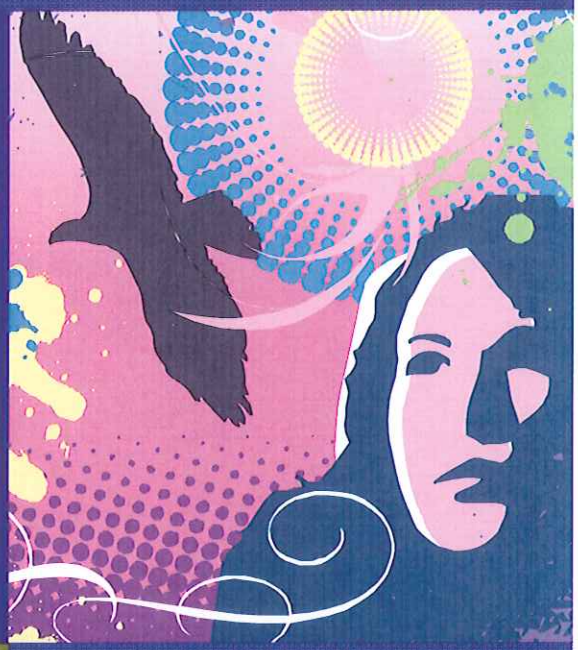
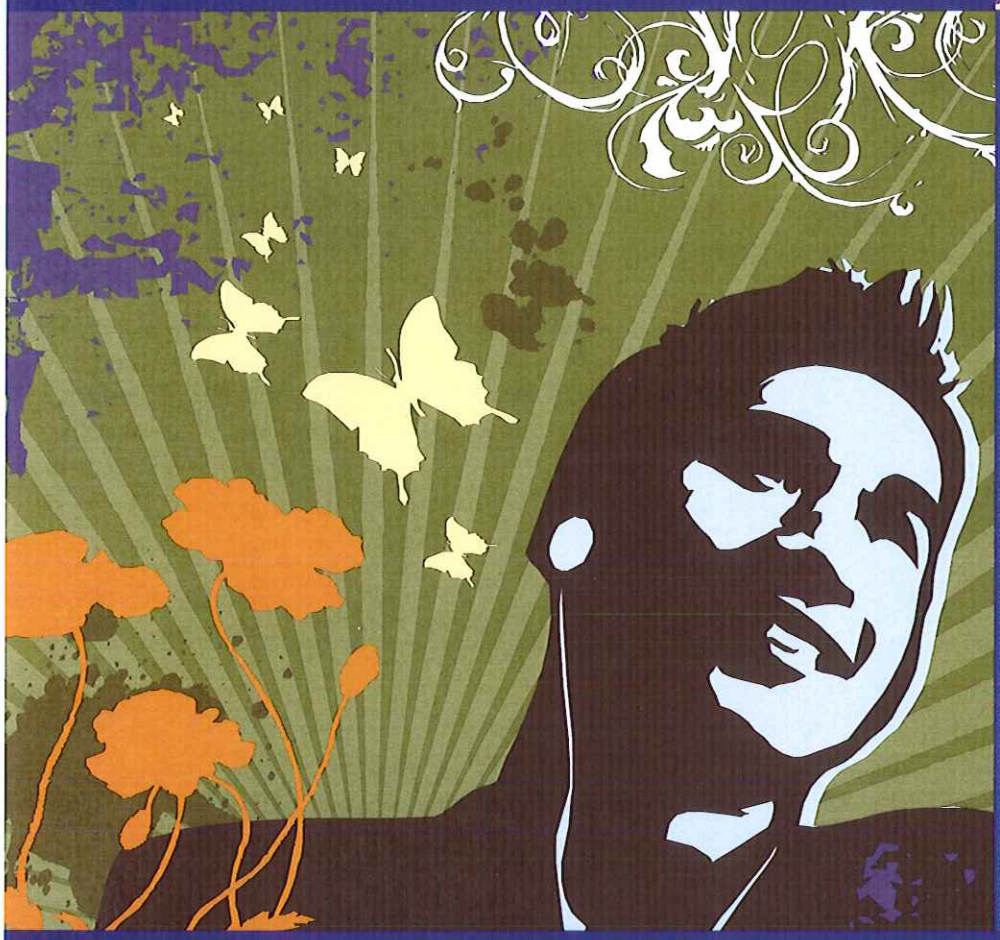
The Los Angeles Transition Age Youth Service Integration Project





Project Blueprint

A Step-By-Step Guide

Presented by:

WESTSIDE REGIONAL CENTER

NORTH LOS ANGELES COUNTY REGIONAL CENTER

LAC DMH

DDS

Westside Family Resource and Empowerment Center
LA County Inclusion Partnership

Sponsored by the Mental Health Services Act (MHSA) in partnership with the California Department of Mental Health and Department of Developmental Services

Section 1

Introduction

Table of Contents

Background

The period of adolescence to young adulthood (14-25 years) is a critical time for youth as they experience significant changes to their environment – transitioning from school to post-secondary education or work, from the pediatric to the adult health care system, and from dependence on family support to living independently, while also managing their own health and developing adult relationships. In the general population, transition age youth (TAY) are at particularly high risk for mental disorders due to the stress involved in the multiple life changes.[1,2]

The risk for mental health disorders may be especially high among TAY with developmental disabilities due to increased social and cognitive demands in relation to abilities, problem-solving challenges, and communication limitations.[3] However, mental health conditions in TAY with developmental disabilities may not be easily diagnosed since these disorders often overlap with the normal emotional and behavioral turmoil of adolescence. They also may be underestimated by health professionals due in part to diagnostic overshadowing or attributing any challenging behaviors to clients' developmental disabilities.

As TAY age out of child-targeted systems of care, they frequently face a loss of services or have difficulty managing developmentally-appropriate care in the adult medical or mental health systems. Many times, families are overwhelmed by the number of agencies that they must learn to navigate and describe frustration with systems that often provide conflicting information and insufficient resources for youth with varying intensity of service needs. They also describe the need for education outreach and training for families and service providers to address these service gaps, as well as the emotional challenges that are associated with this period of transition.

With this knowledge and Mental Health and Services Act (MHSA) funding from the California Department of Developmental Services, the Los Angles Transition Age Youth Service Integration Project (LA TAY SIP) was established in 2011 to identify address the needs of transition age youth with developmental disabilities and with or at risk for co-occurring mental health disorders (dual diagnoses). This project blueprint provides an overview of the LATAY SIP, including outline of program steps used in developing and implementing the program.

We hope that the information presented in this manual will provide a useful training model for anyone interested in replicating our project in order to promote and enhance the well-being of *youth with dual diagnoses.* Please do not hesitate to contact the Project Director, Alicia Bazzano, MD, PhD, at aliciab@westsiderc.org for further information.

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[1] Davis M, Vander Stoep A. The transition to adulthood for youth who have serious emotional disturbance, Part I: Developmental transition and young adult outcomes. J Mental Health Admin. 1997; 24 (4): 400-427.
[2] Vander Stoep A, Davis M, Collins. Transition: A time of developmental and institutional clashes. In H.B. Cark and M. Davis (Eds), Transition to adulthood: A resource for assisting youth people with emotional or behavioral difficulties (pp. 3-28). Baltimore: Paul H. Brookes
[3] Kerker BD, Owens PL, Zigler E, Horwitz SM. Mental health disorders among individuals with mental retardation: Challenges to accurate prevalence estimates. Public Health Rep. 2004 Jul-Aug; 119(4): 409-417.

What is the LA TAY SIP?

The Los Angeles Transition Age Youth Service Integration Project (LA TAY SIP) focused on multidisciplinary approach to foster long-term interagency collaboration, service coordination, person-centered planning, and the creation or enhancement of safety-nets to support youth and their families during the time of transition between child and adult services. The goals of the program included conducting a targeted needs assessment and an outreach and intervention program for those who work with transition age youth with dual diagnoses in Western and Northern Los Angeles County.

The project was developed and implemented by Westside Regional Center, in partnership with North Los Angeles County Regional Center, Los Angeles County Department of Mental Health, and Westside Family Resource and Empowerment Center.

Section 2

Program Implementation

Program Steps

The Los Angeles Transition Age Youth Service Integration Project (LA TAY SIP) was established in 2011 to identify and address the needs of youth with dual diagnoses. We focused on improving the fragmented system of care by enhancing communication and collaboration between key stakeholders in all systems of care interfacing with youth in Los Angeles County.

The project fostered understanding of (1) how each agency's responsibilities fit with work performed by other agencies; (2) how to establish sustainable, multidisciplinary, interagency collaboration to increase coordination and continuation of care; (3) how to create a specific and detailed TAY needs assessment to develop targeted outreach and services for TAY and their families, and lastly (4) how to assist families and providers in cross-systems navigation.

The development of LA TAY SIP included the following program activities:

Step 1	*Establish the Task Force*
Step 2	*Conduct Needs Assessment*
Step 3	*Develop Program Interventions:* ❖ *Community Training* ❖ *TAY Collaborative* ❖ *Resource Directory*

Please see Appendix A for LA TAY SIP Timeline.

Step One: Establish the Task Force

LA TAY SIP was overseen by a Dual Diagnosis Collaborative Task Force, which included approximately 10 representatives from each stage of the service delivery configuration among both the mental health and developmental disabilities systems of care and throughout the Los Angeles County. In addition, we reached out to systems which provide services to transition age youth including Los Angeles Department of Education, Department of Child & Family Services, Department of Rehabilitation, the Department of Probation, as well as other organizations and agencies identified in our needs assessment. The Task Force also included family members so as to reinforce the concepts of client/family-driven mental health and community-based participatory research and programming.

Step Two: Conduct Needs Assessment

WRC, in collaboration with NLACRC, implemented a local needs assessment for TAY (14-25 years of age) in the western and northern areas of Los Angeles County. This two-phase assessment allowed us to build a broad profile of common demographic, diagnostic, and service factors for TAY. It allowed us to develop a profile of TAY, describe what services are utilized most frequently, and identify the needs and strengths of this population, and the barriers faced when transitioning to adulthood. Additionally, the assessment allowed us to identify community partners who regularly work or are involved with dually-diagnosed TAY. The assessment included two phases:

Phase I

The first phase included generating data from SANDIS, the electronic case-management system used by regional centers throughout the state of California. This allowed us to estimate the number of TAY with dual diagnoses receiving services from Westside Regional Center (WRC) or North Los Angeles County Regional Center (NLACRC). Recognizing that this information may be incomplete, we also asked service coordinators to confirm the SANDIS records. From the total population of clients dually diagnosed and served by WRC, we randomly selected 400 cases to gather additional information beyond what was available in the electronic database on diagnoses, visits to mental health professionals, medication use, hospitalization, and demographic characteristics. This information was obtained from paper charts.

Please see Appendix B for the Chart Abstraction Tool.

Phase II

Quantitative data abstracted from charts were augmented with qualitative data from key informant interviews in order to have a more comprehensive understanding of TAY needs. A total of 22 individuals were recruited and interviewed (18 females and 4 males), including representatives from Los Angeles County developmental disability, medical, mental health, and education communities. The informants were selected purposively to ensure a variety of representatives from systems utilized by dually diagnosed TAY. In addition, snowball sampling, a strategy whereby participants help identify other potential interviewees, was used to recruit additional informants. An adequate sample size was determined when interviewee responses became redundant (i.e., we reached a point of content saturation). The final sample consisted of psychologists, physicians, program managers, education specialists, parents and client's rights advocates involved in transition services for youth.

The interviews were semi-structured, in-depth, and guided by open-ended questions. Except for four telephone interviews, all sessions were face-to-face. Most interviews lasted 45 minutes (range of duration: 30-60 minutes). Twelve open-ended questions about the needs and barriers faced by TAY, their families and service providers as youth enter adulthood guided the interviews.

Please see Appendix C for the Key Informant Interview Guide.

One member of the research team took and transcribed notes. The notes were analyzed in detail to identify common ideas and beliefs across the range of key informants. This process consisted of a series of steps:

1) After reading the text for a specific question, the main idea(s) of a particular interview response were summarized in short phrases which we refer to as "codes" (e.g., confusion about role of regional center versus school districts; differences in eligibility across systems; lack of efficient care coordination).
2) Conceptually similar codes were organized into one or more larger categories (e.g., Difficulty Managing Different Systems; Communication & Collaboration)
3) Likewise, substantively similar categories were grouped into higher-order themes that captured the essence of a collection of interview responses (e.g., Cross-system Communication & Collaboration)

Two members of the team individually coded all of the responses; they then reviewed and discussed the codes, resolving any disagreements about the appropriateness of a code assignment or code definition (i.e., paraphrasing of the interview response). Collectively, the research team members grouped the codes into categories and higher-order themes.

Please see Appendix D for the Sample of Codes, Categories, and Themes.

Step Three: Develop Program Interventions

Based on information gathered from our needs assessment, we developed interventions focusing on addressing the needs of TAY and service providers supporting them. The first intervention was a series of trainings for service providers/counselors/educators from regional centers, mental health agencies, and schools that focused on Motivational Interviewing (MI). The second intervention included establishing a TAY Collaborative, and the third intervention focused on developing an online TAY Resource Directory.

First Intervention – Community Training

It was clear from the needs assessment that communication and engagement between families, service providers and case managers could be improved. Family engagement, acceptance of change, and follow-through on recommendations were cited as challenges during the transition process. The families described that a better fit between the general resources offered and their own family situation was needed. The service professionals described that improved motivation and willingness to change would assist TAY and families through the challenging time. Thus, the overall goal of these trainings was to equip participants with skills in using a new, effective communication technique with TAY and their families. Since motivational interviewing (MI) is an evidence-based, client-centered communication method that helps elicit change in someone and improve engagement, it was an ideal technique for enhancing the relationships between providers and families and improving transition outcomes.

MI began in the 1980s with Bill Miller, PhD in the area of alcohol treatment and it is used widely across diverse fields (e.g. healthcare, mental health, social work, education, criminal justice, etc.). Through MI, service providers/counselors/educators can help TAY and their families to be more active in transitioning from school to work, selecting day programs, addressing independent or supported living, obtaining adult medical insurance, etc. MI can improve family-case manager cooperation, help to set the agenda for change, and increase motivation of TAY and their families, which may produce better outcomes along the path to adulthood.

The MI trainings events were held at Westside Regional Center (WRC) and North Los Angeles County Regional Center (NLACRC). Each training event comprised of two 8-hour sessions. There were seven sets of two-day trainings. Liz Barnett, PhD, who is a certified MI trainer, consultant, university researcher, and a member of the Motivational Interviewing Network of Trainers since 2005, led these sessions. Guided by findings from our needs assessment and mentoring from Task Force members, Dr. Barnett tailored the MI curriculum for the needs of our TAY clients. Prior to the trainings, Dr. Barnett spent time with clinical staff, client services staff and families, and participated in transition meetings in develop trainings that would be specific to the needs of transition age youth with or at risk for dual diagnoses.

Please see Appendix E for the Training Materials.

The curriculum included the history of MI, key components of MI skills (e.g., asking open-ended questions, providing affirmation, and using reflective listening), and ways of dealing with discord among clients and their family members. Special emphasis was placed on disengagement, which can be a particularly important sign of discord among TAY. During the training, participants engaged in group-work and role-plays, where they applied newly learned skills to real life scenarios/case studies. Some of the case studies presented included helping families attend transition fairs, find a new health care provider, utilize regional center services offered such as respite, mobility training, day programs, etc. Participants tried to guide the family towards engaging in specific behaviors rather than direct or follow them using the skills including reflective listening, eliciting readiness or interests, addressing discord, and providing clear information and feedback for the family).

All attendees were asked to complete a pre-training questionnaire about MI knowledge, perceived ability, willingness, and self-efficacy on Day 1, a post-training questionnaire on Day 2, and a follow-up evaluation three to six months later to assess retention.

Please see Appendix E for the Training Evaluation Materials.

Separate codebooks were created for the pre-training, post-training and follow-up questionnaires. The codebooks listed all of the questions from each questionnaire and assigned each question a label that was used when entering the data. One person entered all the data into an Excel spreadsheet, while a second person reviewed the spreadsheet and checked for discrepancies between the data on the spreadsheet and the questionnaire. After entering and double-checking the spreadsheet, the data were analyzed using statistical software (e.g., Excel, Stata, SPSS). Along with other statistics, the average response for each question was calculated and the change in response from Day 1 to Day 2 and from Day 2 to follow-up was assessed.

Second Intervention – TAY Collaborative

The needs assessment also revealed a greater need for efficient collaboration and communication between local systems of care. Hence, the second component of LA TAY SIP was to build the TAY Collaborative, including vital constituents working in the areas of mental health, developmental disabilities, education, and other social services.

We created the TAY Collaborative based on a model currently used in Santa Clarita and North Los Angeles – The Interagency Committee, which aims to connect clients with comprehensive and integrated services for dually diagnosed or dually served individuals. The Collaborative provided a setting for knowledge and skill transfer between agencies and was used to increase continuation of care and, ultimately, contribute to improved outcomes for TAY and their families living in our community. In order to streamline communication, our partnering agencies identified TAY Navigators as a point of contact for the other agencies. The multi-disciplinary members of the TAY Collaborative originally met quarterly and now meet monthly

to provide coordinated case management for TAY across agencies. They discussed and offered solutions for intervention and crisis prevention of TAY who had been referred to the collaborative. For each TAY case discussed, the Collaborative members produce a plan for coordinated intervention, identify point persons from each agency responsible for service provision, and provide a data for reconvening and reviewing the case outcomes.

Third Intervention – Resource Directory

Finally, this project created a TAY Online Resource Directory that provided information about organizations, services and other resources pertaining to the needs of individuals with developmental disabilities and mental health conditions. The resource directory was specifically for TAY, families, caregivers, case managers, agency personnel, and others who interact with TAY. It was intended to be an organized, user-friendly, culturally-appropriate guide to services in the area. In addition to a basic description of each organization or resource, it included names, contact information, types of insurance accepted, languages spoken, and specialties of local transition supports, if available. The directory focused on domains (e.g., housing, transportation, etc.) identified in the needs assessment as the most important and hardest to navigate. In order to produce a document that could be easily updated and publically available, we produced the directory primarily as an online version. The information was disseminated via the program website, http://www.reachacrossla.org/LATAYSIP.aspx.

Section 3

Conclusion

Lessons Learned and Next Steps

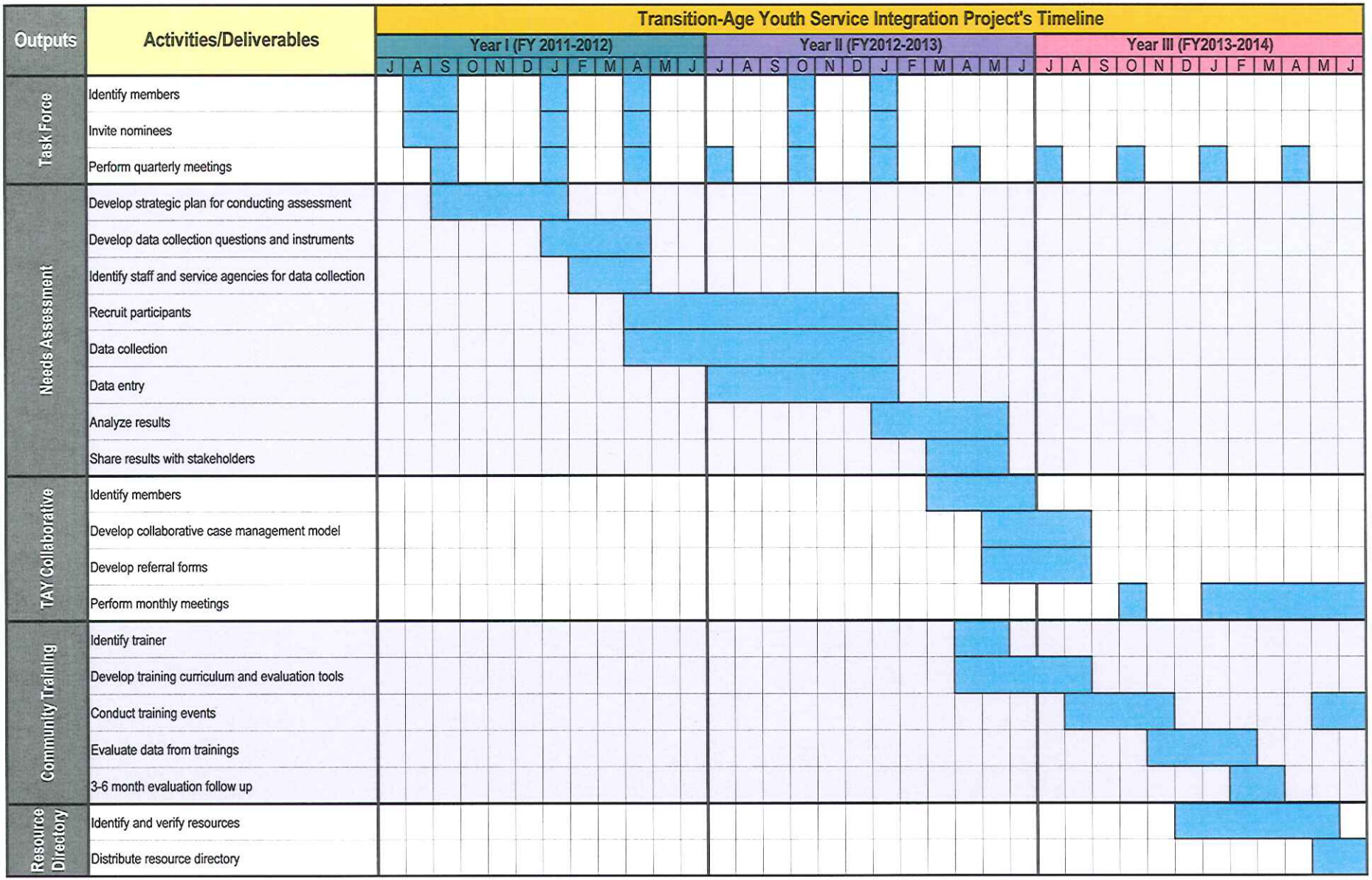
The following major lessons emerged from this project:

❖	*Conducting a needs assessment of TAY benefits from a collaborative approach, which assists with recruitment of responders, shapes the questions asked, and positively impacts sample size (thereby improving validity of the data).*
❖	*Development of training objectives utilizing community-based participatory research principles ensures that training activities continue to meet the needs of the community.*
❖	*Involving community stakeholders from the very beginning of the project ensures that they are part of the critical process of determining overall project objectives, activities, and expected outcomes. We have learned that it takes a long time to build lasting inter-system relationships and fostering these relationships is key to successful interventions.*

The LA TAY SIP successfully increased the knowledge, efficacy, and communication skills among service providers working with youth in the fields of education, developmental disability, and mental health. Although reaching these providers was a necessary first step in addressing needs of youth and their families, future interventions could work directly with youth focusing on direct psycho-educational services in local wellness/drop-in centers. Additionally, continuation of the work done by the TAY Collaborative would be advantageous because it provides direct support for youth with developmental disabilities who have or are at risk for co-occurring mental health conditions.

Appendix A

Timeline


Outputs
Activities/Deliverables
Transition-Age Youth Service Integration Project's Timeline
Year I (FY 2011-2012)
Year II (FY2012-2013)
Year III (FY2013-2014)
J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
Task Force
Identify members
Invite nominees
Perform quarterly meetings
Needs Assessment
Develop strategic plan for conducting assessment
Develop data collection questions and instruments
Identify staff and service agencies for data collection
Recruit participants
Data collection
Data entry
Analyze results
Share results with stakeholders
TAY Collaborative
Identify members
Develop collaborative case management model
Develop referral forms
Perform monthly meetings
Community Training
Identify trainer
Develop training curriculum and evaluation tools
Conduct training events
Evaluate data from trainings
3-6 month evaluation follow up
Resource Directory
Identify and verify resources
Distribute resource directory

Appendix B

Chart Abstraction Tool

Chart Abstraction Tool

Data abstracted on: _____ by: _____

Client Last Name: _____ **Client First Name:** _____

UCI #: _____ **Service Coordinator:** _____

DOB: _____ **Age:** _____ **Gender:** ☐ 0 Male ☐ 1 Female **Zip Code:** _____

Marital Status: ☐ 1 Single ☐ 2 Married ☐ 3 Common Law ☐ 4 Separated ☐ 5 Divorced ☐ 6 Widowed

Residence Type: ☐ 1 Family home ☐ 2 Independent/supported living
☐ 3 CCF ☐ 4 ICF-DDN ☐ 5 ICF-DDH ☐ 6 SNF ☐ 7 Foster Care ☐ 8 Other _____

Language: ☐ 1 English ☐ 2 Spanish ☐ 3 Other

Ethnicity: ☐ 1 Caucasian ☐ 2 African-American ☐ 3 Hispanic/Latino ☐ 4 Asian
☐ 5 Pacific Islander ☐ 6 Native American ☐ 7 Other/Mixed ☐ 8 Unknown

Medical Payers: ☐ 1 MediCal ☐ 2 MediCare ☐ 3 Private ☐ 4 Self Pay ☐ 5 Unknown ☐ 6 Other: _____

Developmental Disability Dx: ☐ 1 CP ☐ 2 Epilepsy ☐ 3 Autism ☐ 5 Other: _____
☐ 4 MR (*If yes:* ☐ 1 Mild ☐ 2 Moderate ☐ 3 Severe ☐ 4 Profound ☐ 99 Undetermined)

Has PDD? ☐ 1 Yes

Mental Health Dx: (1) _____ (2) _____

Date: _____ (3) _____ (4) _____

CDER Disagreement: ☐ DD Dx ☐ MH Dx **[IF ANY BOX IS CHECKED, MARK FOR FOLLOW-UP]**

Primary Inclusion/Exclusion criteria		
Takes behavior-modifying drugs or psychotropic medications **CDER Disagreement:** ☐ Meds	☐ 1 Yes ☐ 1 Anti-psychotic Med: _____ Ind: _____ Med: _____ Ind: _____ ☐ 2 Anti-depressant Med: _____ Ind: _____ Med: _____ Ind: _____ ☐ 3 Mood stabilizer Med: _____ Ind: _____ ☐ 4 Anti-epileptic Med: _____ Ind: _____ Med: _____ Ind: _____ ☐ 5 Stimulant Med: _____ Ind: _____ ☐ 6 Anti-anxiety Med: _____ Ind: _____ ☐ 7 Sedative Med: _____ Ind: _____ ☐ 8 Other Med: _____ Ind: _____	☐ 0 No
Has been seen by a mental health professional in the last 3 years *(NOT for purposes of evaluation)*	☐ 1 Yes ☐ 1 Psychiatrist ☐ 2 Other (Psychologist, MFT, therapist, etc)	☐ 0 No
Had hospitalization due to MH issues in the last 3 years	☐ 1 Yes ☐ 1 In the last year?	☐ 0 No

Other info:

_____

_____

_____

_____

Appendix C

Key Informant Interview Guide

Transition-Age Youth Service Integration Project
Key Informant Interviews

Target Audience: (1) Youth and Families, (2) Service Providers, Coordinators, Administrators

Goal: To learn about needs and barriers faced by transition-age youth, their families, and service providers as youth enters adulthood

Definitions:
Transition-age Youth (TAY) – youth ages 14-25 dually diagnosed with developmental disability and mental health disorders

Systems of services – agencies serving youth with developmental disabilities and/or mental health conditions including but not limited to Regional Centers, Department of Mental Health, Education System, Medical Insurance Companies, Juvenile Justice System.

Questions:

1. What are the most pressing issues for youth and their families as they enter adulthood?
2. Are there any special needs that are not being met or are being met inadequately?
3. What domains of transition to adulthood would you identify as the most challenging for youth and their families?
    a. Education
    b. Employment
    c. Health care (mental and physical care)
    d. Housing
    e. Transportation
    f. Social/Recreation/Community life
    g. Finances
    h. Body awareness (e.g. personal safety, sexuality, dating, hygiene, etc.)
    i. Accessing or navigating services (e.g. healthcare, DMH, RC) or handoff of youth to adult services within healthcare, DMH, RC.
4. From the 9 domains mentioned, could you identify the 3 most challenging during the transition process?
5. What are the barriers to services for youth and their families?
6. What are the barriers to providing or coordinating services for youth?
7. What are the strengths, weaknesses, and gaps in the systems of services for TAY?
8. What skills and knowledge do youth, their family, and service coordinators need to support their transition to adulthood (or to have successful transition to adulthood)?
9. How would they best learn these skills and knowledge? (e.g. trainings, webinars, apps for the phones, interactive computer trainings, printed materials, resources)
10. What partnership or collaborations have you or your organization found most beneficial in providing services and support for TAY and their families?
11. What ideas for changes do you have that would improve the transition services?
12. Are there people or groups you believe we should be talking to about the needs of TAY? Who are they?

Appendix D

Sample of Codes, Categories, and Themes

Sample of Codes, Categories, and Themes from Key Informant Interview

Thematic Codes & Categories	Count
Cross-system Communication and Coordination	
Communication & Collaboration	
Lack of Communication/Collaboration of Systems (Service Coordination)	18
Coordination Between Schools & Regional Centers	1
Lack of efficient care coordination	1
Strength: Communication/Collaboration Between Systems is Improving	1
Funding Challenges	
Lack of Funding	7
Weakness: blended funding	1
Difficulty Managing Different Systems	
Confusion about Role of Regional Center & School Districts	1
Differences in Eligibility for Services	1
Difficulty Managing Different Systems	1
Weakness: differences in diagnostic criteria	1
Weakness: differences in philosophy of DD and MH systems	1
Weakness: differences in terms used e.g. intervention	1
Weakness: gaps between services offered by different systems	1
Weakness: lack of knowledge about eligibility criteria and services offered by different systems	1
Weakness: limited eligibility for RC services during school years	1
Miscellaneous	
Agencies are Overwhelmed with Referrals	1
Lack of financial incentives for care providers	1
Providers Lack Skills Navigating System	1
Strength: Having a Regional Center	1
Strength: Venders Working AB Services	1
Weakness: lack of consistency in transition services offered by school	1
Weakness: wrap around services	1
TOTAL	**45**

Theme →
Category →
Code →

# of times a response with this code was given by key informants

Appendix E

Training Materials

Motivational Interviewing:
A Tool to Engage Transition-Age Youth & their Families

Facilitated by Liz Barnett, MSW, PhD

Want to keep families on track to accomplish important transition milestones?

Want to help keep families out of crisis during the transition years?

Want to help your families be ready for the changes to come?

Then Motivational Interviewing (MI) is the tool for you! Motivational Interviewing is an evidence-based, client-centered communication tool that helps elicit and resolve ambivalence to behavior change. Motivational Interviewing will help you to encourage transition-age youth (TAY; age 14 to 26) with developmental disabilities and their families to be as active as possible in transitioning from school to work, day programs, independent or supported living, adult medical insurance, etc. Improved communication with families and increased motivation of TAY during the transition process will produce better outcomes along the path to adulthood.

Don't wait – Sign up today!

Register online for ONE of the 2-day, all-day training session for WRC service coordinators and program managers. Attendance at ***BOTH*** days is required. Training will be held at WRC. ***SPACE IS LIMITED***.

MI Training: Session 1
- *August 15th and August 29th , 2013*
- *Website: http://wrc-mi-training-august.eventbrite.com*

MI Training: Session 2
- *September 12th and September 26th , 2013*
- *Website: http://wrc-mi-training-september.eventbrite.com*

MI Training: Session 3
- *October 10th and October 24th , 2013*
- *Website: http://wrc-mi-training-october.eventbrite.com*

MI Training: Session 4
- *November 7th and November 21st , 2013*
- *Website: http://wrc-mi-training-november.eventbrite.com*

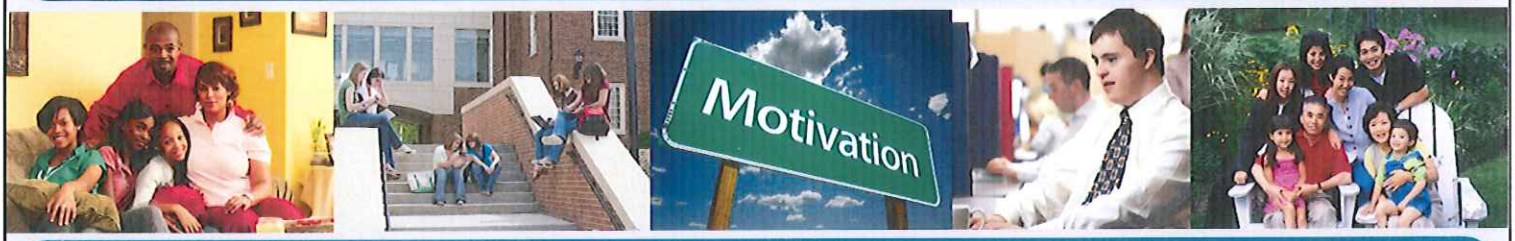
OBJECTIVES: As a result of attending this training, you will be able to:
- Understand the concepts, principles and theory of motivational interviewing as it pertains to transition-age youth with developmental disabilities
- Identify at least 3 examples of "change and sustain talk"
- Identify situations where motivational interviewing skills are most appropriate
- Develop a personal plan for practicing and incorporating the skills and strategies of motivational interviewing into your work

If you have any questions, please call (310)258-4254 or email agas@westsiderc.org

This event is funded by the Mental Health Services Act (MHSA) in partnership with the California Department of Mental Health and Department of Developmental Services.

Motivational Interviewing:
A Tool to Engage Transition-Age Youth & their Families

Facilitated by Liz Barnett, MSW, PhD



Want to keep families on track to accomplish important transition milestones?

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MI Training: Session 1
- *May 21st and May 22nd, 2014*
- *NLACRC Lancaster Office*

MI Training: Session 2
- *June 9th and June 10th, 2014*
- *NLACRC Van Nuys Office*

MI Training: Session 3
- *June 16th and 18th, 2014*
- *NLACRC Van Nuys Office*

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If you have any questions, please call Sara at ext. 6451 or email siwahashi@nlacrc.org

This event is funded by the Mental Health Services Act (MHSA) in partnership with the California Department of Mental Health and Department of Developmental Services.

AGENDA

Motivational Interviewing Training

Training Goals:
To learn and practice Motivational Interviewing skills
To discuss and practice using MI on the job

DAY ONE	MI BASICS
8:30 – 9:00 a.m	Breakfast and Registration
9:00 – 9:30 a.m.	Greetings and Introductions
9:30 – 10:00 a.m.	Overview of Motivational Interviewing
10:15 – 10:30 a.m.	Break
10:30 – 11:15 a.m.	MI Spirit
11:15 - 12:00 p.m.	MI Processes
12:00 – 1:00pm	Lunch
	MI on the Job
1:00 – 2:30	Applying the RULE
2:30- 2:45	Break
2:45 p.m. – 3:15pm	Strategies for Engagement
3:15 p.m. – 4:00 p.m.	Strategies for Discord

AGENDA

Motivational Interviewing Training

Training Goals:
To learn and practice Motivational Interviewing skills
To discuss and practice using MI on the job

DAY TWO	MI BASICS
8:30 – 9:00 a.m.	Breakfast and Registration
9:00 – 9:30 a.m.	Review and Questions
9:30 – 10:15 a.m.	MI Skills
10:15 – 10:30 a.m.	Break
10:30 – 12:00 a.m.	Change Talk Recognizing, responding and eliciting
12:00 – 1:00pm	Lunch
	MI On the Job
1:00 – 2:15	Topics to be determined
2:15 p.m. – 2:30pm	Break
2:30 p.m. – 4:00 p.m.	Topics to be determined

Motivational Interviewing: A Tool to Engage Transition-Age Youth & their Families

with
Liz Barnett, M.S.W, Ph.D.
liz.barnett@gmail.com
MI Trainer since 2005
Member of the MINT

Westside Regional Center
August 15th and 29th, September 12th and 26th,
October 10th and 24th, and November 7th and 21st, 2013

Early Ideas about Motivation

- People are either motivated or not
- If they are not motivated, there is not much we can do
- A client is motivated when he/she does what is suggested
- Advice, information, or confrontation is the best way to bring about change

Short History of MI

- Began in the 1980s with Bill Miller, Ph.D., in alcoholism treatment
- Treatment mired in confrontation and denial
- Encouraged to document the approach by Dr. Stephen Rollnick
- Used widely across diverse fields

Continuum of Communication Styles

Directing ⟷ Guiding ⟷ Following

Twelve Roadblocks to Listening (Thomas Gordon, Ph.D)

1. Ordering, directing, or commanding
2. Warning or threatening
3. Giving advice, making suggestions, or providing solutions
4. Persuading with logic, arguing, or lecturing
5. Moralizing, preaching, or telling clients what they "should" do
6. Disagreeing, judging, criticizing, or blaming
7. Agreeing, approving, or praising

Twelve Roadblocks, cont.

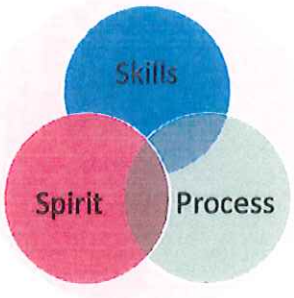
8. Shaming, ridiculing, or labeling
9. Interpreting or analyzing
10. Reassuring, sympathizing, or consoling
11. Questioning or probing
12. Withdrawing, distracting, humoring, or changing the subject

Motivational Interviewing is a collaborative communication style for strengthening a person's own motivation and commitment to change by addressing the common problem of ambivalence.

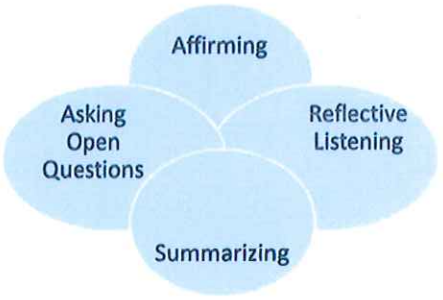
William R. Miller & Stephen Rollnick, 2013

Motivational Interviewing

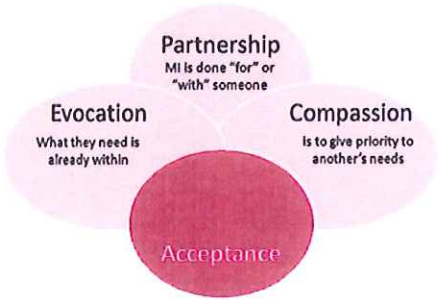
Change Talk

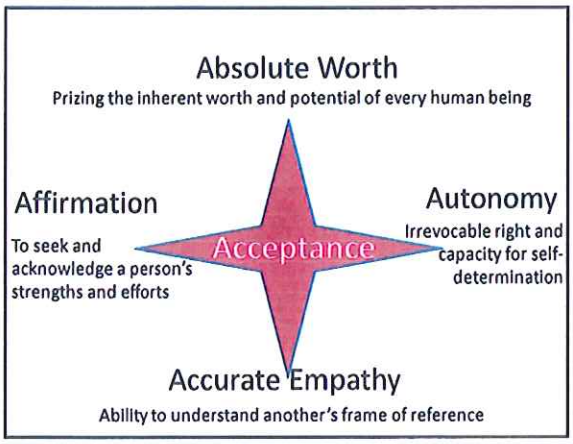


Motivational Interviewing
Skills



Motivational Interviewing
Spirit





The RULE

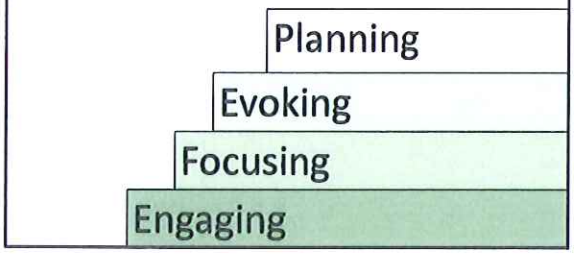
R esist the Righting Reflex

U nderstand Motivation

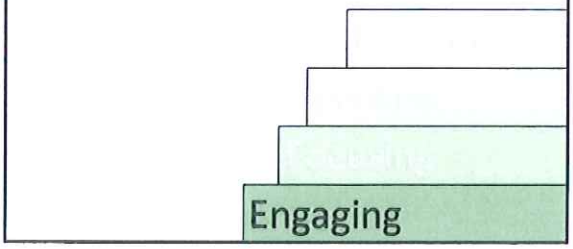
L isten

E mpower

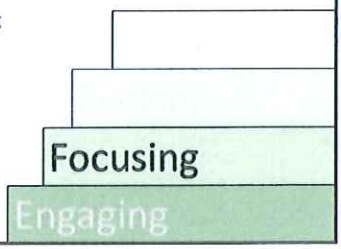
Four Processes of MI



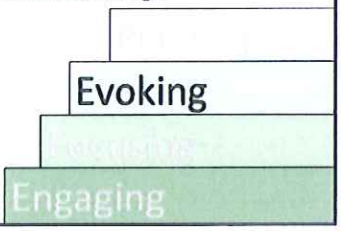
- Rapport Building
- Not specific to MI
- Relationship can predict success



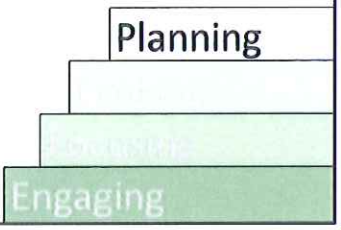
- Find a target behavior
- Develop and maintain a direction
- Negotiate agendas
- Targets include
  - Making a decision
  - Completing a task



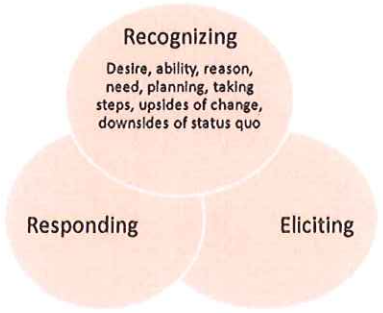
- Not telling. Not expert or didactic approach
- A certain type of language called Change Talk
  - Client's own motivation for change.
    - Desire, ability, reason, needs, actions, efforts
  - People talk themselves into change.



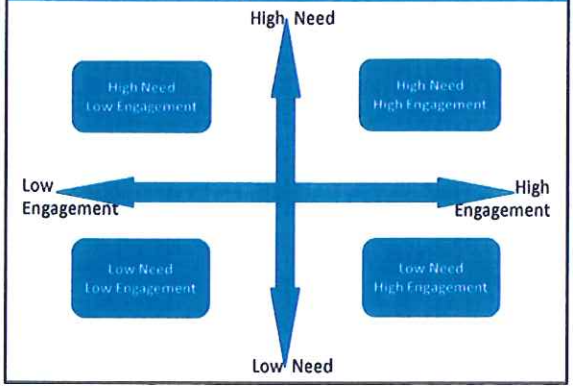
- The how and when of change.
  - Not whether and why to change.
- Develop commitment.
- Best time to share expertise with permission.



Motivational Interviewing
Change Talk



Thinking about Clients



MI Skills

- **O**pen-Ended Questions
- **A**ffirm
- **R**eflect
- **S**ummarize

Ask Open Questions

- Ask questions that have more than one possible answer; encourage client to think about and elaborate on concerns
  - Tell me about .....?
  - What are some of your thoughts about ....?
  - What are the top 3 things on your mind?
  - What concerns do you have ....?
  - How has your thinking changed since the last time I saw you?

Provide Affirmations

- *"Thanks for talking to me today."*
- *"You bring up a good point."*
- *"You certainly see a number of areas where your current situation doesn't seem to be working."*
- *"That's a great idea."*
- *"I can tell that you really do want to do the right thing here."*
- *"I'm impressed by how much thought you've put into this."*

Listen Reflectively

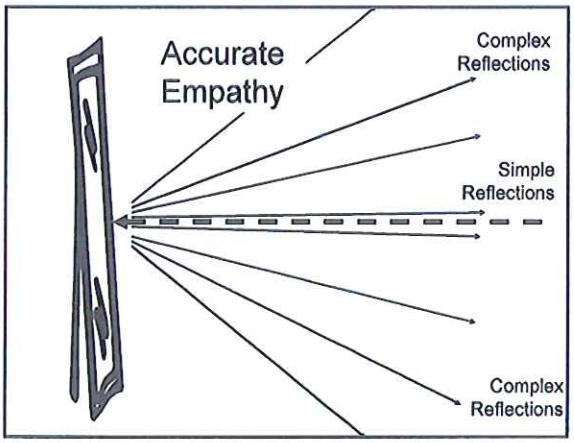
- Listen to the client and reflect back what he or she said, verbally and nonverbally.
- Use reflections to
  - roll with resistance,
  - highlight something, or
  - encourage more talk like it.
- Initiate conversation with an open question and reflect the response.
- Try to use more reflections than questions.

Types of Reflections

- **Simple/Repeat**—Repeat an element of what the client said.
- **Rephrase**—Restate content using different words.
- **Emotive**—Paraphrase the emotional dimension using feeling statements or metaphor.
- **Double-Sided**—Make explicit a contradiction or mixed feelings.

More on Reflections

- A hypothesis (not an assumption) about another person's meaning
- Mirroring back (being a sounding board)
- Reflections can be used to highlight discrepancy, but beware of "confronting."



Summarize
(a special kind of reflection)

Feed back information to let clients hear what they have been saying and that you understand what they have said.

- *"Let me pull together what you've said and you can tell me if I've missed anything."*
- *"What I hear you saying so far is that . . ."*
- *"You said . . ." "You thought that . . ."*
- *"Is that a pretty good summary? Did I miss anything?"*
- *"We've talked about . . ."*

Structure of a MI session

1. Opening / Set Up
   a. Establish agenda (collaboratively)
   b. Set guidelines regarding length
2. Establish Rapport (engaging)
3. Establish a Target Behavior/Action (focusing)
4. Explore Motivation & Ambivalence (evoking)
   a. Transitional Summary
   b. Key Question
5. Consolidate Commitment (planning)
   a. Develop Change/Action Plan (planning)
6. Closing

Opening Strategies

- Assume the client will be apprehensive about talking to you.
- Thank them for being there and acknowledge potential awkwardness
  - *"I'm glad you're made it today, I bet there was part of you that didn't want to come.*
- Ask an open-ended question.

Elicit – Provide – Elicit (EPE)

- ELICIT readiness and interest.
  - *"What do you know about x ?"*
  - *"What concerns do you have about it?"*
  - *"Tell me a little bit about why your considering the program."*
  - *"From your perspective, what happened to get you to this point?"*
- PROVIDE clear information or feedback.
  - *"Would it be ok if told you a little more about it?"*
  - *"Can I share with you some ways its helped other people?"*
- ELICIT the interpretation or reaction.
  - *"What do you think of what I just shared?"*
  - *"How do you think the program could be useful to you ?"*

Giving Advice and Suggestions

- Ask for permission.
  - *"There's something that concerns me. Would it be okay if I asked you about . . .?"*
- Preface advice with permission to disagree.
  - *"This may or may not apply to you, but . . ."*
- Give a small amount of essential information.
  - *"The main thing I'm concerned about is . . ."*

Talking about Doing

- Look for signs of readiness.
- Don't rush to action.
- Test the waters (and be prepared to back down).
  - *"What are you thinking you'd like to do at this point?"*
  - *"Where does this leave you?"*
- Leave the responsibility for change with the client.

Menu of Options (EPE)

- Ask the client what might be helpful or offer a *menu of alternatives.*
  - *"What have you thought of?"*
  - *"There are a few things that might work...*(provide a list*).*
  - *Which of these sound good to you?"*

Autonomy and Support

Leave the responsibility for change with the client.

- "You're right. It's totally up to you"
- "In the end you're the ones who will make these choices".
- "I'm here to support all of you in the choices you make. I'm not trying to make anyone do anything they don't want to do."
- "These choices are for you and your family to make. It's your life."

Exploring Change in the Abstract

Conditional Statement	Plan of Action
"If you wanted to . . ." *"If you decided you wanted to . . ."* *"If the time were right . . ."*	*"How would you do it?"* *"How would you go about it?"* *"What would you do?"*

Asking for Change Talk

- What are some of the good things that would come out of _X_?
- What are some of the downsides of the way _X_ is right now?
- If you were going to _X_, what would be the reasons to do it?

Importance Ruler

How important is it for you right now to...? On a scale from 0 - 10... what number would you give yourself? What makes you a ___ and not a ___?

1. **Identify the target behavior**
2. **Ask how important on the scale**
3. **Ask why not one click lower**
4. **Follow-up w/ Reflection, Elaboration, Summarization**

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Asking for Ability Language

- Tell me about some of the similar challenges you been through and how you did it?
- What are some of the strengths you have? How would these be helpful in accomplishing this goal/task?
- What would make you feel even more confident?

Confidence Ruler

1. Identify the target behavior
2. Ask how confident on the scale
   a) What would it take for one click higher (elicits possible planning),
   b) Why not one click lower (elicits strengths or past successes)
3. Follow-up w/ Reflection, Elaboration, Summarization

If you did decide to change, how confident are you that you would succeed? On a scale from 0 - 10... what number would you give yourself? What would it take to get from a ___ to a ____?

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Dealing with Discord

- Resistance is now conceptualized as discord.
  - Discord focuses on the quality of the helping relationship.
  - Is a signal of a problem in the relationship.
  - Discord is highly responsive to helper style.
  - Predictive of no change

Signs of Discord

- Discord sounds like
  - Arguing
  - Defending
  - Interrupting
  - Disengagement
  - Sustain Talk (desire, ability, reason, and need for the status quo – things to stay the same)

Four Processes of MI

Discord during engaging can come from
- Client prior experiences
- Expectations
- Counselor behaviors

Engaging

Four Processes of MI

Discord during focusing can come from
- Premature focus – setting agenda too soon
- Setting agenda without including the client
- Counselor insistence on a particular topic

Focusing

Engaging

Four Processes of MI

Discord during evoking can come from
- Counselor pushing in a particular direction
- Uncontrolled "righting reflex"

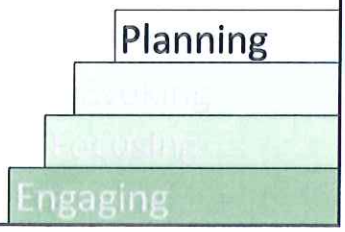
Evoking

Engaging

Four Processes of MI

Discord during planning can come from

- Not engaging client to come up with ideas and solutions.



How to respond to Discord and Sustain Talk

- Use reflective listening
- Apologize
- Emphasize personal choice and control
- Affirm
- Shift focus

Traps to Avoid

- The Question/Answer Trap
- The Premature Focus Trap
- The Expert Trap
- The Confrontation Trap ("Trying to make them see.")

Emphasizing Personal Choice/Control

"It really is your choice about what you do in this situation."

"No one can make you do this. The decision is yours."

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Disclosing Feelings

"I'm feeling a little stuck as we sit here. And I'm wondering whether you feel the same?"

Things to remember

- MI is done "for" and "with" a person.
- MI is a "way of being" with clients.
- The best way to learn MI is to listen to the reactions of your clients.
- The "lyrics" without the "music" is not MI.
- Appropriate when someone is expressing ambivalence or behaving in such a way that you believe there is ambivalence.

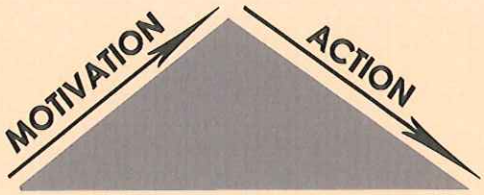
THINGS TO REMEMBER...

R esist the Righting Reflex

U nderstand Motivation

L isten

E mpower



PROVIDE SUMMARIES

- "Let me pull together what you've said and you can tell me if I've missed anything."
- "What I hear you saying so far is that ..."
- "You said ..."
- "Is that a pretty good summary? Did I miss anything?"
- "We've talked about ..."

PROVIDE AFFIRMATIONS

- "You bring up a good point."
- "You certainly see a number of areas where your current situation doesn't seem to be working."
- "I can tell that you really want to do the right thing here."
- "I'm impressed by how much thought you've put into this."

ASK OPEN QUESTIONS

- "Tell me about...?"
- "What are some of your thoughts about...?"
- "What are the top three things on your mind?"
- "What concerns do you have?"
- "How has your thinking about ....changed since the last time I saw you?"

LISTEN REFLECTIVELY

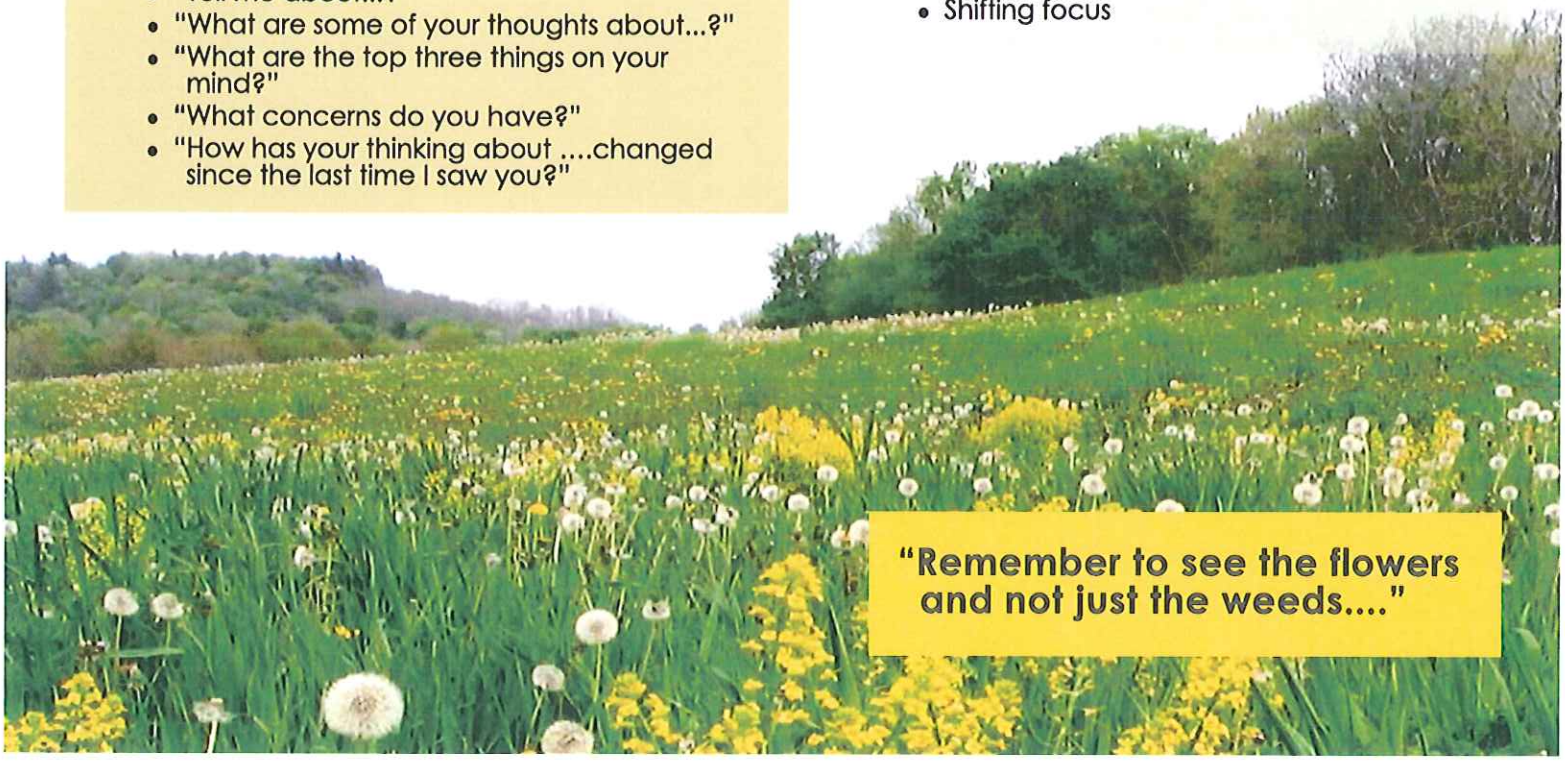
- Listen and reflect back what the client said, verbally or nonverbally
- Use reflections to
  - Roll with resistance
  - Highlight something or encourage more talk like it
- Initiate conversations with an open question and reflect the response
- Try to use more reflections than questions

HOW TO RESPOND TO SUSTAIN TALK

- Emphasizing autonomy
- Reframing
- Explore pros and cons
- Just listen, don't argue

HOW TO RESPOND TO DISCORD

- Reflective listening
- Apologizing
- Affirming
- Shifting focus



Motivational Interviewing Roadmap

Establish agenda for the meeting collaboratively

- State your agenda: "We're here to do/to talk about __."
- State expected time: "We'll spend __ time together to cover __ but I also want to make sure we have time to discuss things you want to talk about."

Establish rapport (engaging)

- "What do you know about __?"
- "What concerns do you have about it?"
- "Tell me a little bit about why you are considering __."
- "From your perspective, what happened to get you to this point?"

Establish a target behavior/action (focusing)

- "What have you thought of?"
- "There are a few things that might work__ (provide a list). Which of these sound good to you?"

Explore motivation and ambivalence (evoking)

- "What are some of the good things that would come out of __?"
- "What are some of the downsides of the way __ is right now?"
- "Tell me about some of the similar challenges you've been through and how you overcame them?"
- "What are some of the strengths you have? How would these be helpful in accomplishing this goal/task?"
- "If you were going to __, what would be the reason to do it?

Consolidate commitment (planning)

- "What are you thinking you'd like to do at this point?"
- "Where does this leave you?"
- "I'm here to support you and your family in the choices you make. I'm not trying to make anyone do anything they don't want to do."

Closing

Use Reflective Listening

- "So what you're saying is ___"
- "It sounds as __"
- "What I'm hearing you say is __"

Giving Advice & Suggestions

- "Would it be okay if I told you a little more about it?"
- "There's something that concerns me. Would it be OK if shared my concerns with you?"
- "This may or may not apply to you, but __."
- "What do you think of what I just shared?"

Project administered by Westside Regional Center and funded by the Mental Health Services Act (MHSA) in partnership with the California Department of Mental Health and Department of Developmental Services.

Appendix F

Training Evaluation Materials

WESTSIDE REGIONAL CENTER

Session # ___3___ Day # ___1____ ID Number:_____

Engaging TAY & Families: Motivational Interviewing
Pre-training Questionnaire

1. Have you ever been trained in Motivational Interviewing?

□ Yes □ No

2. The following statements are either true or false. Indicate your agreement with the following statements but circling the appropriate item to the right.		
a. Counselors'/Service Coordinators' expectations for their clients' and families' abilities to change have no effect upon whether change occurs.	True	False
b. If clients or families are resistant to talk about changing their behaviors, direct confrontation is required to help talk about change.	True	False
c. If clients or families are resistant to talk about changing their behaviors, persuasion is required to help talk about change.	True	False
d. Counselors/Service Coordinators should emphasize personal choice over one's behaviors.	True	False
e. Resistance is best thought of as a product of the interpersonal context in which it is observed.	True	False
f. External pressure and consequences are the only ways to motivate clients or families to change behavior.	True	False
g. Readiness to make change is the family's responsibility – no one can help the family unless they decide they are ready.	True	False
h. The best way to motivate families is to help them resolve their ambivalence about change.	True	False

3. How would you rate your current WILLINGNESS to:	**LOW**		**MODERATE**		**HIGH**	
a. Discuss both the benefits and the drawbacks of transition on the following:						
i. Housing plan	1	2	3	4	5	NA
ii. Employment or further education or day program plan	1	2	3	4	5	NA
iii. Conservatorship or power of attorney	1	2	3	4	5	NA
iv. Obtaining adult health care (including mental health) providers	1	2	3	4	5	NA
b. Not provide education or suggestions if the family is reluctant to hear them	1	2	3	4	5	NA
c. Allow families to make an informed decision to not follow transition recommendations, if they so choose	1	2	3	4	5	NA

4. How would you rate your current KNOWLEDGE AND ABILITY to:	**LOW**		**MODERATE**		**HIGH**	
a. Assess families' readiness to make a change in behavior related to their children's transition	1	2	3	4	5	NA
b. Assess families' risk for difficulties in following through on transition recommendations	1	2	3	4	5	NA
c. Identify transition difficulties, even when the parent doesn't initially say that he or she is having difficulty following recommendations	1	2	3	4	5	NA
d. Recognize warning signs that a client or parent may not agree with transition recommendations	1	2	3	4	5	NA
e. Discuss the pros and cons of transition changes with parents and youth	1	2	3	4	5	NA
f. Provide education about transition that is tailored to the needs of the client and family	1	2	3	4	5	NA
g. Provide suggestions for behavior change around transition that are tailored to the needs of the client and family	1	2	3	4	5	NA
h. Set transition goals collaboratively with parents and youth	1	2	3	4	5	NA
i. Work with families to identify problems or barriers to transition, and to overcome them	1	2	3	4	5	NA
j. Access and/or identify additional educational and consultation resources for families	1	2	3	4	5	NA
k. Successfully motivate families to follow transition recommendations	1	2	3	4	5	NA

5. At this point in time, with which of your families do you:	Not at all	Only when requested	Only when needed	Most families	Every family
a. Assess the family's readiness to change behavior related to their child's transition	□	□	□	□	□
b. Offer education based on the family's needs and interests (*do not count education that is given to all parents*)	□	□	□	□	□
c. Ask family about their transition goals, and agree on goals together	□	□	□	□	□
d. Allow the family to lead discussion about transition topics (e.g. housing, transportation, public benefits)	□	□	□	□	□
e. Use reflective listening skills such as repeating or making summary statements of what the family says	□	□	□	□	□
f. Convey in words or actions that service coordination is a collaborative relationship in contrast to one person being in charge	□	□	□	□	□
g. Have the client or family rate the importance, their confidence, and their readiness for transition	□	□	□	□	□

6. How confident are you in your abilities to:	Not at all confident	A little confident	Somewhat confident	Quite confident	Completely confident
a. Resist the desire to "fix" things for the client/family.	1	2	3	4	5
b. Refrain from engaging in arguments when the client's/family's viewpoint is different from yours.	1	2	3	4	5
c. Listen first & letting the client /family do most of the talking.	1	2	3	4	5
d. Ask more open-ended than closed questions.	1	2	3	4	5
e. Encourage clients/families to talk about their own motivation for change.	1	2	3	4	5
f. Ask permission before offering advice or information	1	2	3	4	5
g. Ask for feedback after addressing concerns or offering advice.	1	2	3	4	5
h. Wait to set the goals until the client/family are ready.	1	2	3	4	5
i. Let go when a client/family are not ready to change.	1	2	3	4	5
j. Guide conversations rather than directing or following them.	1	2	3	4	5
k. Help clients/families identify a specific task or target behavior that can be changed.	1	2	3	4	5
l. Understand the client's/family's motivations for behavior change.	1	2	3	4	5
m. Respond to a client's/family's hesitation to change by reframing the problem or issue or emphasizing autonomy.	1	2	3	4	5
n. Identify and build upon a person's confidence in performing a target behavior.	1	2	3	4	5
o. Recognize a disengaged client/family	1	2	3	4	5

CONTINUE ON NEXT PAGE

7. The following statements are things a person might say to you. For each one, imagine that someone you know is talking to you and explaining a problem he or she is having. You want to help by saying the right things. Think about each statement as if you were really in the situation and write what you would say to be helpful. Only write 1-2 sentences for each situation.

a) We take our child to the pediatrician for health check-ups. I should look into finding an adult doctor for him but we like our pediatrician so much. She knows my son so well.

b) I should check the day programs but I work from 8 to 6pm and I don't think any would be right for us anyway.

c) I can still take my daughter around with me. I don't feel comfortable with her using public transportation alone.

d) My son wants to move out and live independently.....I just don't think it's the right thing for him. I don't think he'll be able to do it. He is better off with us.

8. How long have you been coordinating services or counseling individuals with developmental disabilities?

_____Years _____Months

9. What is your age? (Please check the box next to the appropriate age group)

□ Less than 25 years old	□ 35 – 44 years old	□ 55 – 64 years old
□ 25 – 34 years old	□ 45 – 54 years old	□ 65 years old or older

THANK YOU FOR YOUR PARTICIPATION!

WESTSIDE REGIONAL CENTER

Session # _____ Day # _____ ID Number:_____

Thank you for participating in **Motivational Interviewing: A Tool to Engaging Transition-Age Youth & their Families**. Please take a few moments to share your thoughts and answer the following questions. Your responses are extremely important to us and will help us design and improve future MHSA funded events.

1. The following statements are either true or false. Indicate your agreement with the following statements by circling the appropriate item to the right.		
a. Counselors'/Service Coordinators' expectations for their clients' and families' abilities to change have no effect upon whether change occurs.	True	False
b. If clients or families are resistant to talk about changing their behaviors, direct confrontation is required to help talk about change.	True	False
c. If clients or families are resistant to talk about changing their behaviors, persuasion is required to help talk about change.	True	False
d. Counselors/Service Coordinators should emphasize personal choice over one's behaviors.	True	False
e. Resistance is best thought of as a product of the interpersonal context in which it is observed.	True	False
f. External pressure and consequences are the only ways to motivate clients or families to change behavior.	True	False
g. Readiness to make change is the family's responsibility – no one can help the family unless they decide they are ready.	True	False
h. The best way to motivate families is to help them resolve their ambivalence about change.	True	False

2. How would you rate your current WILLINGNESS to:	**LOW**		**MODERATE**		**HIGH**	
a. Discuss both the benefits <u>and the drawbacks</u> of transition for the following:						
i. Housing plan	1	2	3	4	5	NA
ii. Employment or further education or day program plan	1	2	3	4	5	NA
iii. Conservatorship or power of attorney	1	2	3	4	5	NA
iv. Obtaining adult health care (including mental health) providers	1	2	3	4	5	NA
b. <u>Not</u> provide education or suggestions if the family is reluctant to hear them	1	2	3	4	5	NA
c. Allow families to make an informed decision to <u>not</u> follow transition recommendations, if they so choose	1	2	3	4	5	NA

3. How would you rate your current KNOWLEDGE AND ABILITY to:	**LOW**		**MODERATE**		**HIGH**	
a. Assess families' readiness to make a change in behavior related to their children's transition	1	2	3	4	5	NA
b. Assess families' risk for difficulties in following through on transition recommendations	1	2	3	4	5	NA
c. Identify transition difficulties, even when the parent doesn't initially say that he or she is having difficulty following recommendations	1	2	3	4	5	NA
d. Recognize warning signs that a client or parent may not agree with transition recommendations	1	2	3	4	5	NA
e. Discuss the pros and cons of transition changes with parents and youth	1	2	3	4	5	NA
f. Provide education about transition that is tailored to the needs of the client and family	1	2	3	4	5	NA
g. Provide suggestions for behavior change around transition that are tailored to the needs of the client and family	1	2	3	4	5	NA
h. Set transition goals collaboratively with parents and youth	1	2	3	4	5	NA
i. Work with families to identify problems or barriers to transition, and to overcome them	1	2	3	4	5	NA
j. Access and/or identify additional educational and consultation resources for families	1	2	3	4	5	NA
k. Successfully motivate families to follow transition recommendations	1	2	3	4	5	NA

Learning Objectives

4. Based on your learning from this training, how confident are you in your abilities to:	Not at all confident	A little confident	Somewhat confident	Quite confident	Completely confident
a. Resist the desire to "fix" things for the client/family.	1	2	3	4	5
b. Refrain from engaging in arguments when the client's/family's viewpoint is different from yours.	1	2	3	4	5
c. Listen first and let the client /family do most of the talking.	1	2	3	4	5
d. Ask more open-ended than closed questions.	1	2	3	4	5
e. Encourage clients/families to talk about their own motivation for change.	1	2	3	4	5
f. Ask permission before offering advice or information	1	2	3	4	5
g. Ask for feedback after addressing concerns or offering advice.	1	2	3	4	5
h. Wait to set the goals until the client/family are ready.	1	2	3	4	5
i. Let go when a client/family is not ready to change.	1	2	3	4	5
j. Guide conversations rather than directing or following them.	1	2	3	4	5
k. Help clients/families identify a specific task or target behavior that can be changed.	1	2	3	4	5
l. Understand the client's/family's motivations for behavior change.	1	2	3	4	5
m. Respond to a client's/family's hesitation to change by reframing the problem or issue or emphasizing autonomy.	1	2	3	4	5
n. Identify and build upon a person's confidence in performing a target behavior.	1	2	3	4	5
o. Recognize a disengaged client/family.	1	2	3	4	5

Feedback: Training Session and Instructor (Liz Barnett, MSW, PhD)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5. The trainer was knowledgeable and met course objectives.	1	2	3	4	5
6. The trainer helped me gain useful skills to take back to my work.	1	2	3	4	5
7. The trainer was effective in helping me learn and start practicing Motivational Interviewing skills.	1	2	3	4	5
8. Overall, the training met my expectations and was worthwhile.	1	2	3	4	5
9. The training increased my skills that may improve the quality of life of my clients and their families.	1	2	3	4	5
10. There was an appropriate amount of time for interactive participation and discussion of key concepts.	1	2	3	4	5
11. There was an appropriate amount of time for practicing Motivational Interviewing skills.	1	2	3	4	5
12. The training facilities, refreshments, and set-up of the meeting rooms were acceptable.	1	2	3	4	5

13. The following statements are things a person might say to you. For each one, imagine that someone you know is talking to you and explaining a problem he or she is having. You want to help by saying the right things. Think about each statement as if you were really in the situation and write what you would say to be helpful. Only write 1-2 sentences for each situation.

a) We take our child to the pediatrician for health check-ups. I should look into finding an adult doctor for him but we like our pediatrician so much. She knows my son so well.

b) I should check the day programs but I work from 8 to 6pm and I don't think any would be right for us anyway.

c) I can still take my daughter around with me. I don't feel comfortable with her using public transportation alone.

d) My son wants to move out and live independently.....I just don't think it's the right thing for him. I don't think he'll be able to do it. He is better off with us.

14. Please describe 3 lessons you will take away from this training to your work.

a)

b)

c)

15. After taking this training, what do you think your level of success will be over the next 3 months in motivating parents to follow transition recommendations (BASED ON USING THE SKILLS YOU HAVE LEARNED)? Indicate the degree of success using the following scale:

0% 10 20 30 40 50 60 70 80 90 100%
(no success) (moderate success) (complete success)

16. If you're not expecting complete success (90% +) in motivating parents to follow your recommendations, tell us why?

a)

b)

c)

17. Specific highlights and/or suggested improvements?

THANK YOU FOR YOUR PARTICIPATION AND FEEDBACK!

WESTSIDE REGIONAL CENTER

ID Number:_____

Engaging TAY & Families: Motivational Interviewing
Follow-up Questionnaire

This is a follow-up questionnaire to the **Motivational Interviewing: A Tool to Engaging Transition-Age Youth and their Families** training you attended in _____August_____ at WRC. Please take a few moments to share your thoughts and answer the following questions. Your responses are extremely important to us and will help us design and improve any future MHSA funded events.

1. The following statements are either true or false. Indicate your agreement with the following statements by circling the appropriate item to the right.		
a. Counselors'/Service Coordinators' expectations for their clients' and families' abilities to change have no effect upon whether change occurs.	True	False
b. If clients or families are resistant to talking about changing their behaviors, direct confrontation is required to help talk about change.	True	False
c. If clients or families are resistant to talking about changing their behaviors, persuasion is required to help talk about change.	True	False
d. Counselors/Service Coordinators should emphasize personal choice over one's behaviors.	True	False
e. Resistance is best thought of as a product of the interpersonal context in which it is observed.	True	False
f. External pressure and consequences are the only ways to motivate clients or families to change behavior.	True	False
g. Readiness to make change is the family's responsibility – no one can help the family unless they decide they are ready.	True	False
h. The best way to motivate families is to help them resolve their ambivalence about change.	True	False

2. How would you rate your current WILLINGNESS to:	**LOW**		**MODERATE**		**HIGH**	
a. Discuss both the benefits and the drawbacks of transition on the following:						
i. Housing plan	1	2	3	4	5	NA
ii. Employment or further education or day program plan	1	2	3	4	5	NA
iii. Conservatorship or power of attorney	1	2	3	4	5	NA
iv. Obtaining adult health care (including mental health) providers	1	2	3	4	5	NA
b. Not provide education or suggestions if the family is reluctant to hear them	1	2	3	4	5	NA
c. Allow families to make an informed decision to not follow transition recommendations, if they so choose	1	2	3	4	5	NA

3. How would you rate your current KNOWLEDGE AND ABILITY to:	**LOW**		**MODERATE**		**HIGH**	
a. Assess families' readiness to make a change in behavior related to their children's transition	1	2	3	4	5	NA
b. Assess families' risk for difficulties in following through on transition recommendations	1	2	3	4	5	NA
c. Identify transition difficulties, even when the parent doesn't initially say that he or she is having difficulty following recommendations	1	2	3	4	5	NA
d. Recognize warning signs that a client or parent may not agree with transition recommendations	1	2	3	4	5	NA
e. Discuss the pros and cons of transition changes with parents and youth	1	2	3	4	5	NA
f. Provide education about transition that is tailored to the needs of the client and family	1	2	3	4	5	NA
g. Provide suggestions for behavior change around transition that are tailored to the needs of the client and family	1	2	3	4	5	NA
h. Set transition goals collaboratively with parents and youth	1	2	3	4	5	NA
i. Work with families to identify problems or barriers to transition, and to overcome them	1	2	3	4	5	NA
j. Access and/or identify additional educational and consultation resources for families	1	2	3	4	5	NA
k. Successfully motivate families to follow transition recommendations	1	2	3	4	5	NA

4. At this point in time, with which of your families do you:	Not at all	Only when requested	Only when needed	Most families	Every family
a. Assess the family's readiness to change behavior related to their child's transition	□	□	□	□	□
b. Offer education based on the family's needs and interests (*do not count education that is given to all parents*)	□	□	□	□	□
c. Ask family about their transition goals, and agree on goals together	□	□	□	□	□
d. Allow the family to lead discussion about transition topics (e.g. housing, transportation, public benefits)	□	□	□	□	□
e. Use reflective listening skills such as repeating or making summary statements of what the family says	□	□	□	□	□
f. Convey in words or actions that service coordination is a collaborative relationship in contrast to one person being in charge	□	□	□	□	□
g. Have the client or family rate the importance, their confidence, and their readiness for transition	□	□	□	□	□

5. How confident are you in your abilities to:	Not at all confident	A little confident	Somewhat confident	Quite confident	Completely confident
a. Resist the desire to "fix" things for the client/family.	1	2	3	4	5
b. Refrain from engaging in arguments when the client's/family's viewpoint is different from yours.	1	2	3	4	5
c. Listen first and let the client /family do most of the talking.	1	2	3	4	5
d. Ask more open-ended than closed questions.	1	2	3	4	5
e. Encourage clients/families to talk about their own motivation for change.	1	2	3	4	5
f. Ask permission before offering advice or information	1	2	3	4	5
g. Ask for feedback after addressing concerns or offering advice.	1	2	3	4	5
h. Wait to set the goals until the client/family is ready.	1	2	3	4	5
i. Let go when a client/family is not ready to change.	1	2	3	4	5
j. Guide conversations rather than directing or following them.	1	2	3	4	5
k. Help clients/families identify a specific task or target behavior that can be changed.	1	2	3	4	5
l. Understand the client's/family's motivations for behavior change.	1	2	3	4	5
m. Respond to a client's/family's hesitation to change by reframing the problem or issue or emphasizing autonomy.	1	2	3	4	5
n. Identify and build upon a person's confidence in performing a target behavior.	1	2	3	4	5
o. Recognize a disengaged client/family	1	2	3	4	5

CONTINUE ON NEXT PAGE

6. The following statements are things a person might say to you. For each one, imagine that someone you know is talking to you and explaining a problem he or she is having. You want to help by saying the right things. Think about each statement as if you were really in the situation and write what you would say to be helpful. Only write 1-2 sentences for each situation.

a) My daughter wants to find a roommate and live independently. We are afraid that she will not make responsible choices. I think she should just continue living with us. We are her family.

b) We take our child to the pediatrician for health check-ups. I should look into finding an adult doctor for him but we like our pediatrician so much. She knows my son so well.

c) I have checked a couple of day programs for my son but I think he might be bored there. It's just like babysitting, which we could do at our home.

d) I can still take my daughter around with me. I don't feel comfortable with her using public transportation alone.

7. Since taking this training, what do you think your level of success is in motivating parents to follow transition recommendations (BASED ON USING THE SKILLS YOU HAVE LEARNED)? Indicate the degree of success using the following scale:

0% 10 20 30 40 50 60 70 80 90 100%
(no success) (moderate success) (complete success)

8. Compared to your previous work experiences, how much did using motivational interviewing…..	**Not at all improved**	**Slightly improved**	**Somewhat improved**	**Moderately improved**	**Extremely improved**
a. Improve communication with families?	1	2	3	4	5
b. Improve engagement of families?	1	2	3	4	5
c. Help families take more active steps in the transition process?	1	2	3	4	5

THANK YOU FOR YOUR PARTICIPATION!

Appendix G

TAY Collaborative Materials

WESTSIDE REGIONAL CENTER

TAY Collaborative Meetings

Looking for ways to find more support for youth at risk or diagnosed with mental health disorders?

Trying to identify appropriate mental health or educational solutions for youth?

Want to keep families out of crisis during the transition years?

Want to keep families on track to accomplish important transition milestones?

Then refer to the Transition-Age Youth (TAY) Collaborative for consultation and solution building!

The TAY Collaborative is available to Service Coordinators assisting transition-age youth (ages 14 to 25) and their families/authorized representatives to assist with assessment and planning. When youth's needs are multifaceted and they span over multiple systems of care, it is essential that Service Coordinators meet with the TAY Collaborative team to take advantage of specialized expertise. This is a perfect opportunity to bring specialists from varying systems (education, mental health, probation, regional center, medical) together to sort out complexities of care resulting from challenging conditions.

For more information contact:

Tom Kelly, PhD
310-258-4162
tomk@westsiderc.org

Please return the referral form to Aga Spatzier for scheduling.

Date_____

TAY Collaborative Referral Form

1) Client's name: _____ 2) DOB: _____

3) Living situation: _____ 4) Gender: _____

5) Name and phone number of care provider/guardian: _____

_____

6) Insurance: _____

7) Developmental Diagnosis: _____

8) Mental Health Diagnosis: _____

9) Is the client on any medication (any medication relevant to main concerns)?: _____

_____

_____

10) What services are being provided?: _____

_____

11) Who should attend the meeting (parent, ILS provider, school/DMH/probation staff)?_____

_____

12) Name and phone number of individual(s)above: _____

_____

13) List the three main concerns/issues/questions that you have for the team:

1.

2.

3.

Please return this form to Aga Spatzier, ext. 4254

Westside Regional Center
TAY Collaborative

Meeting at: 5901 Green Valley Circle, Suite 320
Culver City, CA 90230
Phone: (310) 258 4000 – FAX: (310) 338 9744

Visitor Agreement of Confidentiality

By completing this form, you are agreeing to not disclose and/or use anything heard of individually identifiable health/mental health information, as outlined below, consistent with California and Federal law concerning the privacy of such information.

Use and disclosure of Mental Health Information:

Visitor Name: _____

Visitor Address: _____

Company or Organization represented: _____

Phone & email address: _____

Purpose of Visit: _____

As a visitor to the Interagency Collaborative Meeting I agree not to:

☐ Release, Disclose or Use information I hear or obtain at the TAY Collaborative meetings.

****

The information is used for the purpose of assisting in diagnosis, treatment planning and/or obtaining and accessing services with the client being discussed.

_____

This authorization shall become effective ___/___/___. It expires one day from the effective date.

California law prohibits Westside Regional Center from making further disclosures of the specified information to any person or entity not specified herein, unless such disclosure is specifically required or permitted by law. An additional written authorization must be
obtained for a proposed new use of the information or for its transfer to another person or entity.

Please note: If a person authorizes the disclosure of mental health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law prohibits recipients of health information from re-disclosing such information except with written authorization or as specifically required or permitted by law.

Signature of Visitor: _____

Witness: _____

Date: _____ **Time:** _____**AM/PM**