Motivational Interviewing and Managing Homelessness

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Today's Agenda for Discussion MI

I. Review of "What is MI"
II. Applications of MI with Homelessness
III. MI increases the efficacy of treatments when combined or preceding other interventions
IV. Increasing your MI skills even just a little can have an impact on outcomes
V. Yet, one training does not an expert make

What is Motivational Interviewing?

- A “person-centered directive method of communication for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller & Rollnick, 2012, p. 25).

MI is a way of being with the client

- Can be implemented across treatment settings and modalities
- Centers on the idea that ambivalence is the central barrier to change
- Directed toward exploring and resolving ambivalence
- Can be applied to almost any health-related behavior
- Often applied to substance use, medical adherence, and other behavioral activation or change

The Spirit of MI

- **Autonomy**
  - Both implicitly and explicitly recognizing that the client will exercise choice
  - Asking permission
- **Collaboration**
  - Non authoritarian, partnering style; non-judgmental
  - Expertise vs. expert
- **Evocation**
  - Exploring what is important to the client, their ideas, needs, values and reasons for change; making no assumptions
  - Viewing clients as the experts
  - Client speaks more than clinician
- **Compassion**
  - Actively promoting the client's welfare
  - Prioritizing the client's needs

The Four Processes

1. **Engage** the client by listening
   - establish a trusting, mutually respectful working relationship (rapport) in which priorities, wants, needs, and goals of both client and clinician can be shared
2. Work with the client to find a collaborative **Focus** for possible change ("Shared Agenda")
   - an ongoing process in which the clinician seeks to understand the client's values and respects client's readiness for change
3. With a shared agenda or focus area, **Evoke** information about the client's desire, ability, reasons, and need for change
4. Lastly, the clinician supports the client in coming up with a **Plan** for change (e.g. SMART goal)

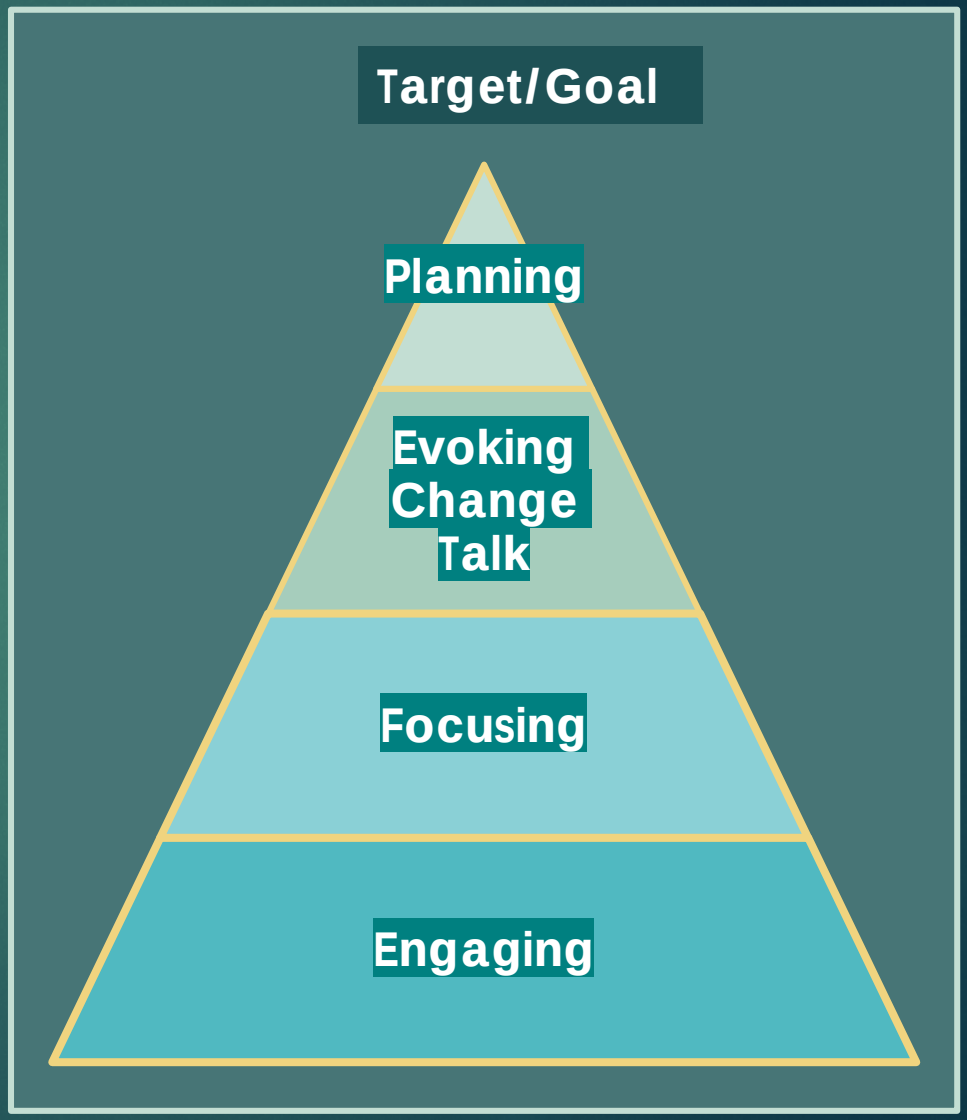
The Four Processes in MI

If you find yourself frustrated by an individual's "failure" to change a behavior, you may want to ask yourself:

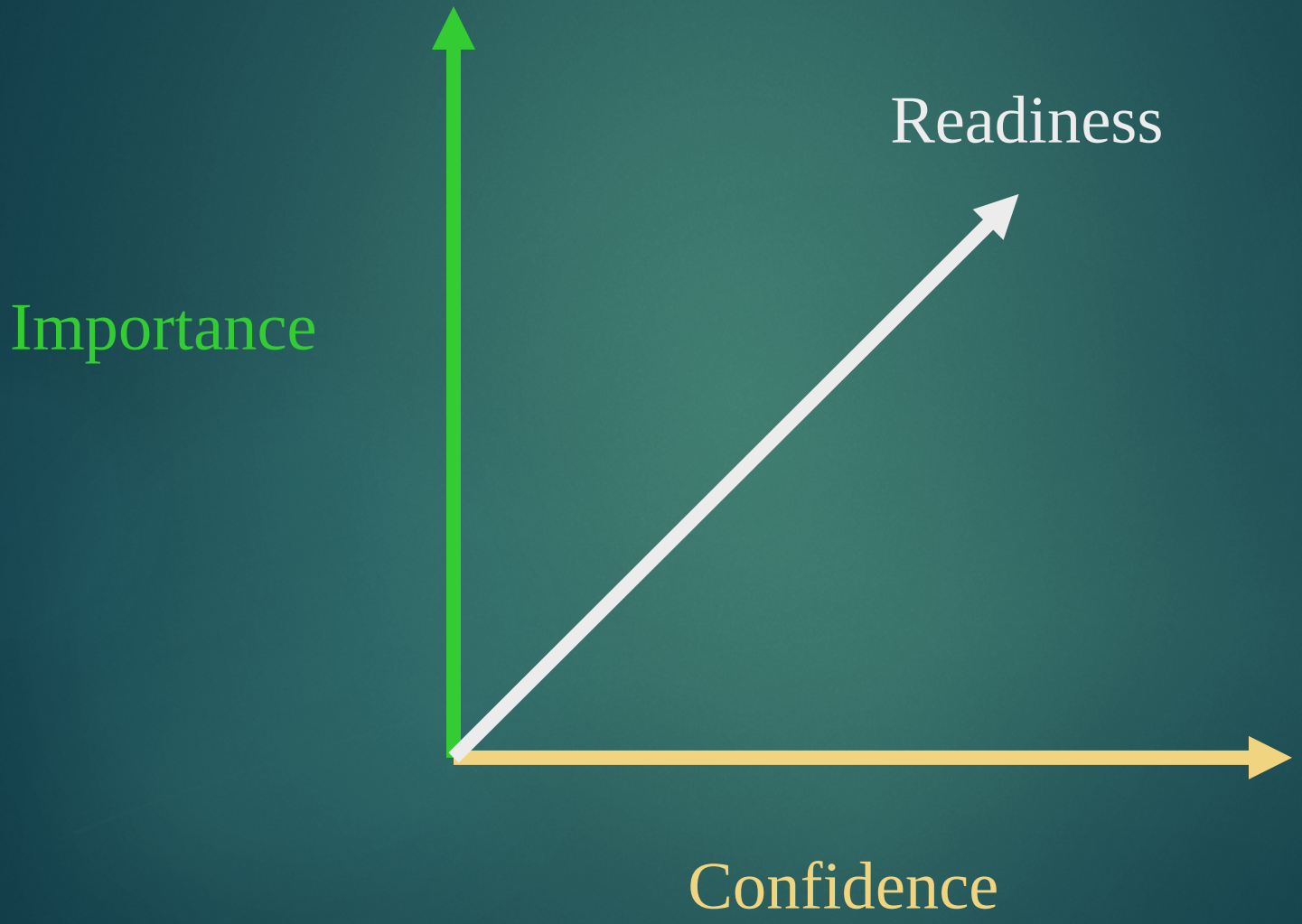
1. Where am I in terms of the 4 processes?
   - Engaging, Focusing, Evoking CT, or Planning
   - often we will find that we are PLANNING

2. Where is my client in terms of the 4 processes?
   - often the client is still in Engaging or Focusing

3. How might I change my approach to meet the client at his/her process (e.g. listen, reflect, ask, listen…)?



The Keys to Readiness



People are generally better persuaded by the reasons which they have themselves discovered than by those which have come in to the mind of others.

-Blaise Pascal, Pensees, #10, 1660

The Model

- Focus of attention: Ask about, reflect, and ask for elaboration about individual's verbalized motivations for change
  - Desire, ability, reasons, need for change
- Rather than confronting the lack of change, the clinician responds with empathy
- Bill Miller observed that arguing for change tends to evoke further defenses for maintaining the status quo

Motivational Interviewing and Homelessness

- MI provides a useful framework for working with individuals who are struggling with substance use, mental illness, and traumatic experiences and/or experiencing homelessness
- Within the spirit of MI is an appreciation of the challenges for changing learned behaviors, some of which may have been an important part of survival

Guiding Principle of MI

Encourage the veteran to voice the argument for change rather than YOU

Remember ..

- "Lack of motivation" is often simply ambivalence; reasons for and against are already there
- If you argue for one side, an ambivalent person is likely to defend the other
- As a person defends the status quo, the likelihood of change decreases
- Resist the "righting reflex" – desire to fix by giving advice or arguing for the "good" side of the ambivalence

Four MI Processes

1. **Engaging:** listening to understand the dilemma using OARS
2. **Focusing:** agenda setting, finding a common and strategic focus, exploring ambivalence, use of information and advice
3. **Evoking:** selective eliciting, selective responding, selective summaries toward change talk
4. **Planning:** moving to a change plan and obtaining commitment

When is it MI? Processes 1, 2, and 3 are necessary for it to be MI

Process I - Engaging

Goals

- **Build** a therapeutic **relationship**
- **Understand** the client's reality
- **Appreciate** the client's feelings, beliefs, values, concerns (including importance and confidence)
- Recognize and **affirm** strengths, motivation
- **Accept** without judgment what you have learned
- Use open-ended questions, reflections, and affirmations (**OARS**)

OARS: Why Reflections?

- Shows you are listening and increases engagement
- Encourages the client to speak more about thoughts of changing
- Generates more talk about change talk than anything else
- Prevent a question and answer dance which may shift the balance from one of collaboration to one of being in charge
- Provide a tool for addressing problems with rapport
- Can decrease conflict by showing you are listening, not arguing

Process II - Focusing

Goals

- **Agenda setting –** what matters to the client and what matters to you? Where is there overlap?
- **Exploring ambivalence –** deepening understanding of motivation, always listening for change talk
- **Offering and sharing information with permission**

Process III – Evoking Change Talk

- Find out more about the Client's thoughts about making a change
- Desire, ability, reasons, need, commitment, activation, taking steps

Change Talk: The Ingredients of Change

Desire:

- I want to stop smoking

Ability:

- I can do this if I just get a handle on my anger

Reasons:

- Getting high makes my family not want to be with me
- I don't want to lose my foot

Need:

- I need to do this so I won't have to stay at a shelter anymore

Commitment:

- I will work with my therapist on my nightmares
- I will schedule an appointment to meet with my doctor about Chantix

Activation:

- I am ready to start getting treatment for my Hep C

Taking Steps:

- I went to an AA meeting last week

Process III: Evoking Change Talk and Softening Sustain Talk

Evoke **Change Talk**:

- Ask
- Reflect
- Seek elaboration

When you hear **Sustain Talk**:

- Shift focus
- Briefly reflect it when necessary to preserve rapport
- Use a double-sided reflection
- Reframe
- Emphasize autonomy

Process IV: Planning

- When importance and confidence are high..
- Offer options
  - *"What is a reasonable next step?"*
  - *"How will you do this?*
- When, what, how?
  - Get SMART!
- Specify what to do if lapse occurs
  (e.g., call, keep appointment)
- Arrange follow-up
- This should be the Veteran's choice of a goal
  - not YOUR choice of a goal!

MI Concepts: Brief Review

- Spirit
  - Partnership
  - Acceptance
  - Compassion
  - Evoking

- Processes
  - Engaging
  - Focusing
  - Evoking
  - Planning

- OARS
  - Open ended questions
  - Affirmations
  - Reflections
  - Summaries

- Two Gold Nuggets
  - Listen for Change Talk
  - Reflect that Change Talk

The Processes..

- Engage: **“Shall we walk together?”**
- Focus: **“Where?”**
  - What concerns do you..? What is your understanding of..? When you think of __, what comes to mind? Tell me about your.. ? Would it be alright if I share..?
- Evoke: **“Why?”**
  - What makes you want..? What let’s you know that you could..? What are some reasons for..? Why should you..? What have you done to..? What’s been going well with..?
- Plan: **“How?”**
  - What would that look like? How might you? What do you think you could do? What is your first step?

Applications of MI

- Homelessness
- Substance Use Disorders
  - Alcohol
  - Tobacco
  - Cannabis
  - Other substances
- HIV and other health problem management
- Medical adherence and/or engagement
- Employment
- Engagement in PTSD, depression, gambling addiction or other mental health treatment
- Safe sex, safe needles
- Other behaviors

https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/empowering-change

MI can increase the efficacy of treatments when combined or preceding other interventions

MI before SUDs treatment

- Randomized trial of 105 OP, DSM-IV dx cocaine dependence, compared detox and MI with detox alone, pts who received the MI intervention:
  - increased their use of behavioral coping strategies
  - fewer urine samples positive for cocaine at the start of subsequent treatment
- Veterans (homeless, unemployed, and SUDS) receiving single session of MI before a SUDs program were more likely to enter the SUDS program (95%) than those not receiving MI first (71%). Those receiving MI were also slightly more likely to graduate from the SUDs program.

Stotts, A. L., Schmitz, J. M., Rhoades, H. M., & Grabowski, J. (2001). ... Journal of Consulting and Clinical Psychology, 69(5), 858-862

R. Morgan Waina, Paula L. Wilbourneb, Keith W. Harrisc,*, Heather Piersond, Jasmine Telekie, Thomas A. Burlingf, Steven Lovettg (2010) Motivational interview improves treatment entry in homeless veterans, Drug and Alcohol Dependence 115 (2011) 113–119

MI before mental health treatments

The effect of a motivational interviewing pretreatment on CPT treatment of PTSD in veterans.

1. Farber, Tanya, Petronko, Michael R., Fishman, Daniel B (2015). Rutgers thesis.
   - MI pretreatment was associated with improved **intrinsic motivation** consistent with values espoused by the veteran
     - impacted the course of subsequent therapy; improved outcomes
     - the moment-to-moment utilization of MI interventions throughout the process of CPT likely served to enhance **client engagement** in treatment

2. Seal, K. (2012).
   - MI facilitated traditional psychotherapy for Iraq and Afghanistan war veterans.
     - participants receiving telephone MI were significantly more likely to **stay in therapy**
     - reported **reductions in marijuana** use and a **decreased sense of stigma** associated with mental health treatment
     - 62% vs 26% **began treatment** for PTSD, MDD, etc.

Combining MI and CBT for medication adherence

- 6 studies
- Mental health and physical health conditions
- Effective: 5 show that MI and CBT combined improve medication adherence over and above either intervention alone and sixth study showed a trend

Cook et al. (2007, 2008, 2009, 2010; Hilliard et al. (2011); Parsons et al. (2005)

Increasing your MI skills even just a little can have an impact on outcomes

“I’m not a psychologist. I don’t have time to become an expert at MI!”

- Even demonstrating some MI consistent behaviors in sessions has been linked to improvements in outcome

- With training, motivational interviewing can be delivered effectively by physicians, counselors, and other staff; professional role does not appear to affect the efficacy of motivational interviewing

Pollak, K.I., Alexander, S. C., & Ostbye, T (2010). Physician Communication Techniquest and Weight Loss in Adults. Project CHAT. Am J Prev Med, 10(4), 321-328.

Rubak S, Sandbaek A, Lauritzen T, Christensen B. Motivational interviewing: a systematic review and meta-analysis. Br J Gen Pract 2005; 55:305.

“How much MI does it take?”

- Motivational interviewing typically achieves its effects in one to four sessions
- Motivational interviewing appears to require a “minimum dose” of about 20 minutes.
- More sessions have been associated with greater efficacy

Rubak S, Sandbaek A, Lauritzen T, Christensen B. Motivational interviewing: A systematic review and meta-analysis. Br J Gen Pract 2005; 55:305.

One training does not an expert make

“I’ve been to a training in MI .. I’m already doing it.”

- You probably are engaging in some MI-consistent behaviors, and it sounds like you value these skills.
- With training and feedback in MI, your MI-consistent behaviors will increase and your MI-inconsistent behaviors will decrease
- While we may achieve proficiency, we are never finished improving our skills in MI
- The more skills that you have, the more robust the outcomes tend to be

What makes MI so effective?

- Behavioral focus
- Finding a shared agenda
- Counselor listens for change talk, reflects it and explores it
- Two primary mechanisms seem to drive effectiveness:
  - Relational component
    - Empathizing, collaborating, evoking pt talk about pt's perspective, and supporting pt autonomy
  - Technical
    - Evoking and reinforcing change talk
    - Engage in MI consistent behaviors (this after brief trainings)
      - change talk or intention language is related to better outcomes
    - Avoid MI-inconsistent behaviors (this doesn't after brief trainings.. takes feedback and practice)
      - MI-inconsistent includes examples such as providing advice without permission, eliciting sustain talk, confronting
      - related to worse outcomes.

Reasonable Training Expectations

- **Individual Study and Self-Training**
  - Self-studying print materials and viewing training videotapes
  - May provide some understanding of the basic approach; research by Miller et al. found that self-training was not effective in improving clinical skillfulness in MI
- **Introduction to Motivational Interviewing (1 hour to 1 day)**
  - Training of up to one day will acquaint you with basic concepts and methods of MI
  - Unlikely to increase the clinical skillfulness of participants in the practice of MI
  - Purpose of this type of workshop is to help participants determine how interested they are in learning more about MI
- **Introduction to MI –Training Option (Introductory Workshop of 2-3 days)**
  - Provide participants with an understanding of the spirit and method of MI and offer some practical experience in trying out this approach
  - Goal for this level of training is not MI proficiency, but rather to "learn how to learn" MI from ongoing practice
  - **Research and experience caution that attendees may leave a one-time introductory workshop overconfident in their mastery of MI**
  - Length of training should ideally be provided in blocks of 4 hours or so, with opportunity in between for practice MI to ID challenges for review at next f/u block (for example, 4/4/4: 4 sessions of 4 hours each spread over 4 months)
  - Research indicates a reduction in MI skill level within 4 months (Miller & Mount, 2001) of training if no additional opportunities for additional feedback and coaching
  - Personal performance feedback (e.g., from practice audiotapes) and/or individual coaching can significantly increase the effectiveness of training in helping participants to improve their clinical proficiency

Sources of Information on MI

- Motivational Interviewing: Preparing People for Change (2012). Miller and Rollnick, 3rd edition, Guilford Press
- Motivational Interviewing in Health Care (2007). Rollnick, Miller and Butler, Guilford Press
- Motivational Interviewing in the Treatment of Psychological Problems (2007). Ed: Arkowitz, Westra, Miller and Rollnick, Guilford Press
- http://www.motivationalinterviewing.org: bibliography; training resources

Contact:

- Elizabeth Jenkins, PhD, Whole Health Psychologist and Health Behavior Coordinator (813) 903-4504

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- Motivational Interviewing: Preparing People for Change (2012). Miller and Rollnick, 3rd edition, Guilford Press
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