Motivational Interviewing

What is the practice?

Motivational interviewing (MI) is an evidence-based counseling approach. The original architects of the approach, Drs. William Miller and Steven Rollnick, define MI as a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion (Miller & Rollnick, 2013, p. 29).

Theoretically, the most robust examples of MI require the use of a relational skills component and a technical skills component (Miller & Rose, 2009). Combining the relational and the technical skills is crucial to MI efficacy. An MI practitioner cannot realize the fullest effect of the approach by simply asking open questions or reflecting. MI practitioners are intentionally demonstrating compassion, a sense of partnership, acceptance of the client through affirmations, accurate empathy, deliberate mentions of autonomy, and genuine curiosity about who the client is, what might motivate that person to change, and how the client thinks they can achieve that change.

What outcomes does this practice produce?

MI is beneficial for guiding individuals toward positive behavior changes. The intent of MI is to evoke from the client the motivation to change that the practitioner believes is present.

The original intent of MI was to help people with alcohol use disorders overcome their ambivalence about stopping or cutting down on their use. In the first published article describing this way of being and talking with clients, Dr. William Miller presented a practice that was in many ways the opposite of the most commonly used approaches of that time (Miller, 1983). Nearly 40 years later, research supports the effectiveness of MI across a broad range of problem behaviors. One significant and early finding was that MI does not have a dose-response requirement, and that even short sessions of MI can increase treatment engagement and adherence (Carroll, 2006).

What is the evidence for this practice?

The growing body of research in support of MI includes more than 250 randomized controlled trials and thousands of articles in peer-reviewed journals. The evidence spans multiple professions and client issues. Results of review studies show that MI is more effective than no treatment, standard care, or being on a waiting list before receiving the intervention (Miller and Rollnick, 2013). While the strongest evidence of benefit remains in substance use disorder (SUD) services (the initial application of MI), research indicates small to medium effect sizes for facilitating health-related behavioral changes across a wide variety of populations and practice settings (Lundahl, 2010).

How is this practice implemented?

In what contexts is this practice implemented (e.g., schools, clinical)?

MI is implemented in mental health and primary care settings, schools, and correctional institutions, and

in community supervision, coaching, social work, home visitation, and any organization where change happens.

What is the dosage of this practice (e.g., one-time training, six-week curriculum)?

MI is intended to be a brief intervention. There is no dose-response requirement, although MI is typically delivered in two to four sessions (Miller & Rollnick, 2013). A small amount of MI is likely to be more effective at moving a client towards change than lecturing, providing information without engagement, or premature goal-setting.

How is the practice delivered (e.g., online, in-person)?

MI can be delivered face-to-face, or via telephone or telehealth with an individual or with a group (Wager & Ingersoll, 2013).

What infrastructure or readiness is needed to implement this practice (e.g., capacity for data analysis, individual full-time equivalent [FTE])?

Full implementation of MI requires institutional support. MI practitioners need feedback and coaching to reach proficiency. Ongoing proficiency checks guard against practice drift. Practitioners might also benefit from continued practice sessions. Agencies may have to alter expectations to support this practice. Because MI is especially person-centered, agencies may need to relax expectations for goal setting or measurable achievements at each and every visit. MI is not intended to take longer, but allowing the client to reach their own autonomous decisions about change will likely result in better outcomes.

For which population(s) can this practice be implemented?

For which population(s) is this best or promising practice (BPP) intended? Has it been adapted for diverse groups? If so, which ones?

MI is intended to be used with any person who is ambivalent about changing their behavior. In that regard, it is not dependent on population type or diagnostic classification. MI has been applied by a broad range of practitioners across a broad range of persons needing help. No known limitations have been documented for age, race, sexuality and gender identity, religion, or ethnicity. The MI text (Miller and Rollnick, 2013), now in its third edition, has been translated into 55 languages.

Most recently, outcomes research has shown that it can be used with elementary school children.

For which populations is there evidence of effectiveness?

Evidence supports the effectiveness of MI with many populations. Applications of MI, still widely used in treatment to stop or reduce alcohol use, have moved well beyond this realm. Growing evidence supports the use of MI in shifting behaviors related to health (mental, physical, and dental), crime, education, parenting, employment, safe and secure housing, and finances.

With which specific populations has this practice been successfully implemented?

MI is a person-centered approach that relies on creating an engaging relationship with the individual. The spirit of MI guides practitioners to take a curious approach and make adjustments to the style based on individual needs. Because of its adaptability, MI is likely to be at least somewhat effective with most populations where the aim of the conversation is to consider change.

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For which populations, if any, is this practice NOT a good fit?

No definitive literature states that MI does not work at all with a particular population.

Who can implement this practice?

What expertise is needed to implement the practice?

People who want to gain competency in MI generally do so through a combination of didactic instruction of the material (e.g., workshops), reading, experiential practice (with feedback), and ongoing coaching. Outcomes are linked to the overall skill level of the clinician.

While the exact level of model fidelity required is unclear, the need to develop and maintain clinician skill is clear. Assuming clinician competency based on training alone is unrealistic. The feedback and coaching condition may be challenging for practitioners, but it is crucial. Because the individual components of MI appear to be simple common sense, practitioners may overestimate their mastery of the style. It is hard for people to report on what they didn't do. Thus, practitioners must engage in a series of coding and coaching trainings to assure fidelity (Schwalbe, 2014).

What specific training or certification is required to implement the practice?

At present, MI does not require a certification process. The MINT (the international Motivational Interviewing Network of Trainers) is currently developing criteria for delivering MI at a basic level.

While there is no certification of MI skillfulness, there are multiple well-validated instruments for assessing fidelity to the model. The Motivational Interviewing Treatment Integrity (MITI) Version 4.2.1 is the most commonly used instrument. With little training, a reviewer can assess whether or not a session qualifies as MI. The reviewer can clearly identify areas of success and those needing improvement. For more information about the tool, visit https://casaa.unm.edu/codinginst.html.

What costs are associated with delivering this practice?

MI is generally considered a low-cost approach given that it can be delivered in relatively few (2-4) sessions.

There are costs associated with practitioners using Motivational Interviewing to ensure fidelity. Costs are determined by the training, fidelity method (e.g., coding of practice sessions), and coaching path.

What costs and commitments are associated with becoming trained in this practice?

What is the cost associated with becoming trained?

Because there are multiple pathways to learning about and learning to use MI to fidelity, costs vary. Practitioners have access to fee-based and free trainings. Coding and coaching typically carry costs for the organization hosting the training.

What is the time commitment associated with completing training?

MI workshops vary in length. Given the amount of material to learn and practice, it takes varying amounts of time to learn the basic content. Looking across training events listed on the MINT website, two to four days is the most common (Miller & Moyers, 2006).

Training boosts skills. To sustain skills time must be dedicated to feedback and coaching. For most practitioners, three to four rounds of feedback and about 5 hours of coaching in 6 months imbeds skills (Schwalbe, 2014). Time for skill maintenance and review will prevent drift.

Are there recognized providers of training in this practice?

The Motivational Interviewing Network of Trainers (MINT) is a membership organization that promotes integrity in MI training. Membership is granted through a competitive and lengthy application process. Applicants must demonstrate excellence in the use of the model through simulated patient interview.

Applicants become MINT members after completing a training of network trainers led by a MINT team. The MINT is currently implementing the initial stages of a structured procedure for assuring that trainers display excellence in real-world settings. A process for providing certification for practitioners to recognize their adherence to the model is also under development.

Does the practice have an associated fidelity assessment?

Multiple well-validated instruments are available for assessing fidelity to the MI model. The MITI 4.2.1 is used most often, but there are many others. A complete list can be found at https://casaa.unm.edu/codinginst.html.

What resources or references are useful for understanding/implementing the practice?

More than 1,200 publications and over 200 randomized clinical trials support the usefulness of MI for a range of problem behaviors and across cultures by a large range of professions.

Where should you go for more information?

- www.motivationalinterviewing.org
- HealtheKnowledge Course: "A Tour of Motivational Interviewing" https://healtheknowledge.org/course/index.php?categoryid=53
- Miller, W.R. & Rollnick, S. (2013). *Motivational Interviewing: Helping people to change* (3rd ed.). The Guilford Press.
- Search for Motivational Interviewing in:
  - MHTTC Training and Events Calendar: https://mhttcnetwork.org/centers/global-mhttc/training-and-events-calendar
  - MHTTC Product & Resources Catalog: https://mhttcnetwork.org/centers/global-mhttc/products-resources-catalog

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