# MOTIVATIONAL INTERVIEWING:
## HIV-Related Health Outcomes and Social Determinants of Health



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# Report Information

**Author:** Jamela Clark & Callie Kaplan

**Project Team**: Callie Kaplan, Katie Buitrago, Yoojin Kim

**Report Design:** Amber (Cason) Crossen

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# Executive Summary

**For individuals experiencing housing insecurity—and other hardships associated with poverty, such as low rates of health literacy, food insecurity, lack of transportation, and restricted access to quality health care—an HIV diagnosis exacerbates an already burdened quality of life.**

For individuals experiencing housing insecurity—and other hardships associated with poverty, such as low rates of health literacy, food insecurity, lack of transportation, and restricted access to quality health care—an HIV diagnosis exacerbates an already burdened quality of life. These larger structural barriers may inhibit HIV+ participants from feeling able to change individual-level behaviors which may complicate their HIV status. One counseling intervention that addresses obstacles to change is Motivational Interviewing (MI). MI is a collaborative, client centered approach that fosters communication between a service provider and their recipient with the goal of identifying and resolving the change goals identified during the counseling session. Studies on healthcare outcomes for chronically ill individuals who received MI interventions indicate that, when followed properly, MI can effect long-term, positive behavior changes. This paper defines MI, explores it's applications among HIV+ participants, describes an MI fidelity monitoring tool, and situates MI relevance while acknowledging the influence of social determinants of health.

MI, like other strengths-based treatments, acknowledges that "good advice" does not always set the gears of behavior change into motion. Therefore, it is the ultimate goal of an MI counselor to identify what motivates their client to pursue opportunity and encourage them to use their newfound strength as a guide towards behavior change. While all strengths-based approaches encourage individuals to pursue opportunities that elicit behavior change, MI specifically assists the practitioner in identifying their client's motivation for change in order to cultivate long-term positive outcomes. MI implementation has been shown to support positive outcomes in individuals experiencing ambivalence to behavior change. MI is particularly celebrated for its successes in a wide range of behavioral treatments. Specifically related to HIV, MI has been demonstrated to be an effective intervention for people living with HIV/AIDS (PLWHA) PLWHA struggling with optimal adherence to antiretroviral therapy (ART).

/like all approaches, fidelity monitoring is a critical component of quality assurance and improvement. The Motivational Interviewing Treatment Integrity (MITI) tool developed by the Center on Alcoholism, Substance Abuse and Addictions (CASAA) at the University of New Mexico, allows practitioners to code MI encounters in order to ensure they are adherent to both MI principles and behavior Use of MITI can help ensure that participants are receiving high quality services and are better supported to reach their health goals.

However, as this white paper details, it is important to identify that the necessary changes that PLWHA are encouraged to pursue by their care professionals are often obstructed by a multitude of barriers that can be attributed to what this paper will identify as macro-level social determinants of health ownership—social and economic

factors that contribute to a person's health that are beyond their control. These factors are influenced by the distribution of money, power, and resources throughout local communities, nations, and the world.

Ultimately, this paper asserts that the line between behavior change and social determinants of health ownership can at times seem invisible. **For PLWHA, however, understanding the history of stigma associated with HIV should be an MI practitioner's signal that an individual is indeed battling against structural barriers to care and should consider using MI in conjunction with other tools in their intervention toolbox and ensure that:**

- **All use of MI is driven by the client.**

- **In the interest of a client's safety, harm reduction and trauma-informed interventions take precedence.**

- **MI, above all, is used as a communication tool; it is not therapy or a cure. If a client needs a profound therapeutic intervention, MI can be used to link them to care, but may not be effective alone to address a complex issue**

While MI was initially intended as an intervention tool to help individuals suffering from substance use, it has crossed over into the fields of housing and employment retention, recidivism reduction, education, and healthcare. **MI is best viewed as a complex communication skill that provides an immediate intervention to equip individuals to overcome ambivalence to a pressing personal change.** As a tool, MI is effective at addressing a specific problem that requires a lifestyle adjustment that an individual has the ability to accomplish, but is reluctant to do so. In particular, **MI should not be offered as a singular psychotherapy service, particularly for those under the weight of social determinants of health as MI helps individuals achieve their best results when it is introduced as a first step to change and combined with other therapeutic treatments.**

**The success of MI rests in the spirit of MI, which embodies compassion, partnership, autonomy, acceptance, and respect for individuals stuck in the throes of difficult decision-making.** [1] When engaging individuals who are facing structural barriers to their personal goals, MI can act as a bridge that connects them to resources that provide additional support against systems-induced social barricades. As this paper explores, **PLWHA, who are more likely to suffer from HIV+ related social stigmatization, is one such group that can benefit from MI support in order to achieve 100% ART adherence, reduced viral load, and linkage to care, especially when there are accompanying healthcare options presented as well, including psychotherapy service.** [2] In doing so, PLWHA can expect an increased quality of life both emotionally and physically.

# Motivational Interviewing, HIV, and Poverty: An Introduction

**The success of MI rests in the spirit of MI, which embodies compassion, partnership, autonomy, acceptance, and respect for individuals stuck in the throes of difficult decision-making.**

**For individuals experiencing housing insecurity—and other hardships associated with poverty, such as low rates of health literacy, food insecurity, lack of transportation, and restricted access to quality health care—an HIV diagnosis exacerbates an already burdened quality of life.**[3] Homelessness acts as an especially complicated agent in the life of persons living with HIV/AIDS (PLWHA). For PLWHA, adequate physical activity, disclosure of HIV status, cessation of substance use, and attendance for medical and behavioral health care appointments, among others, are all important behavior changes that are imperative in preventing HIV-related morbidity, containing the spread of HIV, and improving a PLWHA's quality of life.[4] PLWHA experiencing housing instability-and other hardships associated with poverty- are more likely to be segregated from quality care due to their inability to obtain health insurance, financial security, and physicians who allow flexible scheduling that address transportation and financial difficulties.[5]

The barriers presented by poverty create what the Substance Abuse and Mental Health Services Administration (SAMHSA) identifies as ambivalence, or disparate feelings about changing habits or behaviors.[6]  Individuals experiencing ambivalence may choose to forgo linkage to HIV care, relegating medical health and behavioral change to the bottom of their list of personal priorities thus exacerbating the probability of HIV-related complications[7]. Moreover, PLWHA experiencing homelessness are less likely to adhere to anti-retroviral therapy (ART) medication, a lifesaving medical treatment that prevents the spread of HIV by lowering viral load—the amount of a virus in the blood stream[8]. Taking ART medication as prescribed, otherwise defined as 100% adherence, prevents HIV transmission and progression into AIDS ensuring that PLWHA can live a longer and higher quality of life.[9]

The compounding barriers posed by homelessness and HIV span across regions, affecting homeless PLWHA in both rural and urban environments.[10] Nationally, 1/3 of the population living with HIV/AIDS are homeless.[11] Currently, it is estimated that 4% of the 28,000 PLWHA who live in the city of Chicago experience chronic homelessness.[12] Research suggests that identifying and addressing the barriers that prevent necessary behavior changes is imperative in order to successfully treat all PLWHA.[13] One such counseling intervention that addresses obstacles to change is Motivational Interviewing (MI). MI is a counseling technique that draws upon non-threatening, non-punitive communication between a service provider and their recipient with the goal of identifying and resolving the change goals identified during the counseling session. Studies on healthcare outcomes for chronically ill individuals who received MI interventions indicate that, when followed properly, MI can effect long-term, positive behavior changes.[14]

This review seeks to provide information on the research surrounding MI, explore how MI differs from other counseling interventions, describe the motivational interviewing treatment integrity (MITI) coding tool for fidelity monitoring, and identify the outcomes associated with individuals who received an MI intervention. Furthermore, it will discuss the hurdles that influence ART adherence for PLWHA and explore MI as a useful tool for PLWHA to sustainably overcome their obstacles to change.

# What is Motivational Interviewing?

> **"Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change."**
> - William Miller, Motivational Interviewing: Helping People Change

**MI is an empirically-supported, strengths-based counseling technique. Developed by psychologist William Miller, MI draws upon self-perception theory, or the idea that stagnation can change into motivation once an individual can understand the driver behind their feelings.**[15] Unlike problem-focused treatments that seek to change a participant's behavior by focusing on individual difficulties and assigning tasks to correct these challenges, strength-based interventions redefine barriers to change as an opportunity and then distinguish how the opportunity can be pursued using the participant's strengths.[16] MI, like other strengths-based treatments, acknowledges that "good advice" does not always set the gears of behavior change into motion. Therefore, it is the ultimate goal of an MI counselor to identify what motivates their client to pursue opportunity and encourage them to use their newfound strength as a guide towards behavior change.[17]

While all strengths-based approaches encourage individuals to pursue opportunities that elicit behavior change, MI specifically assists the practitioner in identifying their client's own motivation for change in order to cultivate long-term positive outcomes. Even so, without first establishing a strong interpersonal relationship, sustainable behavior change is difficult to achieve regardless of the counseling technique.[18] Consequently, the relationship between a service provider and their participant can drive the client's motivation and influence the participant's compliance to change goals.[19]

The theoretical base of MI is predicated upon a secure working relationship between clinician and client. MI encourages a practitioner-participant alliance that highlights participant autonomy and identifies the client as the expert on their own life.[20] In order to establish the autonomy of the client, MI relies heavily upon the service provider's ability to collaboratively establish—instead of dictate—outcomes through empathy and reflective communication. This, in turn, helps counselors recognize and define the source of a participant's ambivalence—the uncertainty surrounding change that causes hesitation. The counselor, upon understanding the individual's hesitancy, elicits motivation in their client by reaffirming their strengths in support of an individual-specific pathway toward change.[21]

# Ambivalence and the 5 Guidelines of MI

**"MI is not a way of tricking people into doing what they don't what to do... MI is not a sleight of hand for end-running, outwitting, or hijacking an individual's motivation. It is about eliciting the person's own inherent arguments for change, not imposing someone else's"**

*-William Miller and Stephen Rollnick, Ten Things Motivational Interviewing Is Not*

**MI takes upon the task of eliciting motivation in an individual to use their strengths, which can also be viewed as their personal resources and ability to pursue change goals.** Ambivalence, however, is the emotional blockade addressed by motivational interviewers in order to draw out a client's unique impetus to overcome incertitude.[22] A motivational interviewing approaches a participant's ambivalence as a hesitancy to change but not necessarily an unwillingness. MI practitioners apply the "spirit of MI" in order to help participants transcend incertitude and act upon their personal motivation to change.[23]

The spirit of MI expects motivational interviewers to maintain the following tenets in order to consistently adhere to MI protocol throughout their interventions:

evoking client collaboration, ideas, emphasizing autonomy, and practicing compassion

at all times.[24] MI provides five guidelines for practitioners to follow in order to maintain MI adherence and help their participants overcome ambivalence while acting upon their motivation to change.
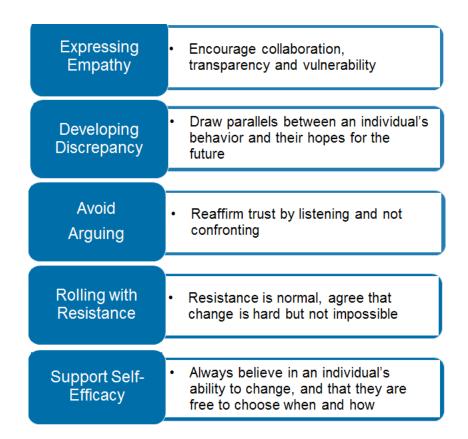
The first, **expressing empathy,** is integral to establishing an interpersonal relationship with clients. Empathy creates a safe and transparent environment that enables the counselor to accept their client's ambivalence as normal and understandable.[25] Empathy allows the practitioner to relate with a client on a more collaborative and non-judgmental level. This, in turn, encourages the exploration of the participant's inner conflicts while evoking an emotional vulnerability that guides the client towards identifying their personal reasons, or motivation, to change.

Next, **developing discrepancy** is the process of drawing parallels between the client's behavior and their hopes for the future.[26] In practice, developing discrepancy requires the motivational interviewer to use active listening and reflections to highlight disparity between the participant's behavior, the consequences of their behavior, and their aspirations. Correspondingly, as the weight of the consequences discussed during the motivational interview become apparent, the participant willfully proposes or seeks out solutions to change their behavior and reject ambivalence.[27]

Guideline three, **avoid arguing,** reaffirms the importance of trust during MI sessions and encourages the clinician to redirect their efforts towards continuous collaboration instead of confrontation. In order to maintain the collaborative spirit of MI, the counselor must maintain their empathetic position and continue to use reflections and active listening to develop discrepancy until the consequences of the participant's

behavior influence them enough to choose change. Most importantly, avoiding arguing helps to prevent discord in communication between the clinician and their client preventing resistance and strengthening collaboration within the relationship.

The remaining guidelines—**rolling with resistance** and **support self-efficacy**—offer strategies to navigate client resistance that maintain the spirit of MI during appointments. Despite the presence of resistance and ambivalence, the motivational interviewer must view their client interactions as a shared partnership and reject the urge to apply power in an attempt to force behavior change.[28] Rolling with resistance and supporting self-efficacy are gentle reminders to the motivational interviewer that ambivalence is normal and to continuously adhere to MI during client sessions.

| Expressing Empathy | • Encourage collaboration, transparency and vulnerability |
|---|---|
| Developing Discrepancy | • Draw parallels between an individual's behavior and their hopes for the future |
| Avoid Arguing | • Reaffirm trust by listening and not confronting |
| Rolling with Resistance | • Resistance is normal, agree that change is hard but not impossible |
| Support Self-Efficacy | • Always believe in an individual's ability to change, and that they are free to choose when and how |

# MI Fidelity and Applications

## Practitioner adherence to MI is a signifant outcome driver that is imperative for participant sucess.

Practitioner adherence to MI is a significant outcome driver that is imperative for patient and participant success.[29] Although there are currently no universal guidelines that determine how often a practitioner's fidelity to MI adherence should be monitored, daily evaluations are impractical.[30] Nevertheless, as seen in a study on MI fidelity and rheumatoid arthritis, evaluating MI adherence leads to significant improvements of patient ambivalence and behavior change.[31] In response to the relationship between MI adherence and participant outcomes, and the need for a simple yet effective fidelity assessment tool, researchers at the University of New Mexico developed the MI Treatment Integrity (MITI) 4.2.1 coding tool.

The MITI coding system uses a Likert scale of 1 – 5 to rank adherence to the spirit of MI using a global rating related to overall communication ability. MITI coding also measures behavioral counts, or overall interviewer behavior, that are defined as either MI adherent (MIA), or MI non-adherent (MINA) behaviors. MIA behaviors, such as empathy, reflecting, and persuading with permission, seek to encourage a client's autonomy and strengthen their personal resolve to overcome barriers to their goals. Conversely, MINA behaviors strip away client autonomy and are identified by interviewer language that confronts the client or offers unwarranted advice (persuasion). Once global ratings and behavior counts are scaled, results are summarized into scores and the session is assigned a MI fidelity rating of low fidelity, fair (beginning competency), or good (competent).[32] Not only is MITI a critical tool to support MI clinician growth, but measuring the fidelity of MI implementation enables implementation of outcomes studies related to MI adherence.

MI implementation has been shown to support positive outcomes in individuals experiencing ambivalence to behavior change.[33] MI is particularly celebrated for its successes in a wide range of behavioral treatments. For example, nurses who attended to elderly patients with rheumatoid arthritis used MI techniques to counsel their physically inactive patients into more physically active lifestyles and consequently improved their patients' treatment outcomes over time.[34] Additionally, a meta-analysis in New Zealand explored the effects of MI treatments on males who use substances in prison before their release. Those who underwent MI treatment accompanied with cognitive behavioral therapy (CBT) to address substance use, mental health, and finance management experienced a 21% lower recidivism rate compared to the study's matched control groups after four years of their release.[35]

In a 2008 study, cardiologists from the New York Presbyterian Hospital Ambulatory Care Network collaborated with case managers to study the inclusion of MI into their treatments for income hypertensive African-Americans who faced barriers to medical adherence. For those in this study who received the additional counseling along with their cardiology visits, adherence to medication over a 12 month period increased by 57% as opposed to

the control group, which only experienced a 43% participant medication adherence rate with a 4% decrease in adherence per quarter.[36] MI applied to substance use renders similar results. A 2015 meta-analysis on substance use and MI showed that substance users who received an MI based counseling intervention had consistently negative toxicology screens as compared to their peers who received other interventions to address their substance use issues.[37]

A 2009 review of four meta-analyses that explored MI interventions for individuals navigating issues such as linkage and retention to care, medical adherence, eating disorders, and general risky behavior such as substance use determined that MI is more effective at eliciting behavior change than no intervention at all, and is especially effective when used as a pre-treatment for individuals enrolled in a long-term or inpatient program.[38] The study also determined that the more often an individual attends an MI session, there is an increased likelihood of improved behavior outcomes.[39] However, the analysis also notes that most clients experienced behavior change between 2 to 4 sessions with their service provider.[40] Three of the 4 meta-analyses, all of which focused on changing risky behavior ranging from substance use to non-disclosure of HIV status and sexual behavior, included a time study component.[41] When analyzing the 3 studies, the authors identified that MI required about 100 minutes less face time with clients in comparison to other counseling and therapeutic options, such as CBT and 12 step programs, to reach the same outcomes, indicating that MI is potentially a more cost-effective treatment tool for clinicians who have limited resources and staff.[42] Additionally, the study concluded that individuals struggling with ambivalence were able to sustain positive behavior change for 1 year with some study groups sustaining change beyond 2 years after their initial MI intervention.[43]

Fidelity to MI can significantly improve health outcomes for people experiencing chronic illness. Empirical studies on MI fidelity determined that when MI is properly executed, a client who is in the throes of a health crisis, such as a newly diagnosed PLWHA, is more likely to overcome their health-related anxiety and achieve their personal goals. In order to develop a culture of MI adherence among clinicians, health navigators, case managers and others within an organization that may frequently use MI, this paper recommends implementing MI supervisory support or "coaching" coupled with the latest version of the MITI coding manual (at publication MITI 4.2.1 Coding) which measures fidelity to MI implementation.

MITI coding with MI supervisory support promotes consistency in MI adherence. It is strongly recommended, however, that in the presence of social determinants of health ownership, the MI clinician depends heavily on communicating with empathy while prioritizing harm reduction and trauma-informed counseling techniques in order to continue building trust and to maintain their client's safety. Any MI supervisory support that includes MITI Coding should account for an MI practitioner's need to protect a client's safety at all times. This paper therefore urges that harm reduction and trauma informed counseling take precedence during an MI session in the instance the client needs linkage to intensive psychotherapeutic care.

# MI and HIV

"Henri Nouwen (2005) observed that 'anyone who willingly enters into the pain of a stranger is truly a remarkable person,' and we agree"

— William R. Miller, Motivational Interviewing: Helping People Change

**Due to MI's capacity to quickly deconstruct barriers to lifestyle change and drive long-term positive health outcomes, there is growing interest by healthcare and other human services professionals surrounding the use of MI as a therapeutic support for PLWHA.** The necessary lifestyle changes for PLWHA upon diagnosis most frequently involves linkage and retention to physical, mental, and oral healthcare; medication adherence; increasing physical activity; reduction of substance use; and safer sex practices.[44] While reluctance to lifestyle change among PLWHA is oftentimes systemic and inherently related to the societal stigma surrounding HIV, the emotional consequences of living with a positive status for PLWHA can act as health barrier.[45]

Delays in implementing necessary health changes post HIV+ diagnosis increases the likelihood of HIV-related physical and psychological complications. Physical drawbacks include, chronic inflammatory disease[46], pulmonary disorders[47] , renal failure [48], and HIV-related neuropathy[49]. Neuro-physical and mental health impairments that arise include  dementia[50], anxiety and depression. [51]  Moreover, without proper retention in care, PLWHA may struggle with managing their medication prescriptions and scheduling, eventually causing suboptimal adherence to ART.[52]

Suboptimal adherence to ART leads to critical health pitfalls, such as a viral load count greater than 200 copies/mL, which increases the likelihood of transmission, developing a resistance to ART medications, and increasing the probability of HIV-related morbidity.[53] Achieving 100% adherence to ART along with retention to comprehensive healthcare (primary care services, dentistry, mental healthcare and support services) is associated with decreased HIV morbidity and a significant improvement in quality of life for PLWHA.[54]

MI shows to be an effective intervention for PLWHA struggling with optimal adherence to ART. A 2017 meta-analysis on the effects of MI on PLWHA who inconsistently followed their ART regimen showed significant improvements to consistency in ART medication intake after 3 sessions.[55] The report also showed that when combined with therapy, such as cognitive behavioral therapy (CBT), MI can have significant impacts on ambivalence to ART adherence as opposed to therapy alone.[56] Additionally, PLWHA are more likely to overcome or seek treatment for their multifaceted sources of ambivalence to ART adherence such as depression, fear of isolation, and risky behavior (i.e. substance use, unprotected sex, etc.), when service providers use MI to elicit change.[57]

MI also demonstrates positive outcomes when addressing ambivalence across age,

gender, and race lines. MI is shown to be particularly effective for HIV+ African Americans and Latinx as the technique depends heavily on respecting shared cultural values such as autonomy, relationship, and respect.[58] African Americans make up 42% of Americans living with HIV while the Latinx population accounts for 25% of PLWHA in the United States, making MI ideal for encouraging linkage to care, status disclosure, and ART adherence among these groups.[59] Youth also respond well to using MI to encourage them to maintain ART adherence. A pilot study on MI interventions and African American urban youth living with HIV showed that 61% of study participants "enjoyed" their MI sessions more than primary care appointments alone, while positive attitude changes in favor of ART adherence and status disclosure improved respectively by 67% and 61% from pre-intervention levels. [60]

# MI, HIV, and Social Determinants of Health

> "With the recognition that the health status of a population depends on much more than health care. In particular, they stress the powerful direct and indirect effects that social factors exert. These determinants range widely: across income, education, housing, stress, social relationships, and more."
>
> — Elizabeth H. Bradley and Lauren A. Taylor, *The American Health Paradox: Why Spending More is Getting Us*

**It is important to identify that the necessary changes that PLWHA are encouraged to pursue by their care professionals are often obstructed by a multitude of barriers that can be attributed to what this paper will identify as macro-level social determinants of health ownership—social and economic factors that contribute to a person's health that are beyond their control.** These factors are influenced by the distribution of money, power, and resources throughout local communities, nations, and the world.[61]  For many of these barriers, it is recommended due to lack of empirical evidence that MI has a direct impact on complex outcomes, that it be used as a pre-treatment option in conjunction with more therapeutic treatments such as cognitive behavioral therapy. [62]

When MI is used as a pre-treatment option, it can play a critical role in supporting participants' autonomy when attending appointments and linkage to more intensive treatments and services. The following chart serves as an exploration of some systems-related barriers that may affect PLWHA, and where there has been some evidence of MI effectiveness in improving the intended intervention outcomes. They should be taken into consideration when considering if MI is an appropriate intervention for an individual. A check mark indicates that there is at least 1 peer-reviewed journal article that has evidenced the link between social determinants of health ownership and MI. The chart is not however a meta-analysis of studies conducted on the applicability of MI nor does it statistically evidence the link between social determinants of health and
MI.

| Social Determinants of Health Ownership for PLWHA | MI as Primary Treatment | MI as Pre-treatment |
|---|:---:|:---:|
| Chronic Homelessness[63] | | ✓ |
| Initimate Partner Violence[64] | | ✓ |
| Poverty[65] | | ✓ |
| Racism and Discrimination[66] | | ✓ |
| Serious Mental Illness[67] | | ✓ |
| Stigma related to[68] | | |
| - HIV+/AIDS | | ✓ |
| - Sexual Identity | | ✓ |
| - Some Mental Illnesses* | ✓ | |
| Substance Use[69] | | |
| - Alcohol | | ✓ |
| - Tobacco | ✓ | |
| - Intravenious and other clandestine substances | | ✓ |

* A 2009 study found that MI helped individuals decrease negative associations with some mental illnesses. However, MI did not help with stigma associated with serious mental illnesses such as schizophrenia[70]

Barriers to behavior change may differ depending on demographics such as age, race, gender identity, etc. For example, when assessing for age, the sources of uncertainty in one's ability to change for PLWHA can range from forgetfulness and medication palatability in young children, to depression and substance use disorders in adolescents and adults.[71] Because of social determinants of health ownership, and previous personal and historical adverse experiences with the healthcare system (i.e. the syphilis study at Tuskegee [72]), African-Americans and Latinx across gender and sexual identities may be more reticent to seek care and sustain ART adherence, citing fear of isolation and perceived negativity from their kin and service providers alike more frequently than their white counterparts.[73]

Housing insecurity and homelessness represent primary manifestations of the systems related barriers that many PLWHA face. The National HIV/AIDS Strategy for the United States 2020, for example, set the goal to reduce homelessness for PLWHA from 7% to 5% by 2020.[74] Unfortunately, homelessness for this population is trending in the wrong direction; an analysis by the Office of National AIDS Policy found that, in 2015, homelessness for PLWHA rose to 9%--a 29% increase from 2014.[75] Secure housing is imperative to successful viral load suppression as homelessness puts PLWHA at risk of disrupting the strict timing mandatory for ART adherence while also acting as a hurdle to accessing comprehensive medical care and treatment.[76] Moreover, a 2011 study on homelessness and ART adherence showed that homeless PLWHA who were injection drug users experienced an increased likelihood of sub-optimal ART adherence by 37% among homeless PLWHA compared to 25% likelihood of sub-optimal adherence among housed PLWHA who were injection substance users.[77]

As housing insecurity and homelessness are often the results of social determinants of health ownership, there is no empirical evidence that MI alone will help housing insecure and homeless individuals find and sustain housing. However, a study involving PLWHA with co-occurring mental health and substance use histories found that when patient navigators at community clinics used MI along with harm reduction and trauma-informed counseling techniques to address homelessness and other unmet needs, over two-thirds of the study participants linked to permanent supportive housing were able to maintain strict 100% adherence to medication. Study participants also successfully achieved viral load suppression within 12 months of study enrollment.[78] It is important to note, however, that this study prioritized harm reduction and trauma-informed counseling techniques due to the presence of serious mental illness (SMI) and long term substance use in the study population.[79] It is equally imperative to highlight that, due to structural factors such local housing affordability, 40% of the study's participants linked to housing were unable to retain long-term housing.[80] These individuals required intensive long-term support, including MI, from patient navigators to ensure that they prioritized their personal health ownership and maintained medical adherence to the best of their abilities in light of their housing troubles.[81]

Intimate partner violence (IPV) is another example where MI can have a critical impact on supporting victims/survivors to seek supportive services. According to a 2014 report by the CDC, people who experience IPV are more likely than those in healthy relationships to be at risk for HIV.[82] The CDC also reported that 55% of American women who have HIV are also in a relationship with an abusive partner.[83] While MI is not empirically proven as a successful singular intervention for IPV[84], MI does provide individuals at the intersection of HIV and IPV

support when navigating important health decisions, such as condom negotiation, that heighten the probability of contracting or transferring HIV.[85] MI also shows promise for addressing uncertainty surrounding HIV testing or PreP initiation for those experiencing IPV who are at risk of HIV.[86] Additionally, a 2018 study identified that although MI is not effective or recommended for supporting victims of IPV to leave their partners, it is recommended as a tool to support some victims to pursue more intensive and long-term therapy strategies such as CBT to address both the drivers and impacts of abusive relationships, as both prevention and treatment.[87]

The line between behavior change and social determinants of health ownership can at times seem invisible. **For PLWHA, however, understanding the history of stigma associated with HIV should be a MI practitioner's signal that an individual is indeed battling against structural barriers to care and should consider using MI in conjunction with other tools in their intervention toolbox and ensure that:**

- **All use of MI is driven by the client.**

- **In the interest of a client's safety, harm reduction and trauma-informed interventions take precedence.**

- **MI, above all, is used as a communication tool; it is not therapy or a cure. If a client needs a profound therapeutic intervention, MI can be used to link them to care, but may not be effective alone to address a complex issue**

Behavior modification is the goal of MI as long as it is the individual, not the practitioner, who determines the change they desire. This paper encourages practitioners to consider the very real presence of social determinants of health ownership and adjust the application of MI as well as the evaluation of MI adherence through MITI when an individual presents challenges related to structural barriers to their change goals. **When tackling systems level barriers to an improved quality of life, MI should be used as a support tool combined with other techniques and applied only to encourage transparency surrounding their unmet needs so that their care team can link them to additional services at the onset of hardship.**

# Summary

**"Motivational interviewing will thrive where there is a community of practice that's got a different set of cultural values running through it. The main idea is to fit systems around people not people into systems."**

- Stephen Rollnick, Motivational Interview, speech at the College of Medicine, Cardiff College

While MI was initially intended as an intervention tool to help individuals suffering from substance use, it has crossed over into the fields of housing and employment retention, recidivism reduction, education, and healthcare. **MI is best viewed as a complex communication skill that provides an immediate intervention to equip individuals to overcome indifferences to a pressing personal change.** As a tool, MI is effective at addressing a specific prob-lem that requires a lifestyle adjustment that an individual has the ability to accomplish, but is reluctant to do so.[88]  In particular, **MI should not be offered as a singular psychother-apy service, particularly for those under the weight of social determinants of health as MI helps individuals achieve their best results when it is introduced as a first step to change and combined with other therapeutic treatments.[87]**

The success of MI rests in the spirit of MI, which embodies compassion, partnership autonomy, acceptance, and respect for individuals stuck in the throes of difficult decision making. [89] When engaging individuals who are facing structural barriers to their personal goals, MI can act as a bridge that connects them to resources that provide additional sup-port against systems-induced social barricades. As this paper explored, PLWHA is one such group that can benefit from MI support in order to achieve 100% ART adherence, re-duced viral load, and linkage to care, especially when there are accompanying healthcare options presented as well, including psychotherapy service. [90] In doing so, PLWHA can expect an increased quality of life both emotionally and physically.

Endnotes

1          Youth Transition Program. (2015). The spirit of motivational interviewing [Blogpost]. University of Oregon, Available here.

2          Corwin, M. (2017, April). Motivational interviewing and HIV: A guide for navigators. Colorado AIDS Education and Training Center, Available here ;George, S., Garth, B., Wohl, A. R., Galvan, F. H., Garland, W., & Myers, H. F. (2009). Sources and types of social support that influence engagement in HIV care among Latinos and African Americans. Journal of health care for the poor and underserved, Vol. 20(4), 1012–1035.

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