Implementing MI and TIC in Integrated Care

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What is Motivational Interviewing?

The desire to help people improve their health and well-being is a noble calling. However, all too often our efforts to help are spent trying to *get* people to change, rather than using a guiding approach to tap into patient's own motivation for change.

Consider whether you've ever heard your colleagues (or yourself) utter something like this:

- I give people my best advice, but they just won't listen.
- She resists all of my efforts to convince her to get screened.
- She just needs to keep her medical appointments.
- He's in total denial about his heart condition.
- Some folks just don't want to be helped.

Many of us have ample experience in trying to persuade, educate, entice, cajole, bribe, guilt-trip, or use other means to *get* people to change. It is a natural human instinct to fix, or make right, what we perceive as misguided or harmful. However, such efforts to persuade someone to change are typically counterproductive, especially if the person is not convinced that making a change is desired or needed. It turns out that people don't like being pressured to do something because someone else thinks they should do it, even if it's in their best interest. The desire for self-determination runs deep in the human spirit.

Motivational interviewing (MI) is a method of talking with people about change. It is "a collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller & Rollnick, 2013). The individual determines the focus or change goal while the practitioner serves as a guide. MI assumes that people already possess what they need to be motivated to change. They are not empty vessels in need of being filled by an external source. They're already filled with desires, life experience, values, hopes, knowledge, skills, wisdom, and more.

MI helps shine a light on and explore the rich resources people already possess, in order to help them make decisions about next steps on their life's journey. According to positive psychology, this process builds positive emotions, which in turn opens people up to their internal and external resources that they can use to improve their lives.

Where and when did it develop?

The concept of Motivational Interviewing (MI) grew out of the experience of providing treatment for problem drinkers and was first described by psychologist, William R. Miller, in an article published in 1983.

Historically the addictions treatment field, especially in the United States, has been characterized by a highly confrontational, shame-based approach believed to break down people's denial so they will come to their senses about their need to change. This approach has proven to be mostly ineffective. In general, human beings tend to resist other people's attempts to get them to change, even when those efforts are well intended.

With the publication of William R. Miller and Stephen Rollnick's seminal book, Motivational Interviewing, in 1991, practitioners were introduced to an alternative way to engage in a "helping conversation" with people misusing substances. The authors described a way of interacting based on a particular conversation style and use of specific communication skills and strategies.

A second edition, Motivational Interviewing: Preparing People for Change, was published in 2002. It further refined the MI approach, provided an emerging research base for MI, and detailed its spread to other areas beyond substance use disorders including health, behavioral health, corrections, and schools.

A third edition, Motivational Interviewing: Helping People Change, 2013, expanded on the MI approach and included some new concepts including the four processes of MI conversations (engaging, focusing, evoking, and planning) and distinguishing between sustain talk and discord. Today, MI has circled the globe, and support and respect for the practice is growing.

How does it work?

Practicing MI requires a healthy sense of humility. It brings us face-to-face with the recognition that we don't have the power to change others. In truth, we can only change ourselves. However, we are able to have an influence on others and their motivation to change. As Madeline Hunter says: "They say you can lead a horse to water, but you can't make him drink. But I say, you can salt the oats." The goal of MI is to help people become "thirsty" for change by creating conditions under which a fruitful conversation about change can occur.

While the MI approach is generally low-key, it has the potential to stir up uncomfortable thoughts and feelings for people due to its evocative nature that invites them to look at difficult realities in their lives. The aim is to help people look honestly at their behaviors without becoming overly defensive. As practitioners, we seek to create a safe, trusting partnership with individuals so that they see us as allies in the process of looking at discrepancies between who they are and who they want to be, and between their actions and their values.

If we confront, people will tend to defend themselves. MI differs significantly from advice-giving or confrontational styles of counseling in this way. The MI style is not flashy or "in the client's face." The focus is on drawing out the person's own knowledge, experience, and inner wisdom in a genuine, empathic manner.

Those who are used to confronting and giving advice may feel they're not "doing anything" when practicing MI. As one practitioner—more accustomed to a confrontational style of counseling—observed, "I feel like MI ties my hands behind my back." For some helpers, this approach can feel dangerous, like we're giving permission for people to maintain risky positions. But, as Miller and Rollnick (2013) point out, these aggressive strategies, typically driven by a desire to help, more often push the person away from engagement and retention in services, as well as miss their goal of enhancing motivation to change and improve.

The evidence for MI

A wealth of studies indicate that MI has a statistically significant positive effect on behavior change, with some studies showing that those changes are durable over time. MI remains effective when used as a stand-alone intervention, infused within other approaches to treatment, as well as a precursor to other treatment (Lundhal et al., 2013). A number of studies have revealed that patients defined as "least ready to change" experience the largest MI effect (Heckman et al., 2010).

Of course, MI works only as well as the practitioner using it and the quality of the alliance that develops between practitioner and person. Poor MI promotes poor results. Structural and environmental factors can also affect the success of MI, like any best practice. For example, housing instability can hinder efforts to address substance use. For others, a history of trauma may create obstacles to accessing mental health treatment. MI sees people's struggles in the context of their lives and works with them to focus and prioritize.

Developing competence

Ongoing practice with accurate feedback and coaching is needed to develop MI skills. Research shows that MI competence requires expert feedback based on observed practice and coaching to support shifts from current practice to MI proficiency. Many individuals and organizations have instituted Learning Circles as a way of increasing their MI knowledge and skills. In addition, many excellent training and coaching opportunities exist.

For information about MI resources including the latest MI related research, visit the Motivational Interviewing Network of Trainers website at:
https://motivationalinterviewing.org/motivational-interviewing-resources

If You Have Five, Fifteen, or Fifty Minutes: MI Basics

Adapted from Miller & Rollnick, 2013

What is it?

"A collaborative conversation style for strengthening a person's own motivation and commitment to change"... "a way of helping people talk themselves into changing"

The spirit (mindset and heart-set) of motivational conversations

Partnership – collaborating with the client's own expertise

Acceptance – communicating absolute worth, accurate empathy, affirmation, and autonomy support

Compassion – promoting the client's welfare, giving priority to the client's needs

Evocation – eliciting the client's own perspectives and motivation

Four processes that guide motivational conversations

Engaging – establishing the relational foundation

Focusing – clarifying a particular goal or direction for change

Evoking – eliciting the person's own motivation for a particular change

Planning – developing a specific change plan that the person is willing to implement

Four conversational skills (OARS)

O*pen questions* – offers client broad latitude and choice in how to respond

A*ffirmation* –statement valuing a positive client attribute or behaviors

R*eflections* – statements intended to mirror meaning (explicit or implicit) of preceding client speech

S*ummaries* – reflections that draw together content from two or more prior client statements

Sample questions to explore ambivalence and elicit/strengthen motivation

Tell me more about this **issue/concern/dilemma** (that's been identified)? What's okay about how things are? What's not?

If you decide not to change anything, **what would be at stake**?

If you *were* to make a change, what would be the **benefits** of (or your **reasons** for) doing so? The **most important** benefit or reason?

If you *were* to decide to change, **how** would you go about it to be successful? What do you think would work for you?

Looking at your life currently, **how important** or urgent is it for you to make this change? *For example, on a scale of 0-10 (0 = not at all important; 10 = totally important), where would you place yourself? What makes it already a ___ and not a ___ (several numbers lower)? What would it take to move from a ___ to a ___ (next highest number)?*

How confident are you that you could be successful in changing? (scaling questions works well here too)

How can I or others be helpful to you in supporting this change?

What do you think you might do as a very **next step** to move towards this change?

Exchanging information

A few considerations

- It's all right, and sometimes imperative, to express your concerns
- There are many pathways to change
- Focus on helping the person evaluate options
- Offer information and advice, don't impose it

Method: Elicit-Provide-Elicit

Elicit

- Ask what person already knows
- Ask what person would like to know
- Ask permission to provide information/advice

Provide

- Prioritize what person most wants to know
- Be clear; use everyday language
- Offer small amounts of information with time to reflect
- Acknowledge freedom to disagree or ignore

Elicit

- Ask for person's response, interpretation, understanding

Adapted from Motivational Interviewing, *3rd edition by Miller & Rollnick, 2013*

MI Self-Appraisal

As the interviewer, I…	*0- not at all*					*5- extremely well*
1. Provided a **safe, welcoming** presence with my words and actions. *Example:*	0	1	2	3	4	5
2. Engaged with and showed **genuine interest** in the person, e.g., what she or he enjoys, needs, values. *Example:*	0	1	2	3	4	5
3. Found out and clarified what the person wanted to **focus** on currently. *Example:*	0	1	2	3	4	5
4. Helped explore **both sides of the person's dilemma**, e.g., what's working and what's not; upsides and downsides. *Example:*	0	1	2	3	4	5
5. Avoided trying to **"fix"** the problem or *get* the person to change by advising, confronting, warning, or teaching. *Example:*	0	1	2	3	4	5
6. Elicited what might be some possible **reasons** to change *if* the person were to decide to change. *Example:*	0	1	2	3	4	5
7. Learned about **possible ways** that he or she might go about making this change. *Example:*	0	1	2	3	4	5
8. Asked **how important** it is at this time for the person to make this change. *Example:*	0	1	2	3	4	5
9. Asked **how confident** she or he feels to be *able* to make this change. *Example:*	0	1	2	3	4	5
10. Inquired about **what steps**, if any, the person might take next. *Example:*	0	1	2	3	4	5
11. Asked permission before providing **information or suggestions.** *Example:*	0	1	2	3	4	5
12. Used the **core skills** of MI (open questions, affirmations, reflective listening, summaries) throughout the conversation.	0	1	2	3	4	5
13. Consistently demonstrated the **spirit** of MI:						
> *Partnership*	0	1	2	3	4	5
> *Acceptance*	0	1	2	3	4	5
> *Compassion*	0	1	2	3	4	5
> *Evocation*	0	1	2	3	4	5

Developed by Ken Kraybill based on Miller, W.R. & Rollnick, S., Motivational Interviewing: Helping People Change, 2013

Implementing Motivational Interviewing in Your Organization

Organizational strategies

Designate an **MI Skills Development** person or team to promote ongoing training and skills practice opportunities within the agency

Develop an organizational **philosophy of care statement** that aligns with MI spirit and practice

Include MI experience as a **job requirement or preference** when advertising for, screening, and hiring new staff, especially direct-service and supervisory positions

In **job interviews**, ask applicants to provide MI-adherent responses to sample statements (e.g. Helpful Responses Questionnaire), demonstrate their MI skills in a "mock interview" in the moment, or submit a sample tape of their practice to be reviewed later

Ensure that **clinical supervisors** are trained in MI and are MI-consistent in their supervisory methods

In **supervisory sessions** make it an expectation for supervisors to pay attention to staff progress in MI skill-building

Include MI skill-building as a **professional development goal** for all practitioners in their job performance plans

Revise program **intake forms and progress notes** to reflect and promote an MI-consistent approach

Participate in **MI-related clinical research** studies (or possibly seek out opportunities to conduct research)

Create MI-related **visual reminders** (posters, signs, buttons, importance and confidence rulers)

Develop an **online MI discussion forum** within your agency

Provide opportunities for select staff to be trained in using the **MICA** (Motivational Interviewing Competency Assessment) or **MITI** (Motivational Interviewing Treatment Integrity) tool to code MI conversations for feedback and coaching

Encourage selected staff to become **trained as MI trainers** through the Motivational Interviewing Network of Trainers (MINT) and participate in the MINT community of practice

Strategies to Build Skills

Establish **MI learning circles** (aka communities of practice, coaching circles) that meet regularly to sustain learning and strengthen skills

- Groups of 4-8
- Identify skillful facilitators and equip them with MI practice activities/resources
- Focus on practicing specific MI skills and incorporating them into practice conversations with accurate feedback and coaching

Offer regularly scheduled introductory and advanced **MI training opportunities** (ensuring that participants are assigned to or already a part of an ongoing learning circle)

Contract as needed with **external MI coaches, trainers, and consultants** to promote ongoing learning

Encourage **self-initiated learning** by providing resources such as MI books, eBooks, articles, training tapes, skill-building exercises, and other learning tools

Code audiotaped segments of MI conversations using the MICA (Motivational Interviewing Competency Assessment) or MITI (Motivational Interviewing Treatment Integrity) tool to provide feedback and coaching

Initiate your own **inspired ideas**…

Selected Resources

Arkowitz, H, Westra, H.A., & Miller WR, Rollnick S. (Eds.). (2015). *Motivational Interviewing in The Treatment of Psychological Problems (2nd edition).* New York, NY: Guilford Press.

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Rollnick, S., Miller, W.R., & Butler, C. (2008). *Motivational Interviewing in Health Care*. New York, NY: Guilford Press.

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Trauma-Informed Care Basics

How can you provide optimal care for people who have experienced trauma? In this article, we share best practices for trauma-informed care. These include understanding trauma and its effects, creating safe physical and emotional space, supporting control and choice, and integrating trauma-informed care across service systems.

Some people experience very few traumatic events in their lives. Others experience chronic traumatic stress that can potentially have a major impact on how people understand themselves, the world, and others. People who have experienced multiple traumas do not relate to the world in the same way as those who have not. They require services and responses that are uniquely sensitive to their needs.

What makes an experience traumatic?

- The experience involves a threat to one's physical or emotional well-being.
- It is overwhelming.
- It results in intense feelings of fear and lack of control.
- It leaves people feeling helpless.
- It changes the way a person understands themselves, the world and others.

Trauma-awareness

We know people can and do recover from trauma, and we want to provide services and environments that support healing. To be a "trauma-informed" provider is to root your care in an understanding of the impact of trauma and the specific needs of trauma survivors. We want to avoid causing additional harm to those we serve.

What does this mean in practical terms? How is this different than business as usual? Here are some concrete practices of trauma-informed care.

Understanding trauma and its impact

Understanding traumatic stress and its impact is essential. Trauma survivors, particularly those who have experienced early childhood trauma/developmental trauma, often develop a set of survival skills that help them to manage past trauma. These survival strategies (like substance misuse, withdrawal, aggression, self-harm, etc.) make sense given what people have experienced. But they can be confusing and frustrating to others and often get in the way of current goals.

Without an understanding of trauma, providers may view those they serve in negative ways. Providers might describe behaviors as "manipulative," "oppositional," or "unmotivated." Yet these behaviors may be better understood as strategies to manage overwhelming feelings and situations. Trauma-informed training can help providers understand these responses and offer trauma-sensitive care.

Promoting physical and emotional safety

Traumatic experiences often leave people feeling unsafe and distrustful of others. Creating a sense of physical and emotional safety is an essential first step to building effective helping relationships. Safe physical environments may include:

- Well-lit spaces
- Security systems; an ability for individuals to lock doors and windows

- Visible posting rights and other important information
- Culturally familiar signs and decorations
- Child-friendly spaces that include objects for self-soothing

Practices that help to create a safe emotional environment include:

- Providing consistent, respectful responses to individuals across the agency
- Asking people what does and does not work for them
- Being clear about how personal information is used
- Permitting people to engage in their own cultural and spiritual rituals
- Provide group activities that promote agency and community (e.g. movement, exercise, yoga, music, dancing, writing, visual arts)

Supporting control and choice

Situations that leave people feeling helpless, fearful, or out of control remind them of their past traumatic experiences and leave them feeling re-traumatized. Ways to help individuals regain a sense of control over their daily lives include:

- Teach emotional self-regulation skills such as altering breathing and heart rate
- Keep individuals well informed about all aspects of their care
- Provide opportunities for input into decisions about how a program is run
- Give people control over their own spaces and physical belongings
- Collaborate in setting service goals
- Assist in ways that are respectful of and specific to cultural backgrounds
- Maintain an overall awareness of and respect for basic human rights and freedoms

Integrating care across service systems

Becoming trauma-informed means adopting a holistic view of care and recognizing the connections between housing, employment, mental and physical health, substance abuse, and trauma histories. Providing trauma-informed care means working with community partners in housing, education, child welfare, early intervention, and mental health. Partnerships enhance communication among providers and help minimize clients' experiences of conflicting goals and requirements, duplicated efforts, and or of feeling overwhelmed by systems of care. It helps build relationships and resources to provide the best quality of care possible.

Becoming trauma-informed means a transformation in the way that providers meet the needs of those they serve. The ideas above are only a beginning. Change happens as organizations and providers take these ideas, as well as their own, and use them to evaluate and adapt their approaches to care.

Adapted from *Trauma-Informed Care 101,* Homelessness Resource Center for Social Innovation
http://homeless.samhsa.gov/Resource/View.aspx?id=46857&g=ComResPosts&t=423

Complex Post Traumatic Stress Disorder (C-PTSD)

Complex Post Traumatic Stress Disorder (C-PTSD) is a condition that results from chronic or long-term exposure to emotional trauma over which a person has little or no control and from which there is little or no hope of escape, such as in cases of:

- Childhood/domestic emotional, physical or sexual abuse
- Repeated violations of personal boundaries
- Long-term objectification
- Exposure to gaslighting/mental abuse and false accusations
- Long-term exposure to inconsistent, push-pull, splitting or alternating raging and hoovering behaviors
- Long-term taking care of mentally ill or chronically sick family members
- Entrapment, kidnapping
- Slavery or enforced labor
- Long term imprisonment and torture
- Long term exposure to crisis conditions

When people have been trapped in a situation over which they had little or no control at the beginning, middle or end, they can carry an intense sense of dread even after that situation is removed. This is because they know how bad things can possibly be. And they know that it could possibly happen again. And they know that if it ever does happen again, it might be worse than before.

The degree of C-PTSD trauma cannot be defined purely in terms of the trauma that a person has experienced. It is important to understand that each person is different and has a different tolerance level to trauma. Therefore, what one person may be able to shake off, another person may not. Therefore, more or less exposure to trauma does not necessarily make the C-PTSD any more or less severe.

C-PTSD sufferers may "stuff" or suppress their emotional reaction to traumatic events without resolution either because they believe each event by itself doesn't seem like such a big deal or because they see no satisfactory resolution opportunity available to them. This suppression of "emotional baggage" can continue for a long time either until a "last straw" event occurs, or a safer emotional environment emerges, and the damn begins to break.

The "Complex" in Complex Post Traumatic Disorder describes how one layer after another of trauma can interact with one another. Sometimes, it is mistakenly assumed that the most recent traumatic event in a person's life is the one that brought them to their knees. However, just addressing that single most-recent event may possibly be an invalidating experience for the C-PTSD sufferer. Therefore, it is important to recognize that those who suffer from C-PTSD may be experiencing feelings from all their traumatic exposure, even as they try to address the most recent traumatic event.

This is what differentiates C-PTSD from the classic PTSD diagnosis - which typically describes an emotional response to a single or to a discrete number of traumatic events.

Adapted from http://outofthefog.website/toolbox-1/2015/11/17/complex-post-traumatic-stress-disorder-c-ptsd

Selected Recovery-Oriented Principles and Guidelines

- Engage in continual learning about types, causes, prevalence, and impact of trauma *and* strengthening of trauma-informed knowledge and skills
- Develop a recovery-oriented "mindset and heart-set" focusing on partnership, acceptance, compassion, and evocation in all areas of providing care and services
- Make every effort to ensure physical and emotional safety for guests and staff
- Integrate bio-psycho-social-spiritual care approaches
- Create spaces and opportunities for self-regulation, quieting, expressing emotions
- Provide opportunities for guests to engage in awareness and mindfulness practices – e.g., stretching, yoga, meditation
- Provide opportunities for robust physical exercise and play
- Promote healing through creating healthy connections and a sense of community with staff and others
- Recognize that recovery can and does happen
- Focus on strengths, resilience, and recovery. Recognize "negative" behaviors as adaptive
- Minimize possibilities of triggering behaviors and re-traumatization
- Maximize personal choice and self-determination in all communications and actions
- Practice cultural humility and responsiveness by seeking to understand each person in the context of their life experiences and cultural background
- Solicit input and involve people seeking services in designing and evaluating services
- Address secondary traumatization for staff and promote self-care

Compiled from multiple sources

Implementing Trauma-Informed Care in Your Organization

Organizational strategies

Designate a **Trauma-Informed Care (TIC) Implementation Team** to assess needs, make specific recommendations, and guide implementation efforts to become more trauma-informed in all aspects of the organization

Use a **TIC Organizational Self-Assessment** tool to determine the organization's initial level of understanding and adoption of trauma-informed practices to create a baseline from which to measure progress over time (using the same tool repeatedly at regular intervals)

Develop an organizational **philosophy of care statement** that aligns with trauma-informed principles and practices

Include TIC knowledge and experience as a **job requirement or preference** when advertising for, screening, and hiring new staff, especially direct-service and supervisory positions

In **job interviews**, ask applicants about their understanding of trauma-informed care and to provide specific examples of working in a trauma-informed manner

Ensure that **clinical supervisors** are trained in and providing trauma-informed supervision, paying particular attention to the impact of the work on staff well-being

In **supervisory sessions** make it an expectation for supervisors to assess and help staff strengthen their trauma-informed knowledge and skills

Include TIC knowledge and skills as a **professional development goal** for staff in their performance review plans

Revise program **intake forms and progress notes** to reflect and promote a trauma-informed approach

Participate in **TIC-related clinical research** studies (or possibly seek out opportunities to conduct research)

Create TIC-related **visual reminders** (posters, signs, quotes, prompts) to post in the agency

Develop an **online TIC discussion forum** within the agency

Encourage selected staff to become **trained as TIC trainers**

Strategies to Build Skills

Establish **TIC learning circles** (aka communities of practice, coaching circles) that meet regularly to build knowledge and skills

- Groups of 4-8
- Identify skillful facilitators and equip them with TIC practice activities and resources
- Focus on practicing trauma-informed conversations with coaching and feedback (not just talking about them)

Offer regularly scheduled introductory and advanced **TIC training opportunities** (ensuring that participants are assigned to or already a part of an ongoing learning circle)

Contract as needed with **external TIC coaches, trainers, and consultants** to promote ongoing learning

Encourage **self-initiated learning** by providing TIC resources – books, eBooks, articles, training tapes, skill-building exercises, and other learning tools

Initiate your own **inspired ideas**…

Selected Resources: Trauma-Informed Care

ACES Connection Resources Center https://www.acesconnection.com/g/resource-center/blog/resource-list-topic-trauma-informed-practice

Bassuk, E.L., Olivet, JO, Winn, LP, & Nichols, K. (2014). *Safety in Support: An Interactive eBook on Trauma-Informed Care.* Available from the ibooks library.

Center for Social Innovation. (2015). *Measuring Trauma-Informed Care in Human Service Organizations: How to Use the TICOMETER.* Available by contacting info@thinkt3.com.

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National Child Traumatic Stress Network
www.nctsn.org

National Council for Behavioral Health. *Trauma-Informed Behavioral Health Care Trauma-Informed Care Organizational Self-Assessment*
http://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare

Substance Abuse and Mental Health Services Administration. *Trauma-Informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

SAMHSA National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint http://www.samhsa.gov/nctic

t3 (think. teach. transform.)
Resource for trauma-informed care training and implementation supports
www.thinkt3.com

The Trauma Center at Justice Resource Institute
http://www.traumacenter.org

Through a Darker Lens: The Trauma of Racism in Communities of Color
https://www.pathwaysrtc.pdx.edu/pdf/fpS1507.pdf

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