# MIA: STEP

## *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency*

## A NIDA-SAMHSA Blending Product

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# Our Objectives

1. Make the case for clinical supervision
2. How to establish and implement new standards in clinical supervision
3. How clinical trials research supports the use of MI and methods of clinical supervision used in the trials
4. Introduce a tool kit for the clinical supervision of counselors using MI methods

# Clinical Supervision Issues

- Roles and reality of clinical supervision
- The case for improvement
- Clinical supervisor competencies
- Lessons based on implementation experience

# Key Supervisory Roles

- **Assure Safety** – risk management, boundary monitoring
- **Assure Quality** – fidelity, competence, professionalism, preparedness
- **Assure Effectiveness** – addressing client needs, service improvement, maximize access and retention
- **Assure Compliance** – rules, regulations, standards, policies

# Current Supervisor Reality

- Oversee direct services
- Juggle administrative and clinical supervision
- Manage daily crises
- Prepare reports
- Carry a caseload
- Maintain payer and referral relationships
- Link management with consumers

# So what's the problem?

- **Issue:** What is happening behind the closed group room or counseling office door?
- **Assumption:** Practice conforms to policy, procedure, and clinical protocol
- **Verification:** Rarely happens
- **Reality:** Clinicians lack performance feedback and mentoring

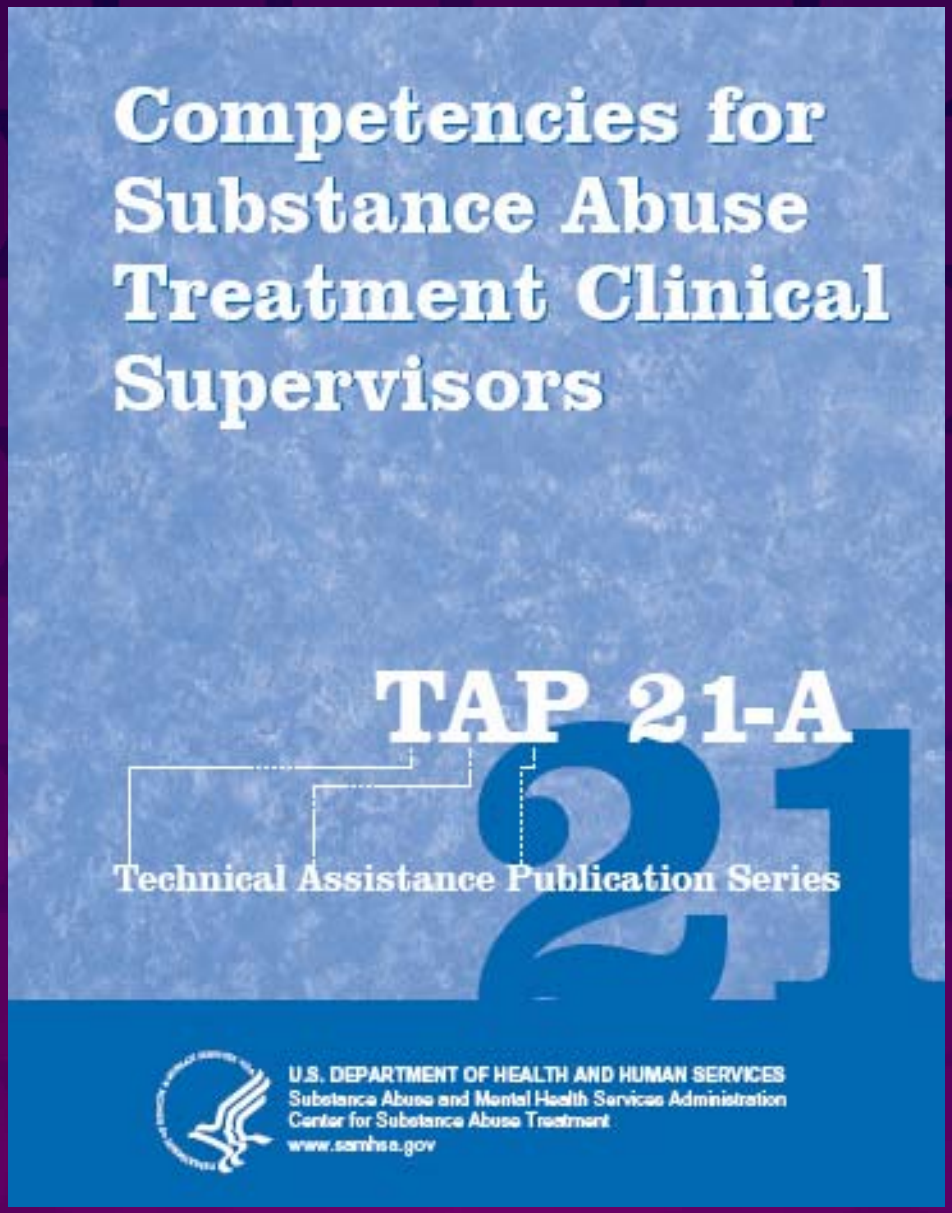
# In summary…treatment agencies need to:

- **Monitor**, evaluate and promote clinical competence
- **Make proficient use** of evidence-based practices
- **Assure treatment efficacy** and cost-effectiveness
- **Minimize client and provider safety risks**

MIA: STEP

# Recent Developments

- Addiction Counseling Competencies revised in 2006 – TAP 21
- New treatment methods being developed with increasing frequency
- Realization that clinical supervision is key to EBP adoption
- Synthesis of essential supervisory knowledge and skills – TAP 21A


Competencies for Substance Abuse Treatment Clinical Supervisors
TAP 21-A
21
Technical Assistance Publication Series
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

# Essential Performance Domains

1. Counselor Development
2. Professional and Ethical Standards
3. Program Development and Quality Assurance
4. Performance Evaluation
5. Administration

# What needs to be done?

- Observe
- Provide feedback
- Mentor/coach/teach
- Evaluate
- Motivate
- Inspire
- Create an atmosphere for continuous learning

# Primary role: Counselor Development

- Establish standards and expectations for job performance
- Monitor clinical services regularly
- Provide feedback to clinicians
- Collaborate on professional development plans
- Facilitate knowledge & skill acquisition

# Evidence supporting the effectiveness of clinical supervision

- Miller et al: *A Randomized Trial of Methods to Help Clinicians Learn MI*
  (Journal of Consulting and Clinical Psychology, 2004)

- Sholomskas et al: *We Don't Train in Vain: Three Strategies of Training Clinicians in CBT*
  (Journal of Consulting and Clinical Psychology, 2005)

# MI Clinical Trial

Studied 5 different ways of training counselors in Motivational Interviewing

1. Manual only
2. Workshop
3. Workshop plus feedback
4. Workshop plus coaching
5. Workshop plus feedback and coaching

(Miller, et al 2004)

# Findings

- Significant improvement immediately after workshop, which disappeared in 4 months
- Significant improvement for the feedback, coaching and f+c groups which was maintained to 12 months
- Key to developing skill is the availability of observation, feedback, coaching, and support

# CBT Clinical Trial

Tested 3 ways of training counselors in the delivery of Cognitive Behavioral Therapy

1. Manual only
2. Manual plus web-based training
3. Manual plus training seminar and supervision

(Sholomskas, et al 2005)

# Findings

- Manual only training did not improve CBT skills
- Web-based training showed modest improvement but clinicians did not achieve proficiency
- Training seminar plus supervision was only condition to produce and maintain skills at a proficient level

# Conclusions

"…face to face training followed by direct supervision may be essential for effective technology transfer and raises questions about whether practitioners should feel competent to administer an empirically-supported treatment on the basis of reading a manual alone"

(Sholomskas, et al 2005)

# Survey

1. How do these findings differ from current practice in your agency?
2. What are the obstacles to offering more direct clinical supervision?
3. What changes could facilitate the improvement of clinical supervision in community agencies?

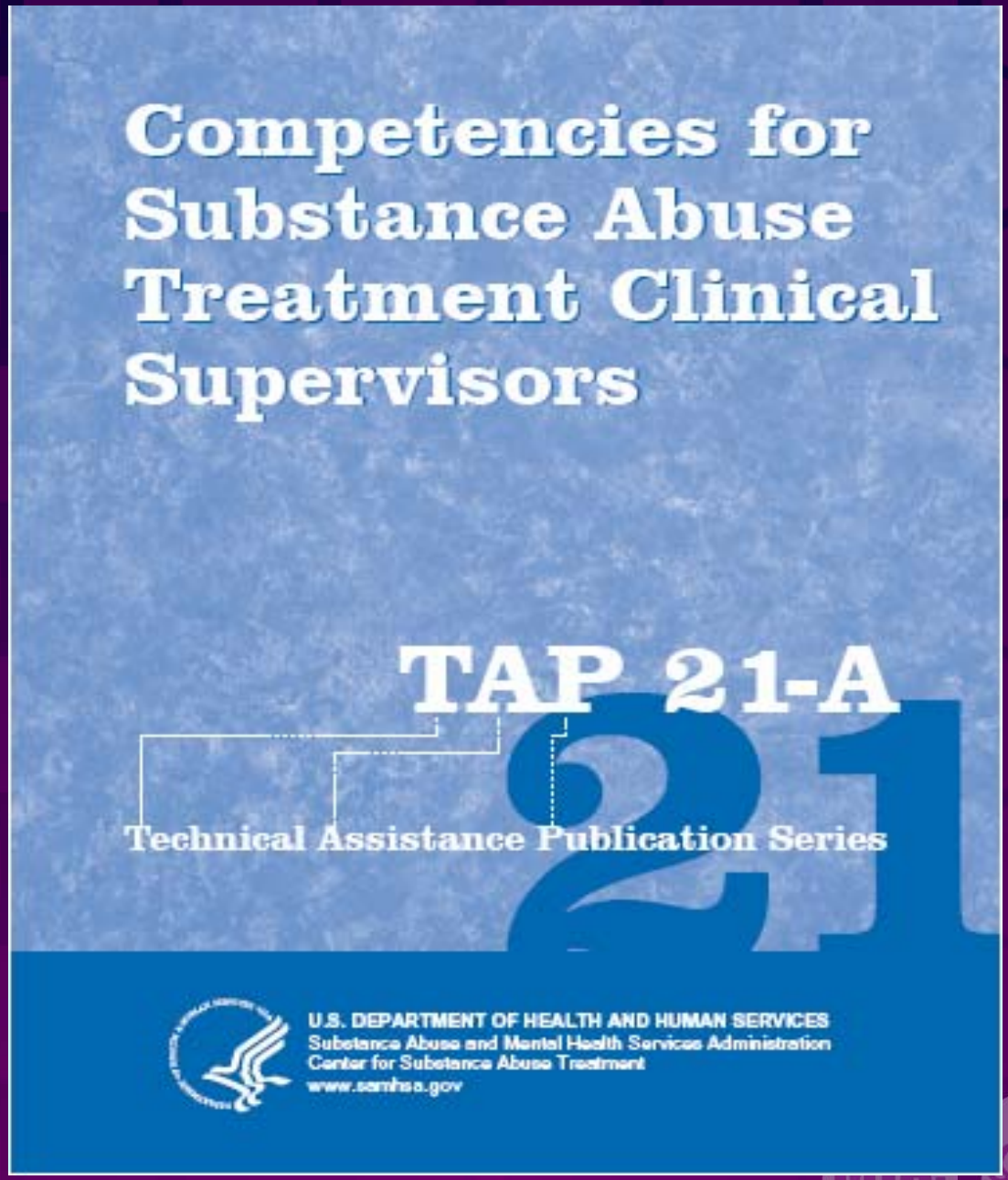
# Key Skills for Effective Supervision

1. Build effective alliance with supervisees
2. Focus on continuous improvement of knowledge and skills
3. Observe clinical activities
4. Provide feedback in tutorial and/or group settings
5. Teach and coach on a regular basis
6. Negotiate professional development plans

# Without Observation…

Clinical Supervisors cannot:

- Reinforce the good work of their clinicians
- Correct clinical mistakes or inconsistencies
- Provide training to improve services
- Assure fidelity with clinical protocol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# Motivational Interviewing Assessment:

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*Supervisory Tools for Enhancing Proficiency*

STEP

# The Clinical Trials

- **MI Protocol**
  - A 1-session MI intake assessment in outpatient treatment

Completed/Published

- **MET Protocol**
  - A 3-session MET intervention the 1st month of outpatient treatment

Completed/Published

- **Spanish MET Protocol**
  - A 3-session MET intervention the 1st month of outpatient treatment conducted in Spanish with primary Spanish-speaking clients

Completed/Under Review

# The Clinical Trials

- **The study design …**
  - Multisite randomized clinical trials community programs (MI: 5 sites; MET: 5 sites; METS: 5 sites)
  - Clinicians randomized to training condition and clients randomized to MI/MET/METS vs. TAU.
  - Assessed at baseline, 1-month and 3-month follow-ups.
  - Primary outcomes: retention (enrollment, sessions attended) and substance use (days of primary drug use)
  - Therapy fidelity and discriminability monitored and independently evaluated

# The Clinical Trials

- **The clinician training model …**
  - 2-day MI expert-led intensive workshop for clinicians and supervisors
  - Program-based supervisors trained/certified in MI and adherence/competence rating system
  - Individually supervised practice cases until certification standards achieved in 3 sessions
  - Ongoing biweekly individual or group supervision
  - MI expert consultant had monthly contact with supervisors

# The Clinical Trials

- **Maintaining MI proficiency during trial …**
  - Initial Proficiency/Certification = at least half of the MI consistent items rated average or above on adherence and competence
  - Maintaining Proficiency = individual and group supervision (rating feedback, tape review, role play, focused skill development)
  - Protocol for Inadequate MI Performance = more intensive supervision until certification standards achieved again.

# The Clinical Trials

- **Steps to maintain proficiency during the trial:**

  A) Follow a disciplined supervision schedule

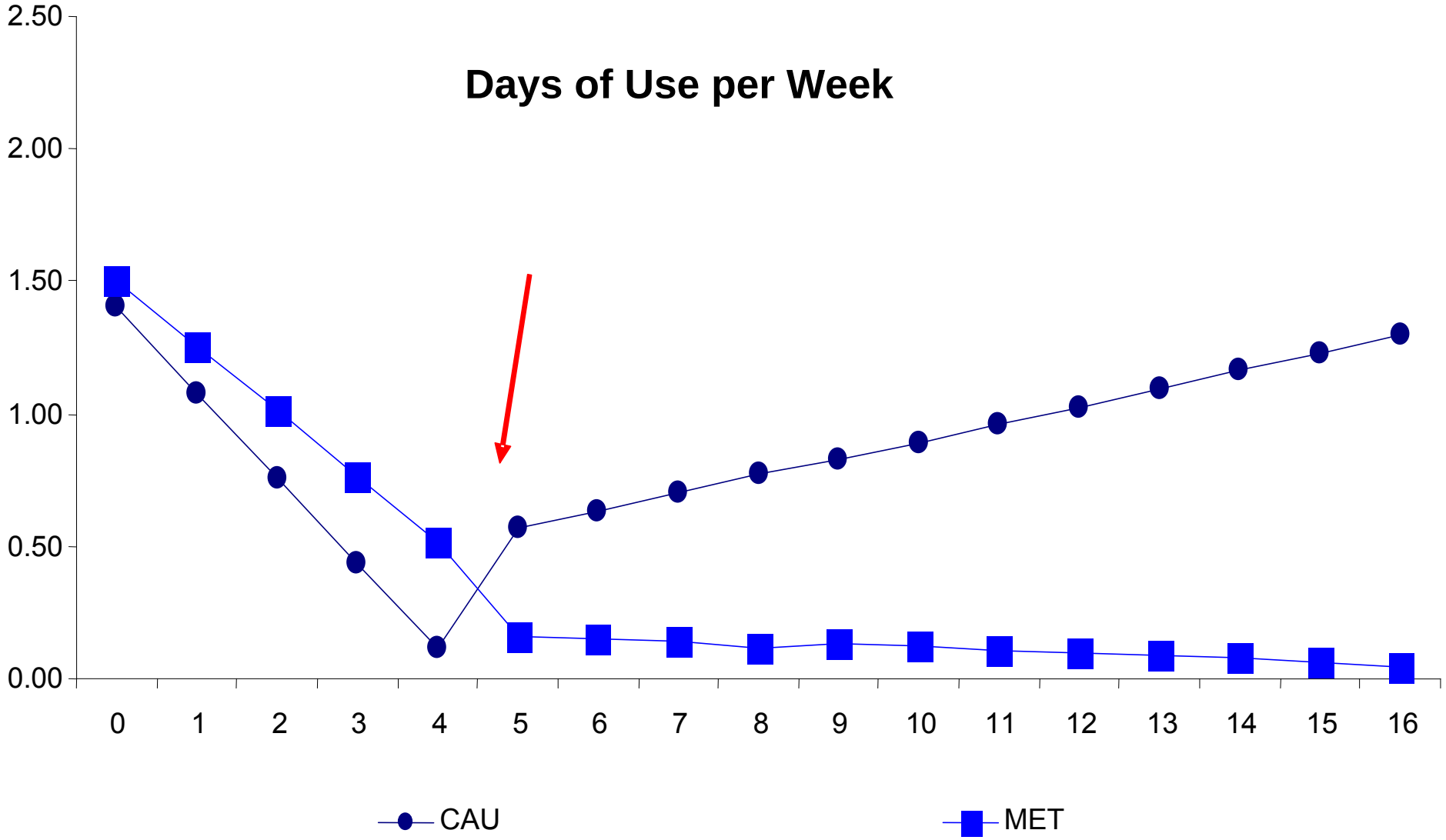
  B) Tape reviews with personalized feedback and coaching

  C) Frequent review of protocol manual and role-play

# Main MI Protocol Results

- **Engagement**
  - MI clients attended more sessions at 4 weeks than standard intake clients (5 vs. 4; effects strongest for primary alcohol users)
- **Retention**
  - More MI than standard intake clients remained in treatment at 4 weeks (84% vs. 75%; effects strongest for primary alcohol users)
- **Substance Use**
  - No overall group differences. For primary alcohol users, trend for MI clients to drink fewer days than standard intake clients.

# Main MET Protocol Finding

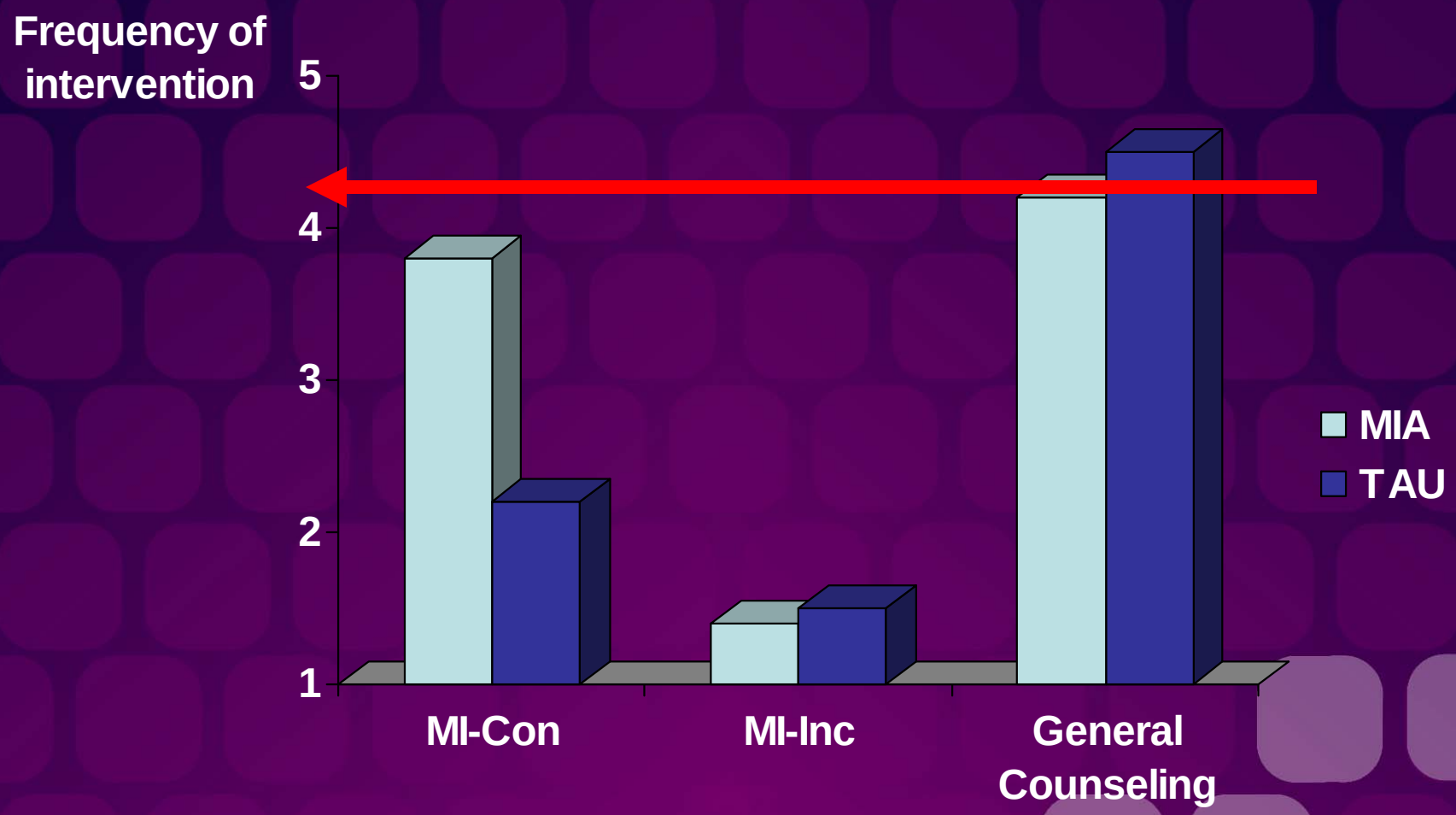


# Important Question #1

Were there differences in the adherence and competence of clinicians trained to use MI and MET from those who continued to conduct counseling-as- usual?

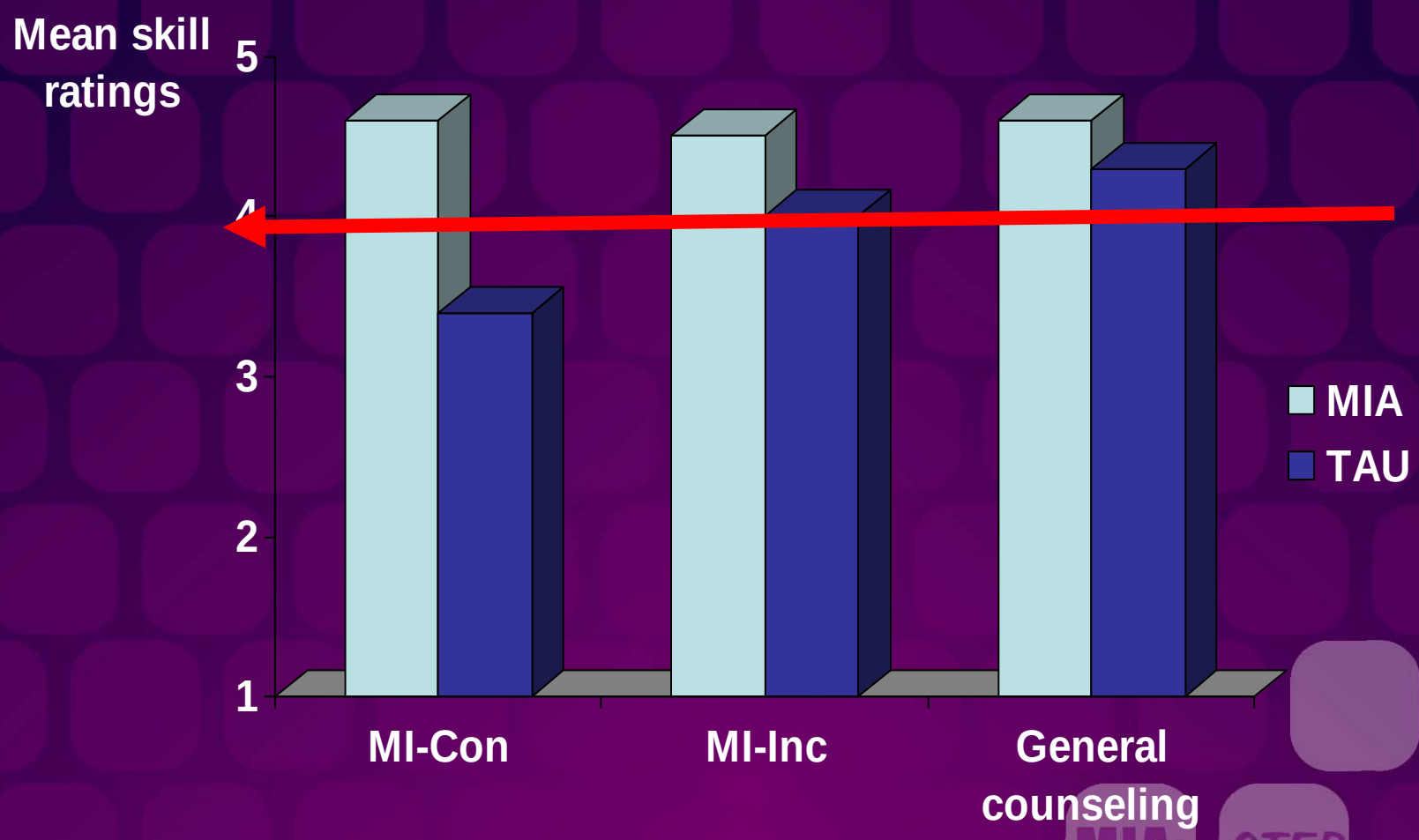
# MIA Protocol Adherence Ratings

(*based on 315/377 sessions*)



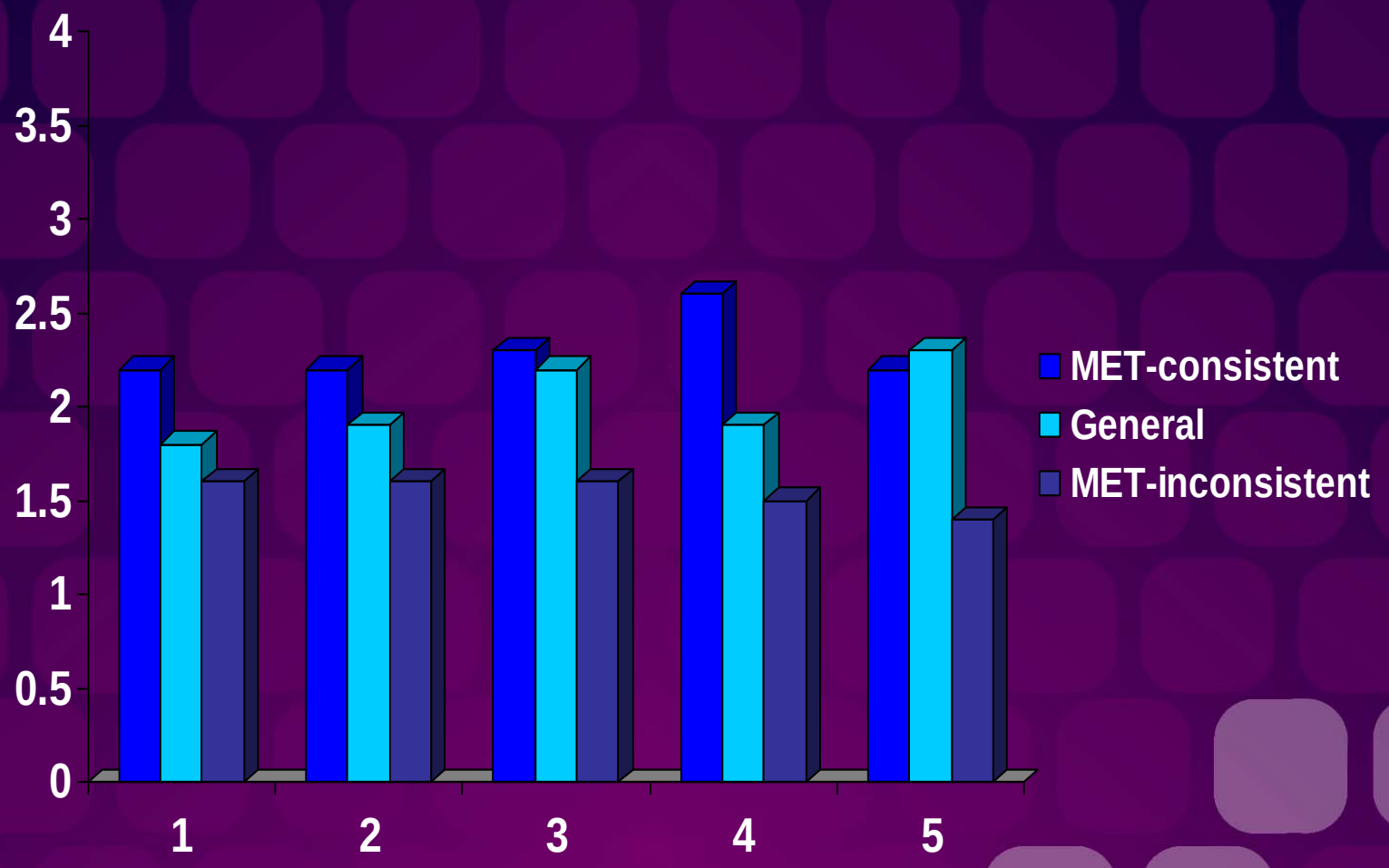
# MIA Protocol Competence Ratings

(*based on 315/377 sessions*)



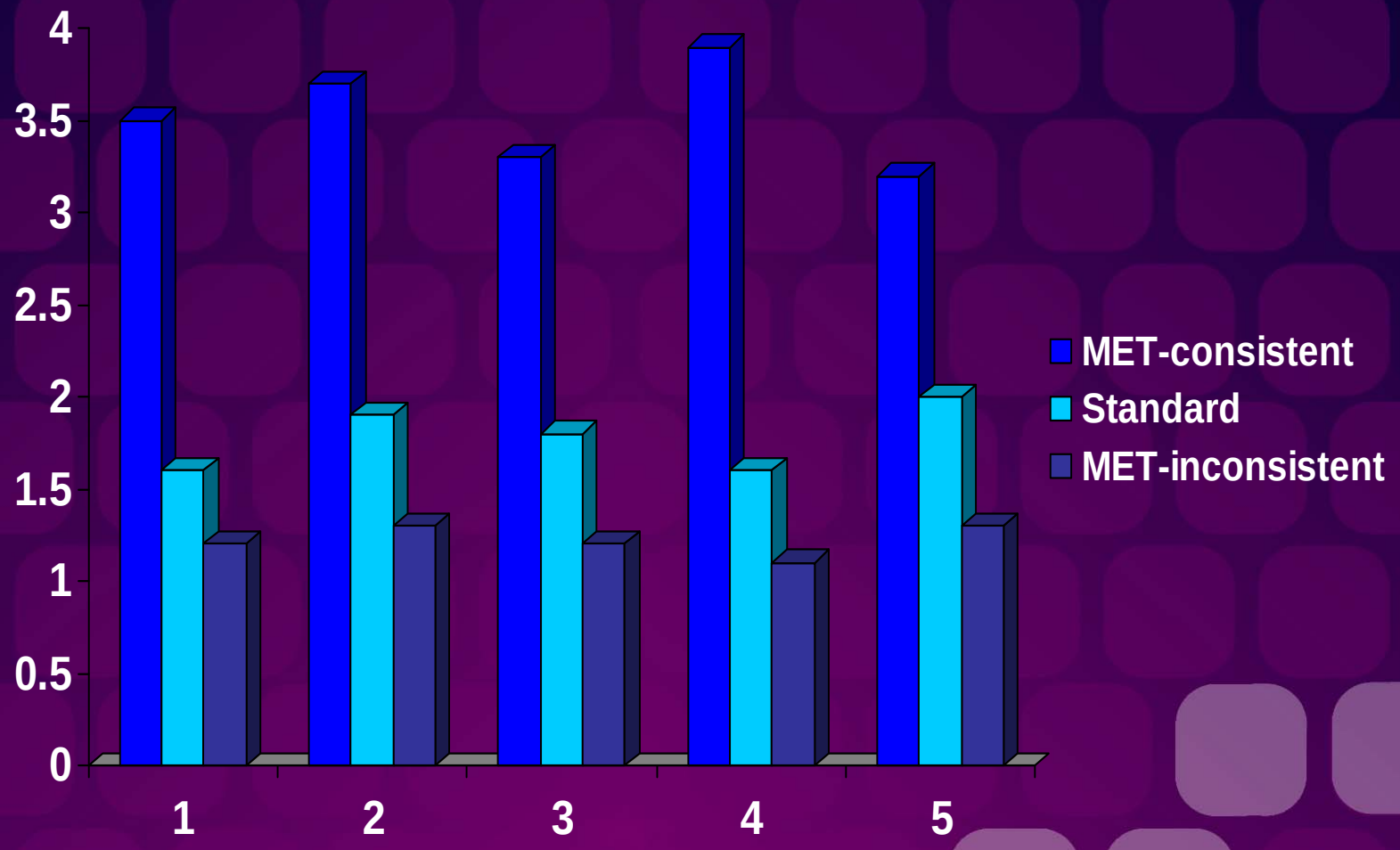
# MET Protocol Adherence

## *TAU at 5 Program Sites*



# MET Protocol Adherence

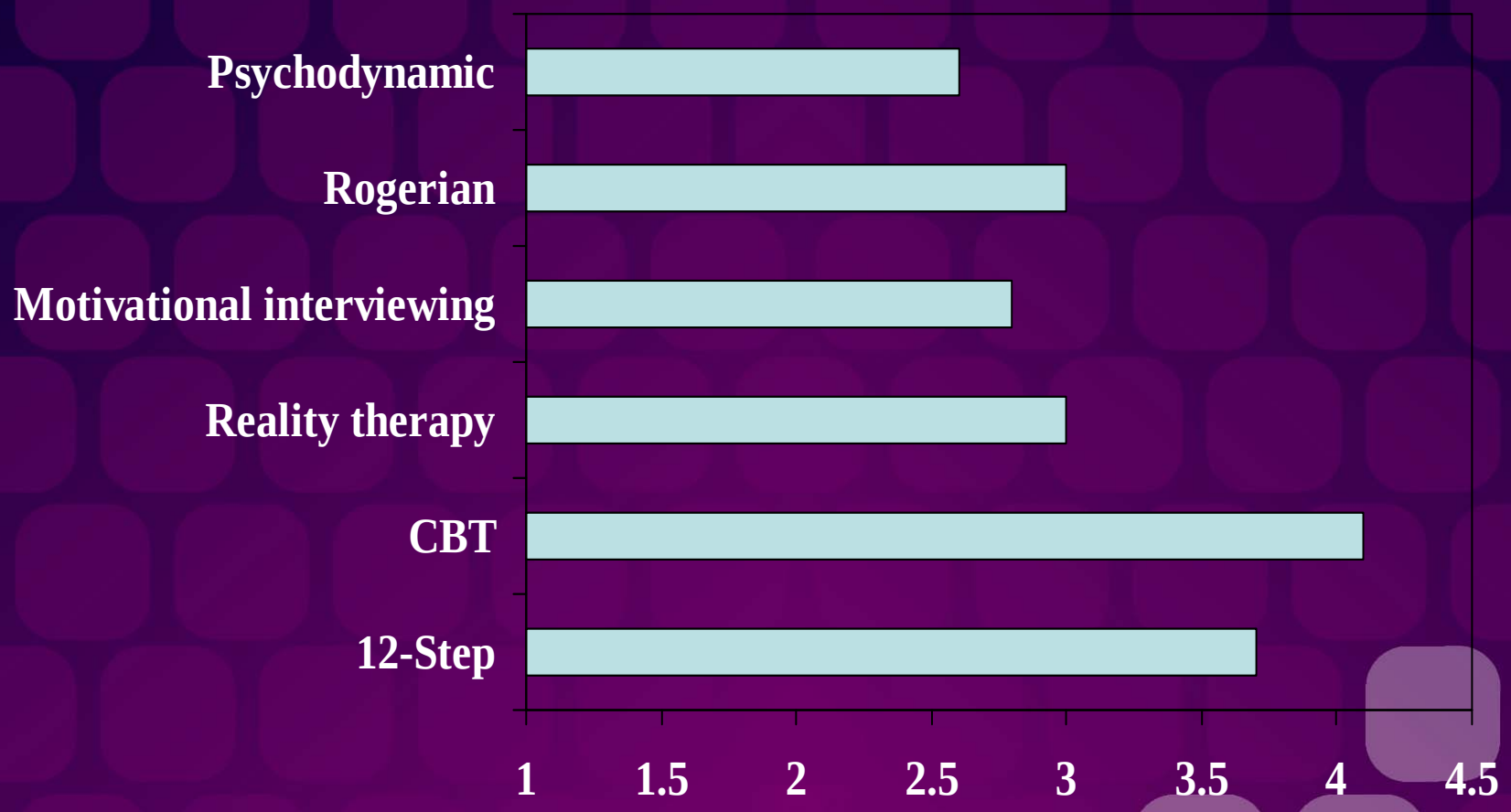
## *MET at 5 Program Sites*



# Important Question #2

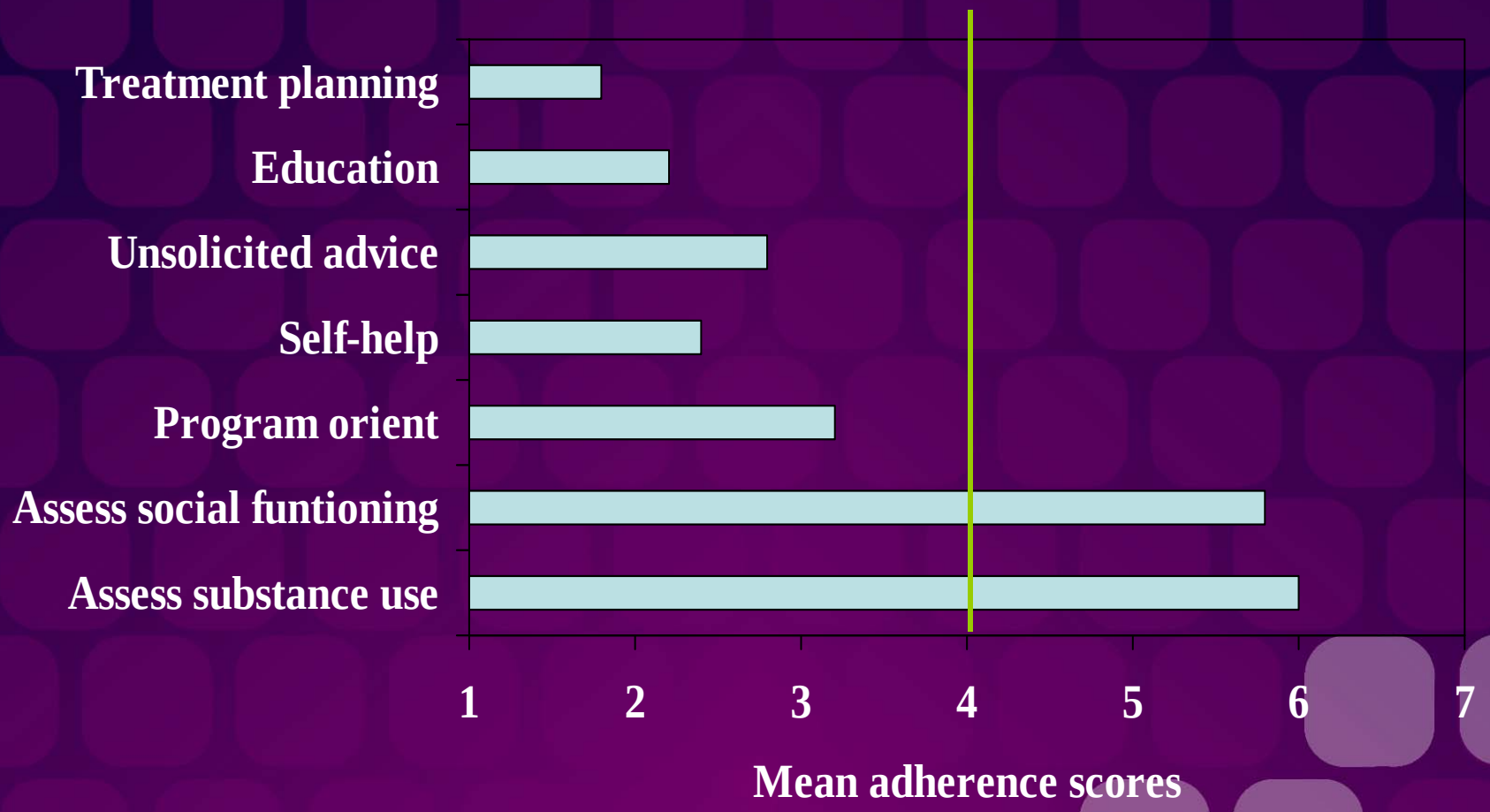
What treatment strategies did the counselors use when providing counseling-as-usual services?

# Primary counseling orientations endorsed *BEFORE* randomization and training

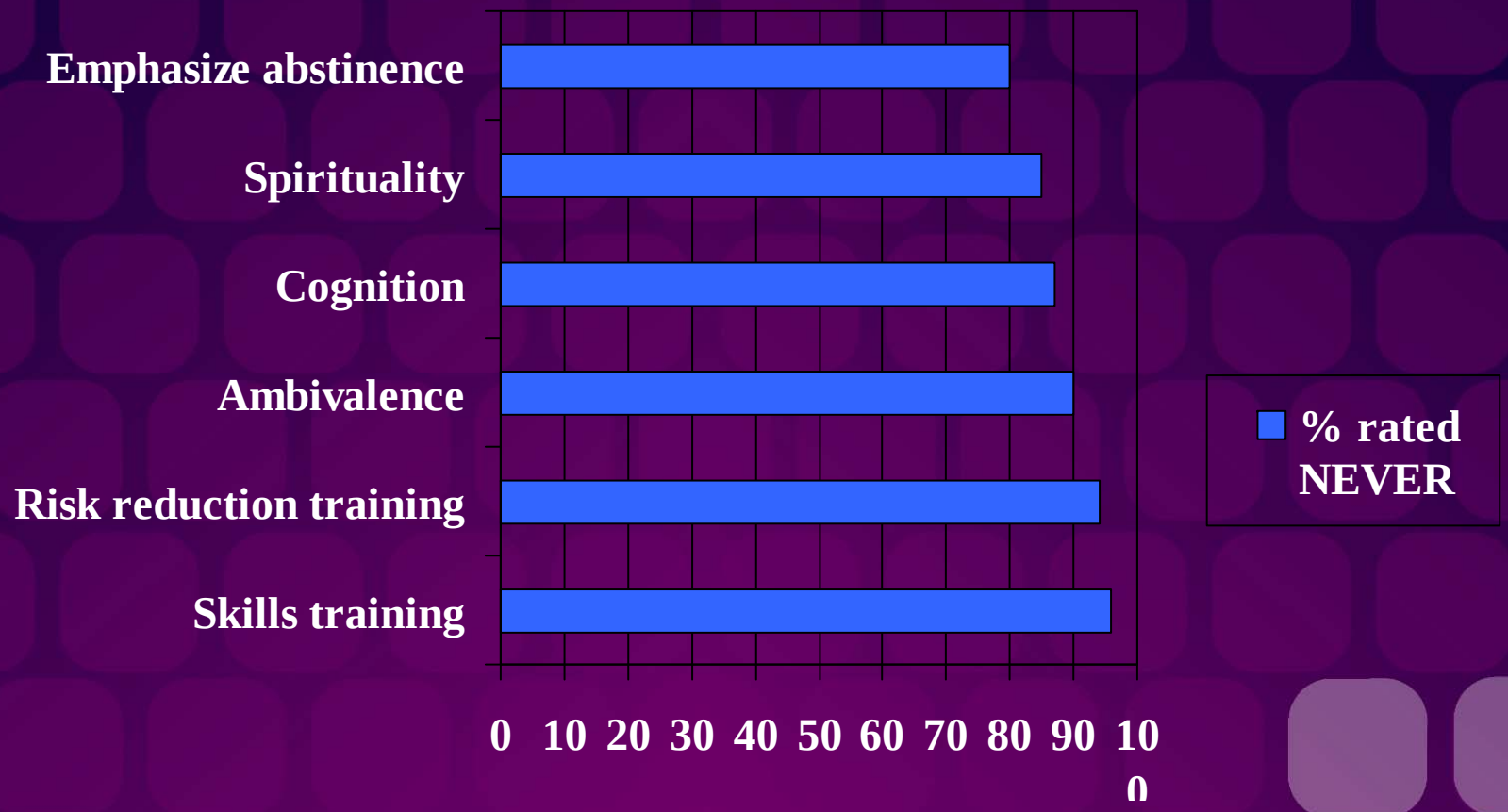


# What interventions characterize counseling-as-usual?

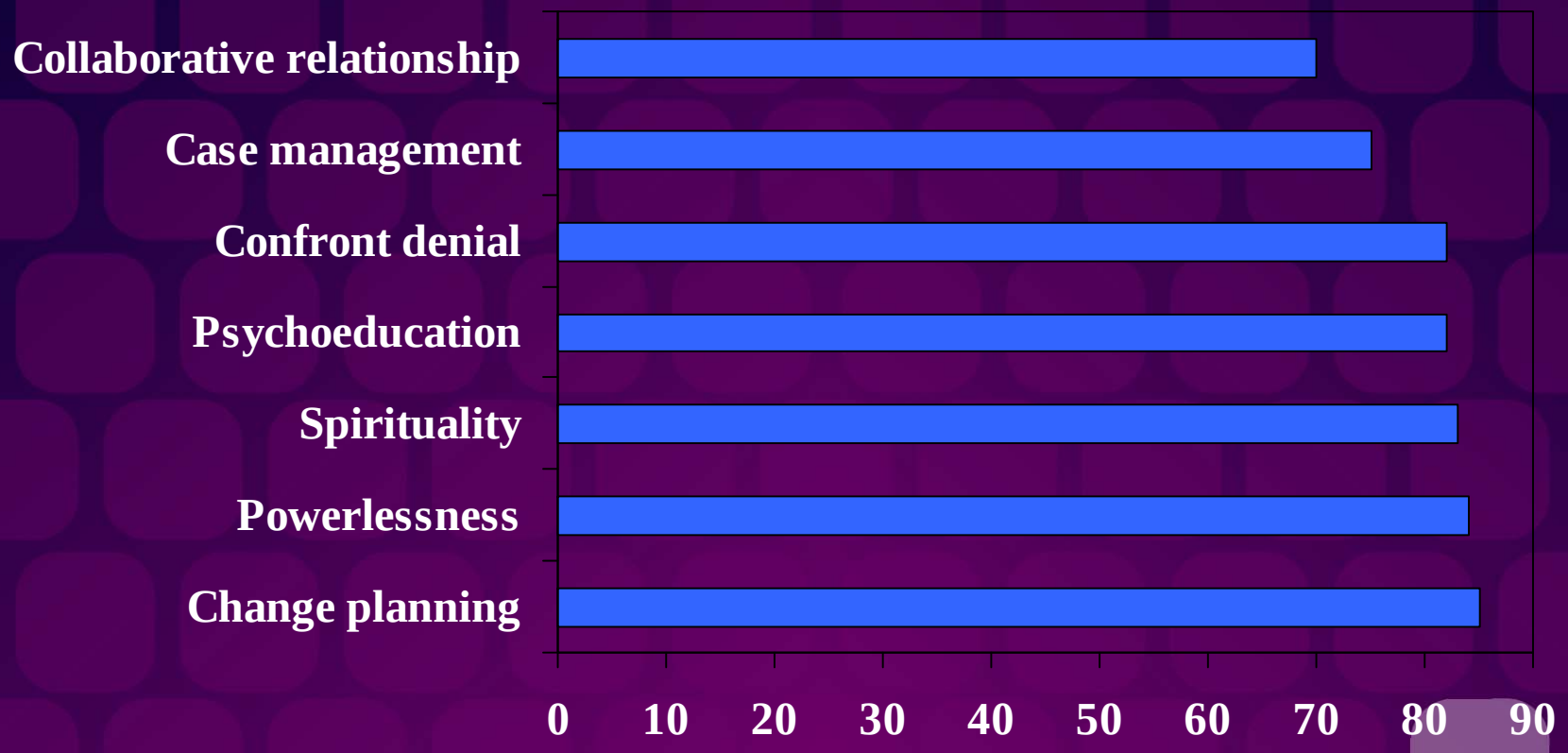
CAU tapes (379 )



# What interventions NEVER occurred in CAU?



# What else RARELY occurred in TAU?



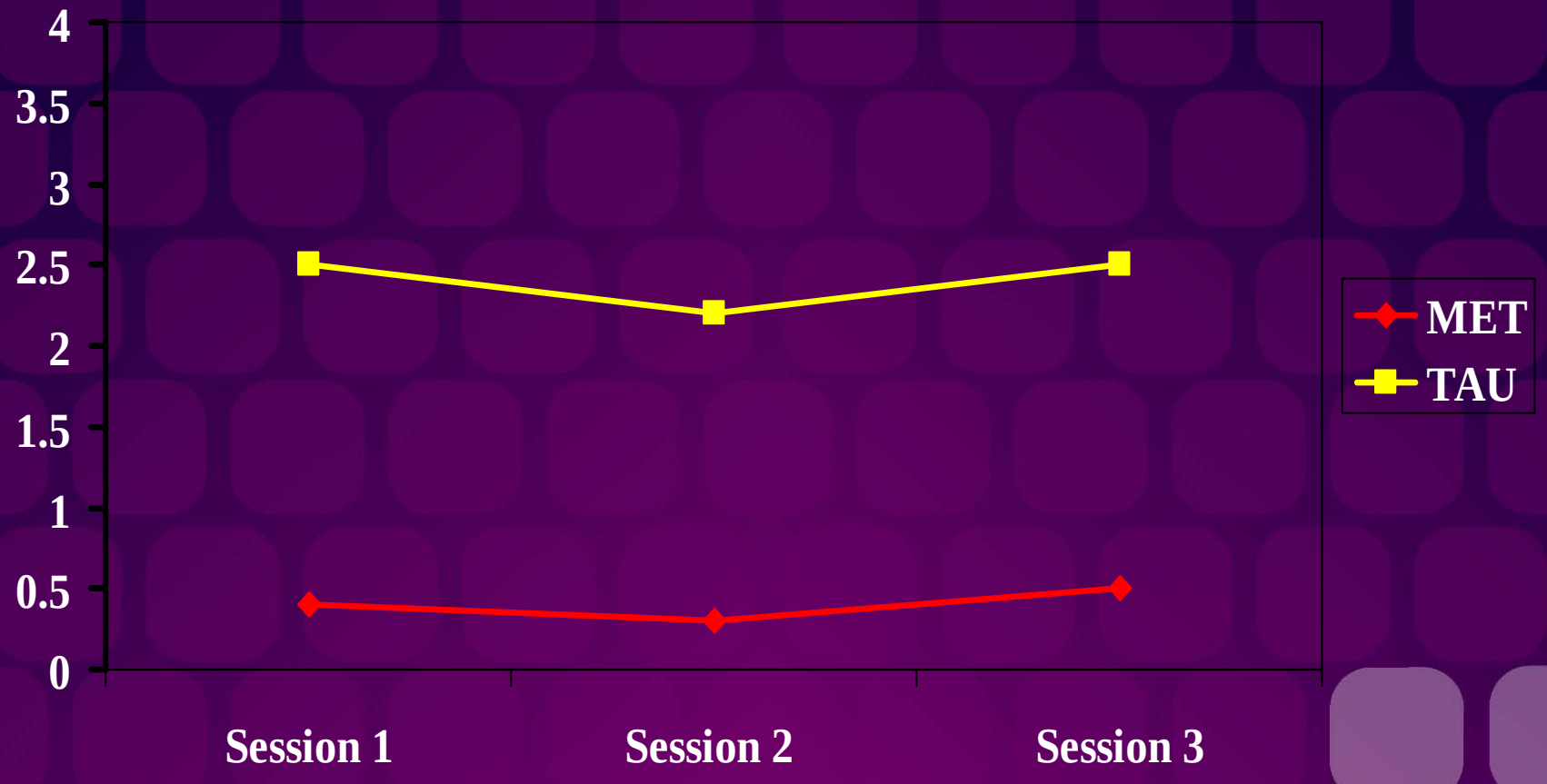
# Important Question #3

What else might have the clinicians been doing when delivering standard counseling services?

# The Informal Discussion Item

To what extent did the counselor speak with the client about topics that were ***not related*** to the problems for which the client entered treatment or make self-disclosures unrelated to the counselors' experiences with recovery?

# Frequency of ‘chat’ by treatment condition: CTN MET vs. TAU



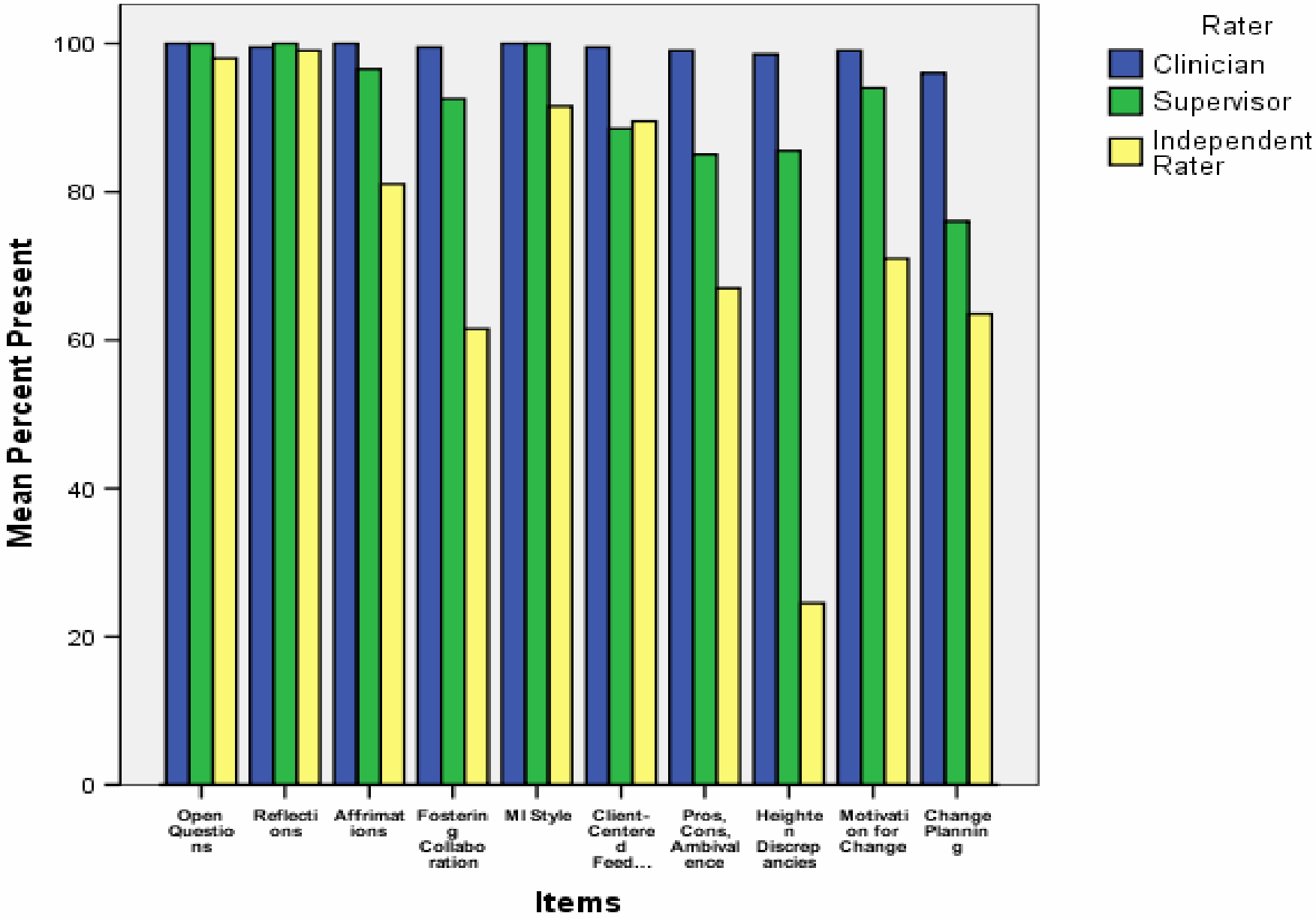
# What Did They Discuss?

| |
|---|
| Common Experiences<br>Personal Information<br>Addiction Problems of Significant Others<br>Psychological/Interpersonal Problems<br>Health Problems |
| Opinions Not Related to Client's Treatment |
| Current Events or News |
| Personal Feelings about Client |
| Work-related Problems |
| Professional Background |
| Other |

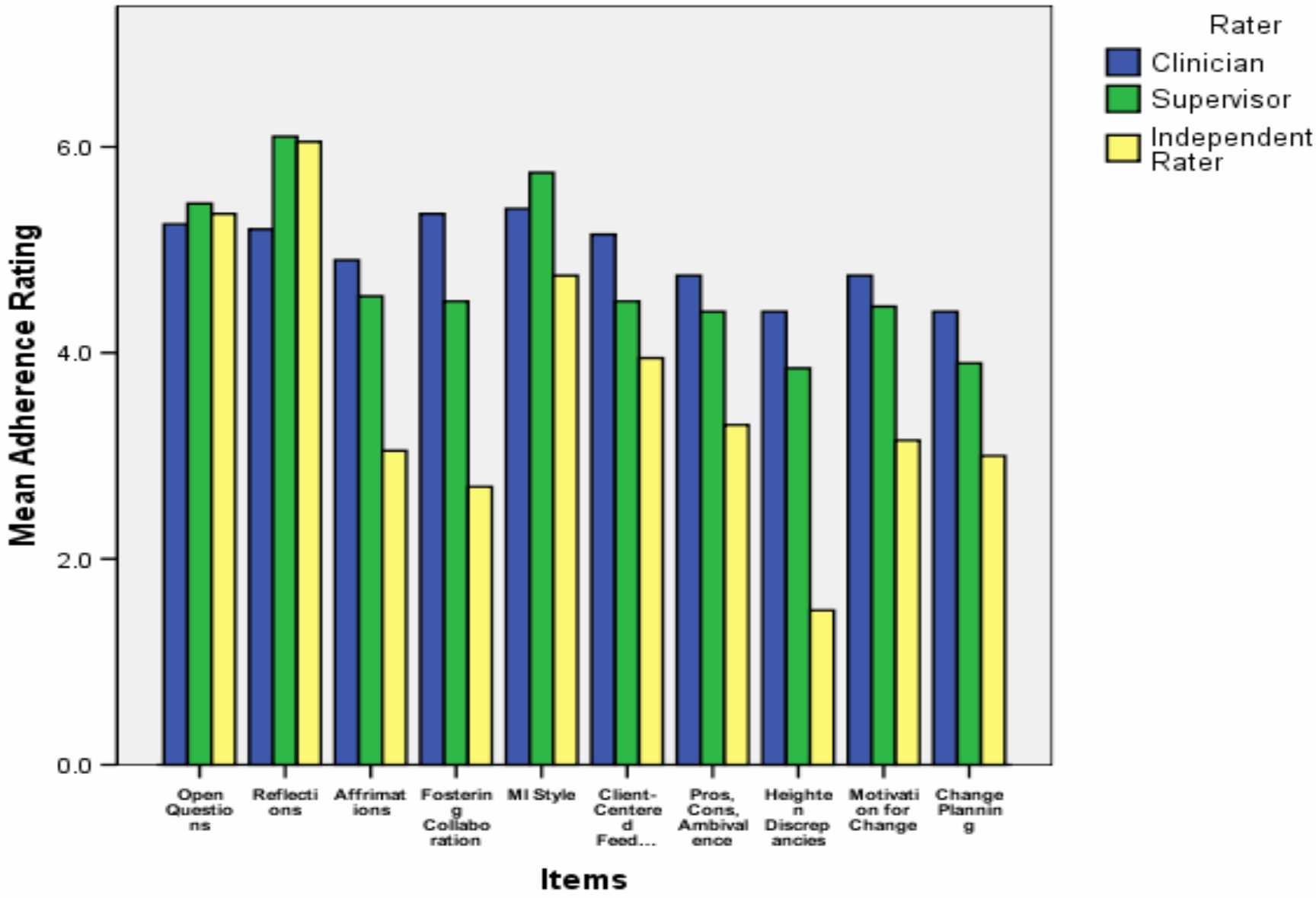
# Important Question #4

How accurately do clinicians and their supervisors who have been trained in MI/MET report what treatment strategies they have used during sessions?

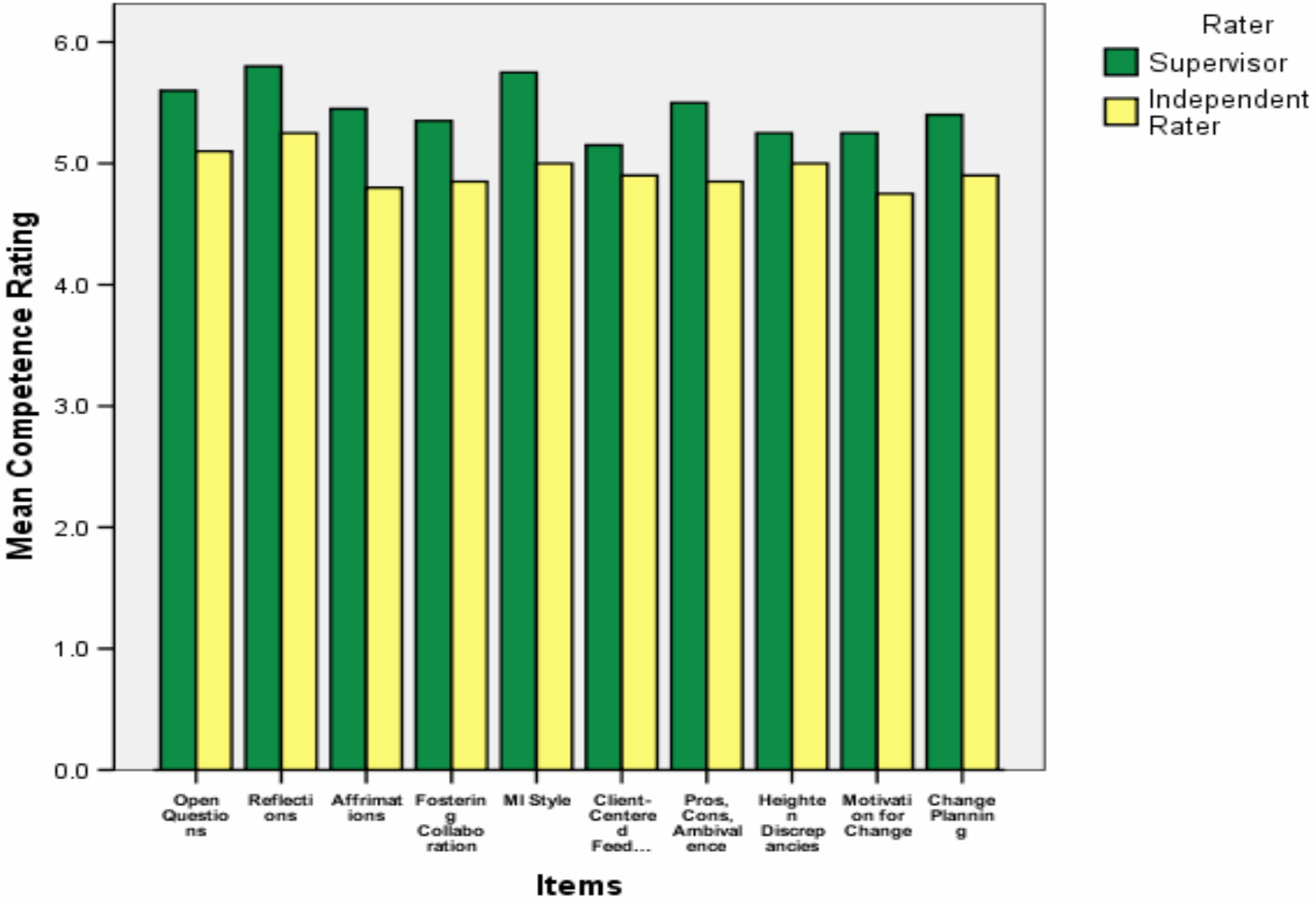
# Agreement about Occurrence



# Agreement about Frequency



# Agreement about Competence



# Why are these studies important?

- They show that a 1-session outpatient program intake incorporating some MI improved retention.

- They show that a 3-session structured MET approach used at the beginning of treatment significantly reduced days of drug use 4 months after clients entered treatment

**WHEN IMPLEMENTED IN REAL WORLD COMMUNITY TREATMENT PROGRAMS**

# Why are these studies important?

- They show that community clinicians can be trained to use MI with adherence and competence when using:
  - taped sessions
  - tape coding
  - clinical supervision based on direct observation, feedback, and coaching

**Consistent with the findings from Miller et al. (2004)**
***JCCP, 72,* 1050-1062.**

# Why are these studies important?

- Training in MI/MET seemed to add MI strategies to the assessment of substance use and social functioning occurring early in treatment. This is important given that ESTs rarely occurred in standard counseling services.
- Training in MI/MET seemed to reduce the amount of talking about things unrelated to the client's treatment (i.e. chatting).

# Why are these studies important?

- Clinicians overestimated how often they use MI strategies in sessions, underscoring the need for direct observation in supervision.
- Supervisors also overestimated how often and well clinicians implemented MI strategies in sessions, underscoring the need for adequate preparation of supervisors to monitor and train their clinicians in ESTs.

# Motivational Interviewing Assessment:

M

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*Supervisory Tools for Enhancing Proficiency*

STEP

# Agenda

- Overview the package
  - Briefing materials
  - Tools
  - Interview rating system
- Application to practice

# Background

- **SAMHSA-NIDA Blending Initiative**
- **Blending products:**
  - → Buprenorphine Treatment: A Training
  - → Short-Term Opioid Withdrawal Using Buprenorphine: Findings and strategies
  - → Treatment Planning MATRS
  - → MI Assessment: Supervisory Tools for Enhancing Proficiency
  - → Promoting Awareness of Motivational Incentives

# Background

- **Blending Team objectives and assumptions**
  - Develop a package that promotes the use of MI
  - Provide tools useful to community providers
  - Field does not need another MI training package
  - MI skills erode quickly without feedback and coaching following training

# Background

- **What the package is…**
  - A tool kit for enhancing clinical proficiency in using MI
  - A resource for supervisors who mentor clinicians
  - A multi-media package of products for enhancing individual and group learning
  - A set of materials in the public domain that can be copied and customized to meet specific needs

# Background

- **What the package is not…**
  - A set of resources for introducing MI
  - A tool for helping supervisors learn MI
  - A curriculum for teaching an MI course
  - A self-paced instructional program
  - A substitute for intensive basic training in MI

# MIA:STEP Overview

1. Briefing materials
2. Summary of the MI Assessment intervention
3. Results of the NIDA CTN Research
4. Teaching tools for enhancing and assessing MI skills
5. Interview rating guide and demonstration materials
6. Supervisor training curriculum

# MI Assessment "Sandwich"

**MI strategies during 1st 20 min**

**Agency Intake or Assessment**

**MI strategies during last 20 min**

# MIA:STEP Toolkit includes everything you need to:

- Introduce the idea of doing an MI assessment
- Implement the MI Assessment protocol
- Provide ongoing supervision of MI
- Train supervisors to use a practical rating system
- Use a MI style of supervision

# Teaching Tools

1. MI Style and Traps
2. MI Assessment Sandwich
3. MI Principles
4. Using Your OARS
5. Stages of Change
6. Reflections
7. Exploring Ambivalence
8. Eliciting Change Talk
9. Assessing Readiness to Change

# Self-Assessment Skill Summaries

1. MI Style and Spirit
2. Fostering a Collaborative Atmosphere
3. Open-Ended Questions
4. Affirmations
5. Reflective Statements
6. Motivation to Change
7. Developing Discrepancies
8. Pros, Cons and Ambivalence
9. Client Centered Problem Discussion and Feedback
10. Change Planning

# Interview Rating Guide

- MI Supervision Guidelines
- General Tape Rating Guidelines
- Rating Adherence and Competence
- Description of Rating Items
- Tape Rating Forms
- References
- Demonstration Recordings
- Training Plan

# 16 Rating Items

## MI Consistent Items

- MI Style or Spirit
- Open-ended Questions
- Affirmations
- Reflections
- Fostering Collaboration
- Motivation to Change
- Developing Discrepancies
- Pros, Cons, and Ambivalence
- Change Planning Discussion
- Client-centered Feedback

## MI-Inconsistent items

- Unsolicited Advice
- Emphasize Abstinence
- Direct Confrontation
- Powerlessness/Loss of Control
- Asserting Authority
- (Closed-ended Questions)

# 2 Rating Dimensions

**Adherence** – How often a particular intervention or strategy occurs. Items rated from 1 (Not at all) to 7 (Extensively)

**Competence** - The quality of the intervention or strategy. Items rated from 1 (Very Poor), to 7 (Excellent)

# Sample Item: Adherence

**OPEN-ENDED QUESTIONS:** *To what extent did the therapist use open-ended questions (i.e., questions that elicit more than yes/no responses) to elicit the client's perception of his/her problems, motivation, change efforts, and plans?*

**Adherence Rating Guidelines**:

Open-ended questions are questions that result in more than yes/no responses and that don't pull for terse answers or very specific pieces of information. Often these questions begin with the following interrogatives: "What," "How," "In what," and "Why (somewhat less preferable)" or lead off with the request, "Tell me…" or "Describe…" The clinician uses open-ended questions to elicit an open conversation about the client's view of his/her problems and commitment to change. In brief, by using open-ended questions, the clinician gives the client a wide range for discussing his or her life circumstances and substance use patterns.

# Sample Item: Competence

***Higher***: High quality open-ended questions are relevant to the therapist-client conversation and pull for greater client exploration and recognition of problem areas and motivation for change, without appearing to be judgmental or leading to the client. They are simple and direct, thereby increasing the chance that the client clearly understands what the therapist is asking. Usually, several open-ended questions do not occur in close succession. Rather, high quality open-ended questions typically are interspersed question-answer trap between the therapist and client. The therapist pauses after each question to give the with reflections and ample client conversation to avoid the creation of a client time to respond to each query.

***Lower***: Low quality open-ended questions are poorly worded or timed or target an area not immediately relevant to the conversation and client concerns. They often will occur in close succession, giving the conversation a halting or mechanical tone rather than one that flows naturally between the therapist and client. Lower quality open-ended questions also may compound several questions into one query (e.g., "Tell me about how you felt before and after you got high and how that all affects your future risk for using cocaine."), making them harder to understand and respond to by the client. Further reductions in Skill Level ratings may occur if the therapist seems to be leading or steering the client or uses a judgmental or sarcastic tone when asking open-ended questions.

# A Rating Example from Demo

Clinician: Well, to kinda summarize at this point, you got 2 DUIs and that concerns you. I mean, you know, you don't like doing that. You don't like driving that way. You don't like driving under the influence. Having to go to an attorney and deal with all this is something you wouldn't want to do.

Reflection – good

Developing Discrepancy – good

Client: Well, it's expensive and inconvenient to say the least. And I don't like having that on my record because I'm not that guy. I'm not the guy who drinks and drives.

Clinician: Like you said, that's not your normal behavior nor something you would normally do.

Reflection – good

Developing Discrepancy – good

Client: No.

Clinician: And you're also concerned about having to rely on it. Like you said, you play in a band…you get those tunes going through your head and it's something you've come to rely on to get you to sleep. And that's not so much something you thought but something your girlfriend has pointed out to you.

Reflection – good

Developing Discrepancy – good

Client: Well, she's kinda got me thinking about it a little bit, and I'm realizing I'm sounding kinda like a jerk talking like the only reason I am here is because of my lawyer or to just make my girlfriend relaxed. I don't want you to think that.

Clinician: You've got some concerns about this yourself. You're kinda thinking well maybe there's something about this I need to look at myself.

Reflection – very good

Fostering Collaboration – very good

Client: You don't want stuff like this to get to a point where it's a problem. I'm kinda heading it off at the pass, you know what I mean? Trying to sort of look at it in a pre-problem stage…maybe determine, is this a problem or is it not a problem? Like I said, both times I got pulled over for DUIs, I didn't feel like I was impaired at all.

Clinician: I gotcha. Your assessment right now is that it's not a serious issue. However, you have some concern that it could develop into one.

Reflection – very good

Pros, Cons, and Ambivalence – very good

Client: You said assessment. That's a good word. That's actually kinda what I'm trying to do here.

Clinician: Try to figure some stuff out for yourself. And you mentioned your girlfriend having a concern about relying on it in the evening. What other concerns does she have or that you have?

Reflection, Fostering Collaboration, Open Question, Motivation to Change

# Rating Forms

- **Worksheet**
  - Use it to rate tape
- **Adherence and Competence Feedback Form**
  - Use it to give clinician performance feedback
- **MI Skills Development Plan**
  - Use it to affirm performance strengths and to target areas for skill improvement

| Rating Item | Frequency & Extensiveness | Skill Level Comments |
|---|---|---|
| 1. MOTIVATIONAL INTERVIEWING STYLE (p. 13) OR SPIRIT | Acceptable | |
| 2. OPEN-ENDED QUESTIONS (p. 16) | ⬇ ///// | |
| 3. REFLECTIVE STATEMENTS (p. 18) | ////////////// Ø | |
| 4. AFFIRMATION OF STRENGTHS (p. 20) AND CHANGE EFFORTS | | |
| 5. FOSTERING A COLLABORATIVE (p. 22) RELATIONSHIP | // | |
| 6. MOTIVATION TO CHANGE (p. 24) | / | |
| 7. DEVELOPING DISCREPENCIES (p. 26) | | |
| 8. PROS, CONS, AND AMBIVALENCE (p. 28) | / | |
| 9. CHANGE PLANNING DISCUSSION (p. 30) | | |
| 10. CLIENT-CENTERED PROBLEM (p. 32) DISCUSSION AND FEEDBACK | // | |

| MI Consistent Items | Adherence Rating | | | | | | | Competence Rating | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | NA | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| MI Style or Spirit | | | x | | | | | | | x | | | | | |
| Open-ended Questions | | | | | x | | | | | | | x | | | |
| Affirmations of Strengths & Self-efficacy | x | | | | | | | x | | | | | | | |
| Reflective Statements | | | | | | x | | | | | | x | | | |
| Fostering Collaboration | | | x | | | | | | | | | x | | | |
| Motivation to Change | | x | | | | | | | | | | x | | | |
| Developing Discrepancies | x | | | | | | | x | | | | | | | |
| Pros, Cons and Ambivalence | | x | | | | | | | | | | x | | | |
| Change Planning Discussion | x | | | | | | | x | | | | | | | |
| Client-centered Problem Discussion and Feedback | | | x | | | | | | | | x | | | | |

| MI Inconsistent Items | Adherence Rating | | | | | | | Competence Rating | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | NA | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Unsolicited Advice, Directions & Feedback | | | | | X | | | | | | X | | | | |
| Emphasize Abstinence | | X | | | | | | | | X | | | | | |
| Direct Confrontation | | X | | | | | | | | | X | | | | |
| Powerlessness, Loss of Control | X | | | | | | | X | | | | | | | |
| Asserting Authority | X | | | | | | | X | | | | | | | |
| Closed-ended Questions | | | | | | X | | | | | X | | | | |
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## Strengths Demonstrated in Session

1. Counselor strategically affirms a disgruntled client by reframing the client's behaviors (e.g., "I really appreciate your honesty in letting me know what upset you in group last week instead of bottling it up and possibly drinking again.")
2. Counselor is supportive throughout the interview and explores the client's dissatisfaction with treatment (i.e., rolls with resistance); this strategy helps the emotionally upset client become calmer and consider possible benefits of staying in the program.
3. Counselor summarizes client's multiple complaints about the "system" and redirects the discussion (i.e., shifts focus) back to his motivation for treatment participation.

## Skill Development

| MI Skill Targeted for Improvement | What specifically will be developed or improved? | How will the goal be reached? |
|---|---|---|
| ▪ Structure and organize client's ambivalence about treatment participation using a decisional balance activity. | • Use of the Pros and Cons decisional balance activity | • Review use of the Pros and Cons sheet.<br>• Role-play the client, with the counselor practicing the decisional balance activity. |
| • Reflecting ambivalence | • Use of double-sided reflections | • Review and model use of double-sided reflections.<br>• Have counselor practice using double-sided reflections when summarizing pro and con dimensions of the decisional balance in role-play. |

# Application to Practice

# MIA: STEP Utilization

1. Lots of uploads and views of materials on ATTC websites.
2. To date, 42 trainers have been trained; 9 trainers have held 11 MIA: STEP trainings, including about 400 supervisors.
3. Nationwide, there are 10 more trainings scheduled through August.
4. 11 more trainings are in the planning stages.
5. Mid Atlantic ATTC has launched the MIA: STEP listserv.
6. 3rd MIA: STEP training of trainers will be held June 4-6th following the Blending Conference (22 participants from ATTC and CTN).

# Applications to Practice

- Facilities learned to separate MI skill training from administrative/case management supervision.
- MI skill training (or other EBP) assumes proficient supervisor, hence investment in hiring and training supervisors is necessary
- Changing hiring practices to support MI (questions asked in interview or even skill demo)
- Investment in tape recorder and tapes or digital recorders in NC

# Applications to Practice

- Counselors reported performance anxiety with first tape review – challenge
- Ongoing group supervision is more efficient and effective for MI skill building purposes
- MI style supervision enhances learning
- Measuring skills (tape rating) is fundamental for competence enhancement
- By-product of counselors learning to tape rate is enhancement of their own knowledge and skills

# Is it working?

- ChangePoint engagement rate (attendance at intake and 1st two group sessions) is 88%, retention (90 days in treatment) is 78% and successful completion rate is 68%.
- Next step is computer based assessment; one more reason to use MI engagement strategies prior to data collection.
- NIDA Health Service Grant testing the effectiveness of MIA: STEP in impacting clinicians' use of MI and client outcomes.

MIA: STEP

# MIA:STEP

The MIA:STEP package is available in several forms:

1. Downloadable pdf version is at: www.nfattc.org, www.midattc.org, and www.nattc.org.
2. Print version plus CDs of tools and demonstration interviews will be available at www.nfattc.org and www.midattc.org
3. CD version only also available www.midattc.org

blending initiative
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# For more information

- Contact your regional ATTC (nattc.org)
- Get a copy of TAP 21A: DHHS Pub No. (SMA) 07-4243 or download from http://download.ncadi.samhsa.gov/Prevline/pdfs/tap21a.pdf