Motivational Interviewing: A Tool to Help Improve Follow-up Dental Care for Children

Enrolled in Denver’s Great Kids Head Start Program

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Introduction and Literature Review

Introduction

In the 1960s, the United States embarked on the “War on Poverty,” under the leadership of President Lyndon Johnson. One of the many programs and initiatives undertaken in this movement was the Head Start program, which began in 1965. Originally a plan to stop juvenile delinquency (Pennsylvania Head Start, n.d., p. 1), Head Start quickly evolved into the comprehensive child development program for impoverished children that we see in preschools across the country. Denver’s Great Kids Head Start (DGKHS) was officially started with a grant in 1997, under the vision of all Head Start programs, “To prepare Head Start children to enter kindergarten confidently with the social, physical, emotional, and cognitive skills and competencies necessary for continuing school success” (DGKHS, n.d., p. 1). To that end, the program provides vision, hearing, and dental screenings; brief physicals; and nutritional and family services in addition to the more familiar preschool education.

During the previous federal review, dental health was identified as a problem area for the DGKHS program and the children it serves. In the ensuing years, the mayor’s office has put considerable effort into addressing this area. The intervention addressed in this health promotion plan is a relatively new method of promoting behavioral change called Motivational Interviewing (MI). Head Start program directors and community partners in the Mayor’s office and at the University of Colorado believe evidence supports the use of MI by nurses, teachers, and family service workers to encourage behavioral change by parents and children regarding dental health and other identified problem areas such as obesity and nutrition. More information regarding the particulars of this intervention will be provided in the following pages.
Population

As a comprehensive program, Head Start focuses on preschool aged children – under age 5 – but also works with the families of those children to ensure well-rounded and healthy development. The population of focus for this health promotion plan consists of children under the age of five and their families living in the DGKHS area whose income is at or below the established poverty level, which in 2008 was an annual income of $21,200 for a family of four (Head Start, 2008). According to the 2000 Census, there were 6,100 children living in the DGKHS area who qualified for the Head Start program (Thornton-Kolbe & Good, 2008, p. 7). Between 2000 and 2006, the population of Denver increased by 10.5% (Thornton-Kolbe & Good, 2008, p. 6), so if we assume a similar increase in the number of qualifying children over the same period, we can tentatively estimate that the number of qualifying children had risen to 6,740. During the 2007-2008 program year, 1,467 children accessed Head Start programs (DGKHS, 2008, p. 1). Thus, assuming the above calculations are relatively accurate, our population of focus comprises approximately 22% of the population of interest. According to ethnicity, 62% of the children enrolled in DGKHS during the 2007-2008 program year were Hispanic or Latino; by race, the majority were either black or African American (25.5%) or Caucasian (40.5%). The remainder were bi- or multi-racial, American Indian, Asian or of unspecified race (DGKHS, 2008, p. 2).

Assessment

DGKHS funded and directed two community assessments last year that are essential to understanding the population of focus. The first is the Head Start Program Information Report for the 2007-2008 Program Year, which is a comprehensive statistical evaluation of both enrolled families and program staff, and provides data ranging from enrollment demographics to
family, medical, dental and mental health services. This report identified a range of needs and assessed the impact of DGKHS on them. Among them were the following health insurance enrollment, medical services – primarily for cases of obesity, vision problems, and asthma (p. 7-8), family services, and dental services.

The second major source is the Denver Metropolitan Head Start Community Needs Assessment for 2008 (Thornton-Kolbe & Good) which provides a more in depth evaluation of the needs of the community and how they can be met. The Needs Assessment covers all Denver-area Head Start programs, not only the Denver Great Kids community. The first need identified by Thornton-Kolbe & Good (2008) was for improved education for adults with a focus on job training and basic math, literacy, and science skills, because adults with higher degrees of education can provide greater opportunities for success for their children (p. 67-69). Like the DGKHS Report, this Needs Assessment also puts strong emphasis on access to health services, focusing on health insurance, primary care availability, community health factors such as second hand smoke and lead ingestion, behavioral health, and, or course, dental health (p. 71-83).

Family services is another area of interest in this assessment, as Denver has the highest rates of new out-of-home placement rates in the state (p. 85). Finally, housing and energy were identified as important needs to be addressed in Denver, 38,553 renters received low income housing assistance in 2007 at the beginning of the current housing crisis (p.90). It is likely that this situation worsened in 2008, making it an even more pressing community need.

Health Issue

In the previous section, we noted that dental health is a considerable concern for DGKHS children and that this would be the central issue addressed by this paper. Dental health is a pervasive problem nationwide: Thornton-Kolbe & Good (2008) report that 53% of children six
to eight years old have cavities. Furthermore, only 66% of children living at or below poverty visited the dentist in the previous year. Between 2003 and 2004, for preschool children living at or near the poverty level the proportion with untreated dental caries was 29% (p. 79). Also reported in the Community Needs Assessment was the finding that “80 percent of tooth decay is found in just 25 percent of children, most of whom are from low income and minority families” (Thornton-Kolbe & Good, 2008, p. 80). In 2007, “almost four in ten Head Start children [were] identified as having dental needs, an increase of 33% in all children from just a few years ago” (Denver Head Start, p. 3). As stated before, for DGKHS children the rate of received dental care versus those who were identified as needing it after a screening was 83.30% (DGKHS, 2008, p. 9).

The nature of the problem as assessed by DGKHS staff and directors is three fold: First, many families do not understand the fundamentals of dental health like brushing teeth, eating low sugar foods and not allowing high sugar foods to stay in the mouth for long periods (juice bottles and suckers, for instance). Second, many families underestimate the importance of having healthy baby teeth, assuming that they will “fall out anyway, so who cares if they fall out early” as one Head Start nurse said. To the contrary, losing primary teeth early may result in chewing and speech issues, as well as malocclusion of permanent teeth – making them hard to clean and more prone to dental disease, as well as potentially requiring costly orthodontic intervention (Goepferd, 2000, para. 5). Furthermore, it has also been linked to more serious health complications like diabetes, coronary artery disease, and premature labor (Macnab, Rozmus, Benton, Gagnon, 2008, p. 2). Many parents view cavities as holes in the teeth, and therefore wait until the problem is highly advanced and symptomatic – painful – for the child, at which point the treatment will be invasive. This distresses parents, who then again wait for
dental health problems to become extreme before accessing care (Weinstein, Harrison, & Benton, 2004, p. 731). Finally, when referrals to a dentist are made after an initial screening, families regularly decide not to follow up on appointments. In conversation, Head Start nurses and other community partners have identified a number of obstacles to following up on these appointments: Insurance coverage may be insufficient and the out-of-pocket expense too great causing parents to choose between food or rent and dental care; transportation and scheduling can be difficult with many parents working more than one job or caring for multiple children. Other possibilities include children’s fear of the dentist and parents’ fears of being labeled as bad parents.

*Intervention & Literature Review*

Dental health has been recognized as a central health issues for decades. As a result, numerous public health initiatives have targeted dental health. The most ubiquitously applied and most successful of these has been fluoridation efforts. Fluoride inhibits bacterial metabolism, inhibits demineralization of teeth once crystallized, and enhances remineralization (and repair) of teeth (Featherston, 2000, pp. 888-889). Jones, Burt, Petersen, and Lennon (2005) discussed efforts to fluoridize water, salt, milk, and toothpastes. They found that all were effective, but that water and milk fluoridation had the greatest effect among poorer people because they did not conflict with other public health concerns – like salt and heart disease, or come at an increased cost to consumers – like toothpastes (p. 672, 673). Riley, Lennon, and Ellwood (1998) found that when Townsend Material Deprivation Index scores and Decayed, Missing, and Filled Teeth scores were plotted against each other, water fluoridation was associated with a slope of approximately half that of unfluoridated communities, which means that it had a significant effect in reducing dental health inequalities (p. 302). Another successful
intervention was implemented in an underprivileged aboriginal population in Canada. The program consisted of daily brush-ins at school, weekly fluoride rinses, dental health guidance by pediatricians and classroom presentations about dental health (Macnab, Rozmus, Benton & Gagnon, 2008, p. 3). The authors found that this significantly reduced the ‘time required to treat’ children for dental caries (p. 4). This intervention created a strong partnership between healthcare workers and families, and has led to a number community led interventions to improve nutrition and immunization rates as well (p. 6).

Dr. Paul Cook and Gloria Richardson, director of DGKHS, have collaborated in the last year to make motivational interviewing a central component in their efforts to encourage improved oral care, as well as other health behaviors, in the DGKHS children and families. Motivational interviewing (MI) is a counseling method that “works by activating a patient’s own motivation for change,” rather than relying on the motives of the health care practitioner (Rollnick, Miller & Butler, 2008, p. 5). Rollnick, Miller, and Butler point out that within health care, the tendency is to direct patients from a place of authority and expertise: practitioners tell patients what to do and expect them to do it (2008, p. 15). MI takes a more guiding stance, involving informing as an expert but also asking and listening, and focuses on helping a “patient make his or her own decisions about behavior change” (p. 19). It recognizes the validity of the patient’s obstacles to change, and then partners with the patient to find agreeable solutions.

DGKHS leaders and community partners believe that MI can and ought to be used to work with parents on improving oral health at home and on increasing the proportion of families who follow up on dental referrals after original screenings. There is considerable evidence supporting the use of MI for encouraging all manner of behavior change. Rubak, Sandboek, Lauritzen, and Christensen (2004) conducted a systematic review and meta-analysis of MI. They
found articles in which MI produced a significant effect in 74% of randomized controlled trials related to reducing BMI, total blood cholesterol, systolic blood pressure, and blood alcohol concentration (p. 309). Furthermore, in studies of MI with alcohol abuse, psychiatric diagnoses, and other addiction problems, motivational interviewing was found to be more effective than traditional advice giving (p. 308) – an important result given the tendency of healthcare professionals to depend on advice giving. Suarez and Mullins (2008) presented a review of the literature concerning MI and also found it to be an effective tool for behavior change in pediatric populations. They found that MI resulted in a significant reduction of caries in two studies, a significant reduction in ambient indoor nicotine levels in homes with smoking parents, diet and BMI changes in obese and overweight children, and improved treatment attendance and adherence in families needing counseling services (p. 423). Thus, there is strong evidence for the use of MI in behavior change for a wide variety of behaviors – many of which, while not directly addressed in this paper, are areas of concern for the DGKHS population.

More specific to the dental caries issue, a few studies suggest that MI can be helpful in affecting parental attitudes and behaviors, and thus altering outcomes in children. Weinstein, Harrison, and Benton (2004) conducted a randomized controlled trial of MI for the prevention of caries in underprivileged Asian immigrant families. Both groups received educational materials, while the experimental group also took part in motivational interviewing sessions. At the one year mark, the researchers compared the two groups and found that “the children in the MI group had 0.71 carious surfaces…, while those in the control group had 1.91 carious surfaces – a statistically significant result” (p. 735). Weinstein, Harrison, and Benton (2006) conducted a follow up study of the same groups and found that only 35.2% of children in the MI group had new cavities, while 52.0% in the control group did – another statistically significant result.
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implying that MI has a protective as well as an immediate effect (p. 791). Finally, where dental treatment – and not just prevention – is concerned, Skaret, Weinstein, Kvale, and Raadal (2003) found that compared to a control, the group receiving MI had significantly more positive attitudes toward dental treatment.

*Cultural Implications*

There are a number of important cultural implications to consider with the use of motivational interviewing, and they concern not only the cultures of the families but also those of the practitioners – nurses, teachers, and family service workers – implementing it. For the families, the major cultural concern with regard to treatment is affordability and access. Many lower income families are unable to afford dental treatment, or would have to sacrifice in other areas that they believe are a higher priority as long as their child appears healthy as they define health (Betz, 2008, p. 158). MI may help patients to reevaluate their priorities, but it does not address their poverty and inability to access the care they need. Another cultural implication that is important to families and DGKHS practitioners is language and communication. One teacher said she felt unable to use MI effectively because she did not speak Spanish and most of the families she would have liked to speak to were Spanish speaking only. For families, this also presents a barrier because if they do follow up they may not be able to communicate their concerns to the dentist, and they may also have difficulty understanding the dentist’s terminology and recommendations (Betz, 2008, p. 158-159).

*Assessment and Theoretical Framework*

*Assessment and Levels of Prevention*

As stated above in the “Population” section of this paper, the target population for this health promotion plan is children ranging in age from three to five years old in need of dental
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care, and their families who are enrolled in DGKHS. To enroll in DGKHS families must live
within a specified area of Denver, and the family income must be at or below the established
poverty level, which in 2008 was an annual income of $21,200 for a family of 4 (Head Start,
2008). As of 2008, 62% of the children enrolled were of Hispanic or Latino ethnicity; by race
the majority of the families were classified as Caucasian (40.5%), followed by black or African
American (25.5%), with the remaining classified as bi- or multi-racial, American Indian, Asian,
or unspecified (DGKHS, 2008, p. 2). The primary language of families enrolled in DGKHS is
led by English (53%), followed closely by Spanish (43%) (DGKHS, 2008, p. 3). Several
teachers and staff at DGKHS have mentioned that their inability to speak the Spanish language
has proven to be the biggest cultural barrier in communicating with families.

According to Gloria Richardson who is the Health Administrator for DGKHS, tertiary
care for necessary dental work has been one of the most challenging criteria for their kids to
meet. When children are enrolled in the Head Start program they are required to have elements
of secondary care including a current physical, up-to-date immunization records, and have a
dental screening. Thus far, DGKHS has successfully employed a system where virtually 100%
of the children are able to meet these secondary preventative care requirements. When the dental
screening has indicated a need for follow-up care with a dentist, however, the situation has
proven more difficult. Ideally according to federal regulations, 100% of the children would
receive the indicated follow-up dental care – though in general, any proportion above 90% is
considered acceptable by reviewers. According to a health assessment conducted for the 2007-
2008 program year, only 83.30% received the needed dental service (DGKHS, 2008, p. 9). The
issue for the staff at DGKHS is how to convince and motivate parents to follow through on
dental care for their kids.
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Fortunately, these children have assets that can be utilized to help remedy the problem. The most obvious asset is DGKHS. It needs to be mentioned that 83.3% of kids in the program are getting follow-up dental care – without DGKHS, these are children who probably would not have received needed dental care. DGKHS is aware of the children who are not getting the follow-up dental care and is using its plethora of resources to help remedy the situation. The particular resource that health promotion project focuses on is the use of Motivational Interviewing (MI) by DGKHS staff to encourage parents to follow-up with dental care for their child.

Another resource these children have is their families. To enroll a child in a Head Start program takes some initiative by the parent. Children whose families have successfully maneuvered through the bureaucratic process of enrolling their child have shown that they are invested in the future of their child. They have also shown that they are capable on following through with the necessary responsibilities of showing up for appointments and gathering the necessary paperwork.

Behavioral Change Model

MI is an intervention that can be used with clients that are in any of the stages of health behavior change as illustrated in the Transtheoretical Model of behavior change. Dr. Paul Cook with the University of Colorado at Denver College of Nursing created a handout outlining the specific MI techniques to use for the client in the various stages of behavior change. In the Precontemplation stage, the goal for the “therapist” is to listen, empathize, and glean more information. In the Contemplative stage the goal is to help the client “…increase the perceived benefits of change” (Appendix B). During the Action stage the goal is to guide clients in “…decreasing the perceived barriers to change” by using encouragement, asking questions that
help the client solve problems, and encouraging the client to change at a slow, steady pace (Appendix B). For the Maintenance stage, the goal is to “…help the client stay focused, and reduce the chance of relapse” (Appendix B). At the time that Dr. Cook created this handout the stage of Preparation in this behavior change model had not yet been identified. When reading the handout, it is important to note that MI was first developed to aid in treatment of drug and alcohol abuse, hence the use of words like “relapse” which may not be readily applicable to dental care follow-up.

Despite the fact that DGKHS plans to use MI to increase parental compliance with follow-up dental care for children, and not as a treatment for drug and alcohol abuse, the model described above can be applied to families. Because parents will be aware of the results from the dental screening, teachers and staff will mostly be using the MI techniques for the parent who is in the Contemplation stage and the Action stage. The goal of the MI intervention on parents is to understand the barriers inhibiting them from following-up on needed dental care for their children, and helping them explore solutions.

Spectrum of Prevention

According to the Spectrum of Prevention Model which helps organize efforts to promote behavioral change within a population, the intervention for this project falls under categories numbered three (educating providers), five (changing organizational practices), and six (influencing policy and legislation) (Cohen & Swift, 1999, Figure 1). Dr. Cook is in the process of educating providers on the practice of MI. The eventual goal is for all of the staff at DGKHS to be trained in the use of MI. It is through this training that “norms will be shaped to improve health and safety” and thus accomplish category number five (Cohen & Swift, 1999, Figure 1); and, if successful, policy change will eventually follow, thus addressing category number six.
There are currently other interventions being implemented that complement the MI education received by staff with the goal of improving dental health within the DGKHS program. An education bin has been assembled that contains literature, pictures, and a DVD all geared toward the dental health of children. This intervention which is presented to a group of parents and children who are enrolled in DGKHS addresses numbers one (strengthening individual knowledge and skills) and two (promoting community education) of the Spectrum of Prevention Model (Cohen & Swift, 1999, Figure 1). The creation of the bin which required a nutritionist, administrators and other professionals, addressed number four (fostering coalitions and networks) of the Spectrum of Prevention Model (Cohen & Swift, 1999, Figure 1).

**Intervention**

*Purpose of Intervention*

MI is being introduced to teachers and nurses of Denver Great Kids Head Start as a tool to assist them in motivating and changing parents’ behavior and elicit follow through on necessary dental appointments for their children, while maintaining the parent’s autonomy in the decision making process. DGKHS identified that a lack of education regarding preventative dental care, financial and situational barriers to care, and the misconception that it is not important to maintain healthy baby teeth are all factors that contribute to parents lack of follow through on dental care for their children. According to the Denver Great Kids Head Start Program Information Report for 2007-2008 Program Year, only 83.3% of students who needed follow up dental care obtained necessary treatment (DGKHS, 2008, p. 3). Through MI, DGKHS is working to achieve 100% compliance on follow up care for children in need of dental treatment, as well as using MI to help educate families on the importance of preventative dental care and identify barriers to care.
The central objective of using MI as an intervention with this population is to meet federal regulations for dental care referrals, meaning that more than 90% of children referred for further treatment will follow up on those referrals. Other objectives involved in this intervention are to increase the proportion of children with a dental home for 83% to above 90%, and have all DGKHS teachers, nurses, and family service workers trained in the use of MI in a short period of time (yet to be determined).

In addition, parents of low-income families often feel that attaining dental care is difficult, and consider dental care among their top 3 parental concerns. According to the Head Start Community Needs Assessment, March 2008, “19.8 percent of Head Start income-eligible families report difficulty in accessing dental care for children while 14.4 percent of families with incomes over the poverty line have reported access problems with dental care in the last year” (Thornton-Kolbe & Good, 2008, p. 125). Through the use of Motivational Interviewing DGKHS will also be able to identify families with barriers to care and assistance to families through Head Start and other appropriate programs and thus reach their goal of 100% compliance.

Description

The process of training staff and implementing the use of Motivational interviewing has continued over the course of the last year. An MI information session was provided for approximately 150 staff in October 2008, which was followed by an in depth MI training in November 2008, which 27 people attended. It is currently 3 months after the first training, and the first staff evaluation of the effectiveness of motivational interviewing is being implemented. Two separate meetings are planned, and a survey, attached in Appendix A, has been created to assess how the use of motivational interviewing is progressing. Areas addressed in the survey, reference the person’s ability to assess a parent’s readiness to change, their comfort in talking
about change and developing a plan. It evaluates how successful they have felt the process of using motivational interviewing has been, and how they feel using MI has changed their approach when addressing parents.

The first group meeting, March 13, 2009, will consist of approximately 200 Head Start staff, teachers, nurses, and social workers. This meeting, in conjunction with the survey, will hopefully provide information about the “trickle down” effect that has occurred amongst the Head Start staff regarding their knowledge and use of MI. One drawback of producing and handing out the survey is that by evaluating MI’s effectiveness after 3 or less months of use, a false or failed result may be produced (Rubak, Sandbaek, Lauritzen, and Christensen, 2005). This matter has been address and discussed, and although it could be too soon to accurately measure the “trickle down,” the information gathered could also be used to create interest and excitement about learning MI amongst Head Start staff.

The second meeting will take place in April, and will encompass the original group of 27 people trained. It will provide direct feedback regarding the incorporation of MI into their practice, and the surveys filled out will provide a statistical analysis.

Evaluation

Motivational interviewing is considered a “cutting edge” strategy that attempts to change a person’s behavior and resolve their hesitation toward treatment. It is a scientifically based intervention that “effectively helps clients change their behavior and that it outperforms traditional advice giving in approximately 80% of the studies” (Rubak, Sandbaek…et al, (2005), p.309), but it requires long term planning for evaluation. When interviewing a teacher who has been practicing the use of MI, she positively noted that the use of Motivational Interviewing has been beneficial in her practice, but further training and time is needed in order to see the full
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benefit. DGKHS staff have also noted that they feel it would be beneficial to have separate training sessions - one for teachers, and one for nurses and family service workers – because of the differences in the services provided by each group.

At DGKHS the process of evaluating the effectiveness of MI is an ongoing long-range project that has only begun to unfold. Clinical evaluation of the children and their parents’ behavioral changes regarding follow up care, may not be available for months after the initial contact. Statistics will need to be compiled by nurses and social workers working with the families. Other sources of evaluation information will include future Program Information Reports, training evaluations such as the survey in Appendix A, monitoring of Action Plans developed by nurses and family service workers, and sign in sheets from training sessions. The information will then be compiled through a system which DGKHS already has in place to document the number of follow up appointments attended, the number of dental caries confirmed in Head Start children, and to demonstrate an increase in family knowledge about preventative care in order to determine if MI is a successful intervention.

In the meantime, the survey that will be distributed at the March 13th meeting will give a preliminary look into how the Head Start Staff are feeling that Motivational Interviewing is working for them and whether or not they are seeing early success.

Results

The results of the MI project will be measured over the course of coming months and possibly years. It will be based on several factors, the outcome of the surveys, the training provided to staff, how consistently MI is used, the statistics that will be produced over the coming months, and how the parents react to MI.
In addition, while available studies support that the use of “MI counseling has an effect on children’s health that is greater than the effect of traditional health education” (Weinstein, Rosamund, Harrison & Benton, 2004, p.735), there is currently not a study in place through Head Start to measure this type of outcome in their Denver population. We agree that it is optimal to provide all children and families who can benefit from Motivational Interviewing the opportunity to receive MI, but a study containing a control group is recommended in order to accurately measure its success within the Head Start population.

Lastly, and possibly the most important factor when considering the results and outcomes with the use of MI, is to discern whether parents are retaining a sense of autonomy when they are making decisions regarding their child’s care, and then are following through with the treatment plan. If successfully carried out, Motivational Interviewing can be a powerful and valuable tool for Head Start nurses and social workers, with significant future results.
Appendix A

KAB Questionnaire

Name: ___________________________ Delegate/Location: ___________________________

Number of yrs worked in education or counseling: ___________________________

Job Title: ___________________________ Age ______ Sex: _____ Race/Ethnicity: ___________________________

Did you attend the Fall Institute in October, 2008 at which Dr. Cook spoke about motivational interviewing?

Please circle one: No ______ Yes ______

Did you attend the Motivational Interviewing training sessions provided by Dr. Cook in November, 2008?

Please circle one: No ______ Yes, one day ______ Yes, both days ______

If you did attend the training session, have you shared what you learned with your colleagues?

If you did not attend, what have you heard about motivational interviewing from your colleagues (if anything)?

(give examples, if possible)

Define motivational interviewing as you understand it. If you are unsure leave blank.

<table>
<thead>
<tr>
<th>1. How would you now rate your Knowledge and Ability to:</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess parents’ readiness to make a change in their behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Assess parents’ risk for difficulties following treatment recommendations</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Identify obstacles to treatment follow-up, even when the parent does not initially say that he or she is having difficulties.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Recognize warning signs that a parent may not agree with treatment recommendations</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Discuss the pros and cons of health behavior change with your parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Provide education that is tailored to the needs of the individual parent/family</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Provide suggestions for behavior change that are tailored to the needs of the individual parent/family</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Set goals collaboratively with parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Work with parents to identify problems or barriers, and to overcome them</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Access and/or identify additional educational and consultation resources for parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Successfully motivate parents to follow treatment recommendations</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. How would you now rate your Willingness to:</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
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<tbody>
<tr>
<td>Discuss both the benefits and the drawbacks of making a change in health behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not provide education or suggestions if the parent is not ready to hear them</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Allow parents to make an informed decision to stop treatment, if they so choose</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Seek supervision or consultation about how to help parents change their behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>
3. **IN THE PAST WEEK, WITH WHICH OF YOUR PARENTS DID YOU:**

<table>
<thead>
<tr>
<th></th>
<th>Every pt</th>
<th>Majority of pts</th>
<th>Only when needed</th>
<th>Only when requested</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess the parent’s readiness to change their health-related behaviors</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>Discuss the benefits (pros) of making a change in behavior</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>Discuss the possible negative effects (cons) of making a change in behavior</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
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<td>Ask about the parent’s previous efforts in making changes in his or her behavior</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>Offer education based on the parent’s needs and interests (do not count education that is given to all parents)</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>Ask parents about their goals, and agree on goals together</td>
<td>O</td>
<td>O</td>
<td></td>
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</tr>
<tr>
<td>Recommend possible techniques for helping motivated parents make a change in their behavior</td>
<td>O</td>
<td>O</td>
<td></td>
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</tr>
<tr>
<td>Ask the parent about his or her progress at the next visit</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
<td>O</td>
</tr>
</tbody>
</table>

4. **Please rate your level of success over the past three months** in motivating patients to follow treatment recommendations. (Please either circle one of the choices, or else write in a percent if you feel that you can provide a more precise estimate of your success rate).

0% Success 25% of Parents 50% of Parents 75% of Parents 100% Success

5. **With how many parents/clients (if any) did you use motivational interviewing in the past week?**

6. **Rank the care areas below in order (1 being most effective, 5 being least effective) where you believe using motivational interviewing would have the most impact on changing parents’ behavior:**

   ___Dental
   ___Childhood Obesity
   ___Nutrition
   ___Medical follow up
   ___Other

7. **Considering your experience with motivational interviewing, how valuable do you think this technique may be to your practice?**

<table>
<thead>
<tr>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>NA</td>
</tr>
</tbody>
</table>
Motivational Interviewing and Dental Health

Appendix B

References


