Mother & Baby Substance Exposure Toolkit

Best Practice No. 8

A part of the California Medication Assisted Treatment Expansion Project

This version was published on 2020-09-04

cpqcc
california perinatal
quality care collaborative

CMQCC
California Maternal
Quality Care Collaborative

HMA
INSTITUTE ON ADDICTION

Understand and implement the principles of Motivational Interviewing

Best Practice No. 8

Outpatient, Labor and Delivery, Nursery/NICU, and Treatment

Overview

Motivational Interviewing (MI) is a patient-centered counseling approach rooted in key theoretical principles—including decisional balance, self-perception theory, and the transtheoretical model of change—that uses directed techniques to enhance patients' intrinsic motivations for and reduce their ambivalence toward behavior change. Introduced in the early 1980s as a counseling strategy for encouraging behavior change among people with alcohol dependence, the principles, methods, and specific techniques employed in MI have been researched and analyzed for a variety of health conditions for which behavior change is a critical part of health-promoting interventions. MI has now been firmly established as an effective, evidence-based practice in the treatment of substance use disorders (SUDs) and other health conditions including diabetes, obesity, and smoking cessation.

MI uses principles of collaboration between the provider and client (rather than confrontation), the intent of which is to develop rapport and trust, along with evocation of the client's own thoughts and ideas (rather than imposing the provider's opinions), and autonomy and self-efficacy (rather than authority). MI recognizes that true motivation for behavioral change rests within the client. While the provider may have different opinions about the timing or approach to a particular condition, an understanding of the client's experience and beliefs and ultimately eliciting the client's own motivations for changing unhealthful behaviors is more likely to result in lasting change.

The optimal implementation of this best practice would be for hospital and office-based providers to organize MI trainings and regular practice opportunities for all of their staff, especially clinical staff involved in gathering patient information who might have the opportunity to motivate behavior change. In the absence of resources for MI training, this best practice includes several techniques that can be employed without significant training. Additionally, the curriculum included in the Resources section of this Best Practice incorporates links to several web-based videos demonstrating some of these techniques that may be helpful adjuncts to staff interested in further MI exposure and practice.

Why we are recommending this best practice

- Motivation is a key to behavior change. It is multidimensional, dynamic, and fluctuating; influenced by social interactions; and can be modified and influenced by the provider's style. The provider's task is to elicit and enhance motivation.

- MI is effective as an adjunct to enhancing entry into and engagement and retention in interventions that support various kinds of behavior change, including but not limited to substance abuse treatment. It has also been used to encourage rapid return to

treatment following relapse.

- MI is increasingly used as a stand-alone brief intervention during routine encounters with patients.

- MI is an approach that has been empirically shown to be more effective than giving advice, which tends to occur frequently in health care delivery.

- "Readiness to change bad habits is generally a developmental process, and the precepts of MI, including patience, listening, empathy, and change talk, can be useful tools." (Prochaska J, et al, 1995).

Strategies for Implementation

Ideally, providers can use MI curricula to become more proficient in these techniques, and all levels of staff can participate in these curricula and employ these techniques. One such curriculum is included in the Resources section for this Best Practice. In the absence of formal training, several specific MI strategies and techniques are described below.

Incorporate the foundational principles of MI into communication with pregnant and parenting women with opioid use disorder (OUD). These foundational principles of MI should be employed continuously over time and include:

- Express empathy through reflective listening
- Develop discrepancy between patient's goals or values and their current behavior
- Avoid argument and direct confrontation
- Adjust to patient resistance rather than opposing it directly
- Support self-efficacy and optimism

Employ the following general style of MI in all patient communication:

- **Asking Permission** – Permission is a deeply respectful foundation of mutual dialogue
- **Engaging** – Engagement is the establishment of trust and a mutually respectful relationship
- **Focusing** – Focus is the ongoing process of seeking and maintaining a direction for the exploration conversation
- **Evoking** – Evoking refers to eliciting the patient's own motivation for change.
- **Planning** – Planning is the process of deciding on a specific plan for change that the patient agrees is important and is willing to undertake.
- **Linear and Iterative Processes** – Change talk within MI is both a linear and iterative process.

The following are specific motivational skills and strategies that can be practiced and incorporated into all patient engagements, especially those that involve behavior change and compliance with treatment plans. Each of these strategies is described in more detail in the MI Curriculum included in the Resources section of this Best Practice.

Employ the **OARS+** model as one set of specific MI skills.

- **O**pen ended questions elicit crucial information that may not be gathered from close ended questions.
    - *Instead of asking "Have you used any drugs during your pregnancy?", one might say "I treat a number of women who have used prescription medications and other drugs during their pregnancy. Please share with me which kinds of prescription meds or other drugs, if any, you have used during or before this pregnancy."*
    - *Instead of asking "Have you ever been in treatment?", one could request "Tell me about your recovery journey."*

- **A**ffirmations are statements of appreciation
    - *"I'm impressed that you followed up with the MAT referral"*
    - *"You've stayed off drugs for 2 months. That's great!"*

- **R**eflections establish understanding of what the patient is thinking and feeling by saying it back to the patient as statements, not questions.
    - *Patient: "I've been this way for so long."*
    - *Provider reflection: "So this seems normal to you" or "So this seems like a hard cycle to break."*

- **S**ummaries are highlights of the patient's ambivalence that are slightly longer than brief reflections and serve to ensure understanding and transition from one topic to another.
    - *For a patient wanting to stop using drugs during pregnancy: "You have several reasons for quitting drugs: You want to get your life back, you want to give your baby the best chance at a healthy life, and you want to be able to manage life's issues without relying on drugs as a crutch. On the other hand, you're worried about what kind of recovery path would work for you; you're worried that you won't have the motivation and strength to stick with a recovery path. Would that sum it up?"*

Rolling with resistance requires the listener/provider to pause and shift conversations when signs of an argument or confrontation begin to appear. Resistance behavior occurs when points of view differ, generally when the provider is moving the patient ahead too quickly, or the provider fails to understand something of importance to the patient. When resistance appears, the listener/provider should change strategies and utilize OARS techniques.

Developing discrepancy involves the listener/provider guiding the conversation so the patient can articulate their personal beliefs and future goals (listen especially for statements about life, family, health, financial status, living situation, and other personal considerations). Developing discrepancy between the patient's behaviors and their broader life goals is essential because patients are more often motivated to change when they arrive at that conclusion themselves rather than hearing it from someone else.

Change Talk is defined as statements made by the patient that indicate motivation for,

consideration of, or commitment to change behavior. There are clear correlations between patients' change talk and outcomes. Once the listener/provider and patient have established a trusting relationship and have open communication about the patient's substance use, the listener/provider can guide the patient to expressions of change talk using some of the techniques listed below. Each of these strategies is described in more detail in the Motivational Interviewing Curriculum included in the Resources section of this Best Practice, along with additional strategies for eliciting change talk.

- **Preparing change talk** employs the **DARN** model as one set of specific MI skills
  - **D**esire to change (*Ask "Why do you want to make this change?")*
  - **A**bility to change (*Ask "How might you be able to do it?")*
  - **R**easons to change (*Request "Share one good reason for making this change.")*
  - **N**eed to change (*Ask "On a scale of 0-10, with 10 being the highest, how important is it for you to make this change?")*

- **Implementing change talk** employs the **CAT** model as one set of specific MI skills.
  - **C**ommitment (*Ask "What do you intend to do?")*
  - **A**ctivation (*Ask "What are you ready (or willing) to do"?)*
  - **T**aking steps (*Ask "What steps have you already taken?")*

Coding and Reimbursement – MI focused on increasing the patient's understanding of the impact of their substance use and motivating behavior change can be coded for reimbursement whenever a positive screen (through interview, formal screening tool, or toxicology) is identified and documented in the medical records. Evaluation and Management (E/M) service codes for both assessment and intervention are listed below (and can be coded with modifier 25 when they are performed during the same clinical visit as other E/M services):

- 99408 – Alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention services 15-30 minutes (the comparable Medicare code is G0396)
- 99409 – Alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention services greater than 30 minutes (the comparable Medicare code is G0397)

Deep Dive

Decisional Balance is a Motivational Interviewing tool that encourages change talk by eliciting the client's own ideas and motivations for change. The grid below is an easy way of remembering the questions asked in Decisional Balance, which are most effective when asked in sequence.

1. **What are some of the good things about using *fill in the substance*?**
This will not elicit much change talk, but will get the client talking in a non-defensive way.

2. **What are some of the bad things about using *fill in the substance*?**
This question begins to elicit a client's ambivalence about their behavior and will start the change talk.

3. **What are some of the downsides of getting into a treatment/recovery program?**
Clients will often start talking about their fears.

4. **What are some of the good things about getting into a treatment/recovery program?**
This question will likely elicit the most change talk, as the client discusses their own ideas and motivations for change. When this comes from the client instead of the provider, it comes without resistance and may include some motivations that the provider would not have considered.

	Good	Not so Good
Not Changing	1. What are the advantages of the status quo?	2. What are the disadvantages of the status quo?
Changing	3. What are the advantages of changing	4. What are the downsides of changing?

Decisional Balance Grid

Resources

1. American College of Obstetrics and Gynecology. Motivational interviewing: a tool for behavior change. ACOG Committee Opinion No. 423. American College of Obstetricians and Gynecologists. Obstet Gynecol 2009;113:243–6.

2. Motivational Interviewing Network of Trainers (MINT), an international organization committed to promoting high quality MI practice and training.

3. Ring, Jeff. Motivational Interviewing Practice Coach Training Curriculum.

References

1. TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment. SAMHSA. https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003. Published October 2019.
2. Miller WR, Rollnick S. Motivational Interviewing: Preparing People to Change Addictive Behavior. Guilford Publications, Inc.; 2002.
3. Prochaska J, Norcross J, DiClemente C. Change for Good: A Revolutionary Six Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward. New York, NY: Avon Books; 1995.

Helen DuPlessis

MD, MPH

Dr. Helen DuPlessis is a Principal at Health Managment Associates.

She has a rich history of involvement in healthcare administration for a variety of organizations, expertise in program and policy development, practice transformation, public health, maternal, and child health policy, community systems development, performance improvement, and managed care. Prior to joining HMA, Dr. DuPlessis served as the chief medical officer with St. John’s Well Child and Family Center. Other notable professional experiences include her work as senior advisor to the UCLA Center for Healthier Children, Families and Communities where she provided leadership, research, program development support, counsel and representation to local, state and national efforts, and community level systems transformation. She also trained and mentored students in various disciplines and educational levels.