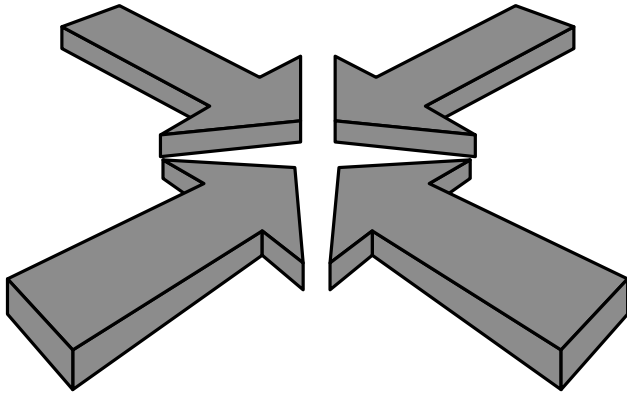


Motivational Interviewing Newsletter for Trainers

September 1, 1996, Volume 3, Issue 3



New Perspectives



Editor's Cup

David Rosengren

One Thing May Not Lead to Another

In the last issue of the MINT I went on and on about the ACP workbook we were finalizing and promised to talk further about the intervention training process in this issue. Since then, we have received the news this grant won't be funded so the planning process ground to a halt. My work on the training stopped so I have nothing new to report in that area. I am happy to report that we are seeking new avenues of funding so there may be more news at a later date.

MI and Grizzly Bears

I just returned from an 8-day backpacking trip in Yellowstone National Park, an excursion which afforded many opportunities for considering the nature of motivation. For example, why would anyone want to trudge around with a 60 lb. pack for 8 - 10 miles every day and then call it a

vacation? Moreover, why would anyone do this in a part of the world where the possibility of being eaten is real?

I am happy to report two clear answers to the above: (1) because coffee never tastes quite the same as it does on a clear mountain morning; and (2) because if you really want to get away from people you need to go where they aren't the highest creature on the food chain. I moved from precontemplation about bear mace at the trip's inception - despite having lived and hiked in Montana for years - to an avowed action type. One sleepless night listening to something "woof" near our campsite and thinking how close our tent was to where the food was hung, resulted in some robust commitments for change. Perhaps it even qualifies as quantum change....

Future Directions of the MINT

We are enjoying the fruits of an expanding training network; of course, this expansion created ripples in unanticipated directions. I receive regular requests from non-MINTies to be placed on the MINT mailing list. They are interested and excited about MI and see the MINT as a potential resource. In addition, the mailing costs have escalated for Bill and the folks at UNM. We are at a crossroads and it is important that we hear from the constituency about what course we should plot. Steve has designed a questionnaire to ask about your thoughts about Training for Trainers and the MINT. Please take a few minutes to fill this out and mail it back to the indicated address. I hear back from an enthusiastic subsample of the MINTies, but I am not sure that this reflects the opinions of the membership as a whole. Please add comments. I will report the results in the next issue of the MINT.



From Across the Pond

Stephen Rollnick

Project MATCH

The results. They are out. Don't ask me, ask Bill. No don't. Leave him in peace. Nothing in writing apparently until... I don't know. Just wait.

Which is the Wackiest Application of MI?

I get these telephone calls about some new application of MI, and they take a now familiar course. I start off raising my eyes to the ceiling and thinking, "Oh no, what wacky nonsense. What am I going to say?" I end up thinking, "You're a cynical dog, Rollnick".

How about this recent one, the opening line of which was, "My name is Dr. ----, I am a biologist by training, and I'm ringing about motivational interviewing...". Oh, no. Cells? Mars? Then he went on, "I'm responsible at our university for student numbers, and they have been falling dramatically. I want to train our tutors to talk in a careful way to students about this, to prevent dropout...". And so it went on. An interesting and legitimate inquiry, although I did wonder about the quality of tutors if they were not able to hold sensitive conversations without motivational interviewing?

It has happened to me before. Joke telephone calls. The biologist was no fake. In case anyone is having fantasies of playing a joke on me, forget it. I'm sharp as anything. Cross it off your list of diversions. Get back to work.

Credit and Acknowledgment

I've probably been a schmuck, distributing ideas and practical strategies in handouts before I publish them. I have had a number of recent disappointments, in two cases, of seeing things in print, unacknowledged. I prefer to trust people

until they prove untrustworthy, rather than the other way round. Please check with me if you are unsure, as I am going to be much tougher on this in the future. I find this a great pity. Bill and I very much want trusting relationships with colleagues on the MINT network.

What's a Curriculum?

Seriously. I am either ill educated or I've had a cultural communication problem with a very fast talking caller from the Department of Adolescent Health of the American Medical Association. He wanted to train some practitioners to do smoking interventions as part of a research study, and said he was unhappy with some of the outlines of MI he had received from US trainers, apparently because they were not readily applicable to brief encounters. Did I have a curriculum? He wanted the training done in eight weeks.

Well, I said that I have a number of summaries of medical adaptations of MI, experience in evaluating such adaptations and advising other research teams. Chris Butler and I were about to publish a smoking method for use in brief health care encounters. "Sounds great, wonderful. Just what we want. You are our man. And the curriculum, have you got it?" Well, I said, I would advise you to first pilot your method, whatever one you choose. Then you need to take into account how much training time you have, and design a curriculum accordingly. "About two hours, we have. Do you have the curriculum?" I have a program for one day, two day, and 3 hour courses, but these were for different groups, in different settings. "Does anyone have a curriculum?" Now, frankly, what could I say? I tell you what I said, following Geoff Williams' guidelines for strong advice-giving (use repetition): "I know who might also be your man, man". And I gave him some medical MINTie addresses. I also sent him materials for review. Who heard from him? Geoff, what did you advise him to do? Anyone from Kaiser get this call? Or did he not take my advice? What is a curriculum?

In Europe

I don't hear a lot from MINTies in Europe, and I think it unlikely that a European network will exist in any dynamic form. We have each others' addresses. Janet Treasure has been in touch, and is active in training and writing in the eating disorder field in UK. The exercise men, Melvyn Hillsdon and Norman Anstiss are also doing

innovative work. I might be visiting Bergen which now has a sizable number of MINTies in the city. Jeff Allison, Rhoda Emlyn Jones and I have established links with the European Addiction Training Centre, which is so efficiently run by Rik Bes, who attended the MINT training in Italy. Rhoda ran a well-received workshop at the recent ICAA congress in Amsterdam.. There is also a movement afoot, supported by European Community money, to run a training for those working with drug abusers in prison.

Papers

Butler CC, Rollnick, S., Stott NCH. The clinician, the patient and resistance to change: Recent ideas on compliance. *Canadian Medical Association Journal*, 1996, **154**: 1357-1363.

Butler, CC & Rollnick, S. Missing the meaning and provoking resistance: a case of myalgic encephalomyelitis. *Family Practice*, 1996, **13**: 106-109.

Rollnick, S. Behavior change in practice: targeting individuals. *International Journal of Obesity*, 1996, **20**: S22-S26.

Mann, R & Rollnick S. Motivational interviewing with a sex offender who believed he was innocent. *Behavioral & Cognitive Psychotherapy*, 1996, **24**: 127-134.

MINT Questionnaire

This is just to give us an idea of how you have been getting on and how much you would like this newsletter to continue.

Publication Dates

The next submission and publication dates for the MINT are:

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

**Center for Health Studies
at Group Health Cooperative of Puget Sound**

Evette Ludman, Ph.D.

I have really enjoyed bringing the MI perspective to the design and practice of behavior change interventions in a variety of randomized trials at Group Health. We are just completing follow-up on a randomized trial (NCI-funded, PI is Stephen H. Taplin, MD) comparing three interventions to promote mammography participation in older women. The participants are women who do not schedule mammograms within two months of receiving a mailed invitation for breast cancer screening from a centralized screening program. The first interventions is a simple reminder postcard, the second a reminder call from a scheduler, and the third a motivational phone call designed to elicit women’s individual concerns about breast cancer screening. I presented some preliminary descriptive findings at SBA this year: (Design, Implementation And Acceptance Of Outreach Telephone counseling To Promote Mammography Participation).

We are also in the middle of a randomized trial funded by NIAAA (PI is Susan J. Curry, Ph.D.) evaluating the effectiveness of a primary-care based intervention for at-risk drinkers. The intervention consists of physician-delivered self-help materials, written personalized feedback about drinking, and up to three motivational phone calls by a trained health counselor. We are pleased with the trial’s progress so far.

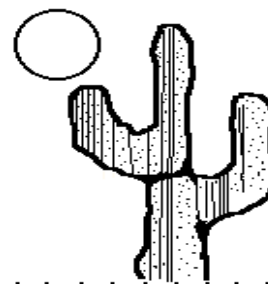
Finally, I am really excited by our upcoming randomized trial of a primary-care based relapse prevention program for those at high risk of depression relapse/recurrence (PI is Wayne Katon, MD, funded by NIMH). I have designed a brief intervention that will include MI, follow-up phone calls, and ongoing personalized feedback. I myself will be on the “frontlines” of care-delivery on this one (I’m a clinical psychologist). It was both challenging and scary to present my intervention ideas to a group of primary care physicians and psychiatrists!

Olin E. Teague Veterans Center

Fred Willoughby, Ph.D.

I have extensively revised my Motivation Enhancement Group Manual since the version I originally submitted. I agree that my first attempt emphasized skills building too much and consequently ignored what would be most helpful to Precontemplators. At that time I myself was a naive Precontemplator. Anyway, I think my current version is much better and I will send it to you in the mail. The current version is 4 sessions in length. I am trying to get the manual developed by Craig Noonan but this appears harder to obtain than the Holy Grail.

I have a research article coming out this fall in the Journal of Substance Abuse titled "Construct Validity and Predictive Utility of the Stages of Change Scale for Alcoholics". My manual is based on much of this research. Basically, I found two groups of Alcohol Dependent VA patients attending an outpatient Substance Abuse Treatment Program while living in a domiciliary, Precontemplators and Participants. Precontemplators were found to be just as aware as Participants that alcohol was a problem and reported just as many alcohol-related consequences. They, however, as you might expect were not as worried or concerned about these consequences and not as receptive to help as the Participants. Perhaps the most interesting finding was that Participants were much more aware of the benefits they obtained from drinking such as mood and social enhancement benefits than the Precontemplators. Consequently, in the group I encourage the Precontemplators to start thinking about and verbalizing their own personal benefits or the "good things" they receive from drinking and drugging. I guess this tactic is necessary in order to enhance their ambivalence about changing since Precontemplators may be well aware of the "less good things" about using. Anyway, this work has been fun and I hope to continue research of The Stages of Change Scale. Keep up the good work with the MINT. Next to my receiving of Sports Illustrated or Money magazine I look forward to each edition of the MINT.



Notes From the Desert

Bill Miller

From the Desert

Despite my intentions, I am still here in the desert. I had an approved sabbatical beginning in July of 1996, but instead I am now Interim Director of Treatment for UNM's Center on Alcoholism, Substance Abuse, and Addictions (CASAA). My prior post has now been assumed by Drs. Scott Tonigan and Vern Westerberg, serving as Co-Directors of CASAA's Research Division. It's a long story. Suffice it to say that I am learning much about healthcare financing and team building, and am putting into practice what I've been preaching for twenty years. I am looking forward to the hiring of my successor as a permanent colleague, and a sabbatical year in Portland, Oregon beginning in July of 1997.

As I receive letters and inquiries from all around, I reflect that motivational interviewing seems to be coming into adolescence. There is a reasonably well-formed character to it, and the major life task now seems to be testing the limits and establishing a clear identity distinct from its peers. It's also not completely clear that the frontal lobes are connected yet; I'm not sure we really *understand* what we are doing.

Because this has been such a busy year for both Steve and me, we decided not to offer a MINT workshop this October. As Steve may comment elsewhere in this letter, he and his wife Shiela had a baby boy (Stefan) in July. Congratulations to the happy if sleepless parents!

As most of you know by now, the results of Project MATCH were presented for the first time at the June meeting of the Research Society on Alcoholism. What a relief finally to have gone public! It's quite an amazing study, and the dataset will become available for analyses by

other qualified investigators in January of 1998. Because one of the three treatments was based on motivational interviewing (the others being Twelve Step Facilitation and Cognitive-Behavioral Skill Training), put on your thinking caps about questions you might like to address to a thoroughly assessed sample of 1,726 clients, with more than 90% follow-up rates at 3, 6, 9, 12, 15, and (for most sites) 36 months. Members of the Project MATCH team are refraining from written commentary on the findings until the report appears in the January issue of the *Journal of Studies on Alcohol* (to be released in December), but we can discuss findings orally with the understanding that such conversations are not to be quoted as professional communications. A preprint of the JSA report can also had by addressing a request to the Executive Committee and signing a release/ confidentiality agreement. To request a copy of the report, contact Dr. Tom Babor at the Department of Psychiatry, University of Connecticut Health Sciences Center, Farmington, CT.

The list of areas to which MI is being applied has continued to grow. I'm also hearing about regular courses on motivational interviewing, often offered as part of curricula for substance abuse counselors. If you currently offer such a course or know of one, pass on the information through this newsletter!

A new training videotape has been released by the Addiction Research Foundation in Toronto. It was developed by Drs. Mark and Linda Sobell (who are now at Nova University in Fort Lauderdale, Florida), and is entitled *Motivational Strategies for Promoting Self-Change*. It is meant to be a companion training tape for their book, *Problem Drinkers: Guided Self-Change Treatment*. The tape briefly describes motivational interviewing and offers some excellent short vignettes demonstrating MI methods. The narrative and actors clearly portray a higher-functioning clientele, so it may be particularly useful in training for settings with higher SES clients. It's a training resource worth having. Contact ARF at 416-595-6059, or fax 416-593-4694.

We keep a current bibliography of articles and resources on MI, a log of ongoing research projects, and of course our list of trainers. If you come across new publications or are aware of

current studies not yet published, please call them to my attention so they can be added to our lists.

The mailing list has become long enough and the newsletter meaty enough that its regular mailing as a free document has become a significant burden on our research budget. One option is to open up a web home page or a bulletin board, but that does shut out colleagues who are less computer dependent. My suggestion is that the newsletter become a subscription document at US\$10 per year, and the mailing list opened to other interested colleagues. This should just about cover the cost of printing and mailing. Comments on this idea are welcome.

Finally, let me share a treatment delivery system that incorporates MI and is designed for a managed care environment. This is what we're working toward now at CASAA. Our management information system data indicate that we do best when we get a good volume of services to clients within 30 days of first contact. This is compatible with the desirability of responding quickly to requests for service. In our state one needs a provisional diagnosis before financial authorization for treatment can be obtained, and a diagnostic summary and treatment plan must be completed within the first 30 days. Further, I've always thought that the staff who meet clients first should be the best you have, because they need good diagnostic skills, an ability to engage and motivate clients and to establish a therapeutic relationship rapidly, a knowledge of the menu of treatment options, and the flexibility and savvy to work with clients to negotiate individual treatment programs. Often intake interviews have been done by lower level staff at an agency, but it seems to me that you need your sharpest people up front.

Putting all that together, we're trying the following system. After a 10-minute prescreening interview by telephone, clients appear for an intake appointment and are immediately seen by a highly experienced senior counselor who is one member of a core care team. He or she sees the client briefly to establish a provisional diagnosis (basically, which drugs, abuse or dependence) and then takes the client to our financial authorization office where a chart is opened within about 10 minutes. Thereafter services are reimbursable. Within about 15 minutes, the client is in outpatient treatment, being seen for Phase I

counseling by the same core team member. A baseline ASI interview is also administered by our Research Division. Phase I consists of up to four individual sessions (we're also experimenting with groups at this stage) to: (1) get a clearer sense of the client's needs and conduct initial assessment, (2) develop a diagnostic summary and establish medical need, (3) enhance motivation for change, (4) describe the menu of treatment options available within and outside of CASAA, and (5) negotiate a treatment plan. The core team meets regularly with a doctoral-level consultant to staff new cases and review treatment plans. In this way a core team of four people has seen every client entering the system. This staffing also serves as a point of utilization review. The original core staffer continues to be the client's advocate through treatment, and provides case management services.

Assuming financial authorization is received to continue care, the client enters Phase II, which focuses on substance abuse, and which lasts not more than 3 months. Specific services (most offered in group format) are selected from a menu of options offered by a shell of other providers within CASAA (and also outside). These modules typically: (1) have specified content, often manual-guided; (2) are of fixed length and known cost; and (3) are based on external or on-site research that documents their outcomes. In this way I can approach managed care organizations with a list of these "products" and can say, "Here's exactly what we do, here's what it will cost, and here are the outcomes you can expect." My hope is that this will simplify authorizations at Phase II into cost-contained services with known outcomes. You may recognize implementation of the "core-shell" model developed conceptually by Fred

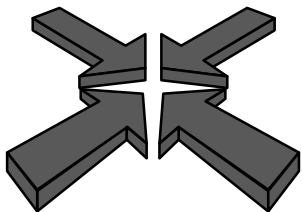
Glaser (but never fully implemented) at the Addiction Research Foundation.

At the conclusion of Phase II, three things happen. First, the treatment plan is updated and the case returns to staffing, where the core team reviews progress and determines whether to recommend further (Phase III) treatment. Phase III may focus on relapse prevention or on other problems related to substance abuse. If utilization review recommends further treatment, authorization to proceed must be obtained from the managed care organization. Second, a follow-up interview may be completed by our Research Division, which in turn provides outcome data to inform managed care. Third, the core staff member works with the client to connect with Phase III services within the CASAA shell, if appropriate, and provides case management linkage to community resources.

This illustrates how motivational interviewing can be integrated with a treatment initiation and matching system that is compatible with the requirements of managed care and of regulatory authorities. The client rapidly is connected with a high-skill clinician, who combines motivational interviewing with the necessary tasks of diagnostic summary and treatment plan development. The client also has a single "primary care" advocate throughout his or her period of service. Comments and suggestions on this system are most welcome.

Adios!

Bill Miller



Inquiries and submissions for this newsletter should be forwarded to:
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MINT QUESTIONNAIRE

Please be wildly frank!

Name (optional):

Country

Please circle the answer of your choice, where appropriate.

1. Looking back, in what way, if at all, did the MINT training help you?

- | | | | | | |
|-------------------------|------------|----------|-------|-----------|----------------|
| (a) In clinical work: | not at all | a little | a lot | very much | not applicable |
| (b) In training others: | not at all | a little | a lot | very much | not applicable |
| (c) In giving lectures: | not at all | a little | a lot | very much | not applicable |
| (d) In writing: | not at all | a little | a lot | very much | not applicable |
| (e) In grant writing | not at all | a little | a lot | very much | not applicable |

2. How many training workshops in motivational interviewing have you done since attending the MINT workshop?

None 1- 5 6 - 10 11 - 15 16 or more

3. Over the last year or two, has your training work in motivational interviewing:

grown slowed down stayed about the same not applicable

4. What was your most recent MI training venture? Please give details.

5. The MINT newsletter: Should we continue with it? How do you feel about it? What changes should we make?

6. What is the most useful or enjoyable part of the newsletter for you:

7. Would you be willing to pay a small yearly subscription cost to offset the cost of distribution? If you are, how much (American)?

No way! \$5 \$10

8. Should we include non-MINTies on a subscription basis? If we do, should they pay more than a MINTie subscription (if we vote for that)?

No way! Same fee Higher fee

PLEASE ADD COMMENTS ON THE BACK OF THIS SHEET ABOUT ANY OF THESE QUESTIONS OR OTHER ISSUES:

Return to: **David Rosengren, Ph.D.**
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