviors

- Support for behavior change

  Use prompts and motivational interventions to increase intent, and encouragement and skills training to increase self-efficacy

Montano, & Kasprzyk, 2008


Theory of
Planned Behavior
Attitude
Subjective
Norm
Perceived
Behavioral
Control
Intention
Behavior

Transtheoretical model

- Definition

  Stage of change. People go through stages: precontemplation, contemplation, preparation, action, maintenance

- Support for behavior change

  Stage specific interventions, resolve ambivalence, support self-efficacy

Prochaska, Redding, Evers, 2008

Social cognitive theory

- Definition

  health behavior is shaped by social context and individual factors, environmental factors, and self-efficacy

- Support for behavior change

  Increase self-efficacy through mastery, modeling, verbal and social persuasion

McAlister, Perry, & Parcel, 2008

General Principles of Brief Motivational Interviewing

Express Empathy

_____
_____

Develop Discrepancy

_____
_____

Roll with Resistance

_____
_____

Support Self-Efficacy (empowerment, self-determination, shared decision making)

_____
_____

Reflections to direct a conversation

Attending

- Use appropriate non-verbal body language
- Make appropriate eye contact
- Lean toward the patient
- Find a non-distracting environment

Following

- Use door-openers – An invitation to talk. “You look like you have something on your mind”
- Minimal encouragement – Short phrases. “Tell me more”, “Go on”, “I see” or “Really?”
- Infrequent questions – Use open-ended questions.
- Attentive listening – Use of silence gives the patient time to think

Reflecting

- Paraphrasing – Restate what the patient just said
- Reflecting feelings – Restate feeling words that the patient just said. Connect feelings to what the patient is talking about
- Reflecting meaning – “You feel _____ because _____”. Pair feeling to message content
- Summarizing – Occasionally summarize the main contents of the discussion.

Criteria 1: Examples of a health concern?

Establishing a Health Concern	
	YES/NO
Substance Abuse (CAGE)	
Have you ever tried to cut down?	
Have others ever been annoyed by your use?	
Do you ever feel guilty about your use?	
Do you ever need an eye-opener?	
Do you smoke?	
Do you take medications as prescribed?	
Weight (BMI>25)	
Cardio-Vascular (BP>140/90)	
Diabetes (A1C>7, FPG>120)	
Are you physically inactive ?	

Criteria 2: Is the patient ambivalent?

Stage of Change	
Pre-Contemplation	No cost from current behavior
Contemplation	More benefit than cost from current behavior
Preparation	More cost than benefit from current behavior
Action	Sustained behavior change, less than 6 months
Maintenance	Sustained behavior change, more than 6 months

Matching Intervention with Stage of Change

Pre - Contemplation
- Disengaged: “What problem?”
- The patient does not seek contact with staff.

Contemplation
- Ambivalence: “Well OK. I might have a problem, but I’m not ready yet.”,
- The patient might have regular contact with staff, reflect on current behavior and discuss pro/con

Preparation
- Seeks advice: “OK, so how do I do this?”
- The patient is searching for the right support and information

Action
- Seeks support: “I’m doing it. And I am changing my behavior. It is hard.”
- The patient is active, and engaged in changing behavior

Maintenance
- Stability: “I did it. I have changed for a while now. I just have to keep it up.”
- The patient needs continued support and encouragement

Relapse
- Shame: “Now what. I just resumed my old behavior.”
- The patient can be embarrassed, shameful and feel guilty

Miller, W. R., & Rollnick, S. (2002). Motivational Interviewing (2nd. Ed.), *What is motivational interviewing?* (pp. 33-42). New York: The Guilford Press.

Skill set 1: Engage patient in your agenda

Elicit – Provide – Elicit

Elicit Context

"What can you tell me about…?"
"How are you affected by…?"
"Do you mind if I talk to you about…?"

Provide Information

"Research suggests…"
"Others have benefitted from…"
"What we know is that…"

Elicit Feed-back

"How does this apply to you?"
"What do you think about that?"
"Where does this leave you?"

Skill set 2: Elicit Change Talk

Rulers

Readiness Ruler

"On a scale from 1 to 10 how ready are you to …"

1	2	3	4	5	6	7	8	9	10

Willingness Ruler

"On a scale from 1 to 10 how willing are you to …"

1	2	3	4	5	6	7	8	9	10

Ability Ruler

"On a scale from 1 to 10 how able are you to …"

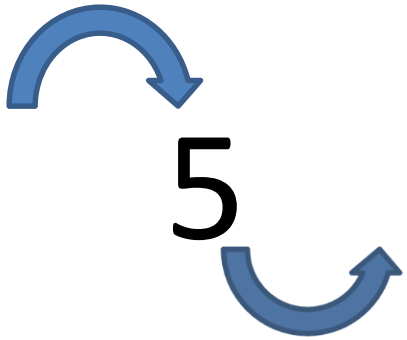
1	2	3	4	5	6	7	8	9	10

Skill set 2: Elicit Change Talk

Readiness Ruler

"On a scale from 1 to 10 how ready are you to stop smoking"

Consolidation:
What are you doing
that makes you a 5?
Why not a 4?



1 5 10

Illicit change:
What would you do
different if you were a 6?

Skill set 3: Simple Decisional Balance

Cost-Benefit Analysis	
Cost of Current Behavior	**Benefit of Current Behavior**

Skill set 4: Complex Decisional Balance

Payoff Matrix		
	Cost	**Benefit**
Current Behavior		
Changed Behavior		

Thank You!

Discussion & Questions?

References

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