South Dakota
Motivational Interviewing Project Evaluation Preliminary Findings

Motivational Interviewing (MI) is a commonly used treatment modality applied in clinical settings to enhance the client’s readiness to change by exploring and resolving ambivalence surrounding health behaviors (Hettema et al., 2005). The MI treatment helps the client to consider all sides of their ambivalence and utilize their own self-determination (Ryan & Deci, 2000) to decided what they will do next using skills they already possess (Baer et al., 1999). The application of MI in clinical settings has proven to increase retention and positive treatment outcomes for a number of health behaviors to include substance use disorders (Carroll et al., 2006). This study examines behavioral health clinicians utilizing MI in correctional and community settings by testing the level of skill that South Dakota behavioral health staff gain through a two-tiered training with personal feedback and coaching.

The purpose of this evaluation is to measure skill acquisition and implementation of a two-tiered MI training with coaching and feedback received by a sample of 75 behavioral health staff working with clients in South Dakota correctional and community settings.

This report includes participant information from cohort one and cohort two consisting of 41 of the 50 training participants that enrolled in the study (cohort three is scheduled to commence in October 2016 - April 2017). Of these participants, 51 percent were behavioral health staff that work in a correction facility and 41 percent were behavioral health staff that work in a community based treatment service organization.

Cohort one consisted of 24 participants, of those 19 consented to the study, two participants resigned from their job, and one moved jobs during the study. In cohort two there were 26 participants, of those 24 consented to the study and one participant who consented did not attend the training. One training participant declined to consent and later resigned. A portion of the participants did not submit an audiotaped client session.
There were a greater number of female workers (78%) than male workers (22%). The majority of participants were White with two being Hispanic/Latino, and one being Alaska Native. Most participants held a Bachelor’s degree (59%) or Master’s degree (31%); eight percent had their Associate’s degree and three percent had some college but no degree. Most participants held a license in Addictions (56%); other licenses included Counseling (10%) and Social Work (5%); two percent selected Other; and 20% were unlicensed professionals.

The Motivational Interviewing Treatment Integrity (MITI) scale, a validated method of determining skill development for MI, was used to code audiotapes that were submitted by training participants post-training. The MITI is a teaching and evaluation tool used by MINT trainers to assess the participants (clinicians) adherence to MI (Madson et al., 2009; Moyers et al. 2014; Moyers et al., 2005; Pierson et al., 2007; Bennett et al., 2007). The MITI scores the clinicians MI adherence fair or good, rates the clinician on a 5-point ordinal scale and provides behavior count scores. The MITI also provides a “global number,” these numbers are a tally of the actual counts of specific clinician behavior during the audiotaped client session. The MITI offers researchers a tool for evaluation of MI treatment integrity.

Two paper and pen surveys were administered to participating clinicians pre-training and post-training. The Motivational Interviewing Knowledge Questionnaire (MIKQ) is a 12 item self-report questionnaire that assesses the clinicians’ feelings of competency and knowledge of MI. The Helpful Responses Questionnaire (HRQ) is a six-item survey that measures the clinicians’ empathy (a key component of MI) and reflective listening skills (Miller et al., 1991).

The Government Performance and Results Act (GPRA) survey was administered immediately following level-one and level-two training, this survey provided participant demographic and training satisfaction information.

The MIKQ and HRQ measures were assessed with paired sample t-test to evaluate MI skill level post-training level-two compared to level-one scores. The MIKQ scores showed significant difference in motivational interviewing skill measurement after level-two training, t (15) = 4.774, p = .000. This is a key indicator of MI fidelity (Miller et al., 2004).
The integration of MI has shown varied success when clinicians have received limited exposure. One-time training in MI inflates the clinicians’ self-efficacy and serves to inoculate them from additional learning. Short-term motivational interviewing skill improvement can decrease in as little as two months; feedback, coaching and supervision can improve and maintain acquired skills as well as evaluate the clinicians’ adherence which facilitates skill development (Miller and Mount, 2001; Miller et al., 2004; Baer et al., 2004; Miller et al., 2006; Madson & Campbell, 2006; Madson et al., 2005; Moyers et al, 2008; Madson et al., 2009; Martino et al., 2010; Young, 2010). On-going consultation, supervision and feedback are necessary for the long-term adoption of skills (Walters et al., 2005; Madson & Campbell, 2006).

The MITI results were assessed using a paired sample t-test to determine difference in motivational interviewing skill level of the clinician post-training level-two compared to level-one scores. Significant findings include, skill level enhancement of technical components summary score of cultivating change talk and softening sustain talk, t (22) = 7.861, p = .000. In addition, the decrease in total non-adherence motivational interviewing showing that clinicians significantly decreased their non-adherence behavior, t (22) = 3.425, p = .002. 

MITI global numbers were also assessed with paired sample t-tests to determine skill level enhancement post-training level-two compared to level-one skill measurement. The MITI global numbers showed significant difference in motivational interviewing skill enhancement for cultivating change talk, t (22) = 5.147, p = .000; softening sustain talk, t (22) = 6.146, p = .000; partnership, t (22) = 3.761, p = .001. There was no significance for empathy in this test.

Although not statistically significant, an interesting finding is of the increases in counselors practice behavior of simple reflection vs. complex reflection. Simple reflections let the client know the clinician is listening but offers little or no additional meaning to what the client has said. The complex reflection adds additional meaning or emphasis to what
the client has said, to convey a deeper and more complex picture (Moyers et al., 2014). In this study the clinician’s simple reflections increased, whereas their complex reflection remained stable. This indicates the need for on-going training and skill building in motivational interviewing with a focus on complex reflection skill development.

Behavioral health clinicians working within corrections and community settings who participated in the South Dakota two-tiered MI training with feedback and coaching significantly increase their motivational interviewing skill levels in the areas of cultivating change talk, softening sustain talk, and partnership. Those same clinicians significantly decreased their total non-adherence behavior with regard to motivational interviewing.

**MI in Correction Populations**
Motivational enhancement strategies in prison-based therapeutic communities are means to increase entry and retention into aftercare (Leon et al., 2000). The use of MI within correction populations has shown to result in decreases in offenses (both in the severity of offences and likelihood of reoffending), increases in treatment retention and motivation to change, and MI has led to documented improvements on attitudinal scales. In youth, MI has been found to reduce alcohol and marijuana-related driving events post-release (Stein et al, 2006). However, more research is needed to determine who responds to MI and how best to utilize MI within the offender population to increase treatment retention, enhance readiness to change and decrease re-offending. The therapy of MI is yet to be empirically validated to decrease recidivism (McMurran, 2009; Stein et al., 2006; Harper & Hardy, 2000).

**Sustainability of Treatment Fidelity**
Stirman and colleagues summarize key elements of dissemination; preparation, use of interpersonal strategies, clinicians’ attitudes, ongoing support, flexibility, adaptability of the innovation, involvement of stakeholders in decision making and planning as well as continued involvement. It can take a number of years to ensure sustainment is accomplished with program fidelity (Stirman, Crits-Christoph, & DeRubeis, 2004). Proactively assessing and addressing potential barriers can improve sustainability of treatment fidelity and skill development (Guydish, et al., 2007).

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References


