Talking to Change: An MI Podcast

Glenn Hinds and Sebastian Kaplan

Episode 17: MI for Multimorbidity, with Kylie McKenzie, MAPS, FCCLP

Glenn Hinds:

Hello everybody, and welcome back to another edition of Talking To Change. A Motivational Interviewing Podcast. My name is Glenn Hinds. I'm in Derry, in Northern Ireland, and I'm joined, as always, by my good friend Sebastian Kaplan. Hi Seb.

Sebastian Kaplan:

Hey Glenn, how's it going?

Glenn Hinds:

Very best. Very best, man. So, you're very welcome to this episode where we are, again, reaching to the far ends of the globe. We'll be speaking to Kylie McKenzie in Australia, in a few minutes. But, before we do that Seb, do you want to remind people how they contact us using the social media?

Sebastian Kaplan:

Yes, have to do that. On Twitter, you can contact us @ChangeTalking, and on Facebook it is Talking To Change. Any questions or feedbacks or comments that you want to email to us, you can do so at podcast@glennhinds.com. That's G-L-E-N-N H-I-N-D-S.

Glenn Hinds:

Thanks. Thanks, Seb. Like I say, we're joined today by Kylie McKenzie, a clinical psychologist. Living outside a small town called Ballarat. The area is Buninyong. Is that right Kylie?

Kylie McKenzie:

Yeah, that's very good.

Glenn Hinds:

Fantastic. Thank you. So, Kylie is a clinical psychologist, and is a fellow of the Australian Psychological Society; College of Clinical Psychologists. She's a member of the Motivational Interviewing Network of Trainers; MINT, and is a registered psychologist and supervisor, with her Psychology Board of Australia. Kylie is a clinical psychologist with more than 18 years' experience in a regional public hospital setting. Kylie's clinical work focused on mental health and chronic illness led to the discovery of Motivational Interviewing as an engaging way to support and promote health behavior change.

Glenn Hinds:

Since becoming a member of the Motivational Interviewing Network of Trainers in 2008, Kylie has been selected as elite trainer for the international workshops in Krakow 2013, Atlanta 2014, and Melbourne 2015. Kylie is a final-year PhD candidate in the department of general practice at the university of Melbourne, and her research is focused on the potential of Motivational Interviewing in working with people living with mental, physical multimorbidity. Hello Kylie, or g'day Kylie.

Kylie McKenzie:

G'day. That's a very good g'day you've got going there, Glenn.

Glenn Hinds:

Yeah. Thank you. Well, you're very welcome, and it's lovely for you to give us your time today. We're really keen to discover more about supporting people with multimorbidity, but before that we do that, if it's okay, as we do with most of our guests now is, we literally just invite them to introduce themselves and explain to us, and the audience, how you became interested and started to use, and practice Motivational Interviewing.

Kylie McKenzie:

Yeah. I've listened to some of the stories of other people, and there's some things that are the same always, and some things are a little bit different. I started working as a hospital-based psychologist after I'd finished my clinical psychology training, and I think that my training had done a really good job of helping me to understand the importance of empathy and relationships in a clinical context. And, the work that I found myself doing was of course all of the psychological work you would do in a hospital, where people referred with depression, or anxiety, or trauma... and, how that impacted on illness and injury.

Kylie McKenzie:

That work went pretty well, but a lot of the work we also did is about health behavior change in a clinical setting. So, people are referred to psychologists in public hospital settings when the person is not making progress in therapy, or their health behaviors are actually impacting on their health outcomes. And so, I found myself doing work that I wasn't specifically trained for, and trying to apply the clinical psychology training, which is very diagnostic-based and assessment-based, and my training was Cognitive Behavioral Therapy. It didn't quite all fit together, and I guess I couldn't really work out why.

Kylie McKenzie:

And, I found myself at an Australian Psychological Society conference in about 2005, in a session that was about, how do you support people with chronic illnesses, to make changes. And I put my hand straight-up for that workshop, and it was led by the indomitable Helen Mentha who is also a member of the Motivational Interviewing Network of Trainers, and she was starting to talk about the potential for Motivational Interviewing. I had never heard about it before. And, I guess I met her, and it made

sense to me straight away. It was, in some ways, familiar but it also offered me what I'd been looking for.

Kylie McKenzie:

So, I had this experience, clinically, where I understood the importance of empathy, and I understood the importance of engaging in people, which are core parts of Motivational Interviewing. But, I think the missing piece was the thing that connected to supporting behavior change that was outside of Cognitive Behavioral Therapy, context of providing people with advice and skill-development when they were really engaged, or ready. So, I was working with people who maybe didn't meet the criteria for a specific clinical psychology diagnosis, but the support of a psychologist in a healthcare setting was really important.

Kylie McKenzie:

And, I think the missing piece for me was that empathy and advice wasn't enough. People needed that support to make change, and MI gave me a way of understanding that. It gave me a framework, and then I got very excited about it and found myself pursuing additional training. And, in 2008 myself and another Australian, Rochelle Cans, traveled across to Ohio and engaged in the training of new trainers, and it opened a very rich world of understanding MI. Understanding that lovely way of describing MI and the divide between the technical and relational, and how they fit together. So, that relational idea of empathy and engagement, and the technical idea of really listening to people's own reasons for making change and making that a core part of the conversation. So, I've taken it from there and been really quite active and interested in introducing other people to that, and how it might work in a healthcare setting.

Sebastian Kaplan:

Great. So, you mentioned that some of the stories overlap. Or, people's initial exposure to MI and what them brought them to MI, there's a lot of overlap there. So, it seems like, in your situation, there was a lot in your work that you felt solid in and had a pretty firm grounding in, that did have some overlap with MI. Like, the ideas around empathy and engagement. And, in the work that you were doing, you kind of ran into a new challenge, one that you weren't necessarily trained for. You know, the application of CBT for someone who's experienced trauma, or who's depressed was something that you were quite comfortable with, but just a primary care patient, maybe struggling with behavior change, posed that challenge for you, or a new direction in your career that led you to discover new ways of having conversations with people.

Kylie McKenzie:

Yeah. I think that's a really lovely summary of my long-winded history. Sebastian, that's exactly it, and I think it's even a bit more than that. That it opened my eyes to the tendency in healthcare to assess and advice, and I think psychologists in healthcare also have that tendency. It is a skill, it is something that can be really useful, but it's limited. It's helpful some of the time, and it's not helpful when people haven't identified for themselves what it is that they want to change. So, if you tell them to go away and

change something that isn't a priority for them, isn't something that they identify as important, or feel like, even, they can achieve, then I think it's a wasted opportunity for supporting somebody to build a healthier life.

Kylie McKenzie:

I've had conversations since I've become known as somebody engaged in Motivational Interviewing with key physicians and people around my own health service, where they say, "Oh, that's right. You're the woman who's been talking about Motivational Interviewing. That all sounds really nice, but doesn't it take a terribly long time, and isn't it a big investment?" And, I think when you then ask people who have that initial experience, "Well, how many of the patients that you see now go away and do exactly what it is that you ask them to do? And, when they come back and you tell them to do it again, do they go away and do it the second time?" And, that was the missing piece for me. That advising people to do something... they go away. Either it's not important to them or you haven't connected with what they are able to do, is an interaction that's not as helpful as one that's focused on their priorities. One that's achievable for them. One that is something that they want to do.

Kylie McKenzie:

I think that that's the tipping-point for clinicians, as well. When they realize that advising people... people go away, they don't do it, they come back. Then they advise them again, they go away, they come back, and they haven't done it. That that's a really frustrating thing for a clinician, but it's also not helpful for patients. And so, some training that we did with a group of allied health professionals... There were nine disciplines as part of the group. In about 2010 we trained 40 allied health professionals, Rochelle Cans and I. One of the outstanding pieces of qualitative feedback we got was, "I've realized that as the clinician, I don't have to do all the talking," and, that was a real stand out, I think, for us as trainers. That the clinicians understood that that idea of drawing out from the patient was not only helpful for them, as in reduce their own burden as clinicians, it was helpful for the patients as well.

Glenn Hinds:

So it seems that there's a theme of the missing piece, and Motivational Interviewing filling that space, in the sense that your first introductory was that there were patients who were common to different clinicians across the hospital setting, who weren't doing what they were being told to do, and because it was about behavior, and they weren't behaving properly... obviously they had be a psychology issue, so they were sent to psychologists. The psychologists were used to giving them information. It worked for some people, but there was this other cohort of people it wasn't working with, and with your training... that you began to realize, this is where the MI would work. Where we engage people in a process where we help them decide what's best forward. What's best for them, and then help them decide to achieve that for themselves.

Glenn Hinds:

But, also in the sense of supporting practitioners that... Their investment is their training, is their time, but it's also in the desire to be helpful and some of the frustration, it sounds like, they were expressing was, "Here we are, doing all this work for people, and they're not making the changes necessary." But, the relief that came when you introduced them to Motivational Interviewing, which was, "I can help these people change, but I don't have to all the work," and we can actually work in conjunction with them, and it was measured by the length of time that they heard themselves speaking. And, that was a relief for them too.

Kylie McKenzie:

Yeah, and I think that was... in that training we did with Allied Health Professionals, part of the process was to encourage them to listen to an initial audio recording that they did, which was just a role play with a colleague, and listen to the amount that they spoke. And then, at the end of the training, to do the same with the new skills on board. That was the key feedback from clinicians, "Oh, I'm not taking up all the time. I'm not asking as many questions, but I'm getting the answers that I need." So, I think that that's an important change, and I also think that one of the ways that I was introduced to Motivational Interviewing training, and I know has been a core part of the Motivational Interviewing Network of Trainer's approach, is that idea of experiential training, or what people describe as, "Real play." Having the experience is part of what it is that... something that's real for you.

Kylie McKenzie:

So, in training talking about a behavior that's a real behavior for you to change, and then being exposed to what Motivational Interviewing skills feel like, and contrasting that with a more traditional advice-giving approach. I know that I ran a training about weight behaviors and weight-management skills training with GPs in Melbourne about two years ago, and that was the feedback when we ran a practice where people were asked to do a real play with their own behavior, and to take that advice giving stance, and one of the GPs looked up at the end of that practice session and just said, "Oh my goodness. He's just said to me, "Everything verbatim." which I say to other patients in my practice, and I don't like it."

Kylie McKenzie:

So it was that very personal sense of, "Ooh. The advice giving, I give is well meaning, but it's actually not necessarily helpful." I think that that change is an important one when clinicians find that it's almost like something clicks.

Sebastian Kaplan:

Just a quick clarification for people in parts of the world that don't know what a GP is, so a GP is a general practitioner. Is that-

Kylie McKenzie:

Yeah. All right. It's a primary-care physician for your part of the world

Sebastian Kaplan:

Exactly. That's right. So, lots of examples, both... well, I guess your own examples, or your own experience with this, but also some training anecdotes around the realization of... or the limitations of advice giving.

Kylie McKenzie:

Mm-hmm (affirmative).

Sebastian Kaplan:

Well intentioned advice giving. Maybe you could talk a little bit about what... because... and I fell in this trap myself quite a bit, where by the end of a training I think people are getting the message that they're not supposed to say anything. Right? And so, how do you strike the balance there? Or, I suppose maybe a different question is, what does advice giving in your work look like and sound like?

Kylie McKenzie:

Yeah. I think that's a really important point, and I've worked with a whole range of clinicians from general practitioners, or primary-care physicians, through to paediatrics, and prosthetists, and speech pathologists. So, really quite a broad base of clinical practice, and I think that that's a very common question, "But, what happens when I need to give advice?" I've even got a slide in my training set that says, "I get all this MI stuff, and engaging, but what happens if I really need to give somebody advice?" That's literally what the slide says. I think that it's a relief to people to then have that idea, and I've heard other people on your podcasts talk about it. That idea of Elicit-Provide-Elicit with advice giving.

Kylie McKenzie:

So, check in with somebody first about what they already know about the topic, before you start offering advice. I usually try and frame that as, when you ask somebody first what they know, you get a bit of an indication of the kinds of language they use to describe what it is that you're talking about. You get an understanding of what they understand and what they misunderstand. So, you've got an opportunity to reinforce things that are helpful, that you know have an evidence base behind them, and to supplement what they know when you offer information to help address things that they haven't understood, as well. And then, talking about the idea of permission with advice giving as well. That sometimes people will actually ask you directly for advice, and sometimes that's really important for them. That if you know something, that it's about meeting them with what their need is as well.

Kylie McKenzie:

So, if somebody asks you for information, share the information. That's part of that collaborative process. I think it's about framing Motivational Interviewing consultation with the idea that you bring information and knowledge and expertise and training and skill into the room, and the person brings themselves and their knowledge of themselves, and what they know about how their lives work and what they are able to

do. And that's the meeting point for the two of you. So that if you can share something that they can then use, that's a really positive thing. The difference is where you're not checking in with them about what it is that's important to them, what they do already know. And, that seems to make sense to people.

Glenn Hinds:

Certainly, I imagine, that that's reassuring for people in primary care and GP settings, where they have a very brief encounter. That the idea that there is advice that needs to be given to them, and that shifting the way they've normally done that, I imagine could be quite threatening if it's not supported to recognize, look, we're not asking you to take a completely new way about this, it's just take one step to say... just checking what the person knows before you go forward, and in many ways what that'll do is probably save you time, because you will only give them the information they need to know, rather than all the information you have.

Kylie McKenzie:

I've had the privilege of going to Glasgow a couple of years ago, and as a part of my research, looking at routine consultations in primary care. So, at the University of Glasgow there was a database of primary care consultations with general practitioners, and the premise of the database was that the GPs, the General Practitioners, saw permission and then just recorded routine consultations. So, I coded the Motivational Interviewing behaviors. 60 of the consultations, which were for patients who met criteria for depressions and also had other chronic conditions.

Kylie McKenzie:

So, a very complex group of people. I think that the stand out from that, and something that I've talked at Motivational Interviewing Network of Trainers conferences about, was that one of the key findings from that research was that in a 10 minute consultation the General Practitioner's asked, on average, 17 questions, and as somebody who's engaged in MI, that sounds like a lot of questions, particularly when you realize that the coding scheme categorizes questions as a volley of questions. So, you might say to a patient, "How have you been this week Misses Jones? And, tell me about how your cough's been this week, and how did you go on the new medications?" in a volley and, that's one question.

Kylie McKenzie:

So, 17 of those offered in a 10-minute consult with a very complex person, doesn't give a lot of room for that collaborative approach that is probably recommended for people with complex needs. It took me a while to really think about what sense to make of that, because of course interestingly, your own writing reflex kicks in, and it's like, well maybe people shouldn't be asking that many questions. And, I think the more useful point that I finally got to was, actually, question asking is a core skill. So if question asking is a core skill, how can we use that in a way that is more helpful with these complex people where you do need to move beyond assess and advise, and do need to think about engaging them in healthy behavior change.

Kylie McKenzie:

And so, the paper that I wrote with my two academic GP supervisors focused on the idea of asking questions in the direction of change. In Australia, we probably use the term, "Don't ask an open slather question," where you're asking somebody about absolutely everything going on in their life. If you're there as their primary care physician, as them about the things that are really pertinent to their healthcare, or the combination of mental physical healthcare. It's got a sense of some direction to the question so that you're focusing the question on something that is about your expertise on why they're consulting you, because I also think clinicians get really scared when you introduce the concept of open questions because they've got a seven minute consultation, or a 15 minute consultation, and it's very difficult to manage if you open up a conversation that's not about their clinical skillset.

Kylie McKenzie:

The idea of asking an open question, that includes language about preferences, strengths, interests, needs and the behavior that, as a clinician, you think might be helpful for them, or that they've identified would be helpful. So, we put together a structure in the paper in the Australian Journal of General Practice, about with asking. To try and say, "Questions are really helpful. Here's a way that you might be able to use in your practice that might be helpful for the patients and for the way that at the current primary care system practices, in most Western countries anyway.

Sebastian Kaplan:

I imagine this is also part of your own evolution as a practitioner, and in your own skillset. Going back to the story that you were saying, about how you were trained initially and how that evolved as you were working with patients, more with chronic illnesses and multimorbidity, that the kinds of questions that you were asking before were probably different, and perhaps you were asking far fewer questions and focused more on effective listening and establishing empathy, but this seems to be also something that's shifted for you in... I guess, having, really, an open mind to what the world of a busy General Practitioner is like, and that asking questions is really integral to that work.

Sebastian Kaplan:

So, it's not about turning a General Practitioner into a psychologist. It's about helping general practitioners' questions that are more effective and more efficient, given the limited time that they have.

Kylie McKenzie:

Yeah, and I think that that's especially true for people with chronic illnesses, because... well, one of the reasons that I headed towards a PhD looking at Motivational Interviewing with multimorbidity, is this idea that people who have multiple-chronic conditions are actually, sort of, called the new norm in healthcare. This is not an unusual presentation in healthcare. So, General Practitioners, psychologists in healthcare settings, anybody working in a hospital-based program, is likely to meet

people who have multiple-chronic conditions, and I think the way we've got our current evidence base set up, is really helpful if you're somebody who meets criteria for a single condition, because we've got a proliferation of single disease guidelines, and they're enormously helpful to guide clinician practice, where you're a person who has a single disease.

Kylie McKenzie:

Where they're less helpful, is where you're a person who has more than one disease, because the studies around the potential for treatment burden indicate if you followed all of the guidelines for each of your chronic conditions, you wouldn't have much time in your life for living. And, that's a really difficult place for clinicians to be because how do they guide somebody, who could potentially follow many guidelines, to follow something that will actually benefit their health. And for me, Motivational Interviewing has a real role there, because most people who have a chronic condition, and particularly with mental-physical multimorbidity, they're not going to follow every single guideline because it's overwhelming. So, how can you work with them to collaboratively pick the targets that might have the best impact for them?

Glenn Hinds:

I'm going to use terms... maybe a lot of people will recognize it. It's almost like a harm reduction in a sense that because there's a number of issues going on in your life, that there's a crossover if I give you this instruction, it may impact on the other condition that you have. So, the multimorbidity that you have itself, is a single entity, and what we're going to try and do is work with that and see how we can mitigate the circumstances to make your life as manageable as possible. It's almost like living with the illness to the best of your ability and making your life as meaningful and healthy as possible, even though you are sick and potentially going to be sick for a long time.

Kylie McKenzie:

Yeah. Absolutely, and there's been Cochrane review, and a follow up to that review, about interventions for people living with multimorbidity. Broadly, the recommendations from that Cochrane review, and guidelines from the World Health Organization, and there's a National Health Service report from the King's Fund in the UK, as well. The recommendations about multimorbidity intervention are, that it's Patient Centered, focused on Health Behavior Change, can be integrated into routine care and delivered by improved communicational consultation skills. And so, those recommendations really, to me, start highlighting the potential foreign approach, like Motivational Interviewing, because, Motivational Interviewing is, by its definition, patient centered.

Kylie McKenzie:

It can be focused on Health Behavior Change. It can be integrated into routine care, and I think it's an example of communication skills that are enhanced. That do feature that patient centeredness, and the focus on health behavior change. That's what highlighted my interest, is the qualities that researchers in multimorbidity are identifying as, most

likely, to be effective for people living with multimorbidity, really align very well with Motivational Interviewing .

Sebastian Kaplan:

Right. It's almost as if the authors of those guidelines were trying to basically say, "Use Motivational Interviewing ," but they probably wanted to back off on one specific recommendation of a particular method of counseling or conversation.

Kylie McKenzie:

Yeah. That's really interesting. I haven't read by the authors of the review, that specifically talk about Motivational Interviewing . And so, I actually don't think that is the case. I think that's just a connection that has potential.

Sebastian Kaplan:

Yeah. I would imagine it's possible that they weren't going for that specifically, but it just... the way that you listed those key features of the recommendation, it was like checking boxes in the MI world, certainly.

Kylie McKenzie:

Exactly, and that fit makes sense to me as well. Look, I think we talked about what connects you with Motivational Interviewing , and that idea of the missing piece. For me, one of the things that is useful about Motivational Interviewing is that our... it actually articulates what's meant by something, like Patient Centered Care, or Person Centered Care. I'm not sure what it's like in the UK, Northern Ireland, or the US but I know that there are a lot of hospitals, in Australia for example, that have Patient Centered Care as one of their core values. To the point that it's written on walls in hospital foyers and entrance ways.

Kylie McKenzie:

And, I think if you were to scratch the surface, most people would struggle to articulate what's meant by that. For me, Motivational Interviewing provides words, behaviors, descriptions of things that you can do as a clinician that operationalize patient centeredness as an idea, and I think that's really useful because when you say to a clinician that you're doing something in the best interest of the patients. You're working with them collaboratively. You don't have clinicians of any variety say to you, "Oh, I don't want to be doing that." It's the how of doing it that is, I think, sometimes hard to connect with as a clinician.

Sebastian Kaplan:

Yeah. I really appreciate you saying that, Kylie. The image of the patient centeredness plastered on the walls. I think there's a wing or two at the hospital that I work at, that I can think of, that are the same. But also, I don't know of any practitioner that would claim to oppose being patient centered. No one's going to raise their hand and say, "That one's not really for me," or, "I don't really abide by Patient Centered Practice," but

I think you're right. There's just a real limited grasp of how you actually do that. As you said, how to operationalize that.

Kylie McKenzie:

Yeah. So patient centeredness is absolutely something that appeals to clinicians. It makes sense to them, and I think most clinicians who are trying to achieve that in their practice, they're just not quite sure how to go about doing that. And, I think one of the things that I've used in training, and have used in training some of the clinicians in the collaborative care trial I'm a part of, working with patients with multimorbidity, is the video about the writing reflex. It's well articulated by Bill Miller in a video which is available, I think, on Vimeo and on Skype, and it's called The Righting Reflex.

Kylie McKenzie:

What he talks about is something that really makes sense to me. That, clinicians, when they are giving advice and telling, confronting, cajoling, trying to encourage somebody through that directive approach, it's coming from a really good place. It's coming from wanting people to have better health outcomes. To live better lives. And, I think the thing that he highlights in that video is that, in fact what it does is it elicits the other side of the argument for people. So that, if you push for the behaviors that might be helpful, what you get back is the other side of the argument.

Kylie McKenzie:

And, he uses a phrase which I've sort of picked up and run with in my training, and I think it's again going back to that idea of the missing piece. He uses a phrase where he says, "It's important to give the patients the good lines." So, rather than us making the arguments for change, it's about encouraging them to make the arguments for change. And for me, a lot of clinicians really click with that idea of, "Oh, actually, if it's my job to engage people with making a change, I can do that better by getting people to talk about it themselves." So, what do they want to do, what are they able to do, what's important to them, and that idea of moving to trying to push people into change by telling them how to do it, and what to do, and drawing from them what they could do themselves, what's important to them. That idea of the good lines, I think, is a concept that makes sense to people and is a way of articulating how you can be patient centered in your practice.

Glenn Hinds:

It seems to be beginning to explain the point that was being made about the person centeredness being written on the wall, and I think back to a piece we did with David Rosengren, where he described the difference between fluency and mastery, and the idea that there's lots of concepts in helping them, perhaps in all aspects of life, that because they're so familiar, there's a fluency to the... my mind recognizes this work, therefore I don't need to do anymore work on it. But, what you're describing is that that shift needs to take place, and that is maybe about supervision, that is maybe about training, but it's certainly about practice, it’s about how do I put what's written on the wall into practice with my clients, and what you're saying is Bill articulated in one way, which

is to create an environment where you ask the types of questions where you elicit the good lines from the clients. So, I'm just curious to what sort of things could people be thinking about doing, or questions could they be asking? How do we get clients to give us the good line?

Kylie McKenzie:

We ask for them. I think that that's a really... you pose a really good question there because that's exactly what we're talking about. Is how do you put into practice the concepts that you're talking about. And in this case, one way that you can get the patients to give you the good lines, is to ask for them. So, if the good lines are what's important to people, what their preferences are, what they're able to do... that you can actually ask questions that incorporate those idea, and the clinical practice paper that I wrote with my supervisory colleagues, Professor Jane Gunn and Associate Professor David Pierce from General Practice at University of Melbourne, that's one of the things that we put into that paper. A structure that has the open question stems.

Kylie McKenzie:

So, what, why, how, tell me about. And the words that form the basis of the good lines. You know, what do you want, how important is it to you, what are you able to do, tell me about what your preferences are, and then also adding into that the target behavior. So, if you can picture it... and you can see it in the article, but if you can picture it, there's like a structure where you can put together a question using open questions stems, using the good lines or the language of change. Or, for those more familiar with Motivational Interviewing, the words more associated with change talk, and the target behavior.

Kylie McKenzie:

And, if you think about that in just natural language, if you say to somebody, "What do you want to do on Saturday night?" They'll say, "I want to." So, by asking somebody questions that involve the good lines, what they want, what they can do, what they've got reasons to do, what they're willing to do, that's often what people will answer with. Then so, you can really facilitate people offering those good lines, and offering their own preferences, values, strengths, interests, and that's what makes it patient centered.

Sebastian Kaplan:

So, this is really getting at what you were talking about a moment ago, about changing the kinds of questions. Not necessarily asking fewer questions just for the sake of coding or something. It's asking really specific, strategic questions in the short period of time the GPs have to draw out a patient's own desires and plans, and ways they might go about making changes as they're grappling with a pretty complex set of circumstances, often times.

Kylie McKenzie:

Yeah, and it's kind of like what we do in clinical work with people. We start with where people are at and we use their strengths... or, we elicit from them what their strengths

are, and one of the things that I think we identified from the observational study of some routine practice, was that asking questions is a core skill. And so, if you can ask questions that support a Patient Centered Approach, and that are focused on Health Behavior Change, then that's a useful thing to do with somebody who's trying to navigate through multiple single-disease clinical guidelines, to get their best outcomes.

Kylie McKenzie:

So rather than trying to get people to do everything, you get them to do the things that are important to them, that they feel like they can do, and that's more achievable. An achievable goal is an important approach to take.

Glenn Hinds:

For me, it sounds like the invitation for us as practitioners, and certainly for physicians, to have a lighter touch in relation to their support of patients that maybe the patient wants to talk about... or, is willing to make certain changes that don't sit with the priority for the practitioner, or the physician, but some progress is better than no progress. And, for some reason I have an image of a knot made up of multiple threads, and it sounds like part of what we're exploring is, what type of questions can I ask to help this knot begin to be undone, rather than me to say which thread needs to be released first.

Glenn Hinds:

And, that that's the invitation for practitioners, is... look, there's a lot of things being influenced here, let's get some progress somewhere, and that momentum itself is going to be progressive and beneficial for the patient, which is ultimately what you're there to do, is to be helpful for them.

Kylie McKenzie:

You offer a really lovely metaphor there, Glenn, because we all know what happens when you pull on the wrong string on a complicated knot. You tighten the knot, and it makes it harder to disentangle, and so by allowing the patient to choose which part of the tangle that we'll start with, you're much more likely to have some success. And, they're more likely to have some success.

Sebastian Kaplan:

So, Kylie, I wonder if we could hear a bit more about something you said a few moments ago. You used the phrase that you work with, collaboratively picking the targets for change, right? And-

Kylie McKenzie:

Yeah.

Sebastian Kaplan:

... it seemed like another nice example of, not just patient centeredness, but of focusing within Motivational Interviewing . Could you talk about an example of an individual who

had multimorbidity? So, maybe bring up a case example, if you will, of somebody who has two or three health conditions, and how you might go about collaboratively picking the targets with that person.

Kylie McKenzie:

Mm-hmm (affirmative). So, there's a couple things I'm thinking about from your question, and from what we talked about, a little bit earlier too, and one of them is about that the clinician in the room holds expertise about something that the patient, or the client, has come to see them about. So, I think it's useful for the clinician to be a part of the conversation about what they can be helpful with. I'm thinking about an example from one of the pediatrists that I work with at the hospital, who had spent a lot of time working with a patient who had multiple-chronic conditions, and trying to get that patient to change his footwear because of the risk with diabetes, of ulcerated feet and then the potential for amputation, and how very important that is.

Kylie McKenzie:

So, he was trying to come at that any which way he could to try and emphasize the importance of footwear that didn't make the situation worse, and trying to engage the patient to change their foot care and their self-care because of the absolutely high risk of a negative outcome. The thing that he came and talked to me about was, it clicked for him one day because he'd done some Motivational Interviewing training that... instead of telling this patient to change what it was he was wearing, he said to him, "What's important to you in the activities you do every day?" And, the patient talked about the idea of being able to be a little more active with his grandkids, and he said, "So, what do you need to be able to be more active with your grandkids?" And the patient said, "I probably need a better pair of shoes."

Kylie McKenzie:

You know, it's a very simple example, but it's trying to tap into what's important to people. I think that doing that within your own clinical framework is an important thing to do. And the other thing that strikes me about the idea of focus, is that sometimes our hospital, or service, or clinic administration systems actually take a lot of time for people to get through, and they can actually be a barrier in the way of getting to a focus for a patient. We ask a stream of questions and a whole range of background information, some of which is important, and some of which isn't.

Kylie McKenzie:

And, I think that there's room for us to think more seriously about how our administration systems can support trying to come to a focus that's important for a patient. So, one of the things that I'm going to evaluate as part of the care navigation trial for multimorbidity that I'm working on, is, what's the impact been of asking people in a survey-based way about evidence-based potential behavioral targets that are important to them. So, it's a depression in primary care trial, and for people who have complexity and chronic conditions. And they're asked about a range of behaviors that we know from the evidence are related to better, or worse, outcomes with depression. So things like sleep,

and healthy eating, and physical activity, financial management... a whole range of contributors to depressive symptomatology, and people are asked to rate those core areas, those target areas, and then that conversation has some focus to it.

Kylie McKenzie:

When you meet with the person... you know, "When you filled out the screening questionnaires, these couple of behaviors appear to be really strong priorities for you. How important are they to you?" And then you've got a conversation that has a focus that is supported by the administration for the clinic. So, I think that there are some things that we can do that support clinicians to have these conversations as well. I'm not sure if I answered your question there, but there's a whole range of thoughts about focus.

Glenn Hinds:

It sounds like, in some ways, that given the multiplicity and the multimorbidity that you're describing that there's a number of doors we could walk through. Let's find the door that easiest to push open and go through that door first. Or, certainly invite to the patient. It's interesting, what you're describing resonates with another conversation we had with Doctor Damara Gutnick, and she talks about the idea of what matters to you. Not what's wrong with you, but what matters to you, and work from the client's priorities. And start the helping conversation there, and it sounds like even by doing that survey approach... I imagine that that speeds things up because it's got the client to begin to think of the patient, to begin to think about what's important for them before they even walk into the consultation. And time has been saved where the practitioner can immediately go, "All right, I can see from what you're saying," and to start working there. In many ways I can see that that would, in some ways, help the patient or client feel that their point of view has been taken serious because that's been the priority for them.

Kylie McKenzie:

Yeah. Absolutely, Glenn. I think that we could invest a lot more time in thinking about how we get to that point, in a way that honors what's important to the patient. Also, I think sometimes I think the clinician's expertise... Like the question you asked me about earlier, Sebastian, where you said, "But, what about in training when people want to be able to provide advice?" Clinicians do hold information, and they can identify sometimes what would be helpful for patients, and it's about how you get those two things to come together in a helpful way.

Kylie McKenzie:

And again, we've talked about what does patient centered mean, what does collaborative practice mean? And I think that how you bring together clinician expertise with patient priorities is... it's not always that easy to do. So, the more we can find ways that support that collaboration, I think the better we'll be.

Sebastian Kaplan:

Yeah. I mean, it does seem like it's trying to find the right balance between relying solely on telling what the patient should do, from the perspective of the provider of course, but also not the other extreme of it only being about drawing out a patient's desires, and goals, and wants, and aspirations... that there's a place in the middle where there is more a focus, when using MI of course, on what's important and what matters to the patient. But, there's absolutely room for a clinician using the clinician's own expertise, to provide some suggestions or some advice about a person's presentation and what their lab results might mean, or what their physical presentation, or their physical exam might suggest. That in essence is the collaborative part of it, that both sides can influence the direction.

Kylie McKenzie:

Yes. Yes. That bringing together the clinician and patient is... it sounds like such a simple thing, but I don't think it is as simple as it sounds, and I think one of the things, as MI trainers, to be aware of is that potential risk that people leaving MI training without a set of skills for being able to support patients with what they do know, and that's the balance. Which is also very similar to that idea I had, where actually asking questions is a core skill. How do we do that in a way that's more helpful? Owning a device and having advice to give is what people invest a lot of their training time in, but how do we offer it in a way that's more helpful?

Kylie McKenzie:

So, I think there's been some discussions, in amongst Motivational Interviewing trainers, at times, about the idea of, is it important to get all clinicians to be Motivational Interviewing proficient? Or, is it most helpful to just get them on the continuum?

Glenn Hinds:

Okay, hopefully the audience... you're not really noticing just how many technical hitches we've had today, but we've just experienced one, and for the sake of continuity I'm just going to summarize it. My understanding is it... what we were talking about before Kylie, was just the fact that the idea of the continuum of understanding both from a practitioner's perspective, which is helping people to get on to a recovery continuum, at any point, is a good place to start.

Glenn Hinds:

And then from a training and practitioner's perspective that, learning to do something helpful, on the continuum of the helping realm itself, is very useful from an MI perspective... that, as trainers when we're going to practice. Like, getting people to do something different, not necessarily pure MI, itself is useful. And just to elaborate on that, if you could, just on the notion of the continuum and what else you were saying about it. Please.

Kylie McKenzie:

Yeah, absolutely. I think that meeting the full criteria of something like the Motivational Interviewing treatment integrity code can be a little overwhelming for clinicians who

meet MI for the first time, and I think the things we took away from the observational study of routine practice in Scotland, that were helpful, were to think about in what ways can you ask more helpful questions as a clinician? So, questions that are in the direction of change. To be very thoughtful about providing advice and direction, and... so that that advice doesn't have a confrontational quality to it.

Kylie McKenzie:

So, of the consultations we observed in Glasgow, 18% of them had something that had a warning or a threatening component to the advice. So not confronting. Asking more helpful questions. Providing advice that's targeted. So, in a 10-minute session, the clinicians were offering 12 pieces of advice, as well as asking 17 questions, and so that's a lot of information for people who are in complex situations, to take on board. One of the strengths we also saw in those consultations was that 2/3 of them... there was a reflection of some sort in the session, and so we've got a baseline where clinicians offer reflections, they ask questions. And to get them on the continuum, can they ask... find a way to ask more helpful questions that are more helpful for... clinicians, and for the patients.

Kylie McKenzie:

And find a way to target information that they offer, and advice that they give so that it does make those priorities of patients. So that those kinds of ways of getting on the continuum of Motivational Interviewing practice, finding ways to be more patient centered, and finding ways that really elicit from the patient what's important to them. Some of the key ideas to take away, in the direction of having a consultation that has a more Motivational Interviewing flavor to it.

Sebastian Kaplan:

Wonderful. Kylie, we're approaching time to start winding down here, and I wonder if you could share a little bit about the research that you're conducting now? We understand that you are close to completing your PhD, so congratulations about that, ahead of time. What are you looking at now, what are some of the... what's your work focusing on?

Kylie McKenzie:

So, I've moved through some core skills in the research process, and that's been good as a longstanding clinician to step back a little bit from that MI enthusiast role, to being somebody who really looks at research and the concepts of MI, and how they apply, and looking at that for multimorbidity. So, the systematic review of Motivational Interviewing and healthcare across a range of conditions was, sort of, step one. The routine care observations was step two, and from there my work has been looking at the development of an intervention that we're calling Care Navigation for people with mental-physical multimorbidity in primary care.

Kylie McKenzie:

So, an intervention that supports them to make changes aligned with an evidence-base for improving depressive symptomatology, and my job now is to have a really close look at some of those consultations, about 10% of which have been recorded, and the clinician reflections about how the session went. Also, the written material that was shared between the patient and the clinician. And, that that's had a deliberate emphasis on supporting self-efficacy and reinforcing the behaviors for the patient's making, in the direction of change. So I'm at this really exciting part of the research, where I get to have a really good look at how an intervention that's been strongly informed by Motivational Interviewing ... how it went. And also, what the clinician's reflections of that has been. So that's next, and I'm hoping from that, I can share something that is really pertinent and helpful to clinicians working with patients or clients who are living with multimorbidity because increasingly... it's a really core part of the work that all of us will be doing.

Glenn Hinds:

So, in some ways it's a bit more depth high practitioners or physicians learn to do things differently, or to influence the conversations that they're already having with patients, in a way that we now know is most efficient for the patient and their outcomes.

Kylie McKenzie:

Yes. So, that and what are the outcomes for the patient. So, there's a lot of research in multimorbidity about the impact of socio-economic disadvantage, and much earlier onset of multimorbidity. So, one of the things that I'm interested in looking at is the context for the patient, and that the... taking what's called a realist approach, to the evaluation. So, what works? For who? And in what circumstances? So, thinking about the approach that has been put in place for this. The situational context for the patient, and also trying to answer the question of, if MI was used, to what extent? Because a lot of the studies about MI don't always report Motivational Interviewing fidelity, or integrity as part of that. So, I'm really interested to know what a brief training program, and what effect that has on the practice of the clinicians as well.

Sebastian Kaplan:

Well, surely exciting developments to come, both in the clinical practice and training around helping people with multimorbidity. So, Kylie as we wind down today's conversation, one of the things that we ask our guests is if they would be willing to... if there are people in the audience that wanted to reach out with questions or comments, if they could contact you directly. So, would you be okay with that, and if so, how would people contact you?

Kylie McKenzie:

Absolutely, I'm okay with that, and I respond when people contact me, as well. My email is kylie.mkenzieunimelb.edu.au, and that's McKenzie with an M-C-K. And oh, I guess Kylie's not a common name outside of Australia, I think it spread to the UK a little bit. So, K-Y-L-I-E.mckenzie.edu.au. I'm also on Twitter as a very, very poor participant. I

pop in and out of there occasionally, but I can be contacted through there and my Twitter handle is @_KMcK.

Glenn Hinds:

Fantastic, and we'll certainly link people to your Twitter handle when we Tweet out this episode and invite comments. You can contact us on the Twitter handle ChangeTalking, and Facebook Talking To Change, and the email address is podcast@glennhinds.com.

Sebastian Kaplan:

Great. Well Kylie, thank you so much, this has been really, really a fascinating conversation and we appreciate your expertise, your knowledge and of course your patience through our technical glitches today.

Kylie McKenzie:

I appreciate your interest in some of the work that I've been doing, and always the value of the conversation, and benefited so much just from hearing the two of you summarize some of the things that I've been thinking through as well. I really hope that some of those ideas are helpful for clinicians who are listening as well.

Glenn Hinds:

Fantastic Kylie. We really appreciate it, again. Seb, as always, good to talk to you man. Have a great day. Kylie-

Sebastian Kaplan:

Okay.

Glenn Hinds:

... thank you very much, and we will be talking to you all soon. Thanks everybody.

Kylie McKenzie:

Thank you.

Sebastian Kaplan:

Thanks guys. Bye-bye.