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The Effect of Motivational Interviewing on Medical Adherence In the Homeless Population

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Background:
New methods of improving medical adherence in the homeless population are important because, in addition to overall health, this population incurs higher than average costs in hospitalizations and medical treatment, disease rates, incarceration, police intervention, and emergency shelter expenses (“Cost of Homelessness” n.d.).

Motivational Interviewing (MI) is a communication technique that could aid in improving medical adherence in this population, but requires further research.

- Avg. life expectancy of chronically homeless individuals is 60 yrs (vs. avg. 80 yrs)
- The homeless individual incurs a $44,400 add'l annual medical expenditure
- Homeless individuals make up 80% of ED visits
- The avg. homeless individual stays in the hospital 4 days longer ($2,500 + add'l cost)

What Is Motivational Interviewing?
MI is a semi-directive, therapeutic method that aims at reversing ambivalence while aiding the patient in reaching conclusions on how to overcome obstacles in their way to ideal/higher functioning. It is a client-centered approach that involves counseling to elicit behavioral change in a non-confrontational manner.

This analysis identified a clear gap in the current peer-reviewed and relevant research on the effect of MI on adherence in homeless population in particular.

OBJECTIVE
The purpose of this paper is to conduct an integrative literature review to determine if MI is effective in improving medical adherence in the homeless population.

Research Question
1. Does motivational interviewing improve medical adherence in the homeless population?

METHODS
An integrative review of the literature, was performed using the databases Cumulative Index of Nursing and Allied Health (CINAHL), Proquest: Nursing & Allied Health, PubMed-NCBI and Google Scholar. The Boolean terms included “adherence” OR “non-adherence” or “compliance” with a sub-search of “homeless” and “motivational interviewing”.

Key Words: integrative review, patient outcomes, homeless, compliance, adherence & non-adherence, motivational interviewing

RESULTS

Figure 1. Analysis of adherence and the homeless

<table>
<thead>
<tr>
<th>Authors</th>
<th>Purpose</th>
<th>Sample</th>
<th>Results</th>
<th>Relevance to this Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auger et al., 2016</td>
<td>Reduce/predictors/barriers to blood pressure control in homeless hypertensive adults</td>
<td>Random sample of among homeless and non-homeless hypertensive patients from 10 NYC shelter-based clinics 210 total participants/43% homeless, mostly male</td>
<td>40.1% of homeless patients have uncontrolled blood pressure &amp; lack of insurance was associated with inadequate blood pressure control</td>
<td>Medical non-adherence related to blood pressure control and lack of insurance. Lack of health insurance and being homeless negatively affected high blood pressure control.</td>
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<tr>
<td>Garden et al., 2013</td>
<td>Evaluate impact of food incentives on adherence in homeless TB patients</td>
<td>Homeless patients of TB department 132 men and 108 women, mean age of 48</td>
<td>Food incentive had a strong positive effect on adherence (95%) compared with control (31%); other incentives like social work support also contributed to adherence increases</td>
<td>Nursing analysis of factors effecting medical adherence in homeless. Food and social support increased adherence.</td>
</tr>
<tr>
<td>Rapal et al., 2009</td>
<td>Investigation of factors associated with adherence to HIV/AIDS medication in the homeless population</td>
<td>358 homeless/ unstably housed HIV/AIDS positive people across three US cities</td>
<td>Depression and high perceived stress associated with poor adherence. Negative attitudes towards treatment &amp; factors like problems accessing healthcare and high rates of mental illness also associated with low adherence</td>
<td>Analysis from field of AIDS medical care analyzing factors associated with adherence in HIV/AIDS homeless. Stress and depression negatively affected adherence.</td>
</tr>
</tbody>
</table>

Figure 2. Analysis of MI and adherence

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Russell et al., 2011</td>
<td>Examine feasibility/efficacy of staff delivered MI to affect on dialysis adherence</td>
<td>29 participants from a non-profit, free-standing hemodialysis clinic in the US</td>
<td>MI positively affected attendance, frequency of shortened visits, blood panels scores not significant however trend in direction of improvement in autonomy support was.</td>
<td>Nursing analysis of MI effects on dialysis adherence. Group experienced better outcomes in treatment.</td>
</tr>
<tr>
<td>Sava An et al., 2016</td>
<td>Evaluate the effect of group MI (GM) on substance abuse treatment engagement in homeless veterans</td>
<td>37 primary alcohol and drug dependent, cigarette smoking homeless veterans with co-morbid psychiatric conditions</td>
<td>Overall substance abuse declined in both GM groups over time, the tobacco focused GM group experienced greater decline innicotine use than the general GM leading researchers to conclude both general GM and targeted GM are useful in changing behaviors in this patient population. MI was seen as significantly improved pain intensity/self-efficacy, anxiety, happiness and mobility compared w/ control which only improved in happiness rating.</td>
<td>Analysis from field of medicine comparing effect of general GM and tobacco targeted GM in homeless veterans with co-morbidities. MI helped produce better-outcomes for patients when targeted on one substance specifically and when general/non-targeted MI was used.</td>
</tr>
<tr>
<td>Tsai Young &amp; Tang, 2013</td>
<td>Examine effectiveness of MI and exercise on pain, function, quality of life, self-efficacy and compliance in (non-homeless) older persons with chronic pain</td>
<td>56 randomized older persons with chronic pain recruited from two elderly community centers in Hong Kong; sample contained similar demographics.65 + years old, with chronic pain for three + months</td>
<td>75 veterans previously waitlisted for a residential treatment program, randomized to received either a single MI session or a standard intake interview</td>
<td>95% of MI group participants entered treatment. Compared with 71% in the visit group, the MI group remained in treatment longer, and had higher rates of program completion/graduation rates.</td>
</tr>
<tr>
<td>Vran et al., 2011</td>
<td>To assess the effectiveness of MI in homeless, unemployed, substance-dependent veterans</td>
<td>56 homeless, unemployed, treatment-eligible, substance-dependent veterans</td>
<td>95% of MI group participants entered treatment, compared with 71% in the visit group. The MI group remained in treatment longer, and had higher rates of program completion/graduation rates.</td>
<td>Public health analysis of the effect of MI in treatment adherence, entry and completion for substance addicted homeless veterans. The group treated with MI experienced better adherence and outcomes.</td>
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</tbody>
</table>

DISCUSSION

There is a clear gap in the research surrounding the effectiveness of MI and the homeless population in particular. Themes linked to medical non-adherence in the homeless population are lack of insurance, lack of interconnected social support, stress and depression/mood disorders and substance abuse. While access to food, social support, clear education/understanding surrounding the importance of adherence, and positive attitude fortification are linked to improved adherence rates in this population. Motivational interviewing is shown to increase feelings of social support, enhance communication efforts, foster self-efficacy and positive attitudes among other benefits. Therefore, the inclusion of MI to enhance adherence in this population is worthwhile and warrants further research.

IMPLICATIONS FOR NURSING
Nurses will inevitably encounter homeless individuals over the course of their career and are particularly suited to be able to enhance medical adherence given their trusted standing within communities and close patient interaction. Despite these facts, physicians are more likely to trained in the tool of motivational interviewing than nurses. This review concludes nurses and patients would experience mutual benefits from incorporation of MI training in nursing school curriculums and in on the job training. The literature analyzed suggests nurses can best implement MI into their practice when they feel supported in doing so, maintain a positive attitude towards change, show interest in the method and do so in appropriate setting/circumstances (private environment, with patients of limited co-morbidity, in non-acute situations etc).

CONCLUSIONS

Conclusion: Research on MI across the fields of nursing, medicine and public health supports its potential usefulness as a tool for improving medical adherence within the homeless population. Further research on the potential benefits of this tool with the homeless is recommended.