An Overview of Motivational Interviewing as Used in SBIRT

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Overview of Motivational Interviewing as used in Brief Interventions - SBIRT

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Alan received a Bachelor’s Degree in Social Work from Florida Atlantic University in 1998 and a Master’s Degree in Social Work from Barry University in 1999. Alan is a MINT (Motivational Interviewing Network of Trainers) recognized MI trainer, an Internationally Certified Clinical Supervisor, and an Internationally Certified Alcohol and Drug Counselor.
“My topic is ‘How To Give A Presentation Without Losing Your Audience’s Attention’. The End. Thank you for coming.”
Acknowledgements

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-Steve O’Neil
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-Dr Sylvia Shellenberger
-Dr Aaron Johnson
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  – Dr Paul Seale
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  – Ms Jafawndra Buckner

www.sbirtonline.org
Guidelines for the Training

Ask lots of questions!
Be critical of everything that is said…
Be kind …

Attitudes:
“What the Heck!” Jump into the experience.
YOU can make this fun!
THE BEST WAY TO ACHIEVE GOOD HEALTH IS TO TAKE CARE OF YOURSELF.

YOUR LIFESTYLE IS DESTROYING YOU.

YOU SHOULD CHANGE YOUR EATING HABITS, AND STOP SMOKING AND DRINKING.

START AN EXERCISE PROGRAM. GET PLENTY OF REST. LEARN HOW TO HANDLE STRESS.

YOU'RE RIGHT, DOC. THANKS!

MAN! I'VE GOT TO FIND ANOTHER DOCTOR!
The Nuts and Bolts
Objectives

• Orient to the SBIRT intervention and use of standardized screening tools
• Introduce a model of brief intervention
• Primer in motivational interviewing
So What Is the SBIRT Intervention?

An intervention based on “motivational interviewing” strategies

1. **Screening**: *Universal screening* for quickly assessing use and severity of potential alcohol, illicit drugs, and prescription drug abuse.

2. **Brief Intervention**: Brief motivational and awareness-raising intervention given to risky or problematic substance users.

3. **Referral to Treatment**: Referrals to specialty care for patients with substance use disorders. Treatment can be brief treatment or specialty AOD treatment.
Goal of SBIRT

The primary goal of SBIRT is to identify and effectively intervene with those who are at moderate or high risk for psycho-social or health care problems related to their substance use.
In a nutshell....
Screening
& Brief Intervention

Screening
What to Say Before Asking Screening Questions

• **ASK PERMISSION!**

• *Would it be ok if I ask you some personal questions that we ask all our patients?*

• *Your responses will be confidential.*

• *These questions help us to provide the best possible care.*

• *You do not have to answer them if you are uncomfortable.*
Universal Screening
NIAAA Single Question

• How many times in the past year have you had 5 or more drinks in a day (Men) or 4 (Woman)?

• How many times in the past year have you used illegal drugs or prescription drugs other than how they were prescribed by your physician?
Approved Screening Tools

- **AUDIT**: Alcohol Use Disorder Identification Test.
- **DAST**: Drug Abuse Screening Test.
- **POSIT**: Problem Oriented Screening Instrument for Teenagers.
- **CRAFFT**: Car, Relax, Alone, Forget, Family or Friends, Trouble (for adolescents).
- **ASSIST**: Alcohol, Smoking, and Substance Abuse Involvement Screening Test.
- **GAIN** or **GAIN-SS**: Global Appraisal of Individual Needs.
3 Tasks for BI

Feedback

Listen & Elicit

Options for Change
Giving Feedback

BAC? AUDIT? DAST? ASSIST?
Quantity - Frequency?
Range: “AUDIT scores can range from 0 for people that don’t drink, 1-7 for low risk drinkers and from 8 to 40 for risky drinking.

Ask: What do you think your score might be?

Normal scores: “Normal AUDIT scores are 0-7

Give score: “Your score was ...and this places you in the (low, high, very high) risk category.

Elicit reaction: “What do you make of that?”
Dig for change talk using open ended questions…

• *Tell me your thoughts about...*

• *What are some things that bother you about drinking?*

• *How would you like your drinking to be 5 years from now?*
Listen & Elicit

1. Good and not-so-good

2. Importance & Confidence Scales

3. Readiness Ruler
Options for Change

Begin with a key question:

What do you think you will do?
What changes are you thinking about making?
What do you see as your options?
Where do we go from here?
What happens next?
Options for Change

Manage your use: (cut down to low-risk limits)
Eliminate your use: (quit)
Never use and drive: (reduce harm)
Utterly nothing: (no change)
Seek support
Options for Change

- **Conditional Statement**
  - If you wanted to...
  - If you decided to...
  - If the time were right...

- **Plan of Action**
  - How would you do it?
  - How would you go about it?
  - What would you do?
Avoid Warnings!
Closing on Good Terms

**SEW**

**S:** Summarize patient’s views
   (especially the pro-change part of what they said).

**E:** Encouraging remarks

**W:** What agreement was reached is repeated.
Motivational Interviewing is making KNOWN what You KNOW
You're a failure! You're wasting your life! You'll never amount to anything!

It's a motivational technique I learned growing up.
Confidence…
• LISTEN!
• LISTEN!
• LISTEN!
• LISTEN!
The Chinese characters that make up
the verb "to listen."

With thanks to Steve Berg-Smith
With thanks to Steve Berg-Smith
RESPECT
• SHOW UP
• BEGINNERS MIND
MOTIVATIONAL INTERVIEWING

DEFINITION & SPIRIT

**DEFINITION:** Motivational interviewing is a person-centered, evidence-based, goal-oriented method for enhancing intrinsic motivation to change by exploring and resolving ambivalence with the individual.

**SPIRIT:** Collaboration; acceptance; evocation; compassion.
"What do you think ... should we get started on that motivation research or not?"
Stephen Rollnick

1989

Stephen Rollnick

2012
“A person-centered, goal oriented intervention focused on resolving ambivalence in the direction of change”

“...not a series of techniques ... but a way of being...”
Four Fundamental Processes

Planning

Evoking

Focusing

Engaging
The processes are somewhat linear....

- Engaging necessarily comes first
- Focusing (identifying a change goal) is a prerequisite for Evoking
- Planning is logically a later step

Engage - Shall we walk together?
Focus - Where?
Evoke - Why?
Plan - How?
...and yet also recursive

• Engaging skills (and re-engaging) continue throughout MI

• Focusing is not a one-time event. Re-focusing is needed, and focus may change

• Evoking can begin very early

• “Testing the water” on planning may indicate a need for more of the above

• The four processes are inter-woven
Can it be MI without....

- Engaging? No
- Focusing? No
- Evoking? No
- Planning? Yes
So it becomes MI when....

• The communication style and spirit involve person-centered empathic listening (Engage) AND

• There is a particular identified target for change that is the topic of conversation (Focus) AND

• The interviewer is evoking the person’s own motivations (or plans) for change (Evoke)
Development of the MI attitude

**Informative model**
- Give expert advice
- Try to persuade
- Repeat the advice
- Represent authority
- Move quickly

**Motivational model**
- Stimulate motivation
- Try to listen & understand
- Summarize the points of view of the patient
- Promote collaboration
- Proceed step by step
Lower fear

**FEAR**

Increase desires

**CHANGE TALK**
- Desire
- Ability
- Reason
- Need

Notice

**COMMITMENT LANGUAGE**

Observe

**CHANGE BEHAVIOR TOWARDS and/or SUSTAIN “HEALTH”**
Motivational Interviewing

- Assumes motivation is fluid and can be influenced
- Motivation influenced in the context of a relationship – developed in the context of a patient encounter
- Principle tasks – to work with ambivalence and resistance
- Goal – to influence change in the direction of health
AMBIVALENCE IS........
Ambivalence is normal
AMBIVALENCE

All change contains an element of ambivalence.

We “want to change and don’t want to change”

Patients’ ambivalence about change is the core of the intervention.

With thanks to Dr. Thomas Freese
Goal of MI

• To create and amplify discrepancy between present behavior and broader goals.

How?

• Create cognitive dissonance between where one is and where one wants to be.
Cognitive Dissonance

Sorry Brad....
UNDERLYING ASSUMPTIONS

Acceptance
Autonomy/Choice
Less is better
Elicit versus Impart
Michelangelo
Ambivalence
Care-frontation
Non-Judgmental
Change talk
Righting reflex
The Righting Reflex.....
How willing do you think this patient will be to change her drinking or reduce her risk as a result of this conversation?

Not willing 0 1 2 3 4 5 6 7 8 9 10 Very willing
I wonder why people get mad when I point out how dumb they are.

I'm just trying to be helpful. I don't want people going through life not knowing what the problem is.

I'm kind of like a doctor. I stopped listening back at the house.
To avoid this...

LET GO!!! With thanks to Dr. Thomas Freese
With thanks to Dr. Thomas Freese
Common Human Reactions to Being Listened to

- Understood
- Want to talk more
- Liking the worker
- Open
- Accepted
- Respected
- Engaged
- Able to change

- Safe
- Empowered
- Hopeful
- Comfortable
- Interested
- Want to come back
- Cooperative
Common Reactions to Righting Reflex

- Angry, agitated
- Oppositional
- Discounting
- Defensive
- Justifying
- Not understood
- Not heard
- Procrastinate

- Afraid
- Helpless, overwhelmed
- Ashamed
- Trapped
- Disengaged
- Not come back – avoid
- Uncomfortable
It’s useful to clarify what is one drink!
My Doctor said "Only 1 glass of alcohol a day". I can live with that.
How Much Is “One Drink”? 

5-oz glass of wine  
(5 glasses in one bottle)  

12-oz glass of beer (one can)  

1.5-oz spirits  
80-proof  
1 jigger  

Equivalent to 14 grams pure alcohol
Eight Stages in Learning MI

1. The spirit of MI
2. OARS – Person-centered counseling skills
3. Recognizing and reinforcing change talk
4. Eliciting and strengthening change talk
5. Dancing with discord
6. Developing a change plan
7. Consolidating commitment
8. Shifting flexibly between MI and other approaches

Adapted from Miller, W. R., & Moyers, T. B. Eight stages in learning motivational interviewing. *Journal of Teaching in the Addictions.*
Ten Things MI is Not

1. MI is not based on the transtheoretical model
2. MI is not a way of tricking people into doing things they don’t want to do
3. MI is not a technique
4. MI is not a decisional balance
5. MI does not require assessment feedback
Ten Things MI is Not

6. MI is not a form of cognitive-behavior therapy
7. MI is not just client-centered counseling
8. MI is not easy
9. MI is not what you were already doing
10. MI is not a panacea
Stages of Change
Prochaska & DiClemente

- Precontemplation: 80%
- Contemplation: 80%
- Action: 20%
- Preparation: 20%
MI –

Like Dancing

Not Wrestling
Fundamental Process

Engaging
Engaging

- Clients need to feel safe
- May take time
- And need to be reworked
- Ambivalence is normal
- Therapeutic alliance is essential to change
• Would you be interested in knowing what your scores mean?
Giving Feedback

BAC? AUDIT? DAST? ASSIST?

Quantity - Frequency?
AUDIT Feedback

Range: “AUDIT scores can range from 0 for people that don’t drink, 1-7 for low risk drinkers and from 8 to 40 for risky drinking.

Ask: What do you think your score might be?

Normal scores: “Normal AUDIT scores are 0-7

Give score: “Your score was ...and this places you in the (low, high, very high) risk category.

Elicit reaction: “What do you make of that?”
OARS

O: open-ended questions
A: affirmation, notice the strengths, see the motivation in what they do...hear their values
R: reflection, use empathy, simple and complex
S: summaries
Closed Questions

- Have a short answer (like Yes/No)
  - Did you drink this week?
- Ask for specific information
  - What is your address?
- Might be multiple choice
  - What do you plan to do: Quit, cut down, or keep on smoking?
- They limit the Client’s answer options
Open Questions:

• Open the door, encourage the patient to talk
• Do not invite a short answer
• Leave broad latitude for how to respond
Open-ended Questions

• “What can you tell me about ___?”
• “How would you like things to be different?”
• “What are the good things about ___?”
• “What are the not so good things about ___?”
• “What will you lose if you give up ___?”
• “What have you tried before?”
• “What do you want to do next?”
Closed Versus Open-Ended Questions

• Do you feel you have a problem with alcohol?
• Is it important to you to complete this program successfully?
• Anything else?

• What problems has your alcohol use caused you?
• How important is it for you to complete this program successfully?
• What else?
Open or Closed Questions?

• What helped you get to the office today?
• Was your family religious?
• What are the good things about your smoking?
• What are the not-so-good things about it?
• If you were to quit, how would you do it?
• When is your court date?
Open or Closed Questions?

• Don’t you think it’s time for a change?
• What do you think would be better for you – A.A. or NA?
• What do you like about not taking your meds?
• How will you get to the AA meeting tonight?
• Is this an open question?
Some Guidelines with Questions

- Ask fewer questions!
- Don’t ask three questions in a row
- Ask more open than closed questions
- Offer two reflections for each question asked
Affirmations

• Emphasize a strength
• Notice and appreciate a positive action
• Should be genuine
• Build feelings of empowerment
• Instill hope and “can-do” attitude
• Express positive regard and caring
• Strengthen the counseling relationship
Affirmations Include:

• Commenting positively on an attribute
  – You’re a strong person, a real survivor.

• A statement of appreciation
  – I appreciate your openness and honesty today.

• Catch the person doing something right
  – Thanks for coming in today!

• An expression of hope, caring, or support
  – I hope this weekend goes well for you!
Fundamental Process

Focusing

Engaging
"Reflective Listening" is the key to this work. The best motivational advice we can give you is to listen carefully to your Clients. They will tell you what has worked and what hasn’t. What moved them forward and shifted them backward. Whenever you are in doubt about what to do, listen”
(Miller & Rollnick, 1991)
Communication is hard...
Here are all the places it can break down!

1. What the speaker means
2. What the speaker says
3. What the listener hears
4. What the listener thinks the speaker means
The Accuracy Function of Reflection

**Bridge the gap by reflection**

1. What the speaker means
2. What the speaker says
3. What the listener hears
4. What the listener thinks the speaker means
Types of Empathic Reflections

♥ Simple/Repeating - Reflect what is said
♥ Simple/Rephrasing – Slightly alter
♥ Amplified - Add intensity to idea/values
♥ Double Sided - Reflect ambivalence
♥ Metaphor - Create a picture
♥ Shifting Focus - Change the focus
♥ Reframing - Offer *new* meaning
♥ Emphasize personal choice
♥ Siding with the negative (paradoxical)
REPEAT
(restate what patient has said)

REPHRASE (synonym)

PARAPHRASE, infer meaning, amplify concepts & values, double-sided, continue paragraph, metaphor, understate feelings, reframe

SUMMARIZE
Repeating: This is the simplest form of reflection, often used to diffuse discord

• *Patient*: I don't want to quit smoking.
• *Counselor*: You don't want to quit smoking.
ARE YOU MIRRORING ME TO HELP YOU ESTABLISH INSTANT RAPPORT?

ARE YOU MIRRORING ME TO HELP YOU ESTABLISH INSTANT RAPPORT?
Rephrasing: Slightly alter what the patient says in order to provide the patient with a different point of view. This can help move the patient forward.

- **Patient:** I really want to quit smoking.
- **Counselor:** Quitting smoking is very important to you.
Amplified reflection: Reflect what the patient has said in an exaggerated way. This encourages the patient to argue less, and can elicit the other side of the Client's ambivalence.

- **Patient**: My smoking isn't that bad.
- **Counselor**: There's no reason at all for you to be concerned about your smoking. *(Note: it is important to have a genuine, not sarcastic, tone of voice).*
Double-sided reflection: Acknowledge both sides of the Client's ambivalence.

- **Patient**: Smoking helps me reduce stress.
- **Counselor**: On the one hand, smoking helps you to reduce stress. On the other hand, you said previously that it also causes you stress because you have a hacking cough, have to smoke outside, and spend money on cigarettes.
Metaphor: Painting a picture that can clarify the Client’s position

- Patient: Everyone keeps telling me I have a drinking problem, and I don’t feel it’s that bad.

- Counselor: It’s kind of like everyone is pecking on you about your drinking, like a flock of crows pecking away at you.
Shifting focus: Provide understanding for the Client's situation and diffuse resistance

*Patient:* What do you know about quitting? You probably never smoked.

*Counselor:* It's hard to imagine how I could possibly understand.
Reframing: Much as a painting can look completely different depending upon the frame put around it, reframing helps Clients think about their situation differently

- **Patient:** I've tried to quit and failed so many times.

- **Counselor:** You are persistent, even in the face of discouragement. This change must be really important to you.
Emphasizing Personal Choice: Reflect the Client’s autonomy

• *Patient:* I've been considering quitting for some time now because I know it is bad for my health.

• *Counselor:* You're worried about your health and want to make different choices.
Reflective listening.....

Who would like to have a brief conversation?
The summary is like a bouquet of flowers that we give to the patient.
Summarizing

- Special form of reflective listening
- Ensures clear communication
- Use at transitions in conversation
- Be concise
- Reflect ambivalence
- Accentuate “change talk”
How Motivational Interviewing is Directive

- Selective eliciting questions
- Selective reflection
- Selective elaboration
- Selective summarizing
- Selective affirming
Fundamental Belief

• *The capacity and potential for change and adherence is within every person!*
Fundamental Process

- Evoking
- Focusing
- Engaging
Tuning into Change Talk
Types of Change Talk:

- **Desire**  
  I want to.... I’d really like to... I wish...

- **Ability**  
  I would... I can.... I am able to... I could...

- **Reason**  
  There are good reasons to...  
  This is important....

- **Need**  
  I really need to...

- **Commitment**  
  I intend to... I will... I plan to...

- **Activation**  
  I’m doing this today...

- **Taking Steps**  
  I went to my first group...
Dig for change talk using open ended questions…

• *Tell me your thoughts about...*

• *What are some things that bother you about drinking?*

• *How would you like your drinking to be 5 years from now?*
Examples of Sustain Talk –

The other side of ambivalence

• I really enjoy gambling (D)
• I don’t think I can give it up (A)
• Gambling is how I have fun (R)
• I don’t think I need to quit (N)
• I intend to keep on gambling (C)
  and nobody can stop me
• I’m not ready to quit (A)
• I went back to the casino today (T)
What is Resistance?

- Discord
- Change Talk
- Sustain Talk
Sustain Talk and Discord

• **Sustain Talk** is about the target behavior
  – I really don’t want to quit smoking
  – I need my pills to make it through the day

• **Discord** is about your relationship
  – You can’t make me quit
  – You don’t understand how hard it is for me

• **Both** are highly responsive to practitioner style
What is Discord?

- Behavior
- Interpersonal (it takes two to have discord)
- A signal of dissonance in your relationship
- Predictive of non-change
Doctors Focus on Alcohol 'Screens'
New York Times 10/27/04
Change and Sustain Talk
DARN CAT

[Image of a cat in mid-leap]

Alan video\Why I Love Dogs.wmv
Yet another metaphor: MI Hill

DARN
Preparatory Change Talk
(Pre-) Contemplation

CATS
Mobilizing Change Talk
Preparation
Action
Change talk is like gold!

• As patients speak about change, they begin to see the possibilities

• No pressure or persuasion is needed
Mining for Change-Talk

• I love to smoke my weed.
• I need to get high to feel right.
• I just want to wake up sober in the morning.
• I actually tested my blood sugars every day this week.
• I stayed away from drug dealing all week.
• It’s just such a hassle to floss my teeth.
• There’s no way I want to be on insulin.
• I definitely can’t afford to get another DWI.
• I wish I could lose weight easily.
• I don’t think I can eat any more fruits and vegetables than I am.
• I’ve been kinda forgetting to take my anti-depressants.
• I hate keeping food records
• I could probably take a walk after dinner.
• I’ll do anything to get rid of the pain.
• I’m sick of smoking; it disgusts me.
• I don’t want to set a bad example for my kids
• I don’t see how drinking 4 or 5 beers a night is a problem.
• I’m killing myself.
• It’s important for me to be a good example for my children.
Evoking Change Talk: Desire, Ability, Reason, Need, Commitment

1. Why have you been thinking about changing your drinking habit? (Reveals desire)
2. If you were to change your drinking habit, how would you do it? (Evokes ability)
3. What are your three most important reasons for wanting to change? (Evokes reasons)
4. How would things be different (better) if you decided to change? (Reveals the need)
5. What is the next step? On a scale of 1-10, how willing are you to change. (Encourages commitment)
Responding to Sustain Talk & Discord

• Ambivalence under pressure leads to discord
• Don’t ignore, but also try NOT to reinforce or engage
• Responses are the same to either
  – Reflections – simple, amplified, double-sided
  – Shifting focus
  – Emphasizing personal choice
Responding to Change Talk

All EARS

• **E:** Elaborating - asking for more detail, in what ways, an example, etc.

• **A:** Affirming – commenting positively on the person’s statement

• **R:** Reflecting – continuing the paragraph, etc.

• **S:** Summarizing – collecting bouquets of change talk
Snatching Change Talk from the Jaws of Ambivalence
Snatching Change Talk from the Jaws of Ambivalence

• Change talk often comes intertwined with sustain talk
• That’s the nature of ambivalence
Snatching Change Talk from the Jaws of Ambivalence

- I really don’t want to stop smoking, but I know that I should. I’ve tried before and it’s really hard.
  - 1. You really don’t want to change
  - 2. It’s pretty clear to you that you ought to quit.
  - 3. You don’t think you can quit.
• See, the thing is, all my friends drink. Some of them probably drink way too much too, but if I quit drinking, I don’t have any friends. I just stay home.
  – 1. That would be pretty lonely
  – 2. Quitting would cause a new problem for you.
  – 3. And at the same time you recognize that you and probably some of your friends are drinking way too much.
• I know you’re worried that I’m getting addicted, and I guess I can see what you mean, but I really need more pain medicine. I don’t know how I would get through the day without it. If you won’t prescribe it, then I’ll find someone else who will.
  – 1. You understand my worry about dependence.
  – 2. It’s hard to imagine how you would get along without more medicine.
  – 3. One way or another, you’re going to get more medicine.
• Write down 3 or 4 statements about some change that you are thinking about making within the next six months:

- **D:** Why do you *want* to make this change?
- **A:** How might you be *able* to do it?
- **R:** What is one good *reason* for making this change?
- **N:** How *important* is it, and why (0-10)?
- **C:** What do you *intend* to do?
- **A:** What are you *ready* or *willing* to do?
- **T:** What have you *already done*?
A taste of MI
How willing do you think this patient will be to change her drinking or reduce her risk as a result of this conversation?

0 1 2 3 4 5 6 7 8 9 10

Not willing Very willing
## Zone I: At Risk
**AUDIT 1-13 (≥ 1 binge); DAST 1-2**

<table>
<thead>
<tr>
<th>Ask Permission (Engage)</th>
<th>&quot;I appreciate your answering our health questionnaire. Could we take a minute to discuss your results?&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Feedback (Focus)</td>
<td>Refer to pyramid &amp; provide patient's AUDIT/DAST score &amp; risk level(s). Ask your physician: &quot;Drinking/using at this level can be harmful to your health and possibly responsible for the health problem for which you came in today. What do you make of that?&quot;</td>
</tr>
<tr>
<td>Enhance Motivation &amp; Elicit Change Talk (Evoke)</td>
<td>&quot;Have you ever considered cutting back or quitting?&quot; If so, &quot;Why?&quot; If not, &quot;What would have to happen for you to consider cutting back/quitting?&quot; &quot;On a scale of 0-10, how important is it that you cut back or quit your alcohol/drug use?&quot; If &gt;0, &quot;Why that number and not a lower one?&quot; (Use numerals also ask about confidence, readiness, OARS: Open-ended questions, Affirmations, Reflections, Summaries)</td>
</tr>
<tr>
<td>Provide Advice</td>
<td>Refer to chart on front of card in providing advise to quit or cut down as per NIH guidelines (or offer advise to quit or cut back drug use).</td>
</tr>
<tr>
<td>Discuss Next Steps (Plan)</td>
<td>&quot;If you were to make a change, what would be your first step?&quot;</td>
</tr>
<tr>
<td>Close on Good Terms</td>
<td>Summarize, emphasis patient strengths, highlight change talk and decisions made. Arrange for follow-up as appropriate.</td>
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</tbody>
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## Zone II: High Risk, Possibly Dependent
**AUDIT ≥ 14; DAST 3-10**

<table>
<thead>
<tr>
<th>Zone II Additional Steps:</th>
<th>&quot;If you go a day or 2 without drinking/using do you ever get sick, shaky, have tremors/seizures/ cramps, or feel/feelings that are not there?&quot; Other means of options for more help:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;Medication (methadone, acamprosate, disulfiram, methadone, Suboxone)&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Referral&quot;</td>
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<td>Counseling/ Brief treatment</td>
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<td></td>
<td>Sober community (e.g., AA, NA, Coolin, Recovery)</td>
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<tr>
<td></td>
<td>Treatment or substance abuse program</td>
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**National Screening, Brief Intervention & Referral to Treatment**

**ATTC**
Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

**SECSAT**
Southeastern Consortium for Substance Abuse Training
Funded by SAMHSA

**SMC**
Substance Abuse Mental Health Services Administration

**SIBRT**
Southeastern Consortium for Brief Intervention and Referral to Treatment

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**www.sbironline.org**

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Rolling with Resistance... Dancing with Discord...
Change talk micro-skills....
Listen & Elicit

1. Good and not-so-good, (Decisional Balance)

2. Importance, Confidence, and Readiness Rulers
Decisional Balance

• Ambivalence is a normal part of the change process
• Use ambivalence to promote positive change
• Weigh pros and cons of behavior
• Increase discrepancy
### DECISIONAL BALANCE SHEET

<table>
<thead>
<tr>
<th>1. Good things:</th>
<th>2. Not so good things:</th>
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Decisional Balance Exercise

• What are some of the good things about your ____ (drinking, smoking, eating whatever you want)? What else?

• What are some of the not-so-good things about your ____? What else?
Responding to decisional balance

• Reflection of both sides of the coin
Double-sided reflection: Acknowledge both sides of the Client's ambivalence.

- *Patient:* Smoking helps me reduce stress.
- *Counselor:* On the one hand, smoking helps you to reduce stress. On the other hand, you said previously that it also causes you stress because you have a hacking cough, have to smoke outside, and spend money on cigarettes.
How important is it to you to do something about your use?

*If 0 was “not important,” and 10 was “very important,” what number would you give yourself?*
Exploring Importance

• *Why are you at x and not w?*
• *What makes it that high?*
• *What would need to happen, if anything, for your importance score to move up from x to y?*
Confidence/Readiness Rulers

How confident are you that if you wanted to change your smoking habit, you could do so?

*If 0 was “not confident,” and 10 was “very confident,” what number would you give yourself?*
Building Confidence

- What have you found helpful in any previous attempts to change?
- What have you learned from the things you tried in the past?
- If you were to decide to change, what might your options be?
- What ways do you know about that have worked for other people?
Building Confidence

• What are some of the practical things you would need to do to achieve this goal? Do any of them sound achievable?

• What, if anything, can you think of that would help you feel more confident?
Confidence
Extreme Confidence
Four Fundamental Processes

- Planning
- Evoking
- Focusing
- Engaging
Options for Change

Begin with a key question:

What do you think you will do?
What changes are you thinking about making?
What do you see as your options?
Where do we go from here?
What happens next?
Options for Change

Manage your use: (cut down to low-risk limits)

Eliminate your use: (quit)

Never use and drive: (reduce harm)

Utterly nothing: (no change)

Seek support
Options for Change

- Conditional Statement
  - If you wanted to...
  - If you decided to...
  - If the time were right...

- Plan of Action
  - How would you do it?
  - How would you go about it?
  - What would you do?
Negotiate a plan of action

• Invite active participation by the patient
• Patient determines goals & priorities
• Patient weighs options
• Together, work out details of the plan
Giving Information and Advice:  

3 Kinds of Permission 

1. The patient asks for advice 
2. You ask permission to give advice 
3. You qualify your advice to emphasize autonomy
Providing Information

• Successful communication requires:
  – Transmission of technical information
  – Interpersonal skills

• Therefore, a relationship is key to good informing
Thoughts about Useful Informing

• Slow down and progress may be quicker
• It’s a person not an information receptacle
• Consider the patient context & priorities
• Amount matters and depends on the patient
• Individualize it
• Beware of righting reflex
Useful Informing

- Ask permission
- Offer choices
- Use other patient examples
- Chunk-Check-Chunk
- Elicit-Provide-Elicit
Giving information and advice:

• **Always ask for permission:**
  “Other patients have found ___ to be of help. Are you interested in knowing about that?”

• **Offer alternatives (menu of options):**
  “We could give you a resourcelist or set up a brief-therapy session with a counselor.

• **Provide more information according to the interest of the patient:**
  “Would you like to know more about AA?”
Finalizing the motivational interview

- Review the commitment
- Review the plan
- Set up a new time to meet
- Express encouragement
Closing on Good Terms

**SEW**

**S:** Summarize patient’s views
   (especially the pro-change part of what they said).

**E:** Encouraging remarks

**W:** What agreement was reached is repeated.
Avoid Warnings!
The MI Shift

From feeling responsible for changing Clients’ behavior to supporting them in thinking & talking about their own reasons and means for behavior change.
That's All Folks
One thing I liked was....
One thing I learned was....
One thing I am going to try is....