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From research to practice:

Motivational interviewing and differentiated mental health care in the HIV response

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Framing the Problem

Mental health is critical to HIV outcomes

Impacts:

- ART adherence
- Retention in care
- Risk behaviors

Key points:

- Mental health is not ancillary; it is central to HIV response effectiveness
- Untreated depression and anxiety reduce adherence and engagement
- Key populations face layered and intersecting vulnerabilities

Research Overview

Assessing Mental Health Service Needs and Barriers to Access for Men Who Have Sex With Men, Transgender Individuals, Sex Workers, and Persons with HIV in Belize

Mixed-methods study integrating:

- **Interviews (n=13)** with People with HIV, MSM, transgender individuals, and sex workers
- **Mental Health Provider survey (n=30)** assessing competence and readiness
- **Policy and systems analysis**

Focus on access, quality, and equity in mental health care

Identified gaps between policy, provider perception, and lived experience

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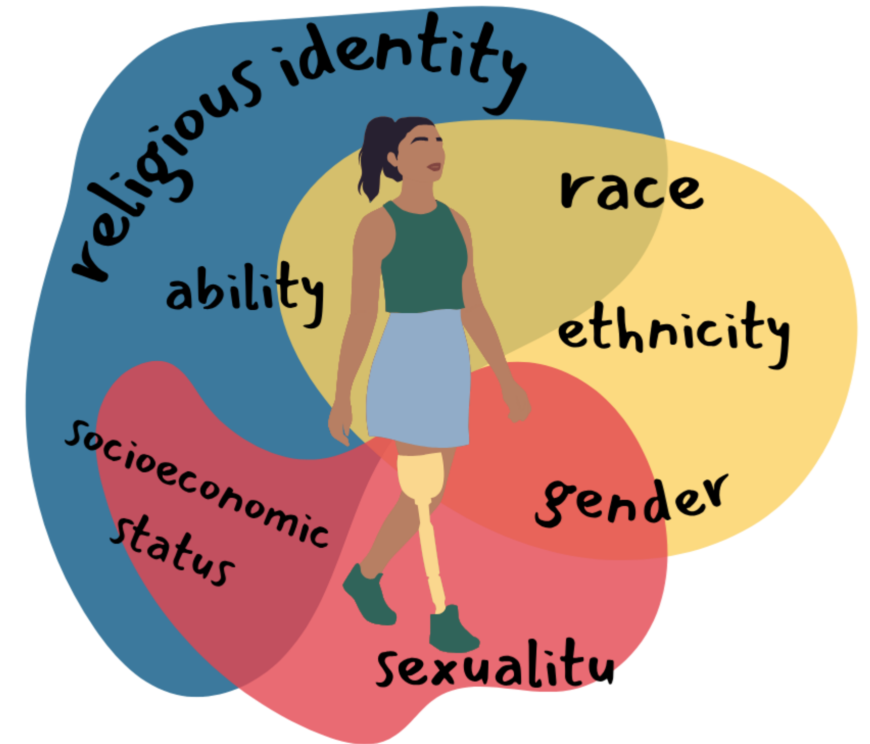
Key Populations & Intersectionality

- Persons with HIV
- MSM
- Transgender individuals
- Sex workers

Intersectionality leads to compounded risk

- Stigma
- Structural barriers
- Social exclusion



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Key Findings:What the Research Reveals

Layered & Intersectional Barriers

- Financial constraints, transportation, and rural gaps
- Stigma and social exclusion limit help-seeking
- Barriers accumulate across the care pathway

Stigma Shapes Care-Seeking

- Religious, cultural, and institutional stigma drive fear and avoidance
- Anticipated and experienced discrimination reduce help-seeking
- Individuals may disengage before accessing services

Trust in Systems is Fragile

- Confidentiality concerns and stigmatized interactions
- Identity invalidation (e.g., misgendering)
- Leads to delayed care and disengagement

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Key Findings:What the Research Reveals

Provider Competence Gaps

- High to neutral self-reported confidence contrasts with client experiences of stigma and harm
- Indicates gaps in competency-based training and applied skills
- Limited accountability and feedback mechanisms

Community as a Critical Support System

- Peer networks and informal supports provide emotional safety and practical assistance
- Community spaces often function as primary sources of trust and affirmation

Limits of Informal Support

- Reliance on community reflects gaps in formal mental health systems
- Informal supports cannot replace accessible, consistent, and clinically competent care

Key Insight: The Nature of the Problem

Barriers are both structural and relational

- **Structural:** access, cost, availability
- **Relational:** trust, stigma, quality of interaction

Barriers are interconnected and cumulative

Effective responses must address both simultaneously

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The evidence highlights two critical gaps in current systems

Relational gap: clients experience judgment, stigma, and lack of trust in provider interactions

Structural gap: services are inaccessible, inconsistent, and not responsive to diverse needs

These gaps require dual-level intervention:

- Improving how care is delivered (provider–client interaction)
- Improving what care is available and how it is organized (service delivery systems)

Practice implications drawn directly from the research:

- Need for trust-building, non-judgmental clinical approaches that center dignity and lived experience
- Need for flexible, context-responsive service models specific barriers

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Practice Solutions

Two complementary, evidence-informed solutions:

- **Motivational Interviewing (MI)**
  - Strengthens engagement, trust, and therapeutic alliance
  - Reduces resistance and supports sustained participation in care
  - Directly addresses relational barriers identified in the research
- **Differentiated Mental Health Care**
  - Tailors services based on individual need, risk, and context
  - Expands access through flexible, tiered, and community-integrated models
  - Directly addresses structural inequities and access barriers

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What is Motivational Interviewing (MI)?

Client-centered, goal-oriented communication approach Designed to strengthen intrinsic motivation for change

Directive yet non-judgmental Grounded in:

- Collaboration
- Autonomy
- Evocation

Focuses on resolving ambivalence, a key barrier to engagement

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press

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Core MI Skills (OARS)

- **Open-ended questions** → explore experiences
- **Affirmations** → reinforce strengths
- **Reflective listening** → validate understanding
- **Summaries** → reinforce change talk

Core approach:

- Listening over directing
- Client as expert
- Non-judgmental, collaborative engagement

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press

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MI in Practice: HIV and Mental Health

- Improves ART adherence and treatment consistency
- Increases engagement and retention in care
- Supports decision-making (disclosure, relationships, identity)
- Reduces risk behaviors through self-efficacy
- Particularly effective in high-stigma and high-ambivalence contexts

MI Responds Directly to Research Findings

- Stigma in care → MI reduces judgment in interactions
- Lack of trust → MI builds relational safety
- Disengagement → MI supports sustained engagement
- Provider-client disconnect → MI centers client voice and experience

Dillard, P. K., Zuniga, J. A., & Holstad, M. M. (2017). An integrative review of the efficacy of motivational interviewing in HIV management. *Patient Education and Counseling*, *100*(4), 636–646. https://doi.org/10.1016/j.pec.2016.10.029

Limits of MI Alone

MI improves interactions, but not system access barriers

Cannot address:

- Cost
- Geographic inequities
- Service availability
- Requires complementary system-level approaches

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Differentiated Mental Health Care

Person-centered, tailored service delivery

Services adapted based on:

- Need
- Risk level
- Identity and context

Stepped care model:

- Low intensity: peer support, psychoeducation
- Moderate: counseling
- High: specialized services
- Crisis: emergency interventions

World Health Organization. (2021). *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: Recommendations for a public health approach.* https://www.who.int/publications/i/item/9789240031593

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Linking MI and Differentiated Care

MI improves **how care is delivered** (interaction)

Differentiated care improves **what care is delivered** (system design)

Together they

Improve engagement

Increase equity in access

Strengthen continuity of care

Application to Belize

MI can be integrated into:

- Primary care
- HIV clinics
- Community outreach

Differentiated care can address:

- Rural access gaps
- Workforce limitations
- Service fragmentation

Supports scalable system strengthening

Workforce Implications

- Shift from confidence-based to competency-based training
- Integrate MI skill-building into provider training
- Ongoing supervision and reflective practice
- Include lived experience perspectives

Practical System Implications

Workforce

- Shift to competency-based training
- Integrate MI skill-building
- Ongoing supervision and reflective practice

Service delivery

- Expand telehealth and mobile outreach
- Strengthen community, clinic partnerships
- Integrate mental health into HIV services

Trust as a System Outcome

Trust must be built through both:

- Interaction (how care is delivered)
- System design (how services are structured)

Requires:

- Confidentiality protections
- Respectful, affirming care
- Consistency in service delivery

Trust is foundational to engagement and outcomes

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Closing

- Mental health is central to HIV outcomes
- Barriers are systemic and layered
- MI and differentiated care offer scalable, evidence-informed solutions

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»"Sometimes all we need… is just some compassion."

Marcus (Research Participant)