Chapter 8—Integrating Motivational Approaches in SUD Treatment Settings

> From its inception MI [motivational interviewing] has been organic, emerging, and evolving through collaborative processes....Our decision was to focus on promoting quality in MI practice and training...."
>
> —Miller & Rollnick, 2013, p. 377

KEY MESSAGES

- Motivational counseling approaches have been widely disseminated to substance use disorder (SUD) treatment programs.
- Adaptations of MI in group counseling, the use of technology, and blended counseling approaches enhance the implementation and integration of motivational interventions into standard treatment methods.
- Training and ongoing supervision of counselors are essential for workforce development and integration of motivational counseling approaches into SUD treatment.

Chapter 8 discusses adaptations for using motivational counseling approaches in group counseling, with technology, and in blended counseling approaches that are applicable to SUD treatment programs. It also addresses workforce development issues that treatment programs may face in fully integrating and sustaining motivational counseling approaches.

Over the past three decades, MI and motivational counseling approaches have been widely and successfully disseminated across the United States and internationally to specialty SUD treatment programs (Hall, Staiger, Simpson, Best, & Lubman, 2015). Research supports the integration of motivational counseling strategies into treatment as a prelude to ongoing treatment to increase client retention and enhance participation in treatment. Motivational counseling can increase adherence to treatment medication and behavioral change plans and makes achievement and maintenance of positive substance use behavior outcomes more likely (Miller & Rollnick, 2013). Depending on the SUD treatment setting, different adaptions of motivational interventions (e.g., individual or group counseling, blended with other counseling approaches) may be effective both clinically and programmatically.

Integrating motivational counseling approaches into a treatment program requires more than providing counseling staff with a few workshops on MI. It requires broad integration of the philosophy and underlying spirit of MI throughout the organization. Just as a counselor using a motivational approach works in partnership with clients to help them move through the Stages of Change (SOC) to achieve long-term behavioral change, organizations wishing to integrate a motivational counseling approach should work in partnership with staff to implement program changes. Organizations also go through a process of change until the treatment approach becomes a new "lifestyle."

Adaptations of Motivational Counseling Approaches

The most common delivery of motivational counseling approaches has been through brief or ongoing individual counseling. For example, MI in SUD treatment was specifically developed as a counseling approach to be delivered in face-to-face conversations between a counselor and a client. Depending on the treatment program, adaptations of motivational interventions may make treatment more cost effective, more accessible to clients, and easier to integrate into existing treatment approaches, as well as ease workload demands on counselors.

Chapter 8 discusses the following adaptations of motivational counseling approaches:

- Group counseling
- Technology adaptations (e.g., Internet-based applications and telephone-based MI)
- Blended counseling approaches

Group Counseling

The current context of service delivery in SUD treatment programs places heavy emphasis on group counseling. Many motivation-enhancing activities can take place in group counseling that cannot occur in individual treatment (e.g., clients can receive feedback from peers). Because social support is intrinsic to group treatment, clients in a group can reinforce and help maintain each other's substance use behavior changes (Holstad, Diiorio, Kelley, Resnicow, & Sharma, 2010).

However, several significant clinical issues arise when conducting groups using MI including (Feldstein Ewing, Walters, & Baer, 2013; Miller & Rollnick, 2013):

- The counselor's ability to translate MI skills to the group context
- The counselor's skill in managing group dynamics
- Fewer opportunities for group members to express change talk and receive reflective listening responses from the counselor
- Varying needs and experiences of group participants
- The counselor's ability to respond to various participant needs (e.g., reflecting commitment language of one participant while responding to another participant's ambivalence about changing substance use behaviors)
- Actively managing social pressures of peer interactions, which are not present in individual sessions
- Responding to and managing sustain talk in a group setting

Perhaps the most challenging aspect of group-based MI is the possibility of group members reinforcing each other's sustain talk instead of reflecting change talk (Miller & Rollnick, 2013). An important adaptation of MI in group is to minimize the opportunities for clients to evoke and reflect sustain talk and maximize opportunities to evoke and reflect change talk (Houck et al., 2015; Miller & Rollnick, 2013). Strategies for accomplishing this include:

- Teaching group members OARS (asking **O**pen question, **A**ffirming, **R**eflective listening, and **S**ummarizing) skills (Wagner & Ingersoll, 2013).
- Identifying the general parameters for group interactions that are in line with the spirit of MI (e.g., group members should support each other without pressure to change, avoid giving advice, focus on positives and possibilities for change) (Miller & Rollnick, 2013).
- Modeling MI skills in groups (Wagner & Ingersoll, 2013).
- Acknowledging sustain talk but emphasizing and reinforcing change talk (D'Amico et al., 2015).

EXPERT COMMENT: MOTIVATIONAL ENHANCEMENT IN GROUP COUNSELING

Conducting motivational interventions in a group versus individual format is more difficult, more complex, and more challenging. Personally, however, I find it much more rewarding. In group counseling, particularly using motivational techniques and strategies, clients learn through the group. It is like a hall of mirrors; clients get the feel of how they come across. For me, when a client uses reflective listening with another client or points out another client's ambivalence, the group is like a living, learning laboratory of experiences practiced first in a safe environment before being tried in the real world. In the end, what the members have is a common goal to reduce or stop substance misuse, and it is here that their mutual support and peer pressure is effective.

Linda C. Sobell, Ph.D., Consensus Panel Member

Evidence shows that, despite some challenges, MI can be delivered successfully in a group context, particularly when group participants hear more change talk than sustain talk (Osilla et al., 2015). Positive outcomes from MI in groups include decreased alcohol use and alcohol misuse among adolescents, greater retention in SUD treatment after detoxification, increased retention in methadone maintenance treatment, and adherence to risk-reduction behaviors in women infected with HIV (Bachiller et al., 2015; D'Amico et al., 2015; Holstad et al., 2010; Navidian, Kermansaravi, Tabas, & Saeedinezhad, 2016).

Integrating MI into group treatment requires group counselors to have training and ongoing supervision in both MI strategies and group process. The **Assessment of Motivational Interviewing Groups—Observer Scale (AMIGOS-v 1.2)** is a validated tool that assesses counselor skills in group processes, client-centered focus, and using MI in groups (Wagner & Ingersoll, 2017). Appendix C provides a link to a downloadable version of AMIGOS. This tool may be helpful for assessing and enhancing counselor competence in delivering MI in groups.

Technology Adaptations

Some evidence shows the effectiveness of adaptations of MI and motivational enhancement therapy (MET) through interactive computer applications, Internet-based applications, and telephone or video conferencing when used selectively to deliver motivational interventions (Miller & Rollnick, 2013). For example, the "drinker's checkup," the original method to give personalized feedback in MET, has been delivered in interactive computer-based applications and has had positive outcomes in reducing alcohol misuse (Hester, Delaney, & Campbell, 2012).

Benefits of brief motivational interventions delivered by interactive computer applications include (Hester et al., 2012):

- Ease of use.
- Cost effectiveness.
- Adaptability to different client populations.
- Flexibility of design.

Although computer- or Internet-based adaptations of motivational interventions may be useful in providing personalized feedback to clients, computers cannot provide empathetic listening responses or evoke change talk. They also limit use of brief interventions that provide feedback to increase client engagement in treatment.

Telephone MI is the most widely used alternative to face-to-face MI and is effective for addressing tobacco cessation, alcohol misuse, and use of illicit drugs (Jiang, Wu, & Gao, 2017). Telephone counseling with, if possible, the addition of a video component has the advantage of reaching client populations in rural settings that do not have access to transportation to the treatment setting. Telephone MI approaches also have the added benefit over computer-based interventions of giving the counselor the opportunity to offer interactive motivational interventions like reflective listening, affirmations, and evoking change talk. For

more information about using technology in SUD treatment, see Treatment Improvement Protocol (TIP) 60: *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015b).

Blended Counseling Approaches

MI as a counseling style is compatible with a wide range of clinical approaches that have been used in SUD treatment including cognitive–behavioral therapy (CBT), psychoeducation, medication-assisted treatment, and case management approaches (Miller & Rollnick, 2013). When thinking about ways to integrate MI into current treatment approach, treatment staff should address some open questions like, "How does MI fit with what we already do?" and "At what points in our treatment approach are we most concerned about engaging clients in treatment, helping clients resolve ambivalence about change, and retaining clients in treatment?" (Miller & Rollnick, 2013). Three examples of blending MI with other SUD counseling approaches supported by research are motivational interviewing assessment (MIA), CBT, and recovery management checkup (RMC).

MIA

The National Institute on Drug Abuse Clinical Trials Network, in cooperation with SAMHSA, developed a protocol to incorporate MI into a one-session assessment intake to improve client engagement in SUD treatment programs (Carroll et al., 2006). This blended approach to the standard initial assessment in SUD treatment sandwiches a standard assessment between a brief MI counseling segment at the beginning and end of the session (Martino et al., 2006).

A challenge of doing a standard assessment with clients just entering treatment is that counselors and clients tend to fall into the question-and-answer trap (see Chapter 3). Counselors ask closed questions to elicit information needed for the assessment, and clients answer with yes, no, or short-answer responses. This pattern of interaction sets up an expectation that the counselor is the expert and the client is a passive recipient of services. It can become an obstacle to client engagement (Miller & Rollnick, 2013).

MIA incorporates MI into typical SUD treatment program intake/assessment processes and facilitates client engagement while addressing the organization's need to collect assessment information for treatment planning and to comply with licensing and insurance requirements.

Research supports MIA as a method to blend MI with standard assessment approaches. An initial study found that clients who participated in the MIA-blended protocol were significantly more likely than clients who participated in the standard assessment to be enrolled in the program after 1 month (Martino et al., 2006). A more recent study found that incorporating MI into the initial intake and assessment processes (whether standard MI or MIA) promoted client retention (e.g., 70 percent remained in treatment after 4 weeks) and enhanced treatment outcomes (e.g., a 50 percent increase in days abstinent) (Martino et al., 2016). This same study found that supervision of counselors in both groups (standard MI and MIA) improved counselor performance of MI, but the counselors who received supervision in MIA showed significantly greater improvements in MI competency, although training and supervision in MIA was more costly. A link to a manual for training and supervising counselors in MIA, Motivational Interviewing Assessment: Supervisor Tools for Enhancing Proficiency Manual, is available for download at no cost in Appendix C (Martino et al., 2006). Another study found that the addition of motivational feedback to a standard assessment enhanced SUD treatment entry for a group of veterans with co-occurring disorders (Lozano, Larowe, Smith, Tuerk, & Roitzsch, 2013).

MI and CBT

Perhaps the most widely adopted counseling approach used in SUD treatment is CBT. CBT focuses on helping clients change thoughts (e.g., drinking is the only way to relax) and behaviors (e.g., drinking to intoxication) that interfere with everyday functioning. CBT strategies include helping clients identify and manage triggers for substance use and practicing new behaviors that reinforce abstinence. CBT is also an evidence-based approach that is widely used to treat mental disorders (e.g., anxiety, depression, posttraumatic stress disorder) that often co-occur with SUDs.

However, some CBT providers have acknowledged difficulties with initial client engagement, low motivation, and nonadherence to CBT practices, such as completing out-of-session assignments (Arkowitz, Miller, & Rollnick, 2015). **Integrating MI strategies to address ambivalence and enhance motivation of clients with co-occurring disorders can improve client adherence to CBT treatment components.**

Strategies for blending MI and CBT include (Copeland, Gates, & Pokorski, 2017; Miller & Rollnick, 2013; Naar-King, Safren, & Miller, 2017):

- Engaging in a brief motivational conversation before a client moves into a CBT-focused component of treatment (e.g., a relapse prevention group).
- Alternating between MI and CBT, depending on the goals of each session.
- Using MI when the clinical focus is on engaging, focusing, evoking, and emphasizing the more directive style of CBT during the planning process.
- Shifting to MI during CBT interventions when counselor–client discord or client ambivalence about a specific change goal arises.
- Using the spirit of MI as a framework and interactional style in which to use CBT strategies.

Integrating MI into CBT approaches that the SUD treatment program already supports can enhance client motivation to engage in CBT and improve long-term maintenance of behavior change (Naar-King et al., 2017). Blending MI and CBT may actually create a more powerful approach for behavioral change in SUD treatment than either approach alone (Copeland et al., 2017; Naar-King et al., 2017). For example, a review of psychosocial interventions for cannabis use disorder found that the most consistent evidence for reducing cannabis use among a variety of interventions was a combination of CBT and MET (Gates, Sabioni, Copeland, Foll, & Gowing, 2016). Other research that evaluated studies on the integrated approach of CBT and MI found a clinically significant effect in treatment outcomes for co-occurring alcohol use disorder (AUD) and major depressive disorder compared with treatment as usual (Riper et al., 2014).

At times, CBT may require counselors to take on the role of a teacher or guide who is more directive, but counselors' overall stance should remain that of an empathetic partner–consultant instead of an expert. For example, in one study, counselors using CBT who explored and connected with clients in treatment for AUD were more successful in evoking discussions about behavior change than counselors who emphasized teaching clients behavior-change skills (Magill et al., 2016). Counselors' most important goal is to develop a relationship of mutual trust and respect with the client. They should view the client as the expert in his or her own recovery. Exhibit 8.1 provides a brief clinical scenario that depicts a counselor blending the spirit of MI with CBT relapse prevention strategies (see Chapter 7) in a counseling approach with a military veteran.

EXHIBIT 8.1. Blending the Spirit of MI With CBT

Jordan is 40 years old. He has been married for 12 years and has two young children. He served in the military and did two tours in Iraq. After discharge, he was arrested twice for driving under the influence and was mandated to alcohol and drug counseling. He was also referred for a psychiatric evaluation and was diagnosed with posttraumatic stress disorder.

Dan is a licensed clinical social worker in a co-occurring services program at a comprehensive behavioral health services program and has been seeing Jordan for 6 months for outpatient counseling. Initially, Jordan was angry about having to go to counseling and Dan's suggestion to try Alcoholics Anonymous (AA) as part of a recovery plan; however, Jordan has been attending AA meetings and asked another veteran to be his sponsor.

Jordan has returned to heavy drinking on three occasions in the past 6 months. His relapse risk is that he stops going to meetings and stops calling his sponsor. Then he finds himself at a local sports bar, thinking that he'll just watch the game (an apparently irrelevant decision), but he ends up getting drunk. Jordan now speaks highly of AA and has been working the 12 Steps with his sponsor. He tells Dan, "I am doing everything my sponsor tells me to do and am committed to my recovery now. I know that if I follow his suggestions and work the program, I will be okay. I just don't understand why I keep slipping."

Dan has established a good rapport with Jordan. He has done a relapse risk assessment, provided information to Jordan about the relapse process, and given Jordan homework to track high-risk situations and the coping strategies he uses to manage them. Jordan seems to respond well to Dan's directive approach but continues to return to drinking. Dan shifts gears in the current session and decides to explore Jordan's understanding of his pattern of disengagement from AA and his sponsor instead of cautioning him again about his behavioral pattern leading up to a return to drinking.

Dan: I'm wondering what you make of this pattern: not going to meetings, not calling your sponsor just before you have a slip. If you could name that pattern, what would you call it? *(Open question)*

Jordan: I guess I would call it my version of "Stinkin' Thinkin'." I work so hard at trying to do the right thing in my recovery, but then I start to think that I am not getting anywhere, you know? I'm not drinking, but I don't feel any better, so I feel like a failure and get tired of trying. It's like I need to take a break from recovery.

Dan: So, you work hard to do the right thing in recovery and really want to feel better, but sometimes you feel discouraged and think you need to take a break. *(Reflection)*

Jordan: Yeah. That describes where I am right now.

Dan: I am curious about that. Would you say you are taking a break from recovery or taking a break from the program? *[Reframe in the form of a question that leaves open the possibility for the client to reject the new perspective]*

Jordan: Gee, I never thought about it that way. I guess I'm still working on my recovery, even if I don't talk to my sponsor. Like the other day, I started to feel like I wanted to go to the bar to watch the game, but I remembered what you and I had talked about last time—that this is a warning flag, and that I could do something different. So, instead of going to the bar, I asked one of my sober friends over, and we watched the game at my house. We didn't talk about the program; we just watched the game.

Dan: You really worked that one out for yourself and didn't let "Stinkin' Thinkin'" take over. Good for you. *(Affirmation)*

At the end of the session, Dan summarizes Jordan's successful approach to "doing something different" and asks Jordan how their conversation was for him. Jordan responds that it was very helpful that Dan didn't lecture him, but rather asked him what he thought. This helped him realize for himself that he is still working on his recovery, even if he doesn't call his sponsor or go to a meeting. Jordan also mentioned that now he doesn't feel like he is failing at recovery, so he thinks he will get back to his AA program.

MI and RMC

RMC is a fairly new addiction treatment approach that uses motivational strategies; it is modeled after approaches used for staying connected to people with chronic medical illnesses like diabetes. RMC is a proactive strategy for monitoring a client's progress in recovery after intensive SUD treatment and for intervening quickly if the client returns to substance use. RMC involves regular telephone calls (more frequently at first, then less frequently) to the client to find out how he or she is coping with recovery.

RMC incorporates MI strategies to enhance motivation to return to treatment if needed. Counselors or peer recovery support specialists can perform RMC. Telephone-based motivational interventions are efficacious in treating and preventing substance use behaviors (Jiang et al., 2017). RMC is an effective method of monitoring clients' progress in recovery in the Action and Maintenance stages and intervening quickly to reengage clients into treatment after a substance use recurrence. It is linked to improved long-term substance use outcomes and increased participation in SUD treatment and recovery support services (Dennis & Scott, 2012; Dennis, Scott, & Laudet, 2014; Scott, Dennis, & Lurigio, 2017).

Workforce Development

MI is not only a counseling style but a conversational style that emphasizes guiding, rather than directing, clients toward changing substance use behaviors (Miller & Rollnick, 2013). Depending on the type of treatment program, an organization might provide aspects of MI training to only a few counselors, the entire clinical staff, or all staff, including support staff and peer providers. As increasingly more programs, including certified community behavioral health clinics (SAMHSA, 2016), adopt a client-centered treatment philosophy and MI as an evidence-based treatment, **organizations should train all staff in the spirit of MI.** This means all personnel—from the first person the client encounters walking through the door to the staff working in the billing department—understand the importance of client autonomy and choice, listening, and guiding instead of lecturing or directing in creating a welcoming environment and engaging clients in the treatment process (Miller & Rollnick, 2013).

> "MI is a complex skill, like playing a musical instrument. Watching others play the piano or attending a 2-day workshop is not likely in itself to turn one into a competent pianist."
>
> —Linda C. Sobell, Ph.D., Consensus Panel Member

MI has been widely disseminated as an evidence-based treatment, yet dissemination is not the same as implementation. Counselors lose their MI skills after a workshop if there is no supervision or coaching after training (Hall et al., 2015; Schwalbe, Oh, & Zweben, 2014). The key to workforce development of clinical staff in MI is to move beyond 1- or 2-day workshops and integrate ongoing training, supervision, and coaching of clinical staff to maintain fidelity to MI-consistent counseling techniques.

Another factor in whether a treatment program implements a motivational counseling approach is how closely the organization's mission and philosophy are aligned with the principles of motivational counseling. Counselors are more likely to adopt an MI counseling style when the organization's philosophy is aligned with MI principles (Ager et al., 2010).

Training

MI is an integrated and comprehensive set of listening and interviewing skills (Miller & Rollnick, 2013). For counselors to learn these skills and consistently integrate them into everyday practice, staff training and learning tasks should include (Miller & Rollnick, 2013):

- Understanding the spirt of MI.
- Developing skill in OARS.
- Identifying change goals.

- Exchanging information (i.e., Elicit-Provide-Elicit [EPE]) and giving advice skillfully.
- Recognizing change talk and sustain talk.
- Evoking change talk.
- Strengthening change talk.
- Responding skillfully to sustain talk and counselor-client discord.
- Developing hope and confidence.
- Negotiating a change plan.
- Strengthening commitment.
- Integrating MI with other counseling approaches.

These learning tasks apply to training counselors in any motivational counseling approach, including brief interventions that use FRAMES (**F**eedback, **R**esponsibility, **A**dvice, **M**enu of options, **E**mpathy, and **S**elf-efficacy) and MET, where the counselor gives personalized feedback and advice. Some tasks are foundational, like learning reflective listening, and are best learned through face-to-face, interactive training experiences. Other tasks, like recognizing change talk and sustain talk, can be learned through reading material, like coded transcripts of counselor-client interactions (Miller & Rollnick, 2013).

An initial workshop that covers the foundational components of MI (e.g., understanding the spirit of MI, OARS, recognizing and responding to change talk and sustain talk) may be a good beginning. This workshop should include both knowledge exchange and interactive skill-building exercises. A meta-analysis of MI training found that training produces medium-to-large-sized effects in MI proficiency both before and after training and medium-sized effects in MI proficiency compared with controls (de Roten, Zimmermann, Ortega, & Despland, 2013). Furthermore, an initial 12-to-15-hour workshop of MI training that included didactic, face-to-face instruction, and interactive exercises increased counselor skills as did more enhanced workshops that used video, web-based, or computer technology (Schwalbe et al., 2014). For an initial workshop, a simple format may be appropriate and potentially more cost effective than complex formats.

Ongoing training is the key to learning and sustaining motivational counseling skills if skills learned during training are not practiced. MI counselor skills introduced in training can erode after only 3 months if they are not used and practiced (Schwalbe et al., 2014). Spreading out training activities over a 6-month period and increasing the practice training hours to 5 or more hours increase counselor skill level and enhance skill retention (Schwalbe et al., 2014). Ongoing training in MI should be integrated into SUD treatment over 24 months as part of professional development to ensure counselor competency (Hall et al., 2015).

There are multiple ways to train staff, and the path an organization chooses is based on many factors. Before implementing MI training, an organization should consider the following questions when developing a strategic plan:

- **Assessing organizational philosophy and the SOC**
  - Is a person-centered approach to service delivery a key component of the organization's mission statement and philosophy?
  - Is MI a new counseling approach for the organization or will MI be blended with current treatment approaches?
  - At what stage of the SOC is staff with regard to integrating a new approach?
  - What kind of preparation is needed to implement a training program?

- **Assessing staff needs**
  - Does support staff need an introduction to the spirit of MI?
  - Which counseling staff members have already been trained and are using MI skills in their counseling approach? Which staff need a foundational workshop?
  - Which clinical supervisors have been trained in MI and demonstrate skill competence?

- **Tailoring a training program to meet staff needs**
  - How will the organization assess current counselor skill level in MI and tailor the training to different counselor skill levels?
  - Which would be most effective for the program:
    - Sending all counseling staff to a series of trainings provided by outside experts?
    - Training one or two clinical supervisors to provide in-house training and ongoing supervision of staff?
    - Bringing an outside expert into the organization to provide training?
    - A combination of outside and in-house training?
  - What strategies will the organization use to balance effective training, supervision, and professional development given cost considerations?

In developing the training plan, the organization should consider integrating a new counseling approach into the SUD treatment program a long-term project that needs buy-in by the entire organization.

COUNSELOR NOTE: IMPLEMENTATION OF MET IN SUD TREATMENT SERVICES IN THE VETERANS HEALTH ADMINISTRATION

In 2011, the Veterans Health Administration (VHA) implemented a national initiative to provide evidence-based MET counseling to veterans with SUDs. VHA developed a competency-based training program (Drapkin et al., 2016) that consisted of an initial 3.5-day training on MI plus assessment feedback, followed by 6 months of consultation with experienced MI training consultants (TCs). TCs provided ongoing supervision and coaching based on direct observation of counseling sessions using audio recordings. Training materials were adapted to address the specific needs of veterans. The VHA model of implementation was based on research in the training and supervision of clinical staff in MI to enhance implementation and fidelity.

Implementation of this competency-based model of training and supervision was enhanced by encouraging training participants to actively engage with the VHA MET community by becoming TCs and "MET champions," who provided information and consultation on how local VHA facilities could best disseminate and implement MET into their SUD treatment approach. TCs participate in monthly national conference calls with other TCs covering advanced MET topics. This model combines the use of outside trainers with in-house workforce development of new trainers and MET champions to create learning communities that sustain the use of MET in VHA facilities.

Supervision and Coaching

Training counselors in MI is the first step in integrating this approach into SUD treatment programs. Maintenance of skills and staying up to date with new developments in any counseling approach require ongoing supervision.

Supervision in MI should be competency based. This means supervision should address counselors' knowledge and proficiency in MI skills (e.g., the spirit of MI, OARS, EPE, recognizing and responding to change talk and sustain talk, evoking change talk, negotiating a change plan) needed to practice effectively. Competency-based supervision of MI includes directly observing counselor sessions, using feedback to monitor counselor proficiency, and coaching to help counselors continue developing their knowledge and skills (Martino et al., 2016). One study on competency-based supervision in MI found that anywhere from 4 to 20 supervision sessions were needed for doctoral-level interns to reach MI competency benchmarks (Schumaker et al., 2018).

Competency-based supervision requires direct observation of counselors, not simply a counselor's self-report or subjective evaluation. **Direct observation is one of the most effective ways of building and monitoring counselor skills** and can include use of video or audio taping sessions, live observation of counseling sessions in person

or via one-way mirrors, or both (SAMHSA, 2009). For more information on competency-based supervision, see TIP 52: Clinical Supervision and Professional Development of the Substance Abuse Counselor (SAMHSA, 2009).

The program should get permission from clients before engaging in direct observation. Written consent forms should include the nature and purpose of the direct observation, a description of how clients' privacy and confidentiality will be maintained, and what will happen to any video or audio recordings after supervision or research is completed. Program should refer to in-house policies and state licensing board and professional ethics code requirements for the use of video and audio recordings for clinical supervision or research.

In addition to being competency based, **MI supervision should be performed in the spirit of MI.** Clinical supervisors should reach a level of skill in using MI to be able to:

- Describe the underlying theoretical foundations of MI.
- Explore and resolve counselor ambivalence about learning and integrating MI into treatment.
- Teach counselors MI skills.
- Model the spirit of MI and its skills in individual and group supervision sessions.
- Give respectful and nonjudgmental feedback to counselors to support self-efficacy and enhance professional development.

Coaching counselors in MI involves coding a recorded or live observation session for consistent (e.g., OARS responses) and inconsistent (e.g., giving unsolicited advice, confrontation) MI responses and using this information to provide feedback to the counselor (Miller & Rollnick, 2013). Because listening to and coding a full session are labor intensive, coaches can code brief sections of a session and produce reliable ratings of counselor fidelity to MI (Caperton, Atkins, & Imel, 2018). Two coding systems for MI have been widely used in research and clinical practice to evaluate counselor fidelity to MI (Miller & Rollnick, 2013):

- **MI Integrity (MITI)** focuses on counselor responses and provides global ratings and specific counts of MI-consistent responses. The most recent version of MITI (MITI 4) has added global ratings and greater accuracy in assessing counselor support for client autonomy and the use of persuasion when giving information and advice (Moyers, Manuel, & Ernst, 2014). The MITI 4 is a reliable way to assess counselor fidelity to MI in both its relational and its technical components (Moyers, Houck, Rice, Longbaugh, & Miller, 2016). Appendix C provides a link to the MITI 4 manual.
- **MI Skills Code (MISC)** counts both counselor and client responses (e.g., change talk, sustain talk) (Miller, Moyers, Ernst, & Amrhein, 2008). MISC is a reliable way to monitor counselor fidelity to MI and can provide an accurate measure of the ratio of client change talk to sustain talk (Lord et al.,2014). The MISC can provide not only feedback to counselors about their use of MI skills but also information about the effects of MI on counselor–client interactions. Appendix C provides a link to the MISC manual.

A positive aspect of using coding systems to assess counselor fidelity to MI is that they provide reliable and accurate measures of counselor skill level. A less-positive aspect of using coding systems is that they require considerable training and quality assurance checks to establish and maintain the reliability of the coach who is doing the coding (Miller & Rollnick, 2013). In addition, counselors may be ambivalent about recording client sessions and having a supervisor, who is responsible for performance evaluations, code the counselor's speech. Potential solutions to consider include:

- Addressing counselor ambivalence in supervision about having sessions coded.
- Creating small learning communities in the organization where counselors, case managers, and peer providers can learn and practice coding snippets of actual sessions or uncoded audio, video, or written transcripts with one another. Appendix C provides links to uncoded transcripts, audio, and video examples of MI counseling sessions.

- Sending audio sessions or short excerpts to an outside coder who can perform the coding and return written feedback for supervisors to discuss with counselors.
- Encouraging counselors to listen to their own recorded sessions and use a simplified method of counting their use of OARS, their inconsistent responses (e.g., giving advice without permission), change talk and sustain talk prompts, and client expressions of change talk and sustain talk (Miller & Rollnick, 2013). Counselors can then review their "self-coding" with their supervisors.

Whichever strategies the SUD organization employs to enhance counselor fidelity to and proficiency in delivering MI, the organization will need to balance cost considerations with effective training, supervision, and professional development. **Administrators and supervisors should partner with counseling staff to move the organization along the SOC toward integrating motivational approaches into SUD treatment.**

Conclusion

Many different motivational approaches have been discussed in this TIP including MI; MET; motivational interventions in the SOC; brief interventions; screening, brief intervention, and referral for treatment; and blending MI with other counseling methods. A growing body of evidence demonstrates that motivational interventions can enhance client motivation and improve SUD treatment outcomes. Integrating MI and other motivational approaches into SUD treatment settings requires the entire organization to adopt a client-centered philosophy and administrative support for ongoing training and supervision of counselors. Motivational counseling approaches are respectful and culturally responsive methods for helping people break free from addiction and adopt new lifestyles that are consistent with the values of good health, well-being, and being integral member of the community.