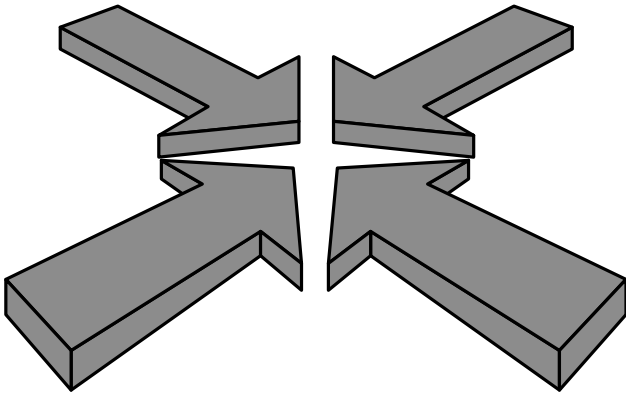


Motivational Interviewing Newsletter for Trainers

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New Perspectives

Teaching MI in Norway

Peter Prescott, Ph.D.
The Bergen Clinics, Bergen, Norway

Bergen, Norway, Oct. 11th. After a beautiful (greenhouse?) Indian summer, North Atlantic weather has blown in from the west. Stationary low pressure areas south of Iceland have driven rain and wind in over the Western coast of Norway. Everything appears to be back to normal. Besides the weather update, I was thinking of giving a short report on our teaching MI here in Norway.

A short historical sidetrack

Bill Miller was a visiting professor at the Hjeltestad clinic, here in Bergen in 1982-3. Since his visit, MI has been one clinic's theoretical foundation. New "generations" of therapists have been introduced to MI, myself included, and I sometimes get a strange feeling of how the past influences the present.

A highlight of 1996

June in Tromso. Above the Arctic circle with snowy mountains surrounding the town, we walked back to our hotel in sunshine at two o'clock in the morning. (Workshops in MI can often be rather intense).

Workshops in 1996

As for the outpatient clinic in Bergen, you could say that MI is our "trademark". Our staff has been very

active in holding MI workshops. Several of us are involved in teaching activities. (Three of us have been to Bill and Steve's "Training for trainers" workshops). We have conducted about 20 workshops this year, mostly of 2-3 days duration, mainly in Norway, but also in Denmark and Sweden.

Workshop participants come from social offices, primary health care settings, special treatment facilities for drug and alcohol abusers and walk-in services for drug addicts. We have also held a workshop for High School teachers and counselors.

Every workshop has been evaluated, and the results are always positive. We did a small follow-up study last winter and sent 100 questionnaires to people who had participated in one of our workshops 6-18 months before. About 60 answered and they still had a positive evaluation of the workshop. A sizable minority reported they felt that the utility and relevance of the workshop had increased in the time gone by. These results were presented at the 10th International Conference on Alcohol in Liverpool in April.

Workshop materials

In 1995, we received funding from the Norwegian government to develop and document the MI workshop. This resulted in an 80-page participant manual with 8 chapters and a 35 minute, professionally produced, demonstration video. The video has 5 sequences: "Atmosphere", "Ambivalence", "Exploring concerns", "Giving information - Increasing concerns", and "Decision making". The video has been a hit. The "client" (a colleague) is very convincing in his role and has become a bit of a cult figure. (We worked on the manuscript for about two weeks. Shooting took one day and editing one day. It was worth it.

The video makes it easier to standardize demonstrations and illustrate counseling techniques. We ask workshop participants to observe and register counselor and client behavior on coded registrations forms. Our "client" changes quite a bit during these 35-minutes and a comparison of Stage of Change after sequence one and then again after sequence three results in

interesting discussions about the nature of change. We also use the video as a trigger for role play.

A few thoughts

- * Teaching skills in dealing with resistance is difficult in a 3-day MI workshop. The nimbleness and flexibility demanded of the counselor is hard to operationalize, and harder to teach, in a few hours.
- * "Hopelessness" seems to be a different type of resistance than Prochaska and DiClemente's other 3 "R's" in Precontemplation. We are attempting to develop interventions towards hopelessness by adapting cognitive techniques from the treatment of depression.

Self motivating statements: We use the following structure in teaching this module:
1.) Identification of SMS. 2.) Eliciting SMS.
3.) Short role plays that focus on one eliciting technique at a time. We have found that techniques from solution focused therapy are useful in eliciting SMS and can be integrated into MI.

Phase Two

This autumn Tore Bortveit and I did a MI - Phase Two workshop. The contents were:

- * Integrating of stages and processes of change
- * Dealing with resistance
- * Eliciting SMS
- * The use of cognitive techniques in MI

We feel that this was a step in the right direction and the workshop was well received, but as always with something new, a few bugs have to be ironed out.

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Cole and Associates

Cathy Cole, ACSW

Just a brief update on my activities since my training last year in Italy. On return home, I was very disheartened to realize that my own substance program was rapidly being downsized and that I would have little, if any, opportunity to do training at my agency, a VA hospital.

Since January of this year, I have been conducting private workshops for professionals. Thus far, these have been limited to one day, designed by the sponsoring groups to satisfy the need for continuing education primarily for counselors and social workers. My focus has been an overview of Motivational Interviewing, Stages of Change Readiness, Five Opening Strategies and then the Five Step Process (Steve's Five Easy Pieces). Until my last workshop, my group has been diverse in both experience and settings, a challenge to meet many needs. A volunteer for the Five Opening Strategies demo decided to be a middle school student having problems with a teacher. I had great difficulty showing the effectiveness of MI and would welcome any feedback from others using MI with adolescents. We discussed this some in Italy.

My last workshop was for addictions folks and was much better to do. However, a one day workshop is an overview, at best, and teaching reflective listening almost impossible, except for a sampler. I am getting good feedback and find that almost no one has heard of this material. I have hopes of implementing MI on a college campus and am exploring the possibility of training peer counselors.

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From Across the Pond

Stephen Rollnick

The MINT Questionnaire

This was my fault. What a pathetic initial response rate: 25%. That's not normal, it's much worse than normal people's return rates. It's a strain on my research nerves, having decided to go ahead with this little survey. Many a delinquent MINT will suffer for this, I promise. You see, it's really part of an experiment on conformity. More to follow. I've got a lovely new little boy who parties all night. I don't need more problems with conformity.

Project MATCH, The Black Box and the Funeral of MI

There are serious implications from the findings of Project MATCH. I've still seen nothing in writing, although word of mouth has it that there were few main effects or matching effects in the comparison of MI, cognitive-behavioral and 12-Step approaches. I hesitate to leap too far ahead with my second-hand understanding, but does this mean that we have another argument for abandoning the distinction between different treatments, with their attendant models? So that means a funeral for MI, doesn't it? Why don't we take the lead, and do it? (*Editor, can you ask someone like Geoff Williams for a passionate response?*) Don't we therefore need a single model, a single method, called something banal like addiction counseling? What should go into this Black Box? We know this already. Quite a lot of MI, and from other approaches as well. The stages of change framework will help. It will be good to take this discussion up again when the results are formally out.

The Outcome Study From Hell

This was it, definitely. I walked into a group of nurses to conduct brief alcohol counseling training to discover that my host, the Principle Investigator, was in a weird state of detachment from the whole process. He had not bothered to iron out

procedural matters beforehand. Most of the first training session was taken up with preliminaries like recruitment and obtaining consent. Then an unexpected thing happened. The nurses devised the scientific procedure themselves, with my host merely offering suggestions here and there. By the end of the session they were fully committed to the scientific process, and rearing to go. This is very unusual for practitioners in this kind of study. They more usually feel alienated by the scientific procedure, and poor morale has, in my experience, almost become a syndrome. Oh yes, the counseling training. When I came back for the second and last training, the nurses believed we were going to discuss more of the scientific stuff, and that my host would be doing the counseling! Readiness to carry out counseling - 0/10. The story gets worse.

Premature Controlled Trials

If I had a wish it would be for fewer controlled trials on behavior change, and much more developmental and process research. As we know, the "delivery" of intervention to patients too often wrongly assumes that practitioners can change their consulting behavior. I was pleased when we recently managed to persuade a prestigious UK funding body to support a three-year development study of practitioner behavior change, in this case on the over-prescribing of antibiotics for coughs, colds and sore throats. We will start with qualitative interviews of doctors and patients, then bring them together in a group to consider our findings and devise suitable interventions, and finally, pilot the training of doctors. A controlled trial is some years down the line. My Head of Department tells me that he detects a culture change within medical funding bodies for research on health behavior change in the UK, away from the facile, oversimplified controlled trial which treats a complex discussion about change like the delivery of a tablet. For those MINTies in the specialist addiction field, can I ask you: where are the audiotapes of consultations about change? After Project MATCH, who wants to run a controlled trial? (*Editor, what does that bloke Miller think?*)

European Activity

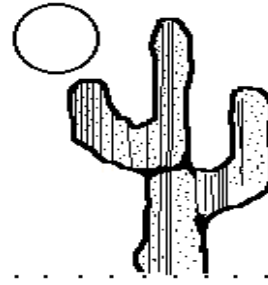
MINTies across the Pond in the USA might want to connect up with these people: *Janet Treasure* continues to work at the forefront of the eating disorder field, and is active in training and writing. A book is coming out soon, I believe, and the reference will appear in these columns soon. *Jonathan & Jo Chick*, from the problem drinking field in Edinburgh, are heading for India, where they will encounter the cross-cultural applicability problem head-on. I'll get them to send us a few paragraphs on their return. *Jeff Allison* from Leeds is quickly developing a specialist knowledge in resistance, working in the probation field. This is one component of MI which needs much more development work. Jeff will be running a workshop for a European-wide network for practitioners working in prisons, in collaboration with myself and Rik Bes, the Dutch MINTman who runs the European Addiction training Institute in Amsterdam. Eventually, we will persuade Jeff to write. *Melvyn Hillsdon & Charlie Foster* are apparently doing well in the *Move-It* exercise project, and in the same field, *Norman (Tim) Anstiss* has developed his Centre for Clinical exercise considerably. He has recently won a grant to establish a chronic back pain centre and is also working hard in the cardiac rehabilitation field. I met up with our *Italian* MINTies recently, who are still enthusiastically chipping away at the addiction treatment establishment producing manuals and addressing conferences.

Recent Publications

STOTT, N., REES, M., ROLLNICK, S., PILL, R. & HACKETT, P. (1996) Professional responses to innovation in clinical method: diabetes care and negotiating skills. *Patient Education & Counseling*, 29, 67-73.

SAMET, J. & ROLLNICK, S. (*In Press*) Beyond CAGE: A clinical approach after detection of substance abuse. *Archives of Internal Medicine*.

ROLLNICK, S. (*In Press*) Whither motivational interviewing? (Editorial) *Journal of Substance Misuse*. (*A review of MI by Noonan & Moyers also in this issue*)



Notes From the Desert

Bill Miller

Let it snow! Let it snow! Let it snow!

Holiday greetings to all Minties! New Mexico is already heavy-laden with snow, and some of the ski areas opened before Thanksgiving with 50" natural bases. Down here at one mile elevation we don't see as much, though as I write this Albuquerque is blanketed in white.

MI Trials

At CASAA we are well underway with the MIDAS study, a randomized trial of motivational interviewing as a prelude to treatment for drug abuse. It's a tough and severe population we're working with, so we're again testing the limits of MI. Meanwhile there are many new applications of MI underway. Here are a few.

Doug Zeidonis, M.D. (Substance Abuse Center, Department of Psychiatry, Yale University; 203-789-7079, x313) presented at the Society for Behavioral Medicine meeting what I believe is the first paper on the use of MI with a schizophrenic population (targeting smoking behavior).

Dr. Rob Nolan (Coordinator, Health Psychology Services, Ottawa General Hospital, Faculty of Medicine and School of Psychology, University of Ottawa; 613-737-8628) has been awarded a 2-year grant to conduct a smoking cessation trial of MI via telephone counseling with over 1,000 female medical patients attending outpatient clinics in obstetrics-gynecology, perinatology, endocrinology, general medicine, cardiology, and respiratory medicine. Materials for assessment and intervention are being prepared in French as well as English.

According to *Joe Haberman* (757-393-8896), the State of Virginia is instituting use of the URICA and MI as a statewide standard in substance abuse care.

Paul Amrhein, Ph.D., a psycholinguist at the

University of New Mexico (505-277-4209), is studying commitment language during motivational interviewing sessions. His preliminary findings show a substantial increase in client commitment-to-change language over the course of MI sessions. He presented a paper on "The Psycholinguistics of Addiction" at a NIDA meeting on treatment readiness, December 3-4.

Alan Marlatt, Ph.D. presented continuing results from their "Lifestyle 99" project at the recent Addictions '96 meeting at Hilton Head, South Carolina. The group of college students receiving the intervention incorporating MI show greater suppression of drinking at 4-year follow-up.

Dennis Donovan, Ph.D. alerted us to two new projects on which he is consulting. Chuck Bombardier and Carl Rimmel at the Seattle VAMC plan to study MET with head injury patients. Karen Schmalting plans to study MI in the treatment of chronic asthma patients.

Delia Smith, Ph.D. at the University of Alabama (Birmingham) School of Medicine is studying the efficacy of MI for overweight women with Type II non-insulin-dependent diabetes. Early results point to increased glucose monitoring, better glycemic control, and increased treatment compliance in the MI group.

Other Things

At the same meeting, Robyn Richmond referred to a small dissertation trial being conducted at Kaiser-Permanente. Medical practitioners are being randomly selected and recruited for paid MI training. The group is studying pre-post skill changes in relation to physician characteristics (such as authoritarianism). Steven Berg-Smith, M.S. at the Kaiser Permanente Center for Health Research in Portland, Oregon, has prepared and is testing a *Hypertension Intervention Project* manual for health professionals, based on MI principles and methods.

Robyn Richmond also made some interesting side comments during her invited address at Addictions 96. She opined that MI does not transfer well across cultures. "Most of the world lives in a male-dominated authoritarian culture," she observed, and MI does not fit (from the perspective of providers) within this perspective. She also noted that physicians don't tend to "take it up," again perhaps because of authoritarian perspective. Robyn was commenting not on the potential effectiveness of MI in various cultures, but rather on barriers to

diffusion of this approach. I invite you to comment in future issues of this newsletter on your own experience in cross-cultural application of MI. (The paper from Robyn's lecture appeared in the June issue of *Addictive Behaviors*).

The timing of this newsletter does not allow me to comment in writing on the Project MATCH findings, but around the time this newsletter arrives the report should be in print. It will appear in the January issue of the *Journal of Studies on Alcohol*, due to be mailed on December 15.

The ADAI library has posted a MI bibliography on the web. The address is:
http://weber.u.washington.edu/~adai/library/bibs/tx_280.htm

We continue to update our MI bibliography at UNM, and maintain an archive of MI literature. If you have new preprints or reprints, please send copies and we will place them in the archive. We are aware of plans to translate our book *Motivational Interviewing* into Slovenian and French.

Finally, Steve and I are in the contemplation stage, moving into preparation, for making some new training videotapes on MI. We plan to use a variety of therapists and clients, and to demonstrate specific elements of the MI approach. Any suggestions you have for what would be particularly helpful in new tapes?

Important MINT Dates

Submission	Publication
4/1/97	5/1/97
8/1/97	9/1/97
12/1/97	1/1/98



Editor's Cup

David Rosengren

Survey Results

Thanks to all who returned the survey on Training for Trainers and the MINT. Jenny is still tallying the

results, but I am happy to report that we did break the 50% return rate (66 of 120). If you have not returned your survey, we would still like to hear from you.

This survey was not meant to be a scientific endeavor, just an effort to take the pulse of the MINT network; I think we have at least partially accomplished that aim. I have a few informal observations.

First, among people who responded, all felt the training had been successful and most people had been active with training since that time. The breadth of training experiences was great, though it seemed that brief training exposures (i.e., 2 hours or less) were the modal type of training done.

Second, most people valued the MINT as an information resource. In particular, people liked the columns by Steve and Bill, appreciated hearing what other trainer's were doing and the areas they were working in, and felt publication information kept them abreast of new developments. People, also want to hear more about what other trainers are doing.

Third, there were very few negative comments; however, there were a handful of people who saw the MINT as being of limited value. I appreciated hearing from these folks because I think they do reflect at least some of the sentiment felt by people who didn't respond. Unfortunately, there were not many specific comments, rather more damning with faint praise (e.g., "I occasionally look at it").

Fourth, feelings were split about whether to include non-Minties on the MINT mailing list. However, there seemed to be a groundswell of concern emanating from the UK. Perhaps someone could fill us in further, but it seems there are either non-clinical types or under-qualified individuals offering MI training's in the UK. Proliferation of this activity was a primary concern of the UK group. There also was some sentiment, more broadly expressed that just the UK, for some type of certification or stamp of approval for MI Trainers.

Fifth, the vast majority of people were willing to "subscribe" to the newsletter. People obviously did not want to pay any more than was necessary, but they were willing to help defray the cost of mailing. However, some people indicated that though they liked the newsletter, they would not be willing to pay to receive it.

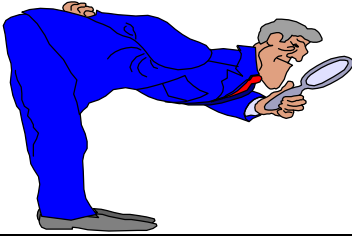
What next?

Most people liked the informal style of the newsletter so don't expect an overhaul of the format. Jenny and I have discussed the possibility of her soliciting guest columns from people. There are some funding issues that we need to work out before that is possible, but don't be surprised if you receive a call from us. Even without direct requests several of you wrote that you had good intentions to write but hadn't quite made it happen. The survey suggests your fellow trainers really hope you will. Consider this a standing invitation to tell us about your work. I would prefer this information in Word 6.0 file, but it is not necessary. Handwritten is fine.

I will be conferring with Steve and Bill in the next few months to determine possible next steps for the MINT. If you have specific concerns, criticisms or suggestions for the newsletter, I would still very much like to hear from you. You can expect to hear more in the next issue of the MINT.

A Request

Could someone please write a piece about Solution-Focused Therapy for the next MINT? My knowledge is rudimentary and I would like to know more, with a particular emphasis on similarities and differences with MI. Thank you.



Survey Says!

Jennifer Neill

Thanks for returning the questionnaires. Our total, once I removed repeat responses, is 66. (I used the second questionnaires for those who completed it twice [n=3]). Allow me to characterize the returned surveys a bit: 7 responses were completely anonymous, 3 anonymous responses came from folks who identified their country as the US; of those who identified themselves, there were 36 US responses, 12 responses from the UK, 3 from Norway, 2 from Sweden, 1 each from Canada, the Netherlands, and Switzerland. As I am hopeful that in the next few weeks we will receive more surveys back, I will, for the moment, call this a preliminary report. We would like to hear from the folks in Italy, Australia, and the rest of our American and European friends!

Before moving into the qualitative responses, I will present more numbers for the researchers in the audience. Answers for the first five questions were scored as follows: not-at-all=0, a-little=1, a-lot=2 and very-much=3. The average score for the questions on how helpful the MINT training was is as follows: 2.59 (n=61) for clinical work, 2.76 (n=66) for training others, 2.32 for giving lectures (n=62), 1.67 for writing (n=55), and 1.26 for grant writing (n=39). Except in the case of grant writing, the training for trainers was rated as “a lot” to “very much” helpful. In some cases, respondents stated that the training was not applicable to the category; most frequently this occurred for the grant-writing category. In a few cases, respondents wrote positive comments on a category, usually for clinical work or giving lectures, but did not circle one of the responses given.

There is a range for the number of training's being given by survey participants. Five said they had performed no MI training's themselves, however 3 of these 5 stated using elements of MI in training's. Twenty-six stated giving 1-5 training's, 8 gave 6-10 training's, 9 performed 11-15 training's and 17 did more than 15 training's during the last 2 years.

More than half, 38 respondents, said that the amount of training work they are doing has grown. Eight said that this work has slowed down while 15 stated it has stayed about the same.

As far as the future of this newsletter is concerned, two-thirds of the respondents would be willing to pay \$10, while only one indicated not wanting to pay to receive it. Roughly a third stated that the MINT should not be distributed to those who have not attended a “Train the Trainers” workshop. Of the other respondents, 20 felt that charging a higher subscription fee to those who have not completed the training would be best. Some suggested that having a variety of payment options, including credit card charges and purchase orders, would make subscribing more palatable. Others recommended distributing the newsletter via email. ***(Have you told us your email address?)***

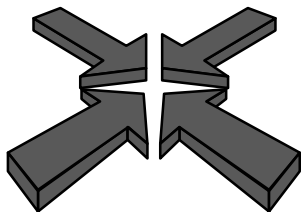
As David mentioned, many of our UK respondents had concerns about distributing the newsletter to those who had little or no training in MI. Some also shared concerns that there are MI training's being done by professionals with little to no clinical experience conducting MIs. One US respondent suggested that we “motivationally interrogate” individuals wanting to receive the newsletter before completing the training. Another frequently cited concern is that the informal style of the newsletter may be misunderstood by a wider audience.

Now, time for me to summarize some of the stories you wrote. There is a wide range of training's being presented by this diverse group, including presentations to groups as small as four or five participants to groups as large as 200. These presentations range from 45 minutes long to 3 day workshops. Many of you are involved in training chemical dependency clinicians and primary care physicians. But high school teachers, probation officers, child welfare workers and telephone interviewers are also being trained in reflective listening and motivational enhancement. The subject matter has expanded to include brief negotiation in decision making for patients in hospital settings, training casino staff to intervene with problem gamblers, working with clients on dietary concerns including eating disorders and diabetes, and helping motivate clients to exercise. One MINTie reported being asked to do a training to encourage people to clean their houses more in order to reduce risk for cancer from environmental toxins. Despite Stephen's worry about the funeral of MI, it seems this creative bunch is finding plenty of clinical utility for the model. Keep the stories

coming and don't be surprised if I call you for more information on the work you have been doing lately!

[Editor's Note: A special thank you to Jenny for the work she put into this survey. Jenny is a staff person on Project START who graciously volunteered her time and talents to assist me in

collecting and analyzing the survey. Jenny is affectionately referred to around here as the DDO (i.e., Deputy Director of Operations, CIA) because of her ability to get things done. Once again, Jenny, well done!]



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