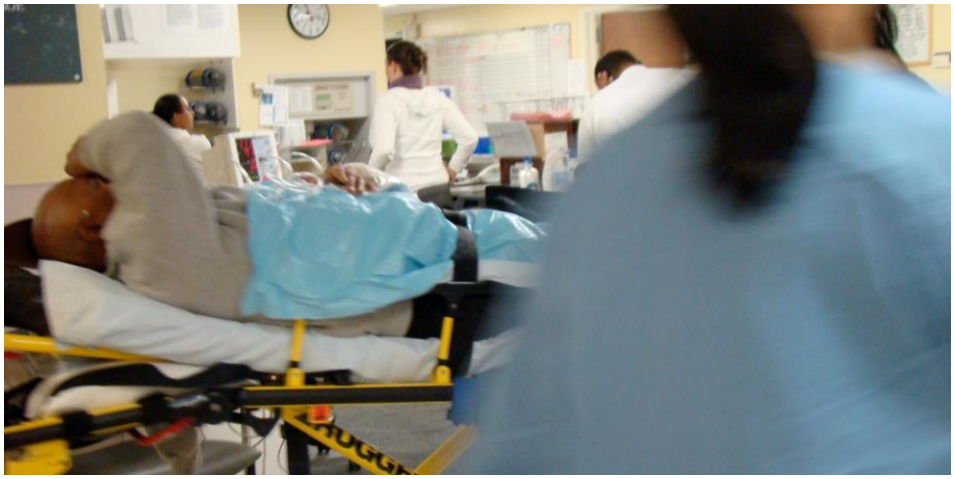
CTN 0047
SMART-ED

BRIEF INTERVENTION AND TELEPHONE BOOSTER THERAPY MANUAL



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Training Overview

INTRODUCTION

This manual is designed to be used as a guide for the delivery of the brief intervention (BI) and telephone booster sessions as part of the research protocol implemented in the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN) protocol 0047 Screening, Brief Intervention and Referral to Treatment in the Emergency Department (SMART-ED).

The BI and booster sessions are based on principles of motivational psychology and motivational interviewing style in which the interventionist attempts to mobilize in a systematic way the inherent resources for change that reside within the patient

This protocol involves one 30-minute BI session using the components in Motivational Enhancement Therapy (MET) delivered during the patient's visit to the ED as well as the two 15-minute booster calls, which will be delivered over the phone during the one month following the baseline assessment. Ideally, the first call will be within 3 days of the patient's discharge from the ED and the second call will be within 7 days after the first call.

The brief intervention, which will be conducted by interventionists in the emergency department, is based on motivational interviewing principles including feedback based on screening information, the FRAMES heuristic, and development of a change plan.

The goal of the first telephone booster session will be to re-engage and reinforce the change plan and support continuing efforts. The second telephone booster session will be a check-in session that reinforces positive changes and/or addresses barriers to treatment engagement.

This is an introductory training in the evidence-based clinical method of motivational interviewing (MI) and motivational enhancement therapy (MET).

- MI is the style we have chosen to use during the face-to-face and the telephone encounters with patients.
- MET is the structure we have chosen to follow during these patient encounters.

After orientation to the underlying spirit and principles of MI, practical exercises will help interventionists to strengthen empathy skills, recognize and elicit client change talk, and roll with resistance. The use of client assessment feedback in MET will be explained in detail; particularly as it relates to the assessments that will be conducted as part of the SMART-ED protocol.

The information in this manual was adapted from several sources, primarily Miller and Rollnick's (2002) *Motivational Interviewing: Preparing People to Change*.

TRAINING PLAN

Interventionists will attend a sixteen-hour workshop that will include didactic materials, demonstrations, and role play exercises to convey essential elements in the use of motivational interviewing. The first day of the workshop will begin by conveying an understanding of the principles, techniques, and style of Motivational Interviewing. During the second day, attendees will begin to learn how to use patient's individualized screening feedback in an MET approach. Exercises will be designed to assist attendees in utilizing all the skills that will be used in typical encounters with simulated clients for both the in-person and over the phone formats.

Following the training, interventionists will submit tapes with pilot study participants and will be certified on these practice patients. Providers will audiotape a session with an actual client in the ED. Providers will be asked to obtain proper consent from their client(s) prior to audiotaping the session. Following certification and protocol implementation, interventionists will receive ongoing feedback from supervisors, who will code audiotaped sessions to ensure continued treatment fidelity.

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Basic Reading on Motivational Interviewing

MI PHILOSOPHY

The three treatment sessions in the SMART-ED brief intervention and described in this manual are designed to build motivation to change and increase the likelihood that patients will engage in treatment. The style in which these sessions are delivered (MI), rather than the content of the material (MET), is the essential element. This client-centered, empathic but directive interaction is designed to elicit behavior change by exploring and resolving ambivalence. This style creates specific interviewing conditions known to inspire and encourage people to explore past behaviors and think differently about future behavior. We hope that many of the patients we serve may enjoy longer, healthier lives as a result of having such salient discussions beginning in the ED.

Motivational interviewing (MI) is first and foremost characterized by a facilitative way of being with another person. This approach requires that the interventionist relates to the client in a non-judgmental, collaborative manner, which is a philosophical stance requiring both skill and patience.

Miller and Rollnick (2002) have described this fundamental spirit as *collaborative, evocative,* and *respectful of autonomy*. MI involves a collaborative partnership, rather than a teacher-student, expert-recipient relationship. It is person-centered, very much attuned to the concerns and perspectives of the individual. MI is also evocative rather than prescriptive; the goal is to draw out that which is already present in the person. Within a human interaction, it is a process of calling forth from another that which is already there or is emergent. The underlying view is that "*You* have what you need," and together we will bring it forth. Finally, MI is respectful of the individual's autonomy, the human capacity and right to choose his or her own course.

Working in the MI style, the therapist acts as a collaborator or guide rather than an expert or authority figure. While certain techniques may be useful in understanding how to deliver the interventions, the hallmark of MET therapy are these collaborative, facilitative and respectful interactions that predominate the therapy session. The directive part of the motivational approach is one where the therapist chooses what to reflect back to the client, and also uses different strategies in different moments of the session to deal with resistance. MET therapists do not have a neutral stance about change and outcome, but rather they are trained to understand the importance of respecting an individual's right to not be ready for change, and the pace at which the individual moves through the process of change.

TWO PHASES OF MI:

Phase I:

Agree to discuss a target behavior
Set the stage for tone & style
Elicit patient's views on the behavior
Summarize those views while highlighting change talk

Phase II:

Discuss change options from a menu of options
Identify personal goals for each drug discussed
Give advice when appropriate
Summarize, arrange any referrals
Close on good terms

THE SPIRIT OF MOTIVATIONAL INTERVIEWING

Definition:

Motivational interviewing is a directive, patient-centered counseling style for eliciting behavior change by helping patients to explore and resolve ambivalence.

The spirit of MI

1. Motivation to change is elicited from the patient, and not imposed from without.

2. It is the patient's task, not the counselor's, to articulate and resolve his or her ambivalence.

3. Direct persuasion is not an effective method for resolving ambivalence.

4. The counseling style is generally a quiet and eliciting one.

5. The counselor is directive in helping the patient to examine and resolve ambivalence.

6. Readiness to change is not a patient trait, but a fluctuating product of interpersonal interaction.

7. The therapeutic relationship is more like a partnership or companionship than expert/recipient roles.

FOUR FUNDAMENTAL PRINCIPLES

EXPRESS EMPATHY

Acceptance facilitates change
Skillful reflective listening is fundamental
Ambivalence is normal

DEVELOP DISCREPANCY

The patient, rather than the clinician, should present arguments for change
Change is motivated by a perceived discrepancy between present behavior and important personal goals or values

ROLL WITH RESISTANCE

Avoid arguing in favor of change
Resistance is not directly opposed
New perspectives are invited but not imposed
The patient is a primary source in finding answers and solutions
Resistance is a signal to respond differently

SUPPORT SELF-EFFICACY

Belief in the possibility of change is an important motivator
The patient, not the clinician, is responsible for choosing and carrying out a plan
The counselor's own belief in the person's ability to change becomes a self-fulfilling prophecy

FRAMES

In an analysis of clinical trials (Miller, Bien & Tonigan, 1993), six elements were identified that were often present in effective brief counseling. These can be remembered via the acronym FRAMES.

Feedback. Often effective brief counseling included something to help people take a close look at themselves, to take a kind of personal inventory. Usually this was in the form of personal feedback on a measure that allowed them to evaluate their own drinking and its consequences.

Responsibility. Effective brief counseling often emphasized the person's responsibility for change. Rather than disempowering the person, the message was in essence, "It's up to you what you will do. You can certainly continue on as you have been, or you can do something different . No one else can do or decide this for you. It's really in your hands." This is done without any shade of shaming, blaming or sarcasm. Rather it is the pronouncement of a truth; that the power for change does not lie in the hands of the counselor.

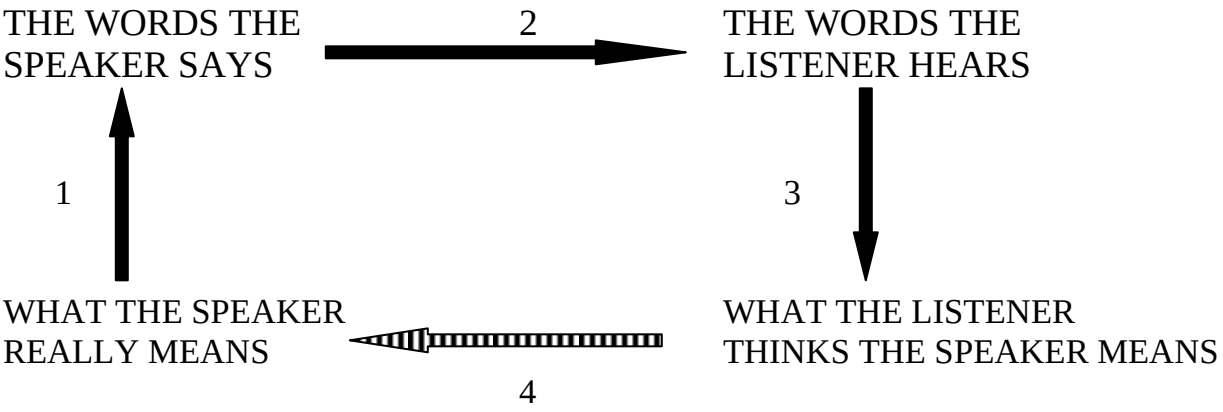
Advice. Nevertheless, every effective brief intervention included clear advice, a recommendation or encouragement that sits side-by-side with the truth that it's up to the person to decide what to do. One useful way to offer advice is first to ask permission to do so: for example, "Would it be all right if I told you some things that others have found helpful?"

Menu. Often the person was provided not with a single recommendation, but rather with a menu of options. Often there is not just one way to move forward, but a variety of possibilities. Offering the person a menu of options elicits the mental set of choosing among them, whereas offering one option elicits the mental set of evaluating what is wrong with the suggestion.

Empathy. Whenever the relationship style of the counselor was described, effective brief interventions were characterized by an empathic, supportive, facilitative approach. Rather than telling, the counselor was listening to and interested in hearing the person's own perspectives, ideas and concerns.

Support. Finally, effective counselors supported the person's confidence in the possibility of change, which psychologists speak of as "self efficacy." The general point here is that change can and does happen, and there are particular ways in which to open oneself to it.

COMMUNICATION MODEL FROM THOMAS GORDON



Communication can go wrong because:

(1) The speaker does not say exactly what is meant
(2) The listener did not hear the words correctly
(3) The listener gives a different interpretation to what the words mean

The process of **reflective listening** is meant to connect the bottom two boxes (4), to check on whether "what the listener thinks the speaker means" is the same as "what the speaker means."

OPEN QUESTIONS

In the early phases of motivational interviewing, the client should do most of the talking, while the counselor listens carefully and encourages expression. One way to do this is to ask open questions: questions that do not invite brief answers.

So what are some open questions that you might ask in order to explore these sources of motivation? Here are some examples:

Desire

What would you like to be different in your life a year from now?
Tell me more about this feeling you have of wanting to feel clear headed.
What do you hope will happen through our work together?
Which of these do you think you might enjoy the most?

Ability

Of these options that we've discussed, which seem most possible for you?
Tell me what you've done in the past that worked for you.
What makes you think that you can stick with this? How would you do it?
How confident are you that this is right for you?

AFFIRMATIONS

Directly affirming and supporting the client during the counseling process is another way of building rapport and reinforcing open exploration. This can be done as compliments or statements of appreciation and understanding.

Examples:

Thanks for talking with me today.
That's a good suggestion.
You're clearly a resourceful person, to cope with such difficulties for so long.
You seem like the type of person who really sticks to their goals.
I enjoyed talking with you today, and getting to know you a bit.

REFLECTIVE LISTENING

Fundamental to MI is the artful and learnable skill of reflective listening, which Carl Rogers termed *accurate empathy* and his student, Thomas Gordon, called *active listening (Gordon, 1970).* In this way of being with people, the listener is far from passive. It is hard work, much harder than asking questions.

The essence of a good reflective listening response is *a statement that makes a guess about the meaning of what the person has said and helps the person continue on in exploring that meaning*.

A reflection is a statement.

A reflective listening response is best posed as a statement rather than a question:

Do you mean that you're wondering if you're using too much cocaine? (Question)
You're wondering if you're using too much cocaine? (Question - voice inflects up at end)
You're wondering if you're using too much cocaine. (Reflection - a statement)

A reflection makes a guess about the person's meaning

A reflective listening statement is the testing of a hypothesis about what the person means. When you can't even guess, the simplest reflection is a direct repetition of part or all of what the person said, adding nothing. At this level there is no guess involved, and there is a danger of the illusion of understanding. Nevertheless, even this level of reflection often encourages the person to continue talking and to clarify meaning.

A somewhat better reflection is to rephrase what the person said, without going much beyond it. The usual method is to find a synonym for a key word in the person's statement, and substitute in the synonym on reflection.

Patient:	I'm not sure why I'm calling.
Counselor:	You're not sure why you're calling. (Repetition)
	You're wondering why you're calling. (Rephrase)

A more complex reflection, the *paraphrase* goes beyond simple rephrase, and makes a guess as to the yet-unspoken meaning. One way to think about this is *hypothesis-testing* about the person's meaning. Another way to think about paraphrase is *continuing the paragraph*, guessing what might be the *next* statement that follows from what the person has said.

Patient:	I'm not sure why I'm calling.
Counselor:	You're uncertain why you called. (Rephrase)
	This is something new for you. (Paraphrase)

You're not sure what to expect. (Paraphrase)
You're wondering if it was a good idea.(Paraphrase)
Talking to me makes you nervous. (Paraphrase)

Sometimes *metaphor* or *simile* can be an effective paraphrase, particularly if you draw on images to which the person relates.

Patient: I'm not sure why I called.
Counselor: It's kind of like calling out into a dark hall. (Simile)
You're in the dark about what you're doing. (Metaphor)

Note that all of these are statements rather than questions, and all are guesses about the possible meaning of what the person said.

A reflection helps the person continue exploring

Here is the test of a good reflection. If the person continues with the line of exploration, going a little further or deeper to explain his or her meaning, it was OK. If the person stops, changes the subject, or backs away from what was previously said, it may not have been a good reflection.

Notice that there is no penalty for "missing," for guessing wrongly about what the person meant. If it's a good reflective listening statement but incorrect, people usually just continue on by explaining what they did mean. Right or wrong, either way you learn more by offering a reflection.

The style of MI relies heavily on accurate empathy. As a rule of thumb, you should be offering two to three reflective listening statements for each question you ask. To do so, avoid asking two or three questions in a row. Ask one good question, then reflect, reflect, reflect. There are five general motivational themes to guide you in asking evocative open questions that foster movement. These have to do with the person's Desire, Ability, Reasons, Need, and Commitment to change.

Desire. First, there is desire for change. Desire is reflected in verbs like want, wish, willing, hope, and like.

Ability. Second, there is language about one's ability to do what is needed. Perceived ability is expressed in words like can, could, and able. The phrase, "I wish I could" bespeaks desire but lack of confidence in ability.

Reasons. Third, there are specific reasons or advantages for change, for putting time and effort into change. Usually these have to do with particular desirable outcomes that the person expects to follow from the change, or the avoidance of undesirable outcomes.

Need. Fourth, motivation for change is reflected in statements of general need. "I've *got* to do something." "I really *need* to be more disciplined about this." "It's very *important* to me to attend to my physical health."

These four, remembered via the acronym DARN, are the engines of change. Research indicates, however, that change is less likely to happen unless one hears *commitment*.

Commitment. Here the person is expressing a verbal intention, commitment, or promise to do something. There are many ways of expressing this that vary in strength. Weak (but nonetheless important) commitments include, "I'll think about it," "I'll consider it," or "I'll try." The latter of these hints at doubt as to *ability*. Like "I wish I could," the phrase "I'll try" bespeaks some willingness, but a lack of confidence. Stronger commitment is expressed in phrases like, "I promise," "I guarantee," and simply "I will."

Research indicates that the more people explore Desire, Ability, Reasons and Need, the closer they move to making a commitment and trying out a change.

LEVELS OF REFLECTION

Level 1: Repeat

These reflections add nothing at all to what the client has said, but simply repeat or restate it using some or all of the same words.

Client: This has been a rough week for me. I came that close to using when my ex and I had an argument. I think I'm feeling kind of down.

Level 1: It's been a rough for you this week, and you're feeling down.

Level 2: Rephrase

These reflections stay close to what the client has said, but slightly rephrase it, usually by substituting a synonym. It is the same thing said by the client, but in a slightly different way.

Level 2: You're feeling pretty discouraged.

Level 3: Paraphrase

These reflections change or add to what the client has said in a significant way, to infer the client's *meaning.* The therapist is saying something that the client has not yet stated directly. Level three reflections include (but are not means limited to):

Continuing the Paragraph – in which the therapist anticipates the next statement that has not yet been expressed by the client. *(It scared you, how close you came to using again.)*

Amplified Reflection – in which content offered by the client is exaggerated, increased in intensity, overstated, or otherwise reflected in a manner that amplifies it. *(It's been such a hard week that you're really demoralized.*

Double-side Reflection – in which both sides of ambivalence are contained in a single reflective response. *(You've been doing really well these past few weeks, and then this week has been harder.)*

Metaphor and Simile – used as a reflection. *(It's like the bridge nearly collapsed this week.)*

Reflection of Feeling that was not directly verbalized by the client before. *(This really surprised you.)*

Summary – which gathers together at least two different client statements, at least one of which was not contained in the immediately preceding client statement. *(You said before that you often feel like using after you get into an argument or conflict with somebody important to you, and it sounds like this was another example.)*

SUMMARIZE

Summary statements serve to link together and reinforce material that has been discussed. There are at least three types of summaries.

Collecting summary:
Offered during the process of exploration, particularly after hearing several change talk themes. These are usually short (just a few sentences), and should continue rather than interrupt the client's momentum. The purpose is to draw together change talk and invite the person to keep going. It is useful to end with "What else?"

> Example: "So this heart attack has left you feeling vulnerable. It's not dying that scares you, really. What worries you is being only half alive — living disabled or being a burden to your family. In terms of things you want to live for, you mentioned seeing your children grow up and to continue your work, which is meaningful to you. What else?"

Linking summary:
Ties together something the client has just said with material from earlier. Purpose is to encourage the client to reflect on the relationship between two or more previously discussed items. Can be especially helpful in clarifying ambivalence. It's better to use "and" rather than "but" to link discrepant components ("and" emphasizes the simultaneous presence of both).

> Example: "On the one hand, you're somewhat worried about the possible long-term effects of your diabetes if you don't manage it well. The ER visit a while back also scared you, and you realized that if no one had found you, your children could be without a father. On the other hand, you're young and you feel fairly healthy most of the time. You enjoy eating what you like, and the long-term consequences seem far away."

Transitional summary:
Marks a shift from one focus to another, such as the wrap-up at the end of a session, or a transition from Phase 1 to Phase 2. Remember that you are deciding what to include and emphasize, not everything that has transpired. Transitional summaries are typically somewhat longer than linking or collecting summaries.

> Example: "OK, we're almost out of time, so I'd like to pull together what's been said so far so we can figure out where to go from here. Your husband is concerned about your drinking and marijuana smoking. You've been very open about exploring this, and I appreciate that. You mentioned several problems in your life that could be related to alcohol and marijuana, such as… When you were arrested that time two years ago, your breath test showed that you were over 0.20, which is really quite intoxicated, even though you didn't feel very drunk. On the other hand, it helps you to relax and… So you're not sure what to do at this point. Is that a fair summary? What have I missed?"

CHANGE TALK

Change Talk is statements made by clients in favor of change.

RECOGNIZING CHANGE TALK

Some clients may come to the first session, or when contacted in the Emergency Department, with little thought about a need to change. Others may be ambivalent about making a change, while still others come already voicing an intention to change, and need relatively little motivation building. While Phase 1 of MI involved building intrinsic motivation to change, there comes a point when it is time to shift the approach to strengthening commitment to a change plan (Phase 2). Once a person has reached a point of readiness, there is usually a window of time during which change should be initiated. How long this window stays open will vary widely. It is important to recognize when the window is open in order to help move the client forward. Recognizing change talk is crucial in order to not rush a client toward a change plan before he or she is ready, and to not continue building motivation to change when the client is ready for action. A number of cues have been described to provide an idea of when to switch from Phase 1 to Phase 2 strategies. Not all of these will happen in all or even most cases, but they are some indicators of readiness for change.

Desire What makes you really do want to change?

Ability I know I can do it if I made up my mind.
I've quit before.
I know what I need to do.

Reasons What might be some of the good things about cutting down on your drug use?
You decided to sign up for this study. What were your reasons?
How might this change you for the better?

Need How important is it to you to stop using drugs?
What is it that you need to do?
What do you think you have to do?

Commitment So what have you decided to do?
What do you intend to do to make that happen?
Will you do that this week? (A closed question, but OK here)
What are you going to do?
What do you plan to do?
What are you prepared to do?
What are you ready to do this week?

In general, explore DARN elements first, rather than asking for commitment too early. As your work progresses, you will develop a sense of when and what the person is ready to commit to, to do.

SIGNS OF READINESS FOR CHANGE

- Little or no resistance
- Decreased discussion about the problem
- Resolve – patient appears to have reached some kind of resolution, and may seem more peaceful, relaxed, calm or settled.
- Envisioning – patient is talking about how their life will be different after a change, or discusses advantages of changing, reasons why they simply must make a change.
- Experimenting –the patient may have begun to consider or experiment with possible change actions since previous session
- Increased change talk

  There are four main categories of change talk, which have been described by Miller and Rollnick:

  Disadvantages of status quo

  Maybe I have been taking a lot of risks.
  In the long run, I can't really keep this up.
  I'm sick of waking up with a hangover.

  Advantages of change

  I'd probably feel better.
  I wouldn't have to worry about DUIs any more.
  Maybe my wife would get off my back.

  Optimism about change

  I think I could probably do it if I wanted to.
  I quit smoking a few years ago. That was tough, but I did it.

  Intention to change

  I've got to do something.
  I'm going to get through this.
  It's time to think about quitting.

In addition to the above four categories, change talk may be present in the form of statements of desire, ability, reasons, need, and commitment (which can be remembered by the acronym DARN-C).

Desire – indicates a wanting, wishing, or willingness for change.

I want to be sober, period.
I really wish I could cut down.
I just want to wake up without a hangover.
Part of me wants to change this.
I sort of wish things were different

Ability – indicates personal perceptions of capability or possibility of change

I'm positive that I could quit.
Very likely, I could do it if I tried.
I can do it.
I think I have it in me.

I might be able to.

Reason –specifies a particular rationale, basis, incentive, or motive for change

I definitely can't afford to get another DWI.

I'm right on the brink of losing my job and my retirement.

If I lose a lot of money again, my husband is going to divorce me.

I don't want to set the wrong example for my kids.

I'm sort of embarrassed when I can't remember what I did.

Need – indicates a necessity, urgency, or requirement for change

I definitely have to get sober.

I really have to quit getting messed up like this.

I have to clean up my act.

I probably need to do something about my drinking.

I guess I need to cut down.

Commitment – implies an agreement, intention, or obligation to change

I guarantee I'll quit.

I'm prepared to stop drinking.

I plan to cut down.

I intend to change.

I'll try to strop drinking and driving.

NOTE: The task of the therapist is to be attuned to the fluctuating level of patient readiness to best determine when to switch from Phase 1 to Phase 2 of motivational interviewing. When there are such signs of readiness, it may be time to shift direction to the new goal of strengthening commitment (Phase 2).

LEVEL OF READINESS

*Patient is ready → Clinician solicits the patient's previous experience in attempting to quit. Both patient and clinician brainstorm alternatives. The clinician encourages the patient to choose a course of action and decide how to accomplish change.

*Patient is unsure → Clinician proposes further assessment. Discussing pros and cons helps the patient recognize the problem behavior.

*Patient is not ready → Clinician expresses concern and refers to sources of help. Providing feedback can raise awareness of the medical aspects of substance use and consequences of continued use.

ELICTING CHANGE TALK

1. Ask evocative questions
   Ask open questions, the answer to which is change talk. (What would have to happen for it to become much more important for you? What concerns do you have about [current behavior]? If you were to change, what would it be like?)

2. Explore Decisional Balance
   Ask first for the good things about status quo, then ask for the not-so-good things ("pros and cons").

3. Ask for Elaboration
   When a change talk theme emerges, ask for more detail. In what ways?

4. Ask for Examples
   When a change talk theme emerges, ask for specific examples. When was the last time that happened? Give me an example. What else?

5. Query Extremes
   What are the worst things that might happen if you don't make a change? What are the best things that might happen if you do make this change?

6. Look Backward
   Ask about a time before the current concern emerged. How were things better, different?

7. Look Forward
   Ask what may happen if things continue as they are (status quo). Try the miracle question: If you were 100% successful in making the changes you want, what would be different? How would you like your life to be five years from now?

8. Explore Goals and Values
   Explore the person's short-term and long-term goals. Ask about what the person's guiding values are. What do they want in life? Ask how the behavior in question fits in with the goals or values.

EVOCATIVE QUESTIONS

1. Disadvantages of the status quo
   - What worries you about your current situation?
   - What makes you think that you need to do something about your blood pressure?
   - What difficulties or hassles have you had in relation to your drug use?
   - What is there about your drinking that you or other people might see as reasons for concern?
   - In what ways does this concern you?
   - How has this stopped you from doing what you want to do in life?
   - What do you think will happen if you don't change anything?

2. Advantages of change
   - How would you like for things to be different?
   - What would be the good things about losing weight?
   - What would you like your life to be like 5 years from now?
   - If you could make this change immediately, by magic, how might things be better for you?
   - The fact that you're here indicates that at least part of you thinks it's time to do something. What are the main reasons you see for making a change?
   - What would be the advantages of making this change?

3. Optimism about change
   - What makes you think that if you did decide to make a change, you could do it?
   - What encourages you that you can change if you want to?
   - What do you think would work for you, if you decided to change?
   - When else in your life have you made a significant change like this? How did you do it?
   - How confident are you that you can make this change?
   - Who could offer you helpful support in making this change?

4. Intention to change
   - What are you thinking about your gambling at this point?
   - I can see that you're feeling stuck at the moment. What's going to have to change?
   - What do you think you might do?
   - How important is this to you? How much do you want to do this?
   - What would you be willing to try?
   - Of the options I've mentioned, which one sounds like it fits you best?
   - Never mind the "how" for right now – what do you want to have happen?
   - So what do you intend to do?

RULERS

It is useful in understanding a person's ambivalence to know his or her perceptions of both importance and confidence. Both should be addressed, because they are both components of intrinsic motivation for change. One simple method involves the use of rulers with gradations from 1 to 10 for each dimension.

Importance:
"How important would you say it is for you to _____? On a scale from 1 to 10, where 1 is not at all important, and 10 is extremely important, where would you say you are?

1	2	3	4	5	6	7	8	9	10
Not at all Important									Extremely Important

This can be followed up with two questions:

"What makes you a _____ and not a 1?"
This question pulls for change talk, as it encourages the patient to verbalize any reasons it may be important to make a change.

"What would it take for you to go from _____ to [a higher number]?"
This question is generally useful if the patient is not interested in changing at the moment, but indicates he or she may change in the future. In other words, the question encourages reflection on the idea "it's not bad enough to change now, but if _____ happens, I should change."

Confidence:
"How confident are you that if you decided to _____, you could do it? On a scale from 1 to 10, where 1 is not at all confident, and 10 is extremely confident, where would you say you are?

1	2	3	4	5	6	7	8	9	10
Not at all Confident									Extremely Confident

This can be followed up with two questions:

"What makes you a _____ and not a 1?"
This question pulls for confidence talk, eliciting from the patient reasons he or she believes in his or her ability to make a change.

"What would it take for you to go from _____ to [a higher number]?"
This question is generally useful if the patient is not is somewhat low in confidence. This may elicit ideas of other resources or sources of strength.

CONFIDENCE AND IMPORTANCE

If importance is low…

You can use any of the methods from "eliciting change talk"

- Asking evocative questions
- Using the importance ruler
- Using the decisional balance
- Elaborating
- Querying Extremes
- Looking Backward / Looking Forward
- Exploring Goals and Values

There are also useful questions to ask:

- What would have to happen for it to become much more important for you?
- What would more your importance score from x to y?
- What concerns do you have about [current behavior]?
- If you were to change, what would it be like?

If confidence is low…

Here is a list of useful questions to ask:

- What would make you more confident about making these changes?
- Why have you given yourself such a high score on confidence?
- How could you move up higher, so that your score goes from x to y?
- How can I help you succeed?
- Is there anything you found helpful in any previous attempts to change?
- What have you learned from the way things went wrong the last time you tried?
- Are there ways you know that have been successful for other people?
- What are some of the practical things you would need to do to achieve this goal?
- Is there anything you can think of that would help you feel more confident?

GIVING INFORMATION AND ADVICE

1. Permission. Particularly as the interview progresses toward specific action, you are likely to be asked for your opinion and advice, for your professional expertise. The general principle in offering information and advice is to do so *with permission*. If the person asks for your opinion, you have permission to give it. If the person has not explicitly asked for information or advice, then you should ask permission before offering it.

Would it be all right if I suggested some things that have worked for other people?

There is one thing I'm concerned about with your plan. May I tell you?

2. Ask-Provide-Ask. A second good practice in providing advice or information is to make it a two-way process. The formula here is Ask-Provide-Ask. In the case of information, you might first ask what the person already knows about the topic. For example:

Patient: How do people get sober?
Counselor: There are many ways. What ways do you already know about?

Patient: How do people make time for meetings?
Counselor: I wonder what ideas you have for how you might make time?

As usual, after asking an open question follow up with reflective listening and "what else" eliciting. Sometimes after the person responds thoroughly to this asking, it is no longer necessary for you to provide input. Usually, though, the next step is for you to provide the information or advice that was requested.

There are actually quite a few different ways people get help, and chances are you'll find that some are better for you than others. Let me tell you about a few different ones I know about...
It really does help to find a regular time for meetings, to build it into your schedule like exercising. It's pretty common for busy people to feel like there's no place to fit it in, but I can suggest some things that have worked for other people. . .

Then ask for the person's response to what you have provided. Ask-Provide-Ask.
Of these programs that I've described, which ones sound most appropriate for you? What do you think?

Those are just a few ways that people have fit meetings into busy lives. How do you think you might do it?

3. Menu of Options. Finally, when offering suggestions it is usually better to provide several options instead of suggesting only one. When a counselor makes a single suggestion, a normal response is to think about (and say) what's wrong with it. When you offer several suggestions you provide a different mental set: to choose among them the one(s) that seem most appropriate.

AGENDA SETTING

The process of negotiating behavior change works best when addressing one specific behavior at a time, rather than attempting to negotiate "a healthier lifestyle in general." A patient's readiness to change will vary from one behavior to another. When there is a range of behaviors that could be discussed it is essential to prioritize and focus upon one clear objective. This makes the whole process more manageable. Agenda setting allows you and the patient to decide together what to talk about.

How to do it

The aim is to be open and honest about your agenda, to understand the patient's agenda, and to help the patient select a behavior, if appropriate. The practitioner's behavior and tone of voice should reflect an attitude of curiosity about what the patient really wants to talk about, and can often be done by asking a series of open questions. The use of an agenda-setting chart can help in this process. For example:

> *"On the questionnaire you filled out, there were several substances that we could talk about. How do you feel about these? Are you ready to think about changing any of them? What do you think? What would you like to talk about today?"*

> *"On the questionnaire you filled out, there were several substances that we could talk about You will be the best judge of what to consider changing. Are there any that you think we could talk about?*

PHASE TWO:
STRENGTHENING COMMITMENT TO CHANGE

While Phase 1 of motivational interviewing involves building intrinsic motivation for change, there comes a point when it is time to shift focus to strengthening commitment to a change plan.

Timing:

While there are no exact prescriptions for when to switch from Phase 1 to Phase 2, there are signs to use as guidelines. For example:

- Decreased resistance
- Decreased discussion about the problem
- Resolve
- Increased change talk
- Questions about change
- Envisioning
- Experimenting

Hazards:

There are several hazards to be aware of when transitioning from Phase 1 (building motivation) to Phase 2 (strengthening motivation to change).

Underestimating ambivalence. People often begin action toward change while still experiencing a fair amount of ambivalence. Be careful not to become too overeager at the first signs of a shift toward change. Ambivalence does not disappear just because the change process has begun.

Overprescription. Remember the concept of collaboration in the spirit of motivational interviewing. It can be tempting to "take over" the process of change and be overly directive; remind yourself that the emphasis on personal responsibility and choice extends to Phase 2 and the negotiation of change strategies.

Insufficient direction. This is the opposite risk: being nondirective and providing too little help, leaving the patient to flounder. The question "What can I do?" is better answered in Phase 2 by a menu of alternatives rather than by reflective listening ("You're not sure where to go from here," is not likely to be helpful at this point.

Initiating Phase 2:

Recapitulation. Remember the idea of a transitional summary: to mark a transition from Phase 1 to Phase 2. You are deciding what to include and emphasize, not everything that has transpired. Transitional summaries are typically somewhat longer other summaries, and are meant to have the effect of drawing Phase 1 to a close. This often leads directly to

a key question.

Key questions. A key question is an open question that elicits from the client what they want and plan to do. Examples:
"What changes, if any, are you thinking about making?"
What happens next?"
"What could you do at this point?"

Meet answers to key questions with reflective listening to clarify the client's thoughts and plans, and to encourage future exploration. Reflection can be used slectively to reinforce change talk and diminish resistance.

Giving information and advice. There are two circumstances in which it is appropriate within motivational interviewing to give information and advice: when the client asks for it, or with the client's permission. A clinician should always elicit the client's own ideas on the subject before providing information or advice. It is generally helpful to offer several ideas (a menu) rather than just one or two.

Negotiating an Action/Change Plan:

Setting goals. The clinician assists the client in considering and selecting realistic, specific goals.

Considering change options. It is useful to generate a range of options when considering possible methods of achieving the chosen goals. Elicit ideas first from then client, then offer suggestions with permission. The client then has a variety of methods from which to choose.

Arriving at a plan. It can be useful to fill in a written change plan, summarizing what it is that the client plans to do. Using a change plan worksheet is often helpful.

Eliciting commitment. Once the plan is in place, the clinician should look for the client's approval of and assent to the plan. Essentially you are asking, "Is this what you want to do?" Remember that if the person is not quite ready to make a commitment, do not press.

How to do a BI

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INITIAL SESSION MECHANICS

All initial sessions will be conducted in a private space in the ED.

**All sessions are to be tape recorded from beginning to end, except if a patient requests that the tape recorder be turned off for a period of time during a session. At the first session, remind the patient, in your own words, that tape recording is a routine part of the study, and that tapes are used both for research purposes and to ensure that the intervention is being delivered in accordance with the protocol. This should not be a surprise because it is specified in the consent form that they signed, and we will review this condition in the consent interview.

**We will provide you with a tape recorder to use in audiotaping sessions. Please ensure, given the space that you are using, that the tape recorder and microphone are placed so that both your voice and the patient's will be clearly audible on the tape. We will also provide the audiotapes that you need. Use one audiotape per session, and on each tape clearly mark the Participant ID Number, the Session Number, and the date.

***After your session, complete a Session Record Form. Please handle and store all tapes and forms with utmost security in order to protect patient confidentiality. The loss of an audiotape would be a serious breach of confidentiality.

ED BRIEF INTERVENTION

Approximately 30 minutes

1. STRUCTURING STATEMENT AND AGENDA SETTING

- *If it's okay with you, I would like to discuss your use of (drug) so I can better understand your perspective. Would that be okay?*
- *I'm not here to tell you how to live your life or try to persuade you to change anything you're not ready to change, okay?*
- *I'm here to discuss what, if anything, **you** may want to change about your use of drugs*
- *We will have about 30 minutes together.*
- *Identify target substance*

2. OPEN MOTIVATIONAL INTERVIEWING:

- *Listen, build rapport, support patient, gain better understanding of the patient's situation*
- *Use OARS throughout*
- *Importance and confidence rulers*
  - *Explore importance*
  - *Build confidence*
- *What are some of the things you like about drug use? (What are some of the not so good things?)*
- *Tell me about a typical day. How does [target drug] fit in?*

3. GIVE PERSONALIZED FEEDBACK:

- *I wonder if you'd be interested in seeing how your alcohol/drug use compares to average use?*
- *Give scores/feedback*
- *Elicit patient's reactions*

4. ELICIT CHANGE TALK & CLARIFY GOALS:

- *Use questions to evoke change talk*
- *Explore goals and values*

5. DISCUSS AN ACTION PLAN:

- *Be careful of hazards: over-prescription, underestimating ambivalence, insufficient direction*
- *Consider range of change options*
- *Problem solving (in MI style)*
- *How would you feel about talking with someone on the phone about this a few more times?*
- *There are lots of promising ways to reach your goal. What do you think you'll do?*
- *So is that something you're willing to commit to doing?*
- *What do you think you'll do?*

6. CLOSE ON GOOD TERMS:

- *Don't push for change*
- *Summarize statements in favor of change*
- *Summarize their goal*
- *Summarize what action they agreed to take (if any)*
- *Emphasize the patient's strengths*
- *Elicit commitment if appropriate*
- *Thank the patient for speaking with you (affirm and voice confidence)*

BRIEF INTERVENTION OUTLINE

Structuring Statement

At the beginning of the session, offer a structuring statement to give your patient clear expectations about your work together. Here are some key points to cover:

1. We will meet today and after you leave the hospital, you can have up to two phone sessions.
2. All of our calls and our time together today will be individual and confidential, and they are free of charge.
3. Sessions will vary in length, but normally will be between 20-30 minutes.
4. As indicated in the consent form you signed, we audiotape record all sessions. This is done for research purposes. If, however, there is any point at which you want to discuss something off tape, we can turn the recorder off for that part of a session.
5. What we talk about here is strictly confidential, and we carefully protect your anonymity and privacy. The director of this study obtained a special certificate of confidentiality that even protects your records from subpoena by any court.
6. If I do my job well, I will not do most of the talking. This is not about my telling you what to do. Rather I will be listening quite a lot to your own experience

After your structuring statement, ask, "How does that sound to you? What questions do you have that I can answer before we get started?" [Not, "Do you have any questions?"]

Open Motivational Interviewing

Most of the rest of the first session should consist primarily of motivational interviewing with regard to substance use based on the results of the screening and baseline assessment. The rhythm here is to ask an evocative open question and then listen, reflect, follow. Your goal is to understand, at a beginning level, how substance use fits into this person's life, the good and not so good things about their use, and how ready they are to change their use.

Remember to listen in particular for "flowers" – material that reflects openness to, hunger (desire or need) for, or reasons and ability to pursue change. Reflect and affirm these when you hear them. Offer periodic bouquet summaries of the flowers the person has offered, and then ask for more.

Also listen carefully to and reflect material from the other side of the patient's ambivalence about change: lack of desire or need, reasons for reluctance, perceived lack of ability or potential. An empathic reflection is usually the appropriate response, and these reluctances (leaves?) can be incorporated into your bouquets. Remember, though, that a bouquet should emphasize the flowers and not the leaves. The leaves and thorns are there as background in the context of flowers.

The facilitator is collecting flowers, seeds of motivation for change. This process would normally continue for most or all of the first session, at the end of which you offer a summary, a full bouquet that you offer back to the patient. It might sound like this.

> Let me see if I can draw together the things you've told me today, and you let me know if I leave out something important. I appreciate your helping me to understand your past and present with regard to your substance use, which will be very useful as we think together about the future.
>
> You grew up in a family where lots of people were using drugs around you. As you came into adolescence you began using drugs and alcohol a little bit, but never thought it was much of a problem. Something changed, though, and suddenly you realized you were using a lot more drugs every day than you thought, so you stopped for a while. So far so good? (Patient nods)
>
> So, for a while you had a really different life. Drugs weren't a part of you at all and you felt really good about how things were going. And then you met someone who used drugs a little bit and somehow you got caught back up in that. And now you're here at the hospital and what you really want is to have a new life, to stay away from drugs. You would like for the pain in your head to quiet down, and to feel that peace you had inside. You're not too sure how to get there. Besides going to NA meetings, which you've started doing, you aren't too sure what else you should be doing. You're curious, too, about other things that people do to get sober.
>
> What have I missed?

When the patient affirms your summary, you have a choice to make. Should you test the waters with regard to readiness? If you have been hearing some signs of readiness, you could try a key question right after this summary. One possible form of this is the "importance ruler":

> So let me ask you this. How important is changing your cocaine use to you at this point? On a scale from zero to ten, where zero is not at all important, and ten is extremely important, how important would you say it is?

And the follow-up question is:

> And why are you at a _____ and not zero? Why is this important to you?

Other possible key questions would be:

> So what are you thinking at this point about your cocaine use? or
>
> What about putting some time into this over the next few months?

How to do a Booster

BOOSTER SESSION MECHANICS

**All telephone booster sessions are to be tape recorded from beginning to end, except if a patient requests that the tape recorder be turned off for a period of time during a session. At the first session, remind the patient, in your own words, that tape recording is a routine part of the study, and that tapes are used both for research purposes and to ensure that the intervention is being delivered in accordance with the protocol. This should not be a surprise because it is specified in the consent form that they signed, and we will review this condition in the consent interview.

*** If the first call, let patient know you will be calling again within the month to check to see how they are doing and make logistic arrangements for the call

***After your session, complete the Brief Intervention Form if in the ED or the Booster Session Form if completing a booster session.

FOLLOW-UP BOOSTER SESSIONS

Up to 2 sessions
Approximately 20 minutes each

1. STRUCTURING STATEMENT AND CHECK IN

- *My name is ____ and I'm part of the study team. Is it okay with you if I begin by telling you what these booster sessions are?*
- *I'm here to continue the discussion you had with the counselor in the Emergency Department about what, if anything, you may want to change about your substance use.*
- *With regard to [target substance] how have things been for you since you left the ED?*
- *How have you been since we last talked? (if this is Booster #2).*
- *What have you been experiencing since the last time we talked?*
- *What has been happening this week, particularly with regard to your substance use?*

2. OPEN MOTIVATIONAL INTERVIEWING:

- *Listen, build rapport and support patient*
- *OARS throughout*
- *Elicit change talk*
- *Problem solving (in MI style) for obstacles patient has encountered*

3. DISCUSS an ACTION PLAN:

- *Where does this leave you?*
- *There are lots of promising ways to reach your goal. What do you think you'll do?*
- *So is that something you're willing to commit to doing?*
- *What do you think you'll do?*

4. CLOSE ON GOOD TERMS:

- *Don't push for change*
- *Summarize statements in favor of change*
- *Summarize their goal*
- *Summarize what action they agreed to take (if any)*
- *Emphasize the patient's strengths*
- *Note the agreement that was reached*
- *Thank the patient for speaking with you*

BOOSTER SESSION OUTLINE

Here is the outline of a typical follow-up booster session. You have flexible discretion in conducting your sessions, but generally sessions will follow this broad outline. The counseling style of motivational interviewing is to be maintained throughout your work with each patient. Sessions should not include counseling interventions other than motivational interviewing for substance use. The goal of the first session will be to re-engage the patient, reinforce the change plan, and support continuing efforts. The second session will be a check-in session and will reinforce changes that have been made and/or address barriers to treatment engagement. Your contract with the patient is to focus on substance use, and does not encompass therapy to address clinical problems such as depression, addiction, trauma, etc.

1. Check-in. This is a broad, open question asking how the patient has been since your last contact, what has been happening, with focus on the person's substance use. Here are a few examples:

> *How have you been doing since your visit to the Emergency Department (for an initial call)?*
> *How have you been since we last talked?*
> *What have you been experiencing since the last time we talked?*
> *What has been happening this week, particularly with regard to your substance use?*

Attend with reflective listening to what the patient has to offer, listening especially for themes that may guide your work together. Explore the patient's substance use by asking open (not closed) questions and following with reflections. There is a pitfall here, in that many patients would willingly spend the entire session recounting the details of their week to a good and sympathetic listener. Remember that the purpose of your time together is to explore ambivalence related to substance use, and it is your job to keep your sessions moving in this direction.

2. Check-back. The next step in most sessions is to check back on any negotiated actions from the following session. How did it go? What did the patient experience? What were the good things and the not-so-good things about their efforts? What problems or obstacles did the patient encounter? This deserves some time and focus, again through open questions and reflection. Ask permission before making suggestions or raising concerns.

3. Exploration. The check-back may point to areas of ambivalence to explore, things that would get in the way of change, successful changes the patient has made in the past. Again, adhere to the general counseling style of motivational interviewing.

4. Negotiation**.** Following from the patient's experience with actions since the last discussion and their goals, negotiate specific steps for the patient to pursue. This is neither one-sided prescription ("Do this in the next few days") nor completely unguided choice ("So what would you like to do in the next few days?"), but something in between. Use the style of motivational interviewing in negotiating practice, including:

> Open questions. What changes have they been successful in achieving in the past?

Reflective listening. Continue to use ample reflective listening, at least two reflections for each question you ask. Avoid the trap of relying heavily on questions, and evoke the person's own motivation through reflection.

Direction. This is not open-ended nondirective counseling. Your contract and focus is on substance use. If the person wanders off, gently bring him or her back to the task at hand, to focus on substance use. It is so unusual and rewarding to have an attentive and accepting listener, that patients will be inclined to process details of their daily life, family relationships, history, etc. Sometimes these details are quite pertinent to substance use, but at other times they are diversions from or even avoidance of a discussion of substance use. Use your judgment to keep focused.

5. Guidance. In exploring change, patients will need some guidance from you, right down to practical details (e.g., Where should I go? How do people get sober?) Help the person leave your session with a clear understanding of what to do.

Ask permission before giving guidance or direction, and frame your advice as suggestion or recommendation.

Would it be all right if I recommended . . .
Could I describe for you . . . .
Would you like to hear a little about . .
May I make a suggestion?

One useful form of guidance is to help the patient practice within your session. If the person is considering calling a referral source to find out about treatment options, have the person try out what they might say on the phone, and discuss the person's experience, difficulties, etc.

6. Commitment. If it is appropriate (remember: do not push for change), end this portion of your session by asking for commitment. Describe (or ask the patient to describe) what action (if any) the patient has chosen, and work out the specific details of when, where and how. Ask if this is acceptable. Then ask some version of a commitment question, to which you are looking for a "Yes" answer. Commitment questions are action-focused. For example:

Will you do that tomorrow?
Is that what you're going to do?
Do you intend to do that this weekend?
Are you prepared to do that in the next few days?

Commitment questions do not ask about desire, ability, reasons, or need, although these themes are related.

Is that what you want to do? (Desire)
Can you do that? (Ability)
Why do you want to do this? (Reasons)
Is this what you need to do? (Need)

A "yes" answer to such questions is not really a commitment. The essence of a commitment question is "*Will* you do this?"

When people answer a commitment question, they do so with varying levels of commitment strength. "I will" is strong commitment. "I'll try" or "I guess so" also signal commitment, but at a much lower level. Here are some examples of committing language, ranging from higher (5) to lower commitment (1).

Strength Levels of Committing Language

	4	3	2	1
I guarantee I will I promise I vow I shall I give my word I assure I dedicate myself I know	I am devoted to I pledge to I agree to I am prepared to I intend to I am ready to	I look forward to I consent to I plan to I resolve to I expect to I concede to I declare my intention to	I favor I endorse I believe I accept I volunteer I aim I aspire I propose I am predisposed I anticipate I predict I presume	I mean to I foresee I envisage I assume I bet I hope to I will risk I will try I think I will I suppose I will I imagine I will I suspect I will I contemplate I guess I will I wager

7. Closure. In closing a session, offer a summary reflection to gather and *celebrate* what has happened in the session, including what the patient has committed to do in the next few days. Ask if the person has any questions, or anything else that needs to be discussed before you finish. Schedule your next meeting.

In sum, a typical session will include:

1. Check-in
2. Check-back
3. Exploration
4. Negotiation
5. Guidance
6. Commitment
7. Closure

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Appendices

CHANGE PLAN WORKSHEET

The most important reasons why I want to make this change are:

My main goals for myself in making this change are:

I plan to do these things in order to accomplish my goals:

Specific action	When?

These are some possible obstacles to change, and how I could handle them:

Possible obstacle to change	How to respond

Other people could help me with change in these ways:

Person	Possible ways to help

I will know that my plan is working when I see these results:

BRIEF INTERVENTION CHECKLIST (SUPERVISORS AND CODERS TO USE)

- ❑ 1. Structuring statement and agenda setting

Notes:

- ❑ 2. Open motivational interviewing

Notes:

- ❑ 3. Give personalized feedback

Notes:

- ❑ 4. Elicit change talk and clarify goals

Notes:

- ❑ 5. Discuss an action plan

Notes:

- ❑ 6. Close on good terms

Notes:

BOOSTER CHECKLIST (SUPERVISORS AND CODERS TO USE)

- ❑ 1. Structuring statement and agenda setting

Notes:

- ❑ 2. Open motivational interviewing

Notes:

- ❑ 3. Discuss an action plan

Notes:

- ❑ 4. Close on good terms

Notes: