Using Motivational Interviewing Tools & Techniques to help Housing Participants

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Primary Question

How can you help residents successfully navigate housing requirements and cope with their past and current environmental, cultural & physical stressors?
Todays Journey...

• **Recognize** SUD as a complex outcome of personal, inter-personal, and social determinants.
• **Review** prevalence & signs of use
• **Introduce** MI and it’s ability to help people move toward change
• **Develop** Effective & Brief strategies of interaction with residents & appropriate referral resources as needed
Introductions...

• Name, and something that no one knows about you

• Passion Activity:
  – Find a partner you don’t know well
  – Take turns interviewing each other about a passion in their lives (5 min each)
  – Your job: understand the essence of their passion. What underlies it’s value?
Substances of Abuse

10 separate classes of drugs

- Alcohol
- Caffeine
- Cannabis
- Hallucinogens
- Inhalants
- Opioids
- Sedatives, hypnotics and anxiolytics
- Stimulants
- Tobacco and other substances
Ten signs of Problem Drinking/Drugging (not all)

• Temporary Memory Loss and Blackouts
• Drinking/Drugging to Cheer Up
• You’ve Tried to Quit Drinking/Drugging But Can’t
• You Drink/Drug to be “Normal” or “Fit In”
• Flushed Skin/Broken Capillaries on the Face (Alcohol)
• Trembling Hands (Alcohol)
• Problems with Family Members as a Result of Drinking/Drugging
• Drinking/Drugging in Secret or Lying About Your Intake
• Anxiety, Insomnia, Nausea When You Stop Drinking/Drugging
• Drinking/Drugging in the Morning
RISKY AND HARMFUL ALCOHOL USE
Effects on the Body

Alcohol can worsen existing health problems:
- Liver disease
- Heart disease and high blood pressure
- Diabetes
- Ulcers and stomach problems
- Depression and anxiety
- Sleep problems

Something to think about:
Risky and harmful alcohol use frequently leads to social, legal, medical, domestic, job, and financial problems. Alcohol may shorten your lifespan and lead to accidental injury or death.
MARIJUANA
Effects on the Body

- Problems with coordination, judgment, learning, memory, reaction time, sensory perception, sleeping
- Cancer of the head and neck
- Respiratory problems, asthma attacks, infections, emphysema
- During pregnancy: less oxygen to fetus, premature birth; drug via placenta, umbilical cord, and breast milk; low birth weight; early lung problems
- In men: low sex drive, low testosterone, low sperm production, erectile dysfunction, increased breast growth, testicular cancer
- In women: low sex drive, irregular periods, fertility problems
- Panic/anxiety, depression, paranoia, lack of motivation, mood swings
- Dry mouth, tooth decay, bad breath
- Increased blood pressure and heart rate, risk of heart attack
- Weight gain, weakened immune system, chronic fatigue, vomiting
Effects of Opiates

- Drowsiness
- Confusion
- Memory loss
- Fatigue
- Hallucinations
- Convulsions
- Dilation of blood vessels causing increased pressure in brain
- Pupil constriction
- Slurred speech
- Respiratory depression
- Nausea
- Vomiting
- Weight loss
- Sexual dysfunction
- Constipation

Signs: Physical

- Dry mouth
- Sweating
- Feeling lightheaded
- Feeling euphoric and overly elated
- Flushed face
- Lack of coordination
- Sleeping too much or sleeping too little
Signs: Psychological

- Confusion
- Loss of appetite
- Irritability
- Mood swings
- Depression
- Panic attack
Signs: Miscellaneous

• Faking pain related emergencies or hurting themselves intentionally so that they can receive pain medication
• Having an excess of pill bottles and prescription pads in their home or in their vicinity
• Wearing long sleeves in the summer or warm climates to hide track marks
Signs: Interpersonal

• Ignoring or avoiding loved ones
• Forgetting family responsibilities, such as picking a child up from school
• Starting fights with loved ones
• Becoming domestically violent with children, parents, or romantic partners
• Lying to loved ones to avoid being caught using opiates
Signs: Financial

• Asking to borrow money from loved ones
• Stealing money to pay for opiates or dealing
• Cashing out retirement accounts or life savings to pay for opiates
• Bankruptcy
• Forfeit of home due to inability to pay rent or a mortgage
• Losing a business or job because of misuse or stealing of business funds to purchase opiates
Despite all these “signs”...

- It's not always obvious or detectable for many, many reasons
Over the past 10 years, alcohol use has...

• Choose one.

A. Increased
B. Stayed the same
C. Decreased
VT has a higher prevalence of past month alcohol use than the U.S. average (aged 12 and over)

Source: National Survey on Drug Use and Health, 2002-2012
How does Vermont compare to the U.S. in prevalence of binge drinking?

• Choose one.

A. Vermont’s problem is worse
B. Vermont’s problem is about the same
C. Vermont’s problem is not as bad
VT has a similar prevalence of binge drinking in past month compared to the U.S. average (aged 12 and over)

Note: Binge drinking is defined as 5+ drinks on the same occasion.

Source: National Survey on Drug Use and Health, 2002-2012
Co-occurring disorders prevalence

Among those with a past year substance use disorder, 42.8 percent had an identified co-occurring mental illness. (NSDUH)

Of mental health residents treated in Vermont’s Designated Agencies, 19% also had an identified substance use diagnosis.
ACE Study – Adverse Childhood Experiences

• Kaiser Permanente study
• 1998-2011
• 17,000 people
• 10 questions re: childhood trauma
• 5 = personal trauma
• 5 = related to family members
ACE study results

• 2/3 had at least one ACE

• 87% had more than one

• 4 or more trauma responses to questions:
  • 15% = women
  • 9% = men
ACE Score of 4 or more

Likelihood of COPD increases 390%

Depression = 460%

Hepatitis = 240%

Suicide = 1,222 %
Stopping the Inheritance of Suffering: Adverse Childhood Experiences

![Bar graph showing prevalence of selected outcomes among adults in the Kaiser ACE study](image)
Trauma and SUD Conclusion

• Traumatic events leave their imprint on residents
• Disasters, terrorist attacks, and other generalized traumatic events may activate pre-existing PTSD or compound the effects of previous trauma
• If clinicians don’t inquire about the effects of a traumatic event, many residents will not discuss them
Our Behaviors are Killing Us - Literally

Dying in Middle Age
Death rates are rising for middle-aged white Americans, while declining in other wealthy countries and among other races and ethnicities. The rise appears to be driven by suicide, drugs and alcohol abuse.

DEATHS per 100,000 people aged 45-54

Case & Deaton, 2015
Suicides are Increasing for Females in US

Figure 2. Suicide rates for females, by age: United States, 1999 and 2014

CDC, 2016: Increase in Suicide in the United States, 1999–2014
Rationale for Assessing Substance Use + Depression in Medical Settings

Incredibly high comorbidity

- Hypertension: 31% None, 52% MHD, 4% SUD, 13% MHD + SUD
- Diabetes: 32% None, 54% MHD, 3% SUD, 11% MHD + SUD
- Coronary Heart Dz: 26% None, 53% MHD, 4% SUD, 17% MHD + SUD
- CHF: 30% None, 48% MHD, 6% SUD, 16% MHD + SUD
- COPD/Asthma: 24% None, 51% MHD, 5% SUD, 21% MHD + SUD

Boyd, C. Faces of Medicaid Data Brief, Center for Health Care Strategies, Dec 2010
SBIRT’s Incredible Potential to Change Health Outcomes

**Figure 1. Determinants of Health and Their Contribution to Premature Death.**
Adapted from McGinnis et al.\(^\text{10}\)
VT prevalence (age 12 plus) of substance use disorder is about the same as compared to the U.S. average

Percent of population who meet DSM-IV criteria for dependence or abuse

49,294 with SUD

Vermont U.S.

Source: National Survey on Drug Use and Health, 2010 and 2012
Past Year Alcohol Use Treatment among Persons with Alcohol Use Disorder in VT (2008-2012 Age 12 plus)

44,857 ≠ Treatment

91%

Did Not Receive Treatment

Received Treatment
Reasons for Not Receiving Substance Use Treatment For Those Who Needed

- **No Health Coverage and Could Not Afford Cost**
- **Not Ready to Stop Using**
- **Able to Handle Problem without Treatment**
- **No Transportation/Inconvenient**
- **Might Cause Neighbors/Community to Have Negative Opinion**
- **Did Not Feel Need for Treatment at the Time**

**Source:** National Survey on Drug Use and Health, 2007-2009
How has society historically viewed substance abuse?

A. A moral failure
B. A family demon
C. A social challenge
D. A criminal justice crisis
An Ineffective Solution

• The solution to any problem is typically driven by its presumed cause.

= Judgment, Blame, Confrontation, Punishment
Meet Dr. Volkow

"Groundbreaking discoveries about the brain have revolutionized our understanding of addiction, enabling us to respond effectively to the problem. We now know that addiction is a disease that affects both brain and behavior. We have identified many of the biological and environmental factors and are beginning to search for the genetic variations that contribute to the development and progression of the disease."

-- Nora D. Volkow, MD
   Director
   National Institute on Drug Abuse
Drug addiction is a brain disease that affects behavior.

Recovery from drug addiction requires effective treatment, followed by management of the problem over time.

Treatment must last long enough to produce stable behavioral changes.

Assessment is the first step.

Tailoring services to fit the individual is an important part of effective treatment.

Drug use during treatment should be carefully monitored.
Discuss with your training partners these 5 Myths
Which ones still exists in your housing setting
Which ones can you do something about & how?
Myth #1

• *People who get addicted are weak and without morals.*

• Addiction is a disease and is not about character. It is true that many people who are addicted do reprehensible things. Driven by changes in the brain brought on by prolonged use, they may lie, cheat and steal to maintain their habit. But good people do bad things, and sick people need treatment – not punishment – to get better.
Can the brain get hijacked?

Research shows that prolonged use can change brain chemistry, sometimes permanently.
Let’s take a look at how addiction develops

- Alcohol
- Opiates
- Cocaine
- Meth-amphetamine
DRUGS OF ABUSE TARGET THE BRAIN’S PLEASURE CENTER

Brain reward (dopamine) pathways

These brain circuits are important for natural rewards such as food, music, and sex.

Drugs of abuse increase dopamine

Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.
The brain reward system compromised

Areas with highest density of dopamine receptors shown in red.
Tolerance

- A reduced sensitivity to a substance that requires higher quantities of that substance to be consumed in order to achieve the same effects as before tolerance was established.
- With an unbalanced reward pathway and an increasingly high tolerance the person is developing symptoms of...more severe use.
Myth #2

- *Substance abuse effects only those who are socially and economically disadvantaged.*

- The truth is that addiction doesn’t discriminate and can and does happen to anyone regardless of wealth or social status.
2010 report shows adolescents with higher SES at greater risk for substance abuse during early adulthood.

- National Longitudinal Survey of Adolescent Health (AddHealth)
- 9,872 adolescents tracked in middle and high school and then followed up between the ages of 18-27.
- Results showed that higher parental education was associated with higher odds of binge drinking and marijuana use and cocaine use in early adulthood.
- Higher household income in adolescence was associated with a higher probability of binge drinking and marijuana use.
Myth #3

*Addiction is a choice.*

- Recovery isn’t as simple as exercising willpower. People don’t choose to become addicted any more than they choose to have cancer or diabetes. There are genetic, neurochemical and behavioral factors that influence addictive behavior. An individual may initially choose to drink or use drugs but stopping is not easy once addicted.
Genes can make individuals vulnerable to addiction
And the other half is environmental

- **Community** - An individual's connection with the community in which they live plays a big part in their likelihood of abusing drugs. Statistics show that if a person's community has favorable attitudes toward drug use, firearms and crime, their risk is increased.

- **Peer** - The single biggest contributing factor to drug abuse risk is having friends who engage in the problem behavior. If an individual's friends have favorable attitudes towards drug use, this can also increase risk. In addition, the earlier a person experiments with AOD, the greater the risk of becoming addicted.

- **Family** - Family conflict and home management problems are contributing factors in drug abuse risk. Also, if parents have favorable attitudes towards drug use or use drugs themselves, often their children will be more likely to abuse drugs.

- **School** - A student's performance, participation, and commitment to school can be a major risk factor in addiction.
Developmental Influences on Substance Abuse

• Temperamental in early years, e.g., “difficulty with self-soothing.”
• Trauma/Victimization History
• Learning Difficulties & Social Impairments
• Deviant Peer Groups & Delinquent Behaviors
• Prior Mental Health Problems
• Family History
• Early Age of Onset
Alcohol and Age of First Use

• Person’s reporting first use of alcohol before age 15 were more than 5 times as likely to report past year alcohol dependence or abuse - than persons who first used alcohol at age 21 or older (16% vs. 3%).
Chronic Relapsing Disorder

• Substance Use Careers Last for Decades
• Median Duration of 27 years from First Use to 1+ years Abstinence
• On Average Recovery Takes Decades and Multiple Episodes of Treatment
• Median Duration of 9 years and 3 to 4 Episodes of Care
• It takes a Year of Abstinence before less than 50% relapse
• Even after 3-7 years of abstinence about 14% relapse
Myth #4

• *Individuals who are addicted must hit rock bottom before they can be treated.*

• We must reject this archaic belief and get people the help they need. This means informing clients that there are effective treatments available whenever the person is ready to get help. And if the person is not ready, initiating an empathic conversation using motivational interviewing can often increase behavioral activation.
The Outdated Model: A Continuum of Substance Use
The outdated model defines a substance use problem as \textbf{Dependence}.
An Outdated Model

• By defining the problem as dependence the outdated model fails to recognize

  • a full continuum of substance use behavior
  • a full continuum of substance use problems
  • and does not provide a full continuum of substance use interventions
Myth #5

• The only way for individuals who are abusing substances to stop using is to go to a 12-step program and enter a residential treatment program.

• Alcoholics Anonymous and the Twelve Steps have helped countless people get and stay sober because it’s a substantial self-help program that works for some but it doesn’t work for everyone. People must be informed about other treatments that are effective, some of which are used in conjunction with AA. Effective programs should offer many modalities of treatment, including behavioral, psychological and medical treatments.
Substance Use – Rethinking from a Public Health Model

• Who need help?
• Defining Severity
• ASAM Guidelines for Treatment Matching
• Levels of Care
• Pathway to Treatment
• http://www.healthvermont.gov/alcohol-drug-abuse/how-get-help/find-treatment
• See VDH ADAP Opiate Alliance
• http://www.healthvermont.gov/response/alcohol-drugs/treating-opioid-use-disorder
Re-Thinking Substance Use Problems From a Public Health Perspective
Who Are We Trying to Reach Now?

- Within Normal Levels (80%)
- Mild (15%)
- Moderate (2.5%)
- Severe (2.5%)

Risky alcohol use
NIAAA Low Risk Drinking Guidelines

<table>
<thead>
<tr>
<th>Category</th>
<th># of Drinks Per Day</th>
<th># of Drinks Per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Female &amp; 65 Plus</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Pregnant</td>
<td>0</td>
<td>0</td>
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</tbody>
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DSM-IV vs. DSM-V for Alcohol-Related Disorders

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-V</th>
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| **Key 1: Alcohol Use**<br>Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absentees, suspensions, or expulsions from school; neglect of children or household).<br>Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol abuse).<br>Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct).<br>**This is not included in DSM-V**<br>Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about the consequences of intoxication, physical fights).<br>Resistance, as defined by either of the following:<br>a) A strong desire or unsuccessful efforts to cut down or control alcohol use<br>b) Markedly diminished effect with continued use of the same amount of alcohol<br>Withdrawal, as manifested by either of the following:<br>a) The characteristic withdrawal syndrome for alcohol<br>b) Alcohol is taken to relieve or avoid withdrawal symptoms<br>Alcohol is often taken in larger amounts or over a longer period than was intended.<br>There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.<br>A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.<br>Important social, occupational, or recreational activities are given up or reduced because of alcohol use.<br>Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the alcohol (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).<br>**This is new to DSM-V**<br>Alcohol is often taken in larger amounts or over a longer period than was intended. (See DSM-IV, criterion 7.)<br>There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. (See DSM-IV, criterion 8.)<br>A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (See DSM-IV, criterion 9.)<br>Craving, or a strong desire or urge to use alcohol.<br>**This is new to DSM-V**<br>Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. (See DSM-IV, criterion 1.)<br>Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. (See DSM-IV, criterion 4.)<br>Important social, occupational, or recreational activities are given up or reduced because of alcohol use. (See DSM-IV, criterion 10.)<br>Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol. (See DSM-IV, criterion 11.)<br>**Tolerance, as defined by either of the following:**<br>a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect<br>b) A markedly diminished effect with continued use of the same amount of alcohol (See DSM-IV, criterion 5.)<br>**Withdrawal, as manifested by either of the following:**<br>a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal)<br>b) Alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms. (See DSM-IV, criterion 6.)<br>**The presence of at least 2 of these symptoms indicates an Alcohol Use Disorder (AUD).**<br>The severity of the AUD is defined as:<br>Mild: The presence of 2 to 3 symptoms<br>Moderate: The presence of 4 to 5 symptoms<br>Severe: The presence of 6 or more symptoms
DSM-V Severity Ratings

• Mild - Presence of 2-3 symptoms
• Moderate – Presence of 4-5 symptoms
• Severe – Presence of 6 or more symptoms

• Early remission – None of the criteria for AUD have been met for < 3 months but for less than 12 months.
• Sustained remission – None of the criteria for AUD have been met at any time during a period of 12 months or longer
ASAM resident Placement Levels*

• Level 0.5: Early Intervention
• Level 1: Outresident Treatment
• Level 2
  • Level 2.1: Intensive Outresident Treatment
  • Level 2.5: Partial Hospitalization
• Level 3
  • Level 3.1: Clinically Managed Low-Intensity Residential Services
  • Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria)
  • Level 3.5: Clinically Managed High-Intensity Residential Services
  • Level 3.7: Medically Monitored Intensive Inresident Treatment
• Level 4: Medically Managed Intensive Inresident Treatment
• Opioid Treatment Services

*Third edition 2013
Assessment of Biopsychosocial Severity and Function in the following domains

• Acute intoxication and/or withdrawal potential
• Biomedical conditions and complications
• Emotional/behavioral/cognitive conditions and complications
• Readiness to Change
• Relapse/Continued Use/Continued Problem potential
• Recovery environment
Substance Abuse Continuum of Care

Highest Level of Care

Specialty Care
= e.g., Residential and Hubs

Intensive Outresident Treatment

Outresident Treatment

SBIRT

Prevention Services

Lowest Level of Care

Fewest Number of People

Largest Number of People
Process for Accessing Treatment in Vermont

Client is screened by a clinician or professional (i.e. physician, drug court case manager, AHS employee, etc.)

Client or provider contacts a treatment substance provider

Provider assesses client with evidence based tools & determines level of ASAM placement criteria

Provider refers client it to the appropriate level of care

Outpatient
IOP
Residential
Medication Assisted Treatment

Recovery Center Referral for Support
Biopsychosocial treatment may include any of the following 5 M’s:

- **Motivate** – Assessment of readiness to change behavior; engagement and alliance building
- **Manage** - the family, significant others, work/school, legal
- **Medication** – withdrawal management; HIV/AIDS; anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
- **Meetings** - AA, NA, Al-Anon; Smart Recovery, Dual Recovery Anonymous
- **Monitor** - continuity of care; relapse prevention; family and significant others support
What’s the best approach?

When you are worried or concerned about a resident’s –

- Health
- Rent
- Maintenance
- Interactions with other residents
Compassionate Reflective Discussions

• No shoulds
• No unsolicited advice
• Ask open questions
• Reflect more than questions
• Affirm self choice
What is MI?

Motivational Interviewing

“A compassionate yet direct interview style for addressing the common problem of ambivalence about change.”

Using the strength of our relationship to help people find and nurture their own desire for positive change
Stronger relationships mean better outcomes

• Over 1,000 research findings demonstrate that a **positive alliance** is one of the best predictors of outcomes (Orlinsky et al, 2004)

• The quality of the client–therapist alliance is a reliable predictor of positive clinical outcome independent of the psychotherapy approaches and outcome measures (Ardito, 2011)
Effectiveness of MI

Note: In this case, the effect size indicates the strength of the relationship between MI and the given outcome. The higher the value, the stronger the relationship between MI and the outcome. Effect sizes range from $d=0.20$ (small) to $d=0.30$ (medium) to $d=0.50$ (large).

Stages of Change

Prochaska & DiClemente, 1983
MI Basics

Spirit - Collaborate

Skills of Engagement – do not give unsolicited advice but test hypotheses to uncover core ambivalence

Core Strategies: Attentive Listening, 2 reflections for one question, summarize with

Compassionate & Complex reflections
MI Spirit

the feeling of the MI spirit is often expressed as genuine curiosity
Skills of MI: O.A.R.S.

Open-ended question

Affirmations

Reflections

Summaries
Open vs. Closed Questions

- **Closed questions**
  - Quick, easier, & efficient
  - Less person-centered
  - Less engaging

- **Open questions**
  - Requires more than a yes or no response
  - Elicit a **narrative** from clients
Open vs. Closed Questions

• Examples:
  • **How** do you understand...
  • **What** are you hoping...
  • **Why** do you think...
  • **Tell me a little more** about...
  • **What** has changed to make you want to...

*The goal is to have the client do most of the talking*
Affirmations

• *Compliments, statement of appreciation*

What should we affirm?
• A person’s struggles, achievements, values and feelings
• Emphasize a strength
• Notice and appreciate a positive action
• Express positive regard and caring
Types of Reflective Listening

- **Simple reflection**: rephrasing, or literal reflection
- **Reflection of meaning**: rephrasing + what you think they might mean
- **Reflection of feeling**: rephrasing + what feeling you think might accompany it.
- **Double-sided reflection**: rephrasing of what the individual has expressed in a way that acknowledges both sides of ambivalence – the struggle against and the struggle towards change.
Core Skills of MI

Reflections

2-sided

Feeling

Meaning

Simple
Core Skills of MI

Reflections
- Simple
- Meaning
- Feeling
- Two-sided

“Of course this happens to me. I finally get a job offer, but now I don’t have a car to get me there.”
Summaries

• “So, let me see if I’ve got this right...”
• “So, you’re saying... is that correct”
• “Make sure I’m understanding exactly what you’ve been trying to tell me...”

Double sided reflections are often highly effective as summaries to illustrate ambivalence.
Practice (5-10 min/person)
Practice (5-10 min/person)

• Think of a problem or a challenge in your life that you are willing to share (exercise, diet...)
• Find a new partner! Someone you don’t know 😊
• Take turns with one of you as speaker, one as interviewer.
• **The Interviewer** is going to use OARS to build rapport, explore the problem, and build a deeper awareness
• Stick mostly to reflections
• *Avoid giving advice!*
• *Debrief*
The Righting Reflex & Ambivalence

• **The Righting Reflex:** The desire to fix what seems wrong and to set clients promptly on a better course, often using a prescriptive approach (advice).

• **The problem:** Clients are typically ambivalent so they know the arguments! **So what do we do?**
The Keys to Readiness

Confidence

Importance

Readiness

Confidence
Elicit Change Talk

• **QUESTION:** What does it sound like when a client is expressing motivation to change?
• **Ex.** A client is discussing their drinking.
• *Change talk can be subtle: the cost of beer, complaints from loved ones, imagining a time without drinking.*
Eliciting Ideas & Building Motivation

MI has collected a number of “tools”:

- Normalizing (“changing can be hard”)
- Pros/cons
- Readiness Ruler
- Looking ahead/looking back
Readiness Ruler

A fast an effective method of assessing motivation

• “On a scale of 1 – 10, how ready do you feel to make a change now”
• “I don’t know, maybe a 4”
• “Why did you choose that and not something lower like a 1 or 2?”
The Process of MI

1) **Engage**: build rapport, use OARS
2) **Focus/raise the subject**: what behavior?
3) **Elicit ideas**: uncover the client’s own reasons for change (change talk) and **build motivation** using OARS
4) **Plan**: create an achievable realistic plan (collaboration) that utilizes support
Engage the client, build rapport using O.A.R.S.

Client Values → Raise the Subject → Elicit Ideas → Plan → Change

Acceptance  Authenticity  Accurate Empathy
Initial Screening = Vital Sign

• Universal
• Essential to get it right = elicit accurate information
• Determines who may be at risk
• Introduce it as part of a wellness approach
• Ensure the time frame is clear and use memory anchors
The Brief Negotiated Interview (BNI)

• The BNI is a formalized way of having a conversation based on MI
• A BNI can take between 5 – 45 minutes
The Brief Negotiated Interview (BNI)

Steps of the BNI:
• 1) Raise the subject (of the behavior)
• 2) Pros & Cons
  – *Build motivation through reflection*
  – *Summarize the client’s ideas*
• 3) Provide information
• 4) Readiness Ruler
• 5) Negotiate a Plan
  – *Identify strengths and supports*
  – *Be specific and achievable*
The Art of Referring Effectively to Specialty Care
Resident Interaction Questions

• What are the indicators that the resident needs a referral?
• What are the indicators that the resident is ready and willing to accept a referral from you?
• What strategies can be utilized with the resident to increase readiness and willingness?
Plan for the Nuts and Bolts

• Whom do you call?
• Do you have access to referral resource information?
• What form do you fill out?
• What is the feedback loop for coordinated care?
Assertive Linkage & Continued Care

• Confirm your follow-up plan with the resident.
• Decide on the ongoing follow-up support strategies you will use.
• Determine communication feedback loop frequency, type of information to be shared.
Which Treatment Provider?

• Clinical expertise to match resident needs – Trauma Informed care (DBT, CBT, MET, etc.)
• Language ability/cultural competence
• Family support
• Services that meet the resident’s needs
• Accessible location/transportation
Common Mistakes To Avoid

• Rushing into “action” and making a treatment referral when the resident isn’t interested or ready.
• Referring to a program that is full or doesn’t take the resident’s insurance.
• Not knowing your referral base.
• Not considering pharmacotherapy in support of treatment and recovery.
• Seeing the resident as “resistant” or “self-sabotaging” instead of having a chronic disease.
Closing Thoughts...

• The basis of MI (and most therapy) is a strong therapeutic alliance: **develop your OARS**

• Doing MI well is an art form (like most therapy)

• Short trainings like this can be dangerous
  — It build confidence, but often does not add skill
  — So take a longer course and practice!
The Tao of Change

• Using MI and the BNI is a way of helping people become their better selves.
• Your greatest tool is the quality of your relationship.
• Working alliance & resident stated reasons/needs = activation to change