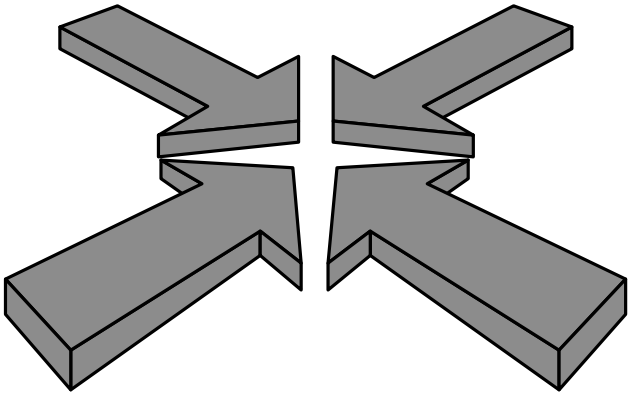
Motivational Interviewing Newsletter for Trainers

May 1, 1996, Volume 3, Issue 2



New Perspectives

"It's been a long cold, winter": A Message from the Great White North

Editor's Note: It was March 24 and -15° when I received this e-mail from Fran Jasiura. Fran is in private practice in British Columbia, Canada.

As an update from this neck of the woods (i.e., Interior B.C. region). I continue to do regular MI trainings, with the government addiction counselors, staff in women's shelters, native bands. I have one booked in May through Okanagan University College, in their Professional Development Continuing Education department. I've moved to an interesting format as requested by the participants. We do 2 or 2 1/2 days initially (depending on their training dollars) of standard MI training and then agree to reconvene at a later date. I find participants are fairly saturated at the end of two days & can't absorb more. Instead, they want some time to go away & assimilate. The trainees are given specific tasks: bring back one clinical case where MI worked; another where it didn't (if appropriate, they then became case examples for more fishbowl practice); insights on their own personal change (each participant identifies a personal goal they wanted to achieve and aims to move one stage of change with it); & additional ideas for resistant behaviors. We then regroup in 6-8 weeks.

The groups also decided to bring in a stationary camera for filming the fishbowls, and the counselors could bring their own blank video tape if they chose to have themselves videotaped. Through it all, I try to demonstrate the spirit of MI by eliciting their ideas, affirming , providing choice, etc. At one of the trainings where we did this follow up, they also wanted as a follow-up topic, "How to introduce MI into the current system" (i.e., the system needed to change)

In terms of measuring training effect,: I have always done the Pre-workshop questionnaire (6 situations designed by Bill & Steve where the counselor has to decide what to say next) both before and after the training; the participants anonymously mark each others responses identifying any of the 12 roadblocks; the participants get personal feedback; & I keep a copy to ascertain training effect. However, I haven't devised a precise instrument to measure the change in incidence of the roadblocks. Any ideas?

Also, besides written evaluation forms, the follow up sessions have proven to be both evaluative (to hear who is using MI, with whom, any concerns, frequency etc) and also motivating (positive outcomes). For example, a couple of trainees weren't expressing enthusiasm for MI and heard from their colleagues: "I'm cutting client time in 1/2!!", "It takes the pressure off the counselor to be perfect.", "It helped me not ask as many questions.", "It helped me slow down, and not follow my agenda.", "I am consciously working on listening rather than asking questions." Doubts seemed to be dispelled and allowed me to address their concerns. Also the number who came back to the follow up sessions 100% in one training , about 95% in the other.

Editor's Cup

David Rosengren

One Thing Leads to Another

I have recently become involved with a group of medical ethicists who are trying to develop a better self-help method for people to do Advance Care Planning (ACP). I want to discuss my approach to this because I think it represents an interesting extension to some of the things we do. I would also be interested in other's thoughts about how to approach these issues. But first, a little background.

Advance Care Planning

ACP is for use when a patient can no longer speak on either his or her own behalf. This could occur for a variety of reasons (e.g., injury, illness) and have differing courses (e.g., acute, chronic), treatments (e.g., palliative, curative) and outcomes (e.g., return to normal functioning, death, permanent coma). This process is more involved than either developing an advanced care directive or providing a durable power of attorney for health care purposes, though these may be outcomes that are sought. It includes identifying and consolidating personal values and decisions with regards to health care states and treatments, and then communicating these to a proxy and/or a health care provider (and preferably both) so that they can represent the client's wishes. The permutations of influencing factors, health care states, treatments, and decisions is nearly endless and therefore health care teams and families are often left in the unenviable position of trying to decipher what the patient might have chosen. ACP is an attempt to reduce this burden for the family, physician, and (ultimately) society.

The Workbook

The immediate goal in all of this is to develop a workbook. The long-term goal is to produce interactive software that can be employed in a variety of settings and that uses branching based upon the client's responses. The latter technology seems better suited in my estimation, but the funding agency has allocated moneys for only the workbook.

My role within this project is to provide consultation about how to engage people in this process. This is stretching my thinking in both MI and Stages of Change. For example, are people most motivated by doing something for themselves or for someone else? For whom is this true? Under what circumstances is this true? Do Stages of Change ideas apply where someone may move very quickly from Precontemplation to Action and behavior change is generally accomplished in a single action or series of actions? Carlo DiClemente says if there is intentional behavior change they do. I still wonder. Do Bill's ideas about quantum change have a place here? And on and on.

The first task is to identify who we target. The goal is to develop a workbook that is flexible enough to be broadly applicable while specific enough to engage people in the ACP process in a meaningful way. My solution is to regard our target audience as precontemplators and contemplators, and for others view the workbook as a forum for consolidating commitment and a place to find action strategies. The goals are therefore familiar ones: raise doubt in precontemplators and resolve ambivalence in the direction of change for contemplators. The first strategy seems easy enough by providing real life examples and exercises that allow users to conclude that what seems clear is often unclear (e.g., Does no life support mean "no bread and water"?). The second is more problematic. We do an early self-efficacy exercise where users identify a preliminary proxy through a series of brief questions which may create some momentum for change but doesn't address the ambivalence piece. We have discussed and rejected the possibility of a brief self-assessment that will allow subjects to self-identify risk (sort of the magazine style quiz, "Ten ways to tell if you should do ACP!"). A decisional balance exercise may be helpful, but space is limited. I remain concerned that we have not addressed this piece well enough.

As this project has unfolded my specific refrain has been, "Simplify." My colleagues agree but fear that too simple a message will result in ACP of limited value. ACP of limited scope may not be acceptable to care providers (e.g., physicians,

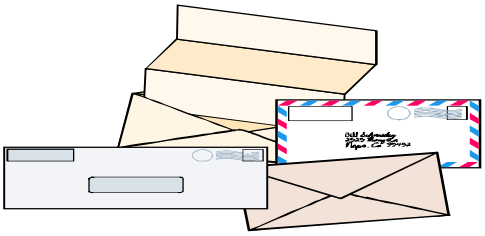
hospitals) who incur some responsibility for substituted judgment for patients. The question then becomes what is the appropriate balance between these issues and how do we integrate this balance in a workbook that people will use?

The best answer, in my estimation, is a graded approach. That is long on examples and exercises, especially at the beginning of the book. In my thinking the goals should be to make the message simple, personally relevant, and interactive (via simple exercises). The simple exercises provide a method for, "getting our foot in the door", providing success experiences and raising client doubts about whether they have fully considered the issues in this process. Once engaged, we can tackle the more complex, interactive nature of this problem.

Most people who have some awareness of ACP issues believe this process is simple - "If I'm a vegetable, then pull the plug" coupled with "my wife/husband knows what I would want." Unfortunately, this level of specificity and communication does little to inform a proxy when a substituted judgment is required. As clients move further into the workbook the message becomes more complex and the ACP solutions are richer. My concern is that we have moved forward with action strategies (i.e., exercises) before we have done anything to resolve ambivalence.

The Intervention

After the workbook is completed, we are hopeful of receiving funding to test its use in the context of a MI style intervention. We have begun to do some planning for an intervention to accompany this manual. A particular challenge is to develop a 2 - 3 hour training module for use with social workers. In the next issue, I will share some thoughts about what we might try and obstacles I foresee.



Mail Call

Dear Editor:

Thanks for referencing our grant submission on MI for smoking cessation in the January 1996 newsletter. I'm pleased to say that our grant was funded by the Heart and Stroke Foundation of Canada. It is a 2-year clinical trial for 1,050 high risk female medical patients who are attending outpatient clinics in obstetrics-gynecology, perinatology (high risk pregnancy), endocrinology, general medicine, cardiology, and respiratory medicine. The trial will follow a standardized 4-session telephone counseling format in which patients will be randomly assigned to either MI or the standard cessation program endorsed by the Canadian Medical Association. Materials for assessment and intervention will be translated into French. This trial is scheduled to get underway by September of 1996. I will keep you posted on our progress.

Sincerely,

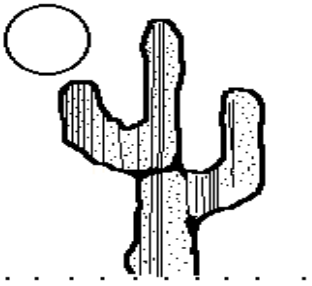
Dr. Rob Nolan
Coordinator, Health Psychology Services, OGH
Adjunct Professor, Faculty of Medicine and School of Psychology, University of Ottawa

Editor's Note: Congratulations Rob! Please do keep us posted.

Publication Dates

The submission and publication dates in 1996 for the MINT are:

Submission	Publication
4/1/96	5/1/96
8/1/96	9/1/96
12/1/96	1/1/97



Notes From the Desert

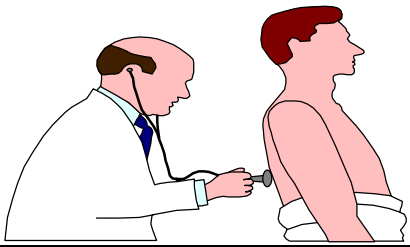
Bill Miller

From the Desert

Bill sends his regrets, but he is currently buried under a dust storm of administrative, research and teaching responsibilities. He will return with a piece for the next issue.

From Across the Pond

Stephen Rollnick



Move-It

Editor's Note: I received this wonderful piece on the Move-It Project, a research program designed to evaluate methods for enhancing subject exercise levels. Unfortunately, the fax cover page has been lost somewhere along the way. I believe this is Melvyn Hillsdon's project at the London School of Hygiene and Tropical Medicine. My apologies to Melvyn for a memory that seems to be failing at an exponential rate, but I believe we exchanged some email about this awhile back.

Move-it: Overview of Methodology

Recruitment
All 45-64 year old patients on the eight GP lists will be sent the baseline lifestyle questionnaire unless GPs request that specific individuals not be contacted.

Subjects returning questionnaires will be divided into Active and Sedentary groups. Subjects who fail to return questionnaires will be reminded by post. If after this time the questionnaire is still not returned, these subjects will receive no further contact.

Sedentary subjects will be classified as such if they:

- do not regularly take exercise to improve/maintain their health and/or fitness.
- have not done physical activity during their leisure time (excluding physical activity at work and in the home) at least once per week for a minimum of 30 minutes each time during the past 4 weeks.

Active subjects will not receive any further contact.

Randomization

Sedentary subjects, free from physical and mental health problems that would prevent participation in moderate intensity physical activity (determined by baseline questionnaire) will be randomly assigned to one of three arms: (1) Direct Advice, (2) Brief Motivational Interviewing or (3) Control.

The two intervention groups will be invited to attend a routine health check lasting 30 minutes. Control subjects will receive no further contact until the 11 month of follow up, when they will be invited for the health check.

subjects failing to attend for their health check will be reminded by the process used to obtain baseline questionnaires.

Consent

Those subjects attending for their health check will be informed at the start of the check that it is part of a trial and will be asked to give their informed consent to participate. Part of the consent will involve subjects completing a Physical Activity Readiness Questionnaire (PAR-Q) to identify the small number of subjects for whom moderate intensity physical activity may increase the risk of a cardiovascular event or lead to orthopedic problems. Subjects failing to consent will still receive the health check buy will not be contacted again. At this time the interviewer will not be aware of the subject's randomized group. This will only be revealed (via laptop computer) when consent has been given.

Initial Health Check

All subjects attending the health check will have their height, weight, resting blood pressure and resting pulse measured. Weight will be measured using a doctor's scale with subjects wearing indoor clothing and without shoes. Body Mass Index (BMT) will be calculated using the formula weight (kg)/height (metres)^2. Resting blood pressure will be measured using a Hawksley random zero mercury sphygmomanometer. Measurements will be taken three times on the right arm. The average of the second and third will be used for analysis. Resting pulse will be measured by palpating the radial pulse for 60 seconds. Intervention subjects will then receive the appropriate treatment, Direct Advice (DA) or Brief Motivational Interviewing (BMi). The differences between these two treatments are shown in Figure 1.

Physical Activity Measurement

All intervention subjects will be posted in a physical activity log book at 3, 6 and 9 months. control group subjects will not receive these log books. The log book will record physical activity for a 1 week period and will be returned using a pre-paid envelope. At month 12, following the final health check all subjects including Controls, will be given a log book to record their physical activity for the following 4 weeks. Subjects failing to return log books will be reminded using the procedure for baseline questionnaires.

A random subset of all subjects will be asked to wear portable motion sensors (accelerometers) to validate self reported physical activity. They will be worn during a period when a diary is kept. Subjects assigned to wear accelerometers will be recalled and will be issued with their accelerometer and give instructions by the project clerk.

Telephone Support

All intervention subjects will be followed up by telephone at he following intervals (weeks): 2, 6, 10, 14, 20, 28, 36

The duration of the telephone contact will be limited to 5 minutes whenever possible. The content of the conversation will depend on randomization, with subjects assigned to advice giving receiving more advice about the importance of exercise and those n motivational interviewing receiving more motivational interviewing. Subjects without telephones will be followed up by post.

Follow Up

At 11 months all intervention subjects will return for a follow up health check. This will be a repeat of the measures taken at baseline. No advice or motivational interviewing will be given during this health check. Control group subjects will also be invited to this health check. The process will be the same as that used for inviting intervention groups. They will be asked for informed consent at the beginning of the health check (they will be consenting to less). They will then have the same measures taken as intervention groups.

At the end of the health check, all subjects (those being followed up and control) will be handed the final 4 week log book. This will be returned by post in a pre paid envelope. Procedures for

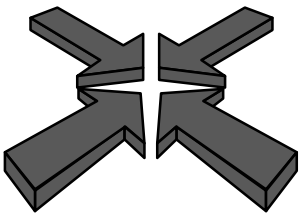
reminding subjects who fail to return will be as before.

Outcome Measures

The main outcome measure will be a comparison of log book records for self reported physical activity over a 1 month period prior to the one year screen. Secondary outcome measures will be readiness to change, body mass index and blood pressure.

Figure 1. Direct Advice vs. Brief Motivational Interviewing

	ADVICE GIVING	BRIEF MOTIVATIONAL INTERVIEWING
Aim of session	To persuade client to increase physical activity level	To explore ambivalence about behavior change and build motivation for change
View of Client	Someone at increased risk of CVD due to presence of major risk factor (physical inactivity)	Someone who feels two ways about taking up regular physical activity, who needs help to articulate pros and cons of physical activity and concerns about physical inactivity
Task of Practitioner	Prescribe program of physical activity	Explore pros and cons of regular physical activity and if appropriate concerns about physical inactivity
Information Giving	Present evidence about risks of inactivity and reasons for change, plus prescription of exercise as 'treatment'.	Present information neutrally about current activity level compared to recommended level and elicit personal reaction
Question Asking	Ask questions to elicit any existing harm resulting from inactivity, to be used to persuade client to change	Open ended questions which encourage client to explore pros and cons of increasing physical activity
Summarizing	Dangers of physical inactivity, benefits of change and how to change	Summarizes all sides of ambivalence using client's language
Resistance	Met with counter arguments and correction	Met with reflection - attempt to reduce quickly



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