Motivational Interviewing for HIV Clinicians: Supporting Behavior Change

Trainer Guide

Motivational Interviewing for HIV Clinicians: Supporting Behavior Change

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Motivational Interviewing for HIV Clinicians: Supporting Behavior Change

Background Information

The purpose of this introductory daylong training is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with a detailed overview of the use of Motivational Interviewing to support behavior change in HIV patients. The curriculum reviews the rationale of using Motivational Interviewing with this population including some of the evidence to support it's use. The training then introduces the core foundations of Motivational Interviewing spirit and the core skills needed to do Motivational Interviewing. The curriculum reviews important aspects of the Motivational Interviewing spirit and helping style; reviews the essential skills in utilizing MI; several opportunities for skill practice are woven throughout the curriculum. The duration of the training is approximately 6 hours of content delivery time (one full day). The introductory training includes a PowerPoint presentation, Trainer Guide, and two-page fact sheet.

Four brief group videos have been inserted throughout the presentation to encourage dialogue among the training participants, and to illustrate how the information contained within the presented can be used clinically.

What Does the Training Package Contain?

- PowerPoint Training Slides (with notes)
- Trainer's Guide with detailed instructions for how to convey the information and conduct the interactive exercises
- Two-Page Fact Sheet for HIV Clincians

What Does This Trainer's Guide Contain?

- Slide-by-slide notes designed to help the trainer effectively convey the content of the slides themselves
- Supplemental information for select content to enhance the quality of instruction
- Suggestions for facilitating questions and group discussions.

How is This Trainer's Guide Organized?

For this guide, text that is shown in bold italics is a "***Note to the Trainer.***" Text that is shown in normal font relates to the "Trainer's Script" for the slide.

It is important to note that several slides throughout the PowerPoint presentation contain animation, some of which is complicated to navigate. Animations are used to call attention to particular aspects of the information or to present the information in a stepwise fashion to facilitate both the presentation of information and participant understanding. Becoming acquainted with the slides, and practicing delivering the content of the presentation are essential steps for ensuring a successful, live training experience.

General Information about Conducting the Training

The training is designed to be conducted in medium-sized groups (20-35 people). It is possible to use these materials with larger groups, but the trainer may have to adapt the small group exercises and discussions to ensure that there is adequate time to cover all of the content.

Materials Needed to Conduct the Training

- Computer with PowerPoint software installed (2010 or higher version recommended) and LCD projector to show the PowerPoint training slides.
- When making photocopies of the PowerPoint presentation to provide as a handout to training participants, it is recommended that you print the slides three slides per page with lines for notes. Select "**pure black and white**" as the color option. This will ensure that all text, graphs, tables, and images print clearly.
- Flip chart paper and easel/white board, and markers/pens to write down relevant information, including key case study discussion points.

Overall Trainer Notes

It is critical that, prior to conducting the actual training, the trainer practice using this guide while showing the slide presentation in Slideshow Mode in order to be prepared to use the slides in the most effective manner.

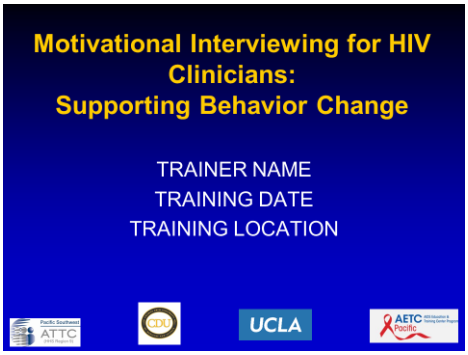
Icon Key

	Note to Trainer		Activity
	References		Image Credit
	Video Source		

Motivational Interviewing for HIV Clinicians: Supporting Behavior Change

Slide-By-Slide Trainer Notes

The notes below contain information that can be presented with each slide. This information is designed as a guidepost and can be adapted to meet the needs of the local training situation. Information can be added or deleted at the discretion of the trainer(s).



Slide 1: [Title Slide]

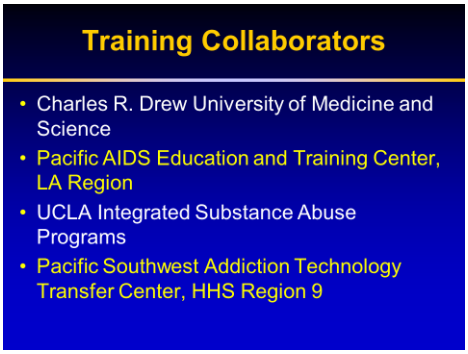
The purpose of this introductory training is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with a detailed overview of the use of Motivational Interviewing to support behavior change in HIV patients. The curriculum reviews the rationale of using Motivational Interviewing with this population including some of the evidence to support its use. The training then introduces the core foundations of Motivational Interviewing spirit and the core skills needed to do Motivational Interviewing.

(Notes for Slide 1, continued)

Slide 1: [Title Slide]

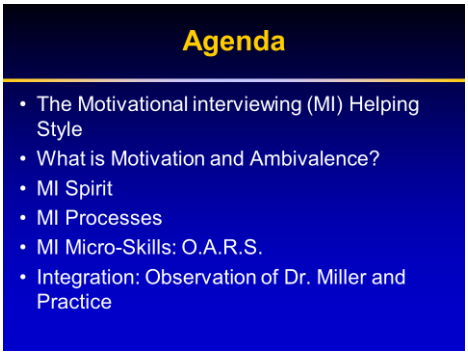
The curriculum reviews important aspects of the Motivational Interviewing spirit and helping style; reviews the essential skills in utilizing MI; several opportunities for skill practice are woven throughout the curriculum. The duration of the training is approximately 6 hours of content delivery time (one full day). The introductory training includes a PowerPoint presentation, Trainer Guide, and two-page fact sheet.

Four brief group videos have been inserted throughout the presentation to encourage dialogue among the training participants, and to illustrate how the information contained within the presented can be used clinically.



Slide 2: Training Collaborators

This PowerPoint presentation, Trainer Guide, and companion fact sheet were developed by the training team at UCLA ISAP through supplemental funding provided by the Pacific AIDS Education and Training Center, based at Charles R. Drew University of Medicine and Science. We wish to acknowledge Thomas Donohoe, MBA, Sandra Cuevas, Maya Gil Cantu, MPH, and Kevin-Paul Johnson, from the LA Region PAETC.



Slide 3: Agenda

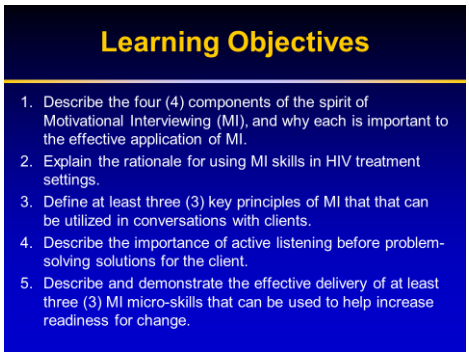
Briefly review each of the agenda items for the day with the audience.

- The training begins by reviewing the fundamental helping styles of how we help people change. We will differentiate the MI helping style from the typical medical-based model of directing.
- We will then review the core concepts of what is motivation and where does it come from. We will explain how ambivalence is the heart of working with MI and supporting effective behavior change.
- We will then review the foundational attitude or "way of being" that we refer to as the MI Spirit. The MI Spirit is essential to building rapport and engaging an individual.
- The MI processes then help us conceptualize the individual steps for helping people change.

(Notes for Slide 3, continued)

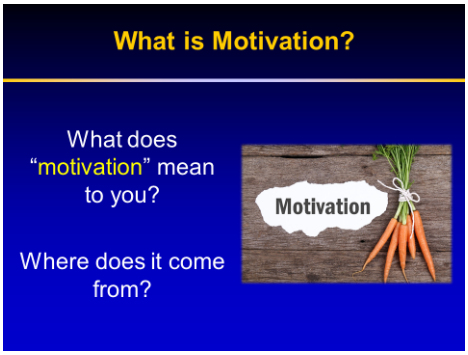
Slide 3: Agenda

- We will also review the core "micro-skills," which are the tools in the tool chest for MI. We will have ample time to practice these core skills.
- Additionally, we have a variety of activities and videos throughout the day to help enhance knowledge and practice the skills.



Slide 4: Learning Objectives

These are the learning objectives that will be covered over the course of the day-long training.



Slide 5: What is Motivation?

The purpose of this group discussion is to engage participants about what motivation means to them. What does it mean for a patient or client to be motivated or not motivated? Can motivation be changed?

Depending on the size of the audience, this discussion should take no more than 5-8 minutes. Consolidate and summarize the different perspectives, and be sure to include the conceptualization of motivation in MI as "a willingness to engage in and continue in change-directed behavior."

This particular conceptualization sets the stage for the remainder of the day by recognizing that change is not all-or-nothing; it can be incremental and does not even have to result in a specific change behavior. The willingness to engage in change-directed behavior is still an important component of Motivational Interviewing. Summarize participant contributions and then give official definition of motivational interviewing (see below).

(Notes for Slide 5, continued)

Slide 5: What is Motivation?

Miller and Rollnick define motivational interviewing as: a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion (p. 29).

REFERENCE:

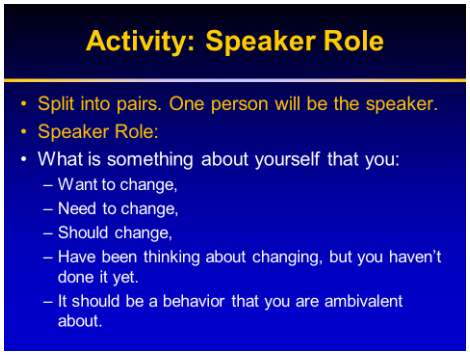
Miller, W.R., & Rollnick, S. (2013). *Motivational Interviewing: Helping People Change, 3rd Edition*. New York, NY: The Guilford Press.

IMAGE CREDIT:

Adobe Stock, purchased image, 2019.

Slide 6: Understanding How People Change: Helping Styles

This slides serves as a transition from the previous slide. Now that motivation has been defined, it's important to begin to consider how exactly we utilize an understanding of the helping interaction to enhance that motivation to change. That starts by contrasting the different Models of Helping Styles. The next slide introduces the "Directing Style of Helping" and requires participants to attempt to model this style of helping that can be a barrier to enhancing motivation.



Slide 7: Activity: Speaker Role

The purpose of this activity is to demonstrate the directive style of counseling/communication. This activity should take a total of 15-17 minutes (5 minutes per person in the Speaker role, plus approximately 5-7 minutes for the whole group debrief).

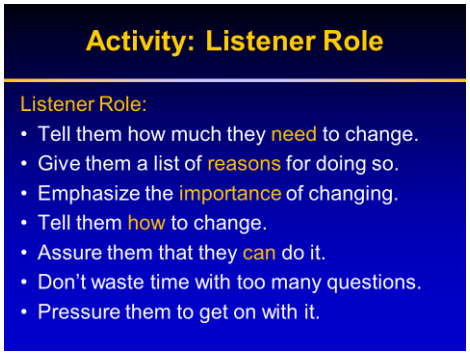
Introduce the activity by first asking participants to pair up. One part of the dyad will be the SPEAKER and the other the LISTENER for the first round of the activity.

(Notes for Slide 7, continued)

Slide 7: Activity: Speaker Role

Initially, focus on defining the SPEAKER role: the SPEAKER should pick an example of something they are attempting to change or some behavior they are thinking about changing. They are not role-playing a client, but instead they pick a topic that they are comfortable speaking about in a work setting. As the "Speaker" they should be themselves and respond naturally in the activity. The topic should also be a behavior change. A neutral decision they are struggling with (such as picking between grad school programs) isn't useful in this activity. It is often useful to provide examples of the types of changes participants could consider discussing – "Often, people pick changes such as exercising more, eating healthier, improving self-care, completing documentation on time, etc."

Additional instructions for the LISTENER are included on the next slide.



Slide 8: Activity: Listener Role

In continuing from the instructions provided on the previous slide, the second part of introducing this topic is to note that the LISTENER will be following a specific set of instructions, whether or not this is their natural style of interacting. The LISTENER will focus on following the instructions on the slide as closely as they can for five minutes. Once the time is up, have the groups switch roles so each person in the dyad gets to be the LISTENER.

After the second five minutes, debrief with the group by asking each participant to think about how it was to be the SPEAKER. Then ask the group to think about how it felt to be the LISTENER. Summarize the participants' reactions to the limitations of this particular type of helping style.

(Notes for Slide 8, continued)

Slide 8: Activity: Listener Role

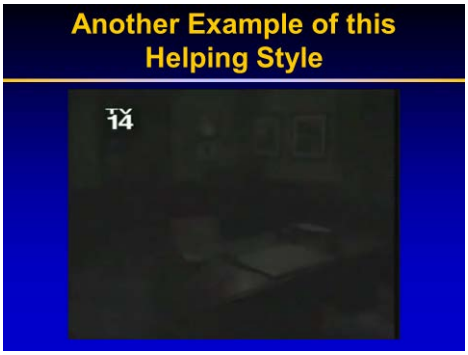
Common reactions from the **SPEAKER** include feeling:

- Angry (agitated, annoyed, irritated, not heard/understood)
- Defensive (discounted, judged, justifying, oppositional, unwilling to change)
- Uncomfortable (ashamed, overwhelmed, eager to leave)
- Powerless (passive, discouraged, disengaged)

Common reactions from the **LISTENER** include feeling:

- Pushy
- Robotic
- Rude
- Know-it-all
- Unable to come up with additional suggestions.

The fundamental point is this helping style often makes clients feels defensive and less motivated to change.



Slide 9: Another Example of this Helping Style

The purpose of the video is to demonstrate the directive style of counseling/communication. This activity should take a total of 7-10 minutes, including a quick de-brief to discuss participants' impressions of the video. Be sure to practice with the video ahead of time, so you can be certain that it will play as intended. When setting up the video, ask participants to write down their impressions about how Bob communicates with his patient. Is his style effective or no? What would you do differently, if you were sitting in Bob's chair?

Video Title: "Bob Newhart – Stop It" (3:49 in duration).

To play the video, advance the slide. The image of the desk will animate out and the video will play automatically in full screen mode.

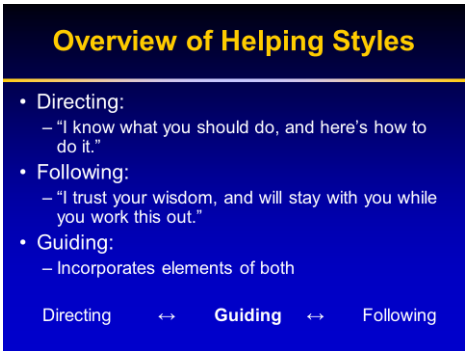
(Notes for Slide 9, continued)

Slide 9: Another Example of this Helping Style

Facilitate a 2-3-minute discussion with participants once the video has played to gather participants' impressions of the video. The video clearly demonstrates that (1) it is easy to fall into this style of communication, especially when the solution seems easy to the provider; and (2) even if Bob's intervention was perfect, it is unlikely to produce the desired outcome.

Questions to guide discussion:

- ***Was Bob's intervention effective with his patient?***
- ***In what ways could Bob change the way he communicated with his patient to increase the chance that she'd be able to overcome her fear of being buried alive?***



Slide 10: Overview of Helping Styles

The purpose of the slide is to distinguish between different types of helping styles.

First, introduce the "Directing" and provide the example of a physician explaining how to take meds, probation officer explaining contingencies and consequences of probation; the directing style does not allow for much conversation and is very instructional. The first dyad activity is an example of this helping style.

Next, contrast the Directing style with the "Following" style. The Following style is similar to Carl Rogers' humanistic therapy of sitting with an individual and supporting them. Examples include: with a dying patient or client with strong emotion in particular session. This is a purely client-centered helping style.

Note to the audience to consider that change is "paradoxical" meaning the harder we push someone to change, the less motivated they become to change. If we resist the urge to push and instead support them to determine their own motivation to change, we greatly increase the likelihood of change-directed behavior.

(Notes for Slide 10, continued)

Slide 10: Overview of Helping Styles

Engage the audience in a discussion as to the limitations of these two styles. Following that discussion, introduce the guiding style as a combination of the two styles to focus on moving towards change. The guiding helping style is partly following because it is client centered, but it also partly directing because MI is a goal-oriented conversation style. In MI there is a strategy to help focus people towards change.

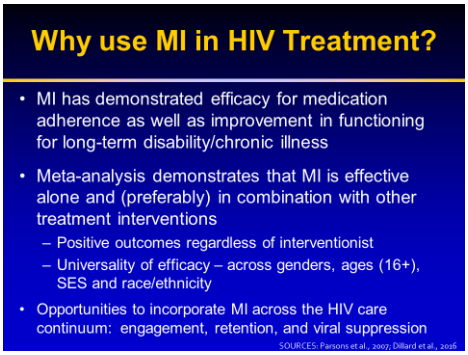
Slide 11: What is Motivational Interviewing (MI)?

Ask for a volunteer from the audience to read the quote or read the quote to the audience. Note that the definition of motivational interviewing expands on the importance of establishing an atmosphere of acceptance and compassion – how important the relationship is.

MI is a style of talking with people constructively about reducing their health risks and changing their behavior. MI is designed to enhance the client's own motivation to change using strategies that are empathic and non-confrontational. MI can also be used for any type of behavior change.

REFERENCE:

Miller, W.R., & Rollnick, S. (2013). *Motivational Interviewing: Helping People Change, 3rd Edition*. New York, NY: The Guilford Press.



Slide 12: Why use MI in HIV Treatment?

Motivational interviewing (MI) is an accessible intervention that can be delivered by a range of professional staff. It has demonstrated efficacy for a number of targeted health behaviors, including medication adherence and improvements in reducing risk behaviors associated with long-term or chronic illnesses including substance use disorders and HIV. The recommended practice is to integrate MI with other evidence-based practices, but MI has been shown to be effective as a standalone intervention in promoting behavior change independent of gender, age (above 15) and across socioeconomic statuses or race/ethnicities.

REFERENCES:

Dillard, P.K., Zuniga, J.A., & Holstad, M.M. (2016). An integrative review of the efficacy of motivational interviewing in HIV management. *Patient Education and Counseling, 100,* 636-646.

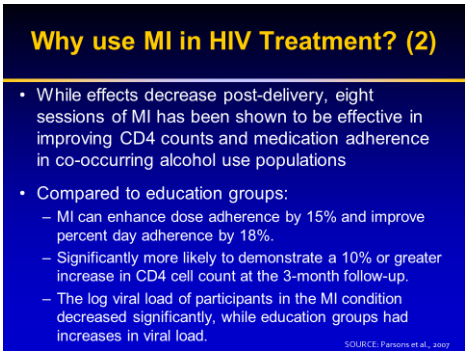
Palacio, A., Garay, D., Langer, B., Taylor, J., Wood, B.A., & Tamariz, L. (2016). Motivational interviewing improved medication adherence: A systematic review and meta-analysis. *The Journal of General Internal Medicine, 31*(8), 929-940.

(Notes for Slide 12, continued)

Slide 12: Why use MI in HIV Treatment?

REFERENCES, continued:

Parsons, J.T., Golub, S.A., Rosof, E., & Holder, C. (2007). Motivational interviewing and cognitive-behavioral intervention to improve HIV medication adherence among hazardous drinkers: A randomized control trial. *Journal of Acquired Immune Deficiency Syndromes, 46*(4), 443-450.

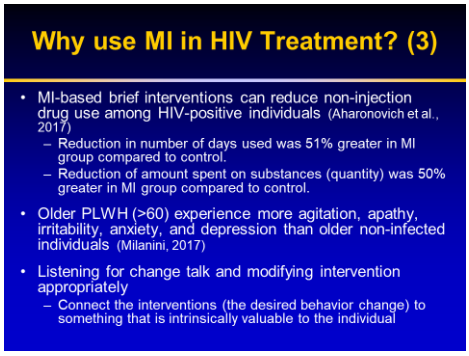


Slide 13: Why use MI in HIV Treatment? (2)

Specifically, MI has demonstrated improvements in CD4 counts and medication adherence among co-occurring alcohol use population in as little as eight sessions. A word of caution though: the effects tend to decrease after the delivery of the intervention so on-going support, contact, and potentially booster sessions are indicated.

REFERENCE:

Parsons, J.T., Golub, S.A., Rosof, E., & Holder, C. (2007). Motivational interviewing and cognitive-behavioral intervention to improve HIV medication adherence among hazardous drinkers: A randomized control trial. *Journal of Acquired Immune Deficiency Syndromes, 46*(4), 443-450.



Slide 14: Why use MI in HIV Treatment? (3)

As a continuation of the previous slide, the way in which language is used can act as a motivational strategy to increase medication compliance. MI-based brief interventions can be useful, particularly among non-injection drug use HIV-positive individuals. A longer timeframe for intervention may be required to create substantial change for individuals injecting drugs. Motivational techniques can also be useful in reducing experiences of agitation, apathy, irritability, anxiety, and depression among individuals diagnosed with HIV. The opportunity to listen for "change talk" means being able to hear what the individual is saying, identify their own self-identified values and incorporate that into an intervention.

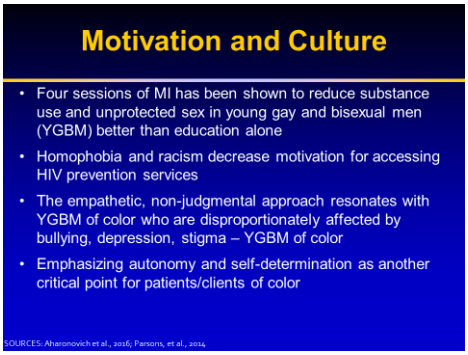
(Notes for Slide 14, continued)

Slide 14: Why use MI in HIV Treatment? (3)

REFERENCES:

Aharonovich, E., Sarvet, A., Stohol, M., DesJarlais, D., Tross, S., Hurst, T., Urbina, A., & Hasin, D. (2017). Reducing non-injection drug use in HIV primary care: A randomized trial of brief motivational interviewing, with and without HealthCall, a technology-based enhancement. *Journal of Substance Abuse Treatment, 74,* 71.79.

Milanini, B., Catella, S., Perkovich, B., Esmaeili-Firidouni, P., Wendelken, L., et al. (2017). Psychiatric symptom burden in older people living with HIV with and without cognitive impairment: the UCSF HIV over 60 cohort study. *AIDS Care, 29(9)*, 1178-1185.



Slide 15: Motivation and Culture

Aspects related to intersectionality such as homophobia or racism decrease motivation for accessing preventative services. The best approach for a practitioner is to continue to utilize MI beyond education alone and to remain empathetic and non-judgmental as previously discussed in this training.

Another aspect of MI that is important for working with patients/clients of color is to emphasize autonomy and self-determination. This strategy highlights the need for relatedness, autonomy, and competence in addition to empathy and non-judgmental approach.

REFERENCES:

Aharonovich, E., Sarvet, A., Stohol, M., DesJarlais, D., Tross, S., Hurst, T., Urbina, A., & Hasin, D. (2017). Reducing non-injection drug use in HIV primary care: A randomized trial of brief motivational interviewing, with and without HealthCall, a technology-based enhancement. *Journal of Substance Abuse Treatment, 74,* 71.79.

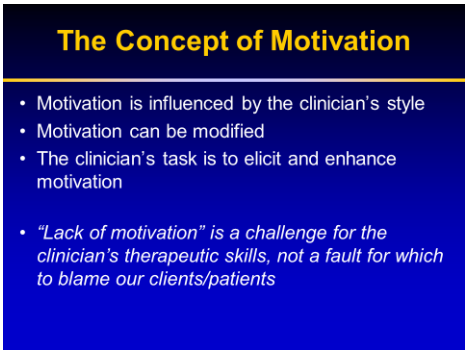
(Notes for Slide 15, continued)

Slide 15: Motivation and Culture

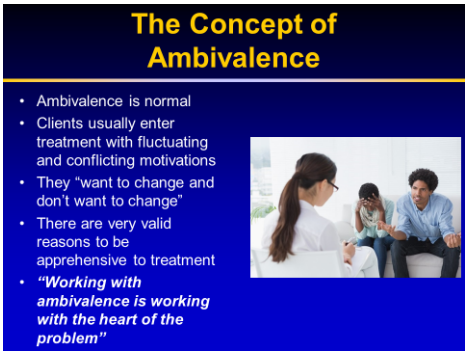
REFERENCES, continued:

Parsons, J.T., Lelutiu-Weinberger, C., Botsko, M. & Golub, S.A. (2014). A randomized controlled trial utilizing motivational interviewing to reduce HIV risk and drug use in young gay and bisexual men. *Journal of Clinical Psychology, 82*(1), 9-18.

Slide 16: The Concept of Motivation



Read through the slide to introduce the role of the clinician/provider in influencing change-directed behavior. Everyone experiences some degree of motivation and motivation is able to be influenced externally, in this case by the clinician. So rather than blaming clients for not being motivated "enough," the clinician has an opportunity to try to enhance the client's motivation and reasons for being in treatment. From an MI perspective, all clients want something in their lives. It's the clinicians job to find do they want, and how can we connect our services to their individual goals.



Slide 17: The Concept of Ambivalence

Read through the slide and emphasize ambivalence as the "heart of the problem."

The first thing to recognize with change is that we all have feelings of ambivalence. What is ambivalence? It's when we feel two ways about something. We may like to drink, but we also don't like having a hangover. Exploring a person's ambivalence about change is one way of assessing where they are in the change process. If we can get an individual to talk about his or her ambivalence about making a change, we gain access into their world and can better understand their perspective.

Highlighting the ambivalence is an important component in beginning to move towards change. Imagine scales with one side being "wanting to change" and the other "not wanting to change." Ambivalence is normal for all people. Ask the audience to come up with experiences of everyday ambivalence they've encountered (such as trying to decide what to have for lunch, what to wear to work that day, whether or not to exercise, etc.).

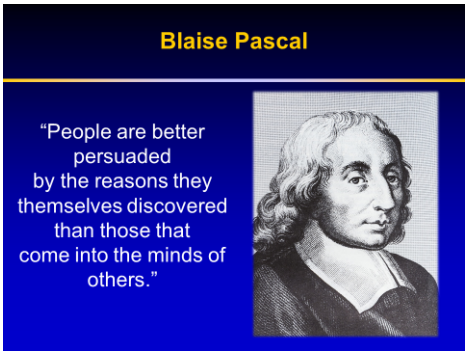
(Notes for Slide 17, continued)

Slide 17: The Concept of Ambivalence

Another important consideration to acknowledge that with clients of color, there are historical and cultural context of patients' ambivalence and distrust because of past and present structural racism and homophobia, past maltreatment of people of color in medical settings and research. Validating the real structural barriers to engagement into treatment is very important.

IMAGE CREDIT:

Fotolia, purchased image, 2017.



Slide 18: Blaise Pascal

Read the quote to the audience. Ask for one or two audience members to give their feedback about how this is related to treatment.

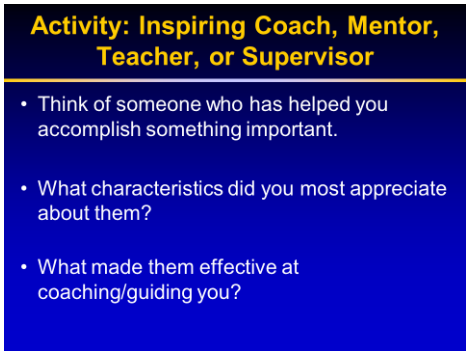
Additional Information for Trainers:

Pascale was a 17th century mathematician, scientist, theologian, and philosopher who recognized, among other discoveries, the paradoxical nature of change long before Motivational Interviewing.

With MI, the goal is to guide clients to discover their own reasons for change. If we evoke these reasons from them, it is significantly more impactful than an outsider telling them to change.

IMAGE CREDIT:

Adobe Stock, purchased image, 2019.



Slide 19: Activity: Inspiring Coach, Mentor, Teacher, or Supervisor

The purpose of this activity is to have participants identify the importance of the underlying spirit of MI, by listing the attributes of an effective or inspiring coach, mentor, or teacher. The activity should take a total of 10-15 minutes

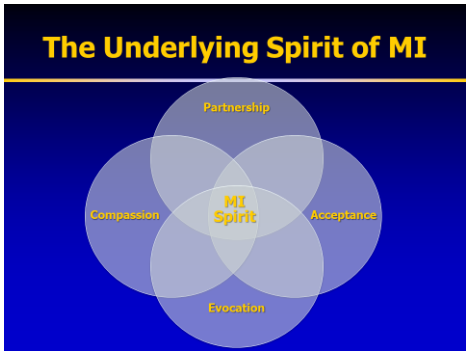
- ***Prompt participants to individually think of someone who has helped them accomplish something important. They should write down all of the reasons this person was an effective mentor. What were their qualities? Why were they so effective? Give them approximately 3 – 5 minutes to write this down in their notes.***
- ***Ask for various volunteers to share some of the characteristics they wrote down.***

(Notes for Slide 19, continued)

Slide 19: Activity: Inspiring Coach, Mentor, Teacher, or Supervisor

- ***During the debrief, the trainer writes on flip chart/white board, if available, to take notes.***
- ***Ask the participants, "What are some common themes among these characteristics?"***
    - ***Guide them toward identifying one of the spirit characteristics (Acceptance, compassion, partnership, evocation).***
- ***When finished, move forward with presenting the "Spirit of MI" slide.***

KEY POINTS: The purpose of this activity is to get participants thinking about characteristics of change agents that help to enhance engagement. Ideally, the trainer would want to identify any aspects of "acceptance" as a transition to the next slide, but participant answers will vary and be valid. Highlighting the common themes (often times "empathy," "nonjudgmental," "supportive," and "believing in me" will come up in discussion) helps to illustrate that there are a set of behaviors that can enhance engagement significantly.



Slide 20: The Underlying Spirit of MI

Click to animate in each of the four circles, starting with partnership, then acceptance, then compassion, ending with evocation.

Transition the conversation from previous slide by noting that the groups all together essentially identified the importance of the underlying spirit of MI. Four specific components are focused on in Motivational Interviewing. *As you present this slide, refer to the list of attributes generated during the coach/mentor activity. Draw 2-3 example from the list that exemplify each part of the MI Spirit.* The MI spirit is the core attitude we want to bring to all of our interactions with the client. It allows us to build rapport and engage the client.

Partnership: being an equal partner in the interaction with the client. They have information about their own lives that we cannot presume to know, while we have information about how to move towards a change behavior. Presuming our own expertise impacts the relationship and prevents movement forward.

(Notes for Slide 20, continued)

Slide 20: The Underlying Spirit of MI

The partnership also acknowledges that the client ultimately gets to choose what they are willing to do. We want to guide them to make their own choices.

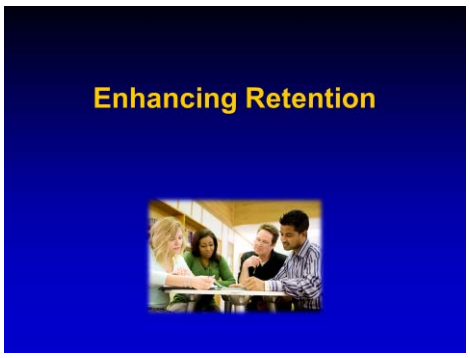
Acceptance: accepting your client's experience without judgement and being able to convey the acceptance. Acceptance is a critical component of engaging individuals in treatment. Before any change may occur, clients have to feel like they're heard and respected. As noted previously, one major facilitator to engaging individuals in treatment is ensuring that individuals are treatment with respect. Acceptance means being willing to tolerate and try to understand what someone is bringing to a particular interaction. This does not mean that you have to agree with what the person does or says or even endorse it, but a component of developing empathy is attempting to display a willingness to tolerate someone else's experience. Acceptance of the client's readiness to change is also very important.

Compassion: compassion is a recognition of another's experience and being able to appropriately communicate to the individual a desire to support them. Compassion also involves genuinely believing the client cant be successful in accomplishing their own goals.

(Notes for Slide 20, continued)

Slide 20: The Underlying Spirit of MI

Evocation: evocation is the process of drawing out one's experiences. Consistent with the other themes of the spirit, because we do not presume to know what the individual's experiences are, we want to be honestly curious about them. We want to evoke the individuals goals, their reasons for change, and ultimately evoke how would they like to make this change.

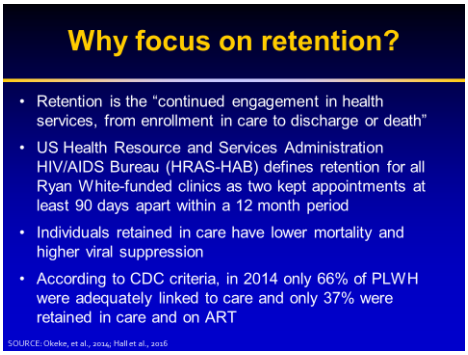


Slide 21: Enhancing Retention

This section will focus on barriers to retention and the importance of retention in initiating change for individuals in substance use treatment or living with HIV/AIDS. The section will also present Motivational Interviewing as one tool to enhance retention and engagement as a critical component of care.

IMAGE CREDIT:

Fotolia, purchased image, 2017.



Slide 22: Why focus on retention?

It is important to focus on retention as retention results in continued engagement in health services. Retention and engagement should start from the first meeting and continue until "discharge or death." Under the US Health Resource and Services Administration definitions of retention, a patient must keep two appointments within 90 days during a 12 month period. Retention is important as research shows that individuals who are able to be retained in care have lower mortality and high viral suppression. Based on this criteria, the CDC found that, in 2014, only 2/3 of PLWH were appropriately and adequately linked to care with only 37% of individuals retained in care and on ART.

REFERENCES:

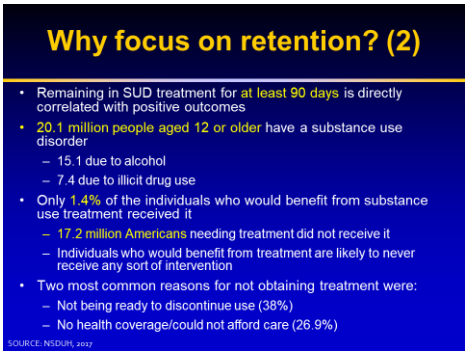
Hall, B.J., Sou, K., Beanland, R., Lacky, M., Tso, L.S., Ma, Q., Doherty, M., & Tucker, J.D. (2016). Barriers and facilitators to interventions improving retention in HIV care: A qualitative evidence meta-synthesis. *AIDS and Behavior, 21*(6), 1755-1767.

(Notes for Slide 22, continued)

Slide 22: Why focus on retention?

REFERENCES, continued:

Okeke, N.L., Ostermann, J., Thielman, N.M., (2014). Enhancing linkage and retention in HIV care: A review of interventions of highly resourced and resource-poor settings. *Current HIV/AIDS Report, 11*(4), 376-392.



Slide 23: Why focus on retention? (2)

Additional evidence of the importance of retention on enhancing substance use treatment outcomes exists. Studies show that remaining in treatment for at least 90 days is directly correlated with positive outcomes. It's important to note that while this provides a measure to treatment success, the types and quality of services and interventions a client receives during the 90 days play a key role.

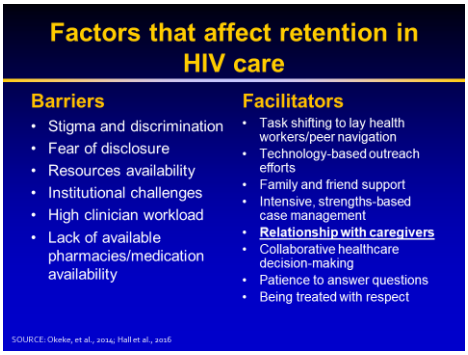
Recent surveys show that 20.1 million people, 12 and older, have a substance use disorder, with 15.1 million having an alcohol use disorder, and 7.4 having an illicit substance use disorder. However, less than 2% of individuals who would benefit from some form of substance use treatment actually receive any sort of intervention. 17.2 million Americans needed treatment in 2016 but did not receive it. This means that individuals who would potentially benefit from treatment are likely to never receive any sort of intervention. When surveyed, the two most common reasons for not obtaining treatment were not being ready to discontinue use (38% of people identified this as a reason) and not having adequate health coverage (26.9% reported this).

(Notes for Slide 23, continued)

Slide 23: Why focus on retention? (2)

REFERENCE:

Ahrnsbrak, R., Bose, J., Hedden, S.L., Lipari, R.N., & Park-Lee, E. (2017). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health.* Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.



Slide 24: Factors that affect retention in HIV care

Multiple factors affect retention in care. Some of the barriers include: stigma and discrimination that may be experienced either in an individual's community or even at a health institution itself. Fear of disclosure of status is relevant to HIV care and substance use and care must be taken in order to ensure privacy is maintained. Institutional challenges such as resource availability and high clinician workload can impact the quality of care and burnout must be considered to ensure effective workforces. Related to previous discussions in the presentation of limited transportation as a basic need, not having access to a pharmacy or needed medications can also act as a significant barrier.

Alternatively, there are a number of facilitators that can guide practice in focusing on enhancing retention. Utilizing lay health workers or individuals with lived experience who can assist in navigating a confusing health system can enhance retention. Using technology to outreach or provide reminders to patients can be a useful tool in improving retention.

(Notes for Slide 24, continued)

Slide 24: Factors that affect retention in HIV care

Considerations of engaging family and friends as supports can be useful when appropriate family and friend supports are available, including enhancing relationships with caregivers. When patients are treatment with respect and given opportunities to ask questions and get questions answered, the patient is more likely to feel that they are a part of a collaborative treatment team and be more likely to remain in care.

Additional Information for Trainers:
Examining a peer navigation program for a year found that the proportion of patients who attended two clinic visits in a 6-month period increased from 64% to 79%. Another study of 51 women living with HIV reported an increase in the proportion of women who attended all clinic visits over a 6-month period from 10% to 58% with the assistance of a nurse-patient navigation program to enhance engagement. Critical in this program was the inclusion of a transportation resource which helped to reduce barriers to accessing care.

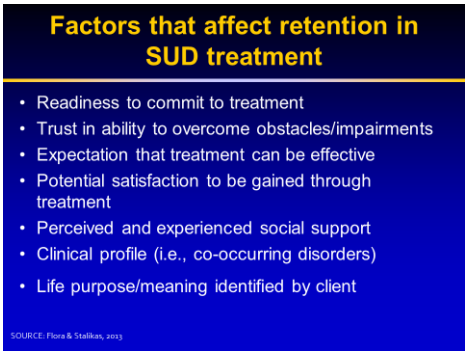
(Notes for Slide 24, continued)

Slide 24: Factors that affect retention in HIV care

REFERENCES:

Hall, B.J., Sou, K., Beanland, R., Lacky, M., Tso, L.S., Ma, Q., Doherty, M., & Tucker, J.D. (2016). Barriers and facilitators to interventions improving retention in HIV care: A qualitative evidence meta-synthesis. *AIDS and Behavior, 21*(6), 1755-1767.

Okeke, N.L., Ostermann, J., Thielman, N.M., (2014). Enhancing linkage and retention in HIV care: A review of interventions of highly resourced and resource-poor settings. *Current HIV/AIDS Report, 11*(4), 376-392.

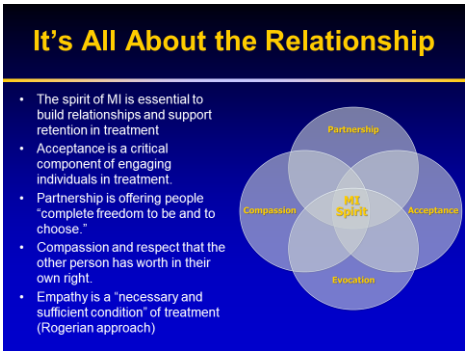


Slide 25: Factors that affect retention in SUD treatment

When considering the impact of substance use disorders on treatment engagement, providers should consider the individual's readiness to commit to treatment. The more ready an individual is, the more likely the individual is to be retained in treatment. The extent the which a client perceives a provider as having trust in the client's ability to overcome obstacles/ impairments can also enhance retention. The client must see the treatment as potentially being effective and that there must be some potential satisfaction that can be gained through treatment. A sense of community or social support enhances engagement and the purpose of the client's life/meaning combine to enhance retention.

REFERENCE:

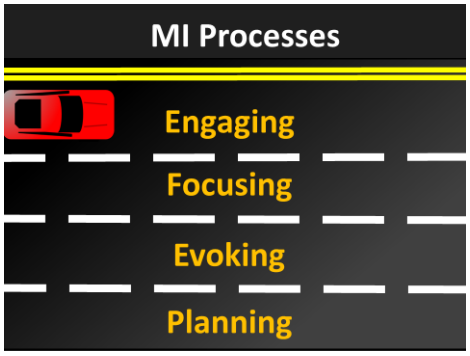
Flora, K. & Stalikas, A. (2013). Factors affecting substance abuse treatment across different treatment phases. *International Journal of Psychosocial Rehabilitation, 17*(1), 89-104.



Slide 26: It's All About the Relationship

One way to support retention and engagement in treatment is the therapeutic alliance. Establishing and building the relationship is important.

- **Autonomy** is offering people "complete freedom to be and to choose." While this seems counterintuitive, the nature of change is such that the more an individual is pushed to change, the less willing that individual becomes to actually make a change. Change originates when an individual is provided an opportunity to consider their own motivations within an atmosphere of compassion and acceptance.
- The concept of **absolute worth** is based in respecting that the other person has worth in their own right. It recognizes that people have some expertise in their own lives that providers cannot presume to know. It is important to focus on helping individuals recognize that expertise in situations where they do not see it themselves.
- **Empathy** is a "necessary and sufficient condition" of treatment (Rogerian approach).



Slide 27: MI Processes

We conceptualize the MI processes as lanes on the highway. These processes are the roadmap of where we want to take the conversation. We must start with the "Engaging" lane before we can proceed to "Focusing." We must take time "Focusing" before we can proceed to "Evoking." We must spend time "Evoking" before we can proceed to "Planning."

The 4 processes are:

- **Engaging** (active listening, accurate empathy, client-centered style). Engaging is building the relationship and establishing rapport.
- **Focusing** (identify target behavior about which they are ambivalent and/or struggling to change – must be their own goal). It's important to identify a clear, shared goal.
- **Evoking** (drawing out client's intrinsic motivation for change and their own ideas about how to change). It's important to evoke the clients own reasons for change.

(Notes for Slide 27, continued)

Slide 27: MI Processes

- **Planning** (consolidating commitment by selectively reinforcing commitment language; developing a "menu of options"; assisting with change plans; reviewing/revising change plan as needed. Planning is the collaborative process of identify the steps to make a change.

Although we are trying to move from Engaging to Focusing to Evoking to Planning, we also must be flexible. It's similar to driving on the freeway where one must be flexible and change last as needed.

The processes don't take place in a nice linear sequence; in any interaction we may be doing some of each, and we might even say that we're always involved in "engaging" in one way or another.

Slide 28: MI: Principles

Briefly explain the principles, linking them to the OARS by noting that "the way we implement these principles is through the MI microskills, or OARS". When participants are able to apply the OARS consistent with the MI Spirit, they will be demonstrating the MI Principles. These principles are different strategies we will use throughout the processes.

- The strategic goals of MI are to: (a) resolve ambivalence; (b) avoid eliciting or strengthening resistance; (c) elicit "Change Talk" from the client; (d) enhance motivation and commitment for change; and (e) help the client move through the Stages of Change. A series of MI micro-skills (which will be described on the next slide) can be used to move a patient/client through the Stages of Change to elicit and reinforce self-motivational statements (a.k.a., Change Talk).

(Notes for Slide 28, continued)

Slide 28: MI: Principles

- **Empathy** may be the most crucial principle. It creates an environment conducive to change, instills a sense of safety and a sense of being understood and accepted, and reduces defensiveness. Empathy sets the tone within which the entire communication occurs. Without it, other components may sound like mechanical techniques.
- By **developing discrepancy**, the clinician can help the client to become more aware of the discrepancy between their addictive behaviors and their more deeply-held values and goals. Part of this is helping client to recognize and articulate negative consequences of use. It is more effective if the *client* does this, not the clinician.
- With regards to **rolling with resistance**, in general, it is not helpful to argue with clients. Confrontation elicits defensiveness, which predicts a lack of change. It is particularly counter-therapeutic for a clinician to argue that there is a problem while the client argues that there isn't one. for change to occur.

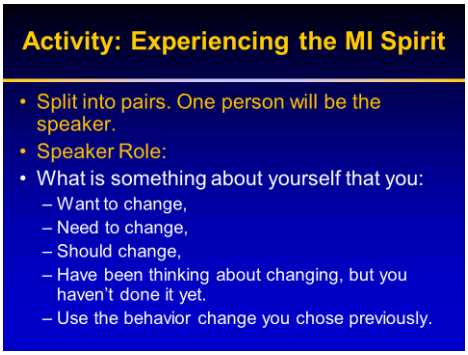
(Notes for Slide 28, continued)

Slide 28: MI: Principles

- **Supporting self-efficacy** can be The client does not need to accept a diagnostic label (e.g. “addict” or “alcoholic”) conceptualized as a specific form of optimism, that is, a “can-do” belief in one’s ability to accomplish a particular task or change. This principle is crucial to help the client see and experience his/her own ability to make positive changes. Part of this is the *clinician* believing in the client’s ability to change.

REFERENCE:

Center for Substance Abuse Treatment. (1999). *Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 35*. HHS Publication No. (SMA) 13-4212. Rockville, MD: Substance Abuse and Mental Health Services Administration.

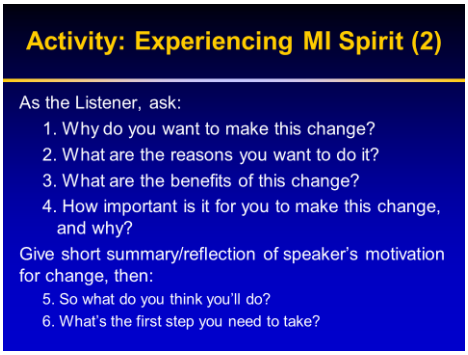


Slide 29: Activity: Experiencing the MI Spirit

The purpose of the activity is to see what it is like to experience the four components of the MI spirit in the context of the therapeutic interaction. This activity should take a total of 15-17 minutes. Allow 5 minutes for each person to be the SPEAKER, then switch roles. Allow approximately 5-7 minutes for the de-brief. Instruct participants to pair up with their partner from the previous activity.

Refer the participants back to the "real play" (their own work-appropriate example of something they want to change in their lives).

Additional instructions are included on the next slide.



Slide 30: Activity: Experiencing MI Spirit (2)

- ***As the SPEAKER, try to notice when you're experiencing any of the 4 characteristics we've identified, and pay attention to how it makes you feel. After 5 minutes, you and your partner will switch roles.***
- ***As the LISTENER, use the questions above as a guide for this interaction.***

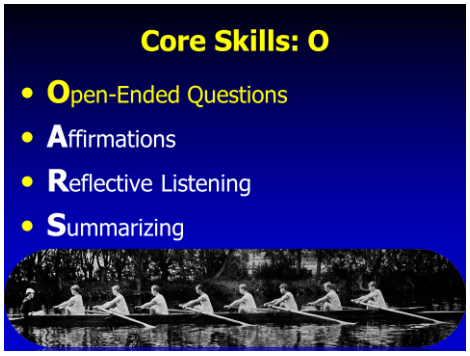
"As the Speaker, what was that like for you? How was it different from the previous real-play?"

"Which of the characteristics that we've identified did you experience? What thoughts and/or feelings did it evoke from you?"

Key Points: This type of interaction typically make people feel more heard, more understood, and more motivated for change. This evoking, empathic approach often enhances motivation for change. This activity is a direct contrast to the directive-helping style we did previously.

Slide 31: MI Micro-Skills: the O.A.R.S.

This is a transition slide to introduce the MI Micro-skills (the OARS). The OARS are the skills that allow participants to do Motivational Interviewing. Reiterate that it is important to remember to maintain the MI Spirit as participants are using the OARS.



Slide 32: Core Skills: O

The next section reviews in detail the four core skills of MI (the OARS), starting with open-ended questions. We use the acronym "O.A.R.S." to help folks remember the key tools in the toolchest in MI. Just like the oars of a boat, the MI "O.A.R.S." are the tools to help us move the conversation forwards.

Open-ended questions: (a) solicits information in a neutral way; (b) helps the person elaborate his/her own view of the problem and brainstorm possible solutions; (c) helps the therapist avoid prejudgments; (d) keeps communication moving forward; (e) allows the client to do most of the talking.

Affirmations should be focused on achievements of the individual, and are intended to: (a) support the individual's persistence; (b) encourage continued efforts; (c) assist the individual in seeing the positive in the situation; and (d) support the individual's proven strengths.

With **reflective listening**, one should: (a) listen to both what the person says and to what the person means; (b) check out assumptions; (c) create an environment of empathy (nonjudgmental); and (d) be aware of intonation (statement, not question). The clinician does not have to agree with the client.

(Notes for Slide 32, continued)

Slide 32: Core Skills: O

Summaries capture both sides of the ambivalence (You say that _____ but you also mentioned that _____.) They demonstrate the clinician has been listening carefully. Summaries also prompt clarification and further elaboration from the person. Lastly, summaries prepare clients to move forward.

IMAGE CREDIT:

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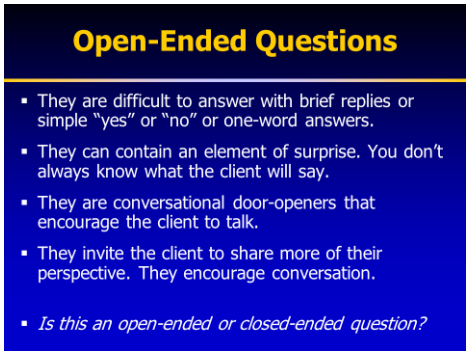
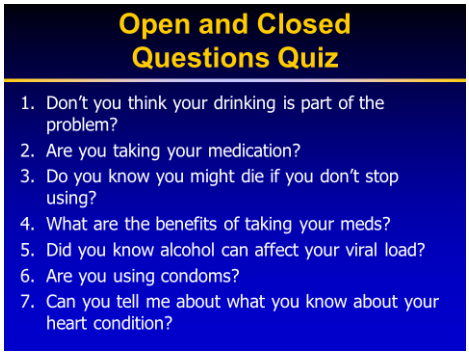


Slide 33: Open-Ended Questions

Read through each point, noting the importance of open-ended questions related to the MI spirit:

- ***Instruct participants to write this down: "Open ended questions typically start with 'what,' 'how,' 'tell me,' and 'why.' Try to use these to form your open questions."***
- ***A "yes" or "no" answer does not allow for evocation of information and does not convey acceptance or partnership; indicates only an interest in information gathering***
- ***Because we want to evoke (a component of the Spirit) as much information as possible from the individual, open-ended questions are helping in keeping clients talking.***
- ***Ask participants "is this an open-ended or closed-ended question?" (it is closed because it forces the individual into a choice).***



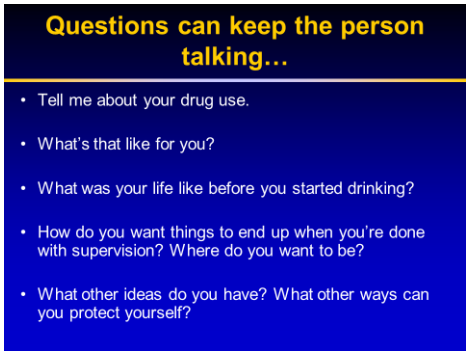
Slide 34: Open and Closed Questions Quiz

The purpose of this brief activity is to ask participants, as a large group, whether each question is open-ended or closed.

As a whole-group, read through each sentence one at a time and ask the participants if the question is open or close.

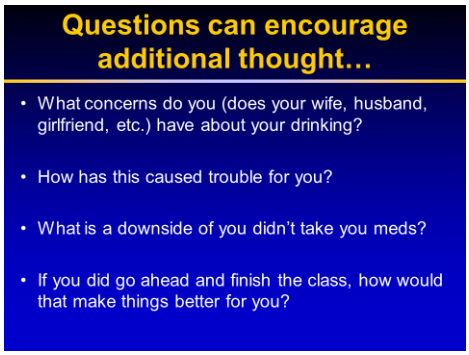
If participants respond that the question is closed, ask for a volunteer to turn the question into an open-ended question. You can elicit multiple options to rephrase each closed question. Help the participants to come up with open-ended alternatives to the close-ended questions above.

All questions are closed except for #4, which means you should have participant rephrase all of the other questions to be open-ended.



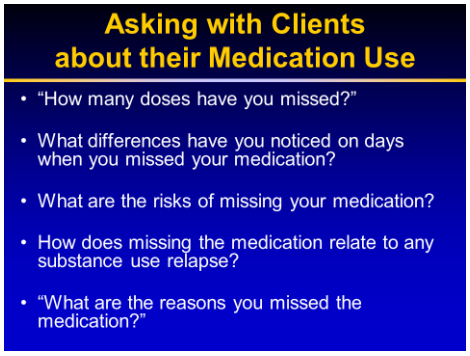
Slide 35: Questions can keep the person talking…

The slide contains additional examples of open-ended questions for participants to consider.



Slide 36: Questions can encourage additional thought…

The slide contains additional examples of open-ended questions for participants to consider.



Slide 37: Asking with Clients about their Medication Use

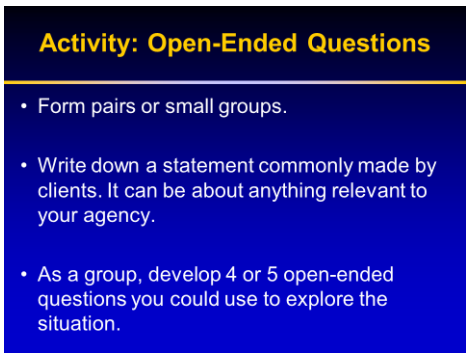
When talking to clients about their medication adherence, use open-ended questions when able to determine whether or not the individual recognizes having acted differently when missing doses or to determine whether missed doses were related to substance use/relapse. It may be useful to help the client identify reasons as to why they were unable to take medications to develop insight around medication adherence. When asking questions, it is important to ask without judgement. Two useful questions to ask are: *"how many doses did you miss"*; and *"why did you miss doses?"* In asking these questions, it is essential to talk to the client during the first session in which medication is identified as an important goal about the reason a provider might be asking these questions. Without establishing the purpose behind these questions, they can easily be construed as judgmental, even if the provider is intending to ask them without judgment.

(Notes for Slide 37, continued)

Slide 37: Asking with Clients about their Medication Use

Let the client know ahead of time that these questions will always be asked because people miss doses, but just because doses are missed does not mean it will not be discussed in the hopes of coming up with coping mechanisms and organizational strategies to prevent missed doses in the future.

Slide 38: Activity: Open-Ended Questions



The purpose of this activity is to practice crafting open-ended questions, based on a specific scenario/client statement. This activity should take about 15-20 minutes total (allow 7-10 minutes for group to work; debrief 5-10 minutes depending on size of audience). Each pair or small group should write down a client statement. For example, a client statement could be "I know I'm supposed to take my medicine every day, but it's hard to remember." Participants should then brainstorm 4 or 5 open-ended questions that would help to further explore and understand the situation in the context of the four MI principles.

(Notes for Slide 38, continued)

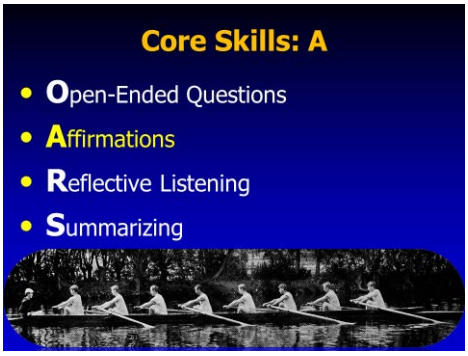
Slide 38: Activity: Open-Ended Questions

You can give them some example statements to consider as they write their own:

1. ***"I don't want to take my meds."***
2. ***"Marijuana is my medicine, and it's legal anyway."***
3. ***"All I want is help with housing. I don't want treatment."***
4. ***"I'm afraid to tell my family about my HIV status."***
5. ***"The doctors say I need to exercise for my hypertension, but it's difficult to start."***
6. ***"I don't know why I'm here"***
7. ***"I don't have a drug problem. You cannot help me"***

For the de-brief, ask each group to share the client statement first and then share the open questions they developed. Also ask them why they chose questions. What information were they trying to gather?

- ***Trainer: Comment on them in context of the four MI principles***
- ***You do not necessarily need to go around the entire room, especially if the training is large in size.***



Slide 39: Core Skills: A

To start the discussion around affirmations, ask the participants "What are affirmations?" Try to elicit the definition from them. Also ask the participants, *"What is the purpose of using affirmations?"* Use their descriptors to connect with the bullet points on the following slide.

IMAGE CREDIT:

Purchased image, n.d.

Slide 40: Affirmations

Affirmations highlight the client's strengths, skills, or efforts they are making. They are powerful tools to build engagement and enhance the client's self-efficacy. We are trying to help give the clients hope and beliefs in themselves.

Effective affirmations comment on an enduring trait, like being resourceful, smart, strong, or persistent. You can provide some specific examples to demonstrate how they should sound:

- *"No matter what challenges come up, you keep trying!"*

(Notes for Slide 40, continued)

Slide 40: Affirmations

- *"Even when things are tough, you're resourceful and find a way to make things work!"*
- *"You've put your family first and worked really hard to support them!"*

IMAGE CREDIT:

Adobe Stock, purchased image, 2019.

Slide 41: Affirmations are Positive Reinforcement

Affirmations are a great way to enhance the client's self efficacy. Affirmations are also a great tool to build rapport and engage the clients. Emphasize the importance of being authentic and specific.

Many clients have had negative experiences in the treatment system and many have had previous failures in treatment. Affirmations are a great way to help get the clients engaged and hopeful for the future.

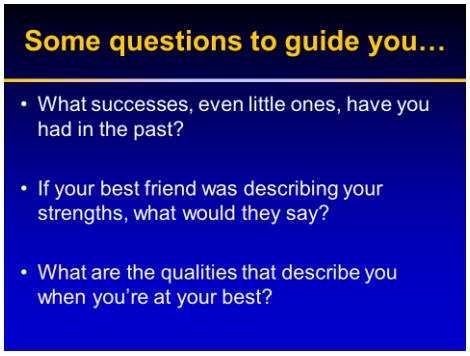
(Notes for Slide 41, continued)

Slide 41: Affirmations are Positive Reinforcement

For the first bullet, it is important to draw a distinction between confidence (a feeling of self-assurance arising from one's appreciation of one's own abilities or qualities [general]) and self-efficacy (belief in one's ability to succeed in specific situations or accomplish a task [specific to task]). One can have confidence generally, but not feel self-efficacy about accomplishing a specific task. Our goals is to increase the person's belief that they have the specific skills/ability to accomplish their treatment/recovery goals.

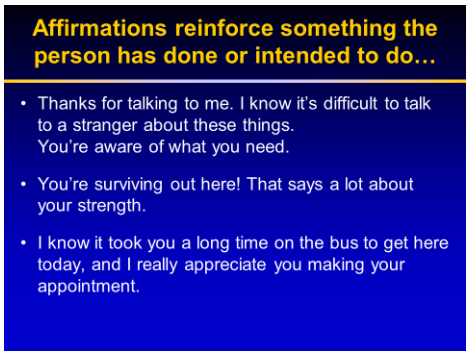
Slide 42: Affirmations can Boost Self-Efficacy

Read aloud these examples of using affirmations to enhance self-efficacy.



Slide 43: Some questions to guide you…

If you need some help in identifying possible affirmations, you can ask these questions to help elicit some of the client's skills/strengths/efforts.

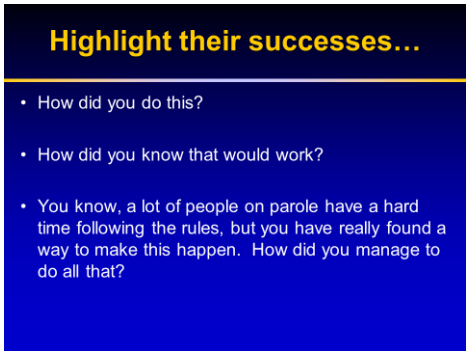


Slide 44: Affirmations reinforce something the person has done or intended to do…

One important purpose of affirmations is to reinforce positive behaviors that will help the client make changes. These are some examples of affirmations to help encourage positive efforts.

Slide 45: Call attention to something admirable or interesting

This is a list of possible affirmations. Remind participants that the more specific the affirmation is, the more effective it is. Affirmations are a great way to enhance the client's self-efficacy by specifically pointing out an admirable characteristic or skill/strength the client has.



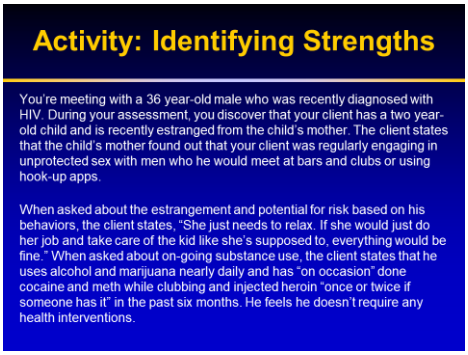
Slide 46: Highlight their successes…

These are some open-ended questions that help the client to think about successes that they may have had in the past. If the client is able to come up with examples, make sure to reinforce their identified strengths. Many clients have experienced setbacks or obstacles in their recovery that can lead to low self-efficacy. Highlighting successes, even small ones, can help enhance their self efficacy and hope.

Slide 47: Use Affirmations Thoughtfully

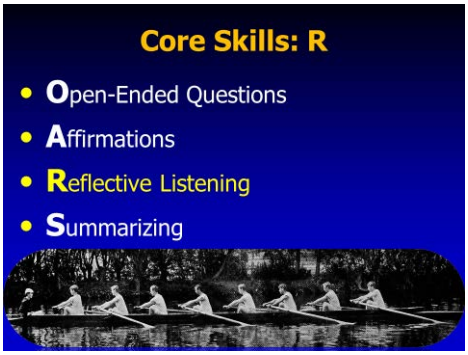
Affirmations are an underutilized skill, and we want to encourage people to use more affirmations in their conversations. However, the caveat is that affirmations should be thoughtful. Excessive praise can come off as inauthentic and can negatively affect the relationship with the client. Providers should be thoughtful with their affirmations.

The more specific and concrete the affirmation, the more effective they are. For example, "*Great job!*" isn't necessarily bad, but you can make it better by being more specific. "*I know changing your diet hasn't been easy, but you've done a great job at sticking with it this week!*"



Slide 48: Activity: Identifying Strengths

Read through the vignette. Divide the training participants into groups of 3-5. Give them 5-7 minutes to discuss how they might identify strengths of this individual if they were working with him. Debrief as a whole group and ask for volunteers to share some of the skills or strengths they highlighted.



Slide 49: Core Skills: R

To start the discussion around reflections, ask the participants "What are reflections?" Try to elicit the definition from them. Reflections are paraphrasing statements of what the client says. It's rephrasing or repeating the client statements.

Reflective listening is an MI micro-skill that clinicians can use to express empathy with clients.

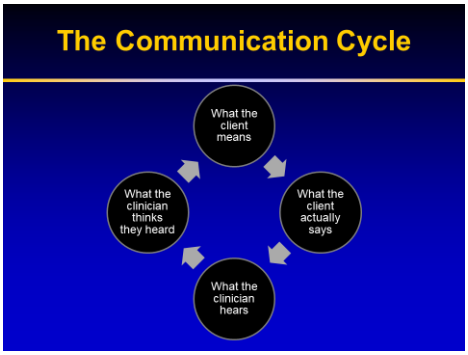
Also ask "Why are reflections useful?" Use their descriptors to connect with the bullet points on the following slide.

IMAGE CREDIT:

Purchased image, n.d.

Slide 50: Expressing Empathy through Reflective Listening

Reflections are a great way to express empathy and allow the client to feel heard. Reflections help to check our understanding of what the client said. Reflections are also a great way to highlight the client's own motivation, e.g. "*You've thought a lot about the importance of cutting back on your drinking.*"



Slide 51: The Communication Cycle

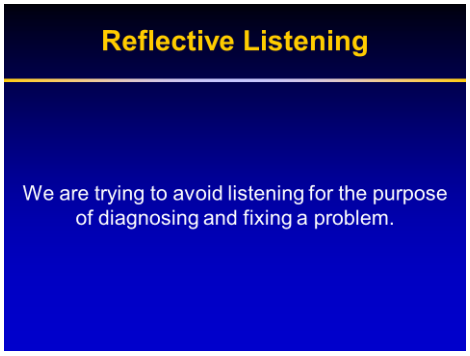
This diagram depicts the four components of the communication cycle. In order to have accurate empathy, one must check in to see if "what the client means" is the same thing as "what the clinician thinks they heard." You should read through the components individually and then make the key points below.

Reflections are a great tool to check your understanding of what the client says. They help to figure out if what you heard is what the client meant. Essentially, you are asking "Is this what you mean?"

At least three places exist where communication can go wrong in getting from 1 to 4 in the diagram included on the slide:

- Speaker doesn't say exactly what they mean
- Listener doesn't hear accurately
- Listener interprets what is said differently from what is meant

Reflective listening is designed to connect what the client means to what the clinician think they heard. It helps us make sure you are on the same page with the client.



Slide 52: Reflective Listening

This slide serves as a transition to introducing in more detail the micro-skill Reflective Listening.

Reflections are a way for us to better empathize with our clients. They shouldn't be used to help us try to fix the problem for them. The following video helps to highlight what we are trying to avoid.

This transition sets the stage for the "*It's not About the Nail*" video on the next slide.

Slide 53: It's Not about the Nail

The purpose of the video is to demonstrate the power of reflections. This activity should take no more than 5-7 minutes, including a quick de-brief to discuss participants' impressions of the video. Be sure to practice with the video ahead of time, so you can be certain that it will play as intended. When setting up the video, ask participants to write down their general reaction of the conversation that ensues between the man and woman (the good and not so good elements of the conversation), and also ask them to think about the question "Why do we want to avoid trying to fix the problem for the client." Reflections are a tool to help clients feel heard and understood. It demonstrates that we are listening and curious about their perspectives. Reflections can help us meet the client where he/she is are. They demonstrate the collaborative nature of the conversation.

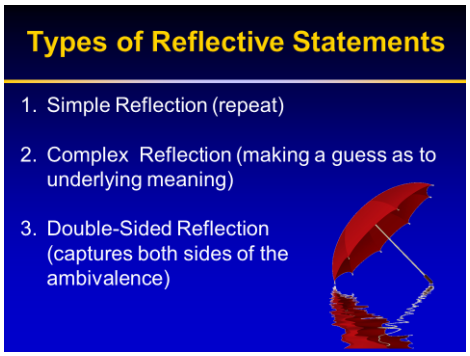
Video Title: "It's Not about the Nail" (1:40 in duration).

(Notes for Slide 53, continued)

Slide 53: It's Not about the Nail

Be sure to practice with the video ahead of time. The video will play automatically on mouse click. If the video does not play, you may have to add it from the file. You can do this by going to "Insert → Video → Video from File (or Video from My PC)" Locate the file on your computer to add it to the slide.

Slide 54: Types of Reflective Statements



This slide identifies the three types of reflections. The following slides include detailed definitions. In this training, complex reflections and amplified reflections are combined into category #2 above.

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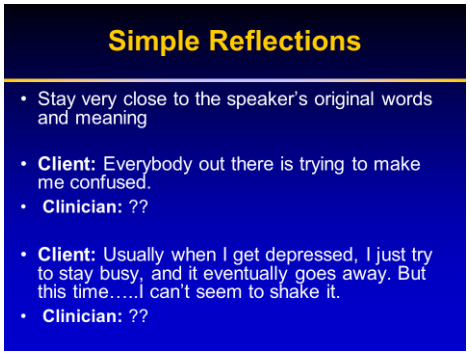


Slide 55: Simple Reflections

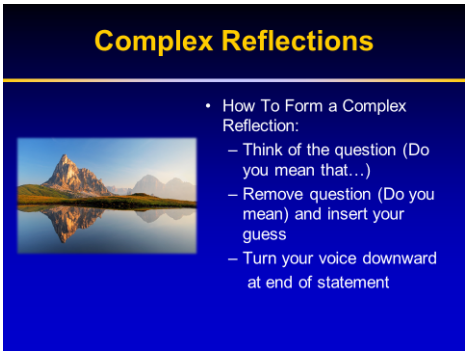
Simple reflections re-state what the client said using the same words or a basic paraphrase. They stick very closely to the content of what the participant had said. Demonstrate a simple reflection using the following example (or use one of your own):

Client: "*I'm worried about what my friends will think if I quit smoking marijuana.*"

Interviewer: "*You're concerned about your friends' reaction if you quit smoking.*"

After demonstrating a simple reflection, read the client example on the slide above and ask the participants to come up with a simple reflection. You can ask for more than one participant to provide a simple reflection.

Simple reflections are good for two things: (1) to confirm what you heard is correct; and (2) to get "unstuck" – reflect back the last thing you heard to buy yourself a few seconds to figure out what to say next. They can also elicit the client to elaborate or tell you more about what they are saying.



Slide 56: Complex Reflections

According to Miller and Rollnick, a complex reflection adds some meaning or emphasis to what the person has said (beyond surface level), making a guess about the unspoken content or what might come next (continuing the thought or highlighting the underlying emotion of the statement). Making a bit of a guess and continuing the thought/adding emphasis often adds momentum to the exploration process. You're using what you know about the client and your conversation to reflect the emotion underneath the statement. Complex reflections are a great tool to take a conversation to a deeper, more emotional level. More complex reflections tend to move the conversation forward. Making guesses like this in the form of reflective statements can feel uncomfortable at first, but it usually does facilitate communication and understanding. It is important not to jump too far in guessing what the person means. This is a judgment call, and if your guess is too far off, you will see it in the person's response.

(Notes for Slide 56, continued)

Slide 56: Complex Reflections

You're asking yourself "How is the client feeling about this?" or "What do they really mean by this?" Instead of asking the question, you make an educated guess and reflect it to the client as a statement. Provide a demonstration to show the skill in action:

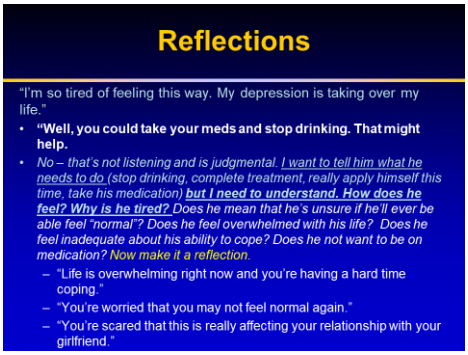
Client: "*I've quit smoking before, and I know it's really hard.*"

Interviewer: "*You're worried you might fail if you try to quit smoking.*"

Reflections are statements by definition. Be mindful of your tone of voice at the end of the statement. If your tone rises up, your statement will sound like a question instead. Demonstrate how this sounds.

IMAGE CREDIT:

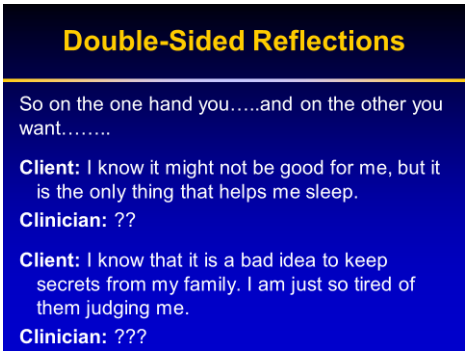
Adobe Stock, purchased image, 2019.



Slide 57: Reflections

This slide demonstrates the process of forming a complex reflection. It starts with an example of something a client might say, and proceeds through how to form the complex reflection.

Start presenting the slide by saying, "Here is an example of the thought process of creating a complex reflection. Then read the bullets step by step to walk the participants through the process.



Slide 58: Double-Sided Reflections

Double-sided reflections help to highlight the client's ambivalence, and help us arrange the conversation to encourage positive talk about change. When you use a double-sided reflection, you want to end on the side of change. The setup is: "On the one hand (insert sustain talk), and on the other hand (insert change talk)."

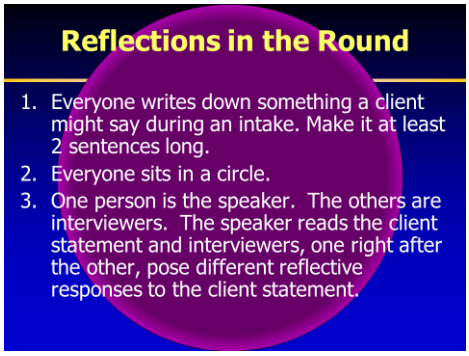
Double-sided reflections demonstrate the importance of ending on the side of change by giving an example of what happens if you end on the sustain talk.

Client: *"I could quit smoking any time I want to, but I just don't want to."*

Interviewer: (the wrong way) *"On the one hand you know you can quit smoking, but on the other hand quitting is not important to you right now."*

Interviewer: (the right way) *"On the hand quitting smoking isn't your top priority, but on the other hand you're confident you'll be successful when you're ready."*

After each "client" example in the slide, ask the participants to give you a double-sided reflection. If they end the double-sided reflection on sustain talk, coach them to end of the side of change.



Slide 59: Reflections in the Round

The purpose of this activity is to provide participants with practice in crafting reflections. If people have difficulty, you can coach them along the way. If someone really does not want to participate, you can ask the whole audience who would like to respond with a reflection. This activity should take a total of up to 10 minutes.

- ***Arranging the chairs in a circle is optional. The exercise also works if the participants are seated in rows.***
- ***Read the information on the slide aloud to participants, and give them a minute or two to write down their client statements.***
- ***Ask for a volunteer to read the statement they wrote.***
- ***Then ask the person seated to their left to respond to that statement with a simple reflection. You can repeat this with the next person to the left a few more times (2 or 3 usually works).***

(Notes for Slide 59, continued)

Slide 59: Reflections in the Round

- ***Now ask the next person to the left to offer a complex reflection. These are harder and you may need to coach them to reflect the emotion or feeling behind the statement. You can repeat this a few more times until you think the participants get the point.***
- ***Ask for a new volunteer to read one of their statements and continue with the steps above.***

NOTE: If no one comes up with a client statement that contains ambivalence, the trainer should come up with a statement and ask someone to do a double-sided reflection.

Slide 60: Empathetic Listening & Reflections

Now that participants have practiced creating reflections, we want to demonstrate their usefulness in a broader conversation. Reflections are powerful tools to elicit conversation. We usually think we have to ask questions to learn more about the client, but reflections can be incredibly useful tools to help engage clients and encourage conversations. In this video, Dr. Bill Miller is interviewing a relatively non-verbal client who was coerced into treatment. Instruct participants to pay particular attention to Dr. Miller's use of reflections and questions throughout the conversation (and the ratio of questions to reflections), and write down specific examples of how reflections were used effectively. The video and de-brief should take a total of about 10-12 minutes.

Video Title: "Non-Communicative Client" (24:02 in duration; you only need to play about 5-7 minutes of the video to make the point).

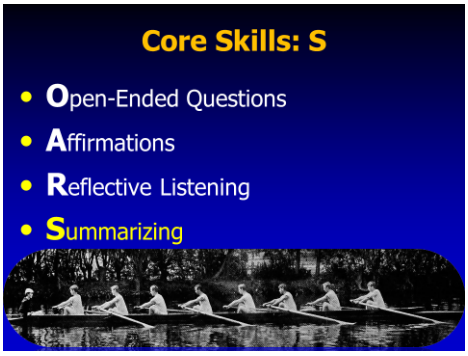
(Notes for Slide 60, continued)

Slide 60: Empathetic Listening & Reflections

Be sure to practice with the video ahead of time. Introduce the video before playing it as a way of showing how reflections are useful to enhance engagement in a way that reduces barriers that questions may not.

The video will play on mouse click. If the video does not play, you may have to add it from the file. You can do this by going to "Insert → Video → Video from File (or Video from My PC)" Locate the file on your computer to add it to the slide.

After the video is over, ask for the participants' general reaction. What did they notice about his approach? How many questions did Dr. Miller ask? What did they like about it? How might that client have responded if Dr. Miller asked mostly questions?

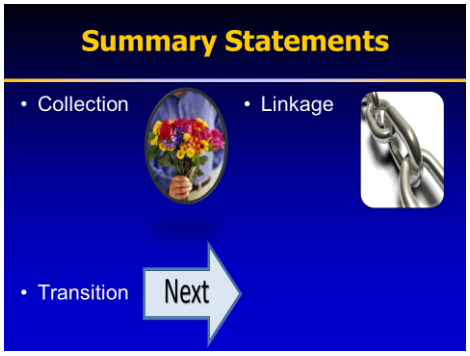


Slide 61: Core Skills: S

The final skill we're going to discuss is Summarizing. To start the discussion, ask the participants "Why do we use summaries? How are they useful?" Try to elicit the definition from the participants.

IMAGE CREDIT:

Purchased image, n.d.



Slide 62: Summary Statements

Summaries highlight and reinforce the most important points in a conversation. It's a series of reflections stacked together into a broader overview. A summary is like a bouquet of reflections.

Summaries can be used to:

- Gather a collection of reflections together to reinforce the most important topics covered in the discussion.
- Link topics together, e.g. summarizing a discussion of the client's mental health symptoms and then substance use and asking what the connection between them are.
- Transition from one topic to another. Or transition from one MI process to the next.
- Reinforce statements the clients make that shows their motivation for change.

IMAGE CREDITS:

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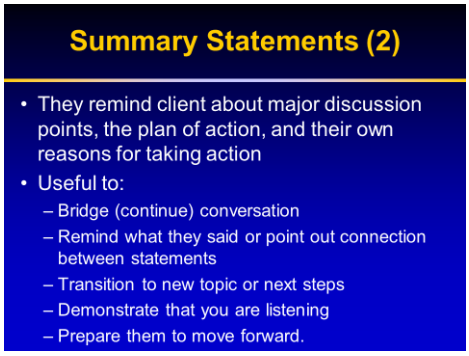
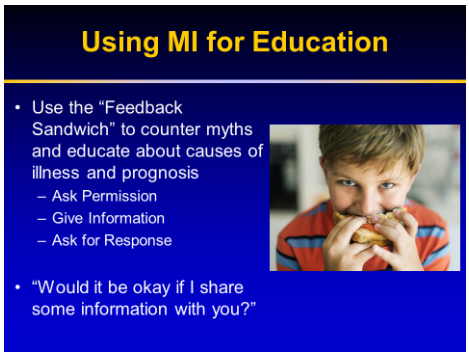




Slide 63: Summary Statements (2)

Read the key points to finish this section on summaries. Summaries are very helpful to consolidate key points or pieces of information that you want the client to remember.

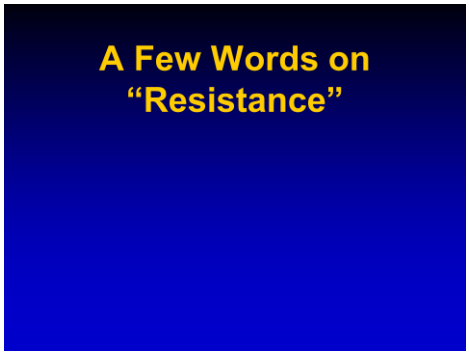
Slide 64: Using MI for Education

This slide explains how to provide education in an MI-friendly manner. The key is to use the feedback sandwich. The first step is to ask for permission. The second step is to provide the factual information. The third step is to then ask the client for their reaction to the information. What do they think about it? It can be helpful for the trainer to demonstrate a brief example of this feedback sandwich.

You can also use the feedback sandwich to give clients ideas or options for how to make their changes.

IMAGE CREDIT:

Adobe Stock, purchased image, 2019.



Slide 65: A Few Words on "Resistance"

The next section briefly present two advanced concepts: resistance and change talk.

If you are very low on time, you can skip this section.

Slide 66: Where does resistance start?

This slide is here to demonstrate the concept of resistance. The quick activity should only take 2-3 minutes. Ask someone to volunteer to join you at the front of the training. When the volunteer comes up, direct him/her to stand next to you with his/her hand up. You will then place your hand over his/hers and gradually begin to push against his/her hand. Once he/she starts to push back, gradually increase the force of pressure until he/she adds additional pressure. Let this go on for approximately 30 seconds, then thank the participant and allow him/her to return to his/her seat. Ask the participant why he/she pushed back and he/she will likely say because you started pushing. Ask why he/she didn't just walk away and he/she may not have a response.

This is analogous to the way in which "resistance" occurs in treatment. A client comes in and will try to push the counselor. However, if there is no push back, then there is truly no resistance.

(Notes for Slide 66, continued)

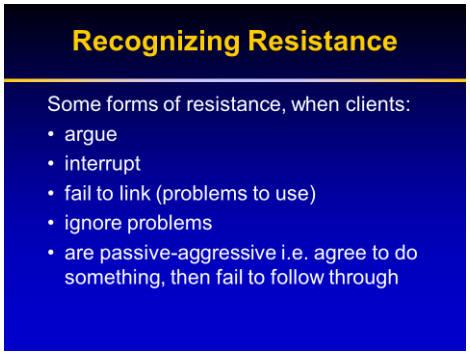
Slide 66: Where does resistance start?

So if a counselor is able to recognize the times that he/she feels compelled to push back and avoid that impulse, he/she is much more likely to reduce the possibility of resistance between the client and counselor.

Miller and Rollnick state that, "[T]here is no particular reason why the therapist should badger clients to accept a label, or exert great persuasive effort in this direction. Accusing clients of being in denial or resistant or addicted is more likely to increase their resistance than to instill motivation for change. We advocate starting with clients wherever they are, and altering their self-perceptions, not by arguing about labels, but through substantially more effective means (Miller & Rollnick, 1991, p. 59)."

REFERENCE:

Miller, W.R., & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: Guilford Press.



Slide 67: Recognizing Resistance

Resistance may arise in a few different ways:

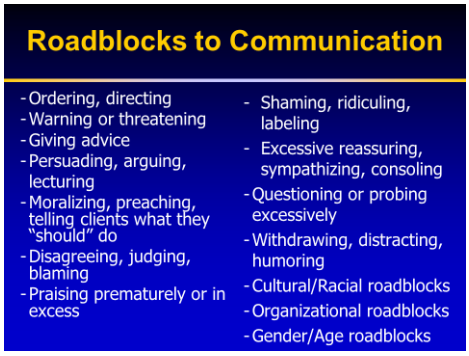
Arguing – whether it's the client try to provoke you into an argument or the counselor arguing with the client

Interrupting – not letting the counselor speak

Fail to link – not recognizing the problems linked to substance use; this is an opportunity for education and motivational enhancement

Ignore problems – the client makes it clear that they do not feel comfortable or motivated to talk about the identified issues

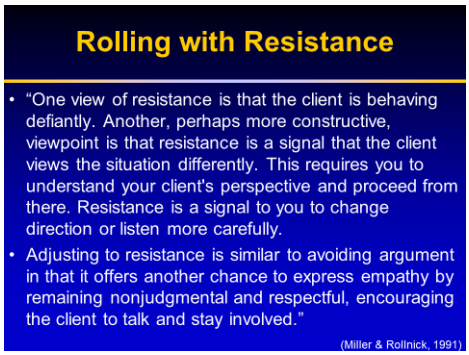
Passive-aggressiveness – not complying with treatment recommendations despite seeming willing to do whatever the counselor recommends



Slide 68: Roadblocks to Communication

Read through the list of potential roadblocks to communication. Ask the audience which they have encountered before. If there are no audience contributions, pick one or two to describe.

"Giving advice" – whenever we start giving advice, we miss the opportunity to understand the person and hear them out. This is counter to the MI Spirit.

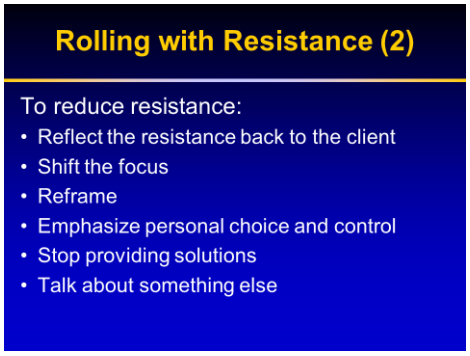


Slide 69: Rolling with Resistance

Ask two members from the audience to read each of the points. Ask two-three audience members what they think of the statements.

REFERNCE:

Miller, W. R. and Rollnick, S. (1991) *Motivational Interviewing: Preparing People to Change Addictive Behavhior*. New York: Guilford Press.



Slide 70: Rolling with Resistance (2)

This slides provides some recommendations for "Rolling with Resistance," and strategies to avoid getting stuck in pushing back against the client. Review the examples below:

- **Reflect the resistance** – "*that sounds really frustrating*"
- **Shift the focus** – "*What else would you like to talk about?*"
- **Reframe** – "*It seems like there are a lot of people trying to get you to do something you don't want.*"
- **Emphasize person choice and control** – "*I'm not trying to get you to do anything you don't want to today. We're just going to have a conversation about what we might be able to accomplish together. What you decide to do from there is up to you.*"
- **Stop providing solutions** – Just like the "It's Not About the Nail" video, sometimes moving away from continuing to point out a flaw or problem is not the best approach
- **Talk about something else** – Find out what the individual is interested in. What sorts of activities or experiences outside of the clinical discussion are of interest?

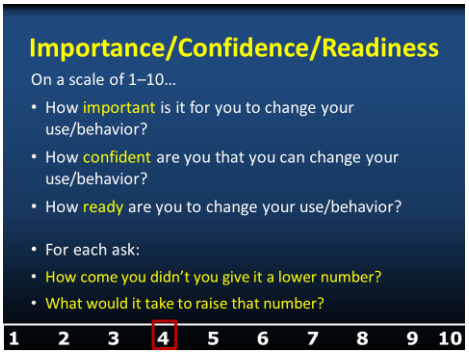
Slide 71: "Resistant" Trucker Interview

This is an optional video if you have time. The purpose of this video is to show participants how to roll with resistance. Introduce the video by noting that the client is fairly resistant to treatment and ask participants to write down specific examples of how the counselor (Dr. Terri Moyers) uses the OARS micro-skills.

Video Title: "Resistant Trucker" (7:53 in duration; you only need to play about 5-7 minutes of the video to make the point).

Be sure to practice with the video ahead of time. Introduce the video before playing it as a way of showing how reflections are useful to enhance engagement in a way that reduces barriers that questions may not.

The video will play on mouse click. If the video does not play, you may have to add it from the file. You can do this by going to "Insert → Video → Video from File (or Video from My PC)" Locate the file on your computer to add it to the slide.



Slide 72: Importance/Confidence/ Readiness

Another tool is the confidence or readiness ruler. This is really just a numberline from 1 to 10. You can preprint one or simply draw one on a piece of paper. To use the ruler, you need to pick the issue that the patient is most concerned about.

The ruler can be used to determine how ready the person is to make a change, how important making a change is to them or how confident they are that they will be able to make the change. In our example below we will use readiness.

Bullets 1-3. You show the patient the ruler and ask him or her, "On a scale of 1 to 10, with 1 being not at all ready and 10 very ready, how ready are you to… change your drinking/work on your relationship/try another strategy for your pain, whatever you think the issue is they want to talk about. Only focus on one issue in the intervention.

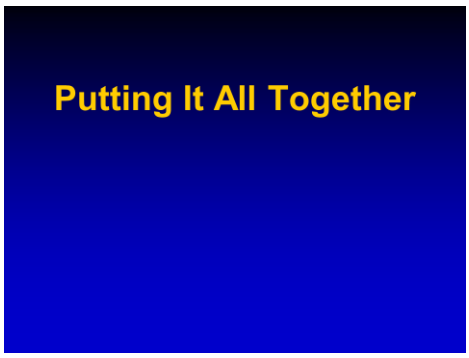
More than likely, people will not choose 1, but will aim a little higher. If they choose 1, it is not an issue that they are willing to talk about at all which probably means that you are not focusing on the issue that is most important to them. Refocus and try another issue.

(Notes for Slide 72, continued)

Slide 72: Importance/Confidence/ Readiness

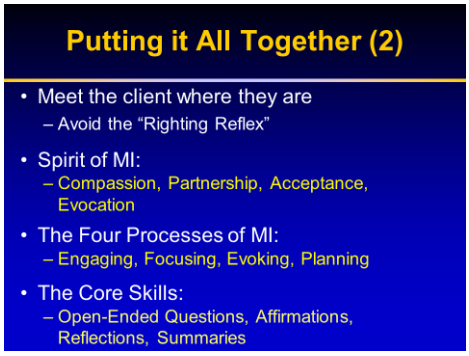
Bullets 4-5. After the patient responds, you counter by asking why they didn't chose a lower number, e.g., "Why not 2?" You want them to defend the higher number. Their responses will be very informative and will likely contain some change talk.

You should never go more than two points below the number they originally select. This ensures that you do not minimize too dramatically the number they select, or make them feel as if they need to make huge changes to reach a new number. You can also ask them to explain why they have not chosen a number that is 2 above the number they selected, as this can provide relevant information as well.



Slide 73: Putting It All Together

Having reviewed the four micro-skills, let's begin to put the OARS together.



Slide 74: Putting it All Together (2)

One final activity will provide participants an opportunity to put together all of the concepts and skills that have been reviewed up until this point in the training. Review key reminders of all the topics covered so far that are listed in the bullet points above. Remind participants to meet the client where he/she is, and engage the client in a conversation that avoids the "righting reflex**." The Spirit of MI should be the foundation of all interactions. The processes help conceptualize how to proceed through treatment, and the core skills allow the provider to engage with the client.

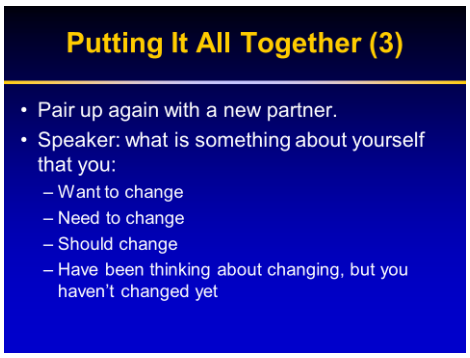
Instruct participants to select a partner they have not worked with previously. This activity will take 20-30 minutes (10 minutes for each person to be the INTERVIEWER, and 5-10 minutes for the de-brief).

(Notes for Slide 74, continued)

Slide 74: Putting it All Together (2)

A quick note about the "righting reflex" – the righting reflex is a "knee jerk" reaction, which pushes the clients to your perceived right answer instead of listening and understanding where the client is coming from with regards to the behavior in question, and guiding him/her to and answer that makes sense them. The male character in the "It's Not about the Nail" video is a great example of the righting reflect – he was pushing instead of guiding.

Additional instructions are included on the next slide.



Slide 75: Putting It All Together (3)

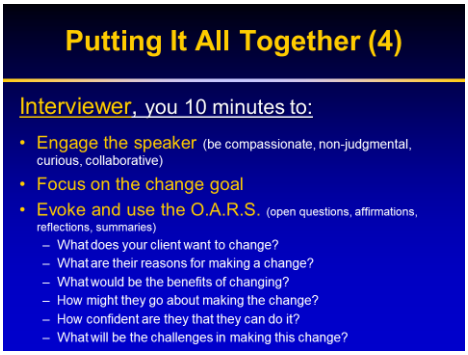
Explain that this is the final activity will allow them to put together all the components that we've discussed today. Read the instructions for the SPEAKER role above.

Be sure to re-iterate:

The personal change should be something real for them. They are <u>NOT</u> role-playing a client.

You should also explain that the change should be a behavior, and it should not be a neutral choice. For example, a neutral choice "Should I get a Honda or a Toyota?" or "Should I go to Grad School A or Grad School B?" is not ideal for this exercise. You can use MI to help clients with a neutral choice, but today we are focusing on behavior change.

Additional instructions are included on the next slide.



Slide 76: Putting It All Together (4)

The INTERVIEWER'S job is to engage the client in a conversation about the change they're like to make and put the MI Spirit and skills into action. They should engage the SPEAKER, focus on a change goal, and if the speaker is reader they can start to discuss the change plan.

You should keep track of time for the audience. In summary you should announce:

- ***The first round starts now.***
- ***(After 10 minutes) announce that the first round is finished. The pairs should switch roles.***
- ***Announce the start of round 2.***
- ***(After 10 minutes) announce that round 2 has finished.***

After both rounds (20 minutes total), you should debrief the activity and ask the interviewers about their experiences. Spend approximately 5-10 minutes getting the participants' experiences in contrast to their first role play: what went well, what was different, what went not-so-well.

Slide 77: Go out and practice your MI skills!

To wrap up the training, discuss the importance of practicing using your MI skills with your clients. Continuing to improve your skills requires ongoing practice, coaching, and discussion. Without this conscious effort to practice the skills, it's easy to go back to your normal style.

ADD TRAINER(S) NAMES AND CONTACT INFORMATION AND REPLACE IMAGES FOR TRAINER'S ORGANIZATION

This concludes the presentation. Thank the participants for their time and address any last-minute questions about the content. Encourage participants to reach out to the Pacific Southwest ATTC or the LA Region PAETC, should they have questions or concerns following the training session.

Acknowledgements

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