Session 3, Part 3
MI: Enhancing Motivation To Change Strategies
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Overview of Session 3, Part 3: Getting Started

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<td>Define MI to understand core principles and to practice core MI skills and strategies</td>
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### Learning Objectives

At the end of the session, you will be able to—

- Describe the stages of change.
- Demonstrate at least two methods to elicit change talk.
- Use a decisional balance and readiness ruler.
- Describe an overarching MI strategy effective in brief intervention.

### Session Agenda

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Welcome and Introduction of Trainers and Participants
Slide 1 (5 minutes)

Trainer

- Welcome training participants.
- Orient participants to the training facility (including location of restrooms, etc.).
- Provide acknowledgments.
- Introduce trainers.

Learning Objectives
Slide 2 (5 minutes)

- Describe the stages of change.
- Demonstrate at least two methods to elicit change talk.
- Use a decisional balance and readiness ruler.
- Describe an overarching MI strategy effective in brief intervention.

Stages of Change
Slides 3–12 (5 minutes)

Theoretical Framework Informing MI

Stages of Change

In MI, there are five stages of change your patient can go through:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
**MI Informed by Stages of Change**

In the *precontemplation* stage, the patient does not feel there is a problem and therefore does not consider the need for change.

The clinician’s goal at this stage is to build a trusting relationship and raise awareness. The clinician’s tasks are to engage, inform, encourage, explore, and acknowledge lack of readiness.

In *contemplation*, the patient sees the possibility of change but is ambivalent and uncertain about beginning the process in the contemplation stage. The clinician’s task is to focus and explore, evaluate pros and cons, and resolve ambivalence. The clinician’s goal is to resolve ambivalence and build motivation and confidence.

In the *preparation* stage, the patient begins making a plan to change and sets gradual goals. The clinician’s goal is to support self-efficacy and motivation, negotiate a plan, and facilitate decisionmaking.

The *action* stage occurs when the patient begins implementation of specific action steps and behavioral changes. The clinician’s goal is to support implementation of the plan. The task of the clinician is to support the patient’s follow-through and self-efficacy.

*In the maintenance stage*, the patient continues to sustain desirable actions or repeats periodic recommended steps. The clinician’s goal in this stage is to help the patient maintain change or the new status quo. The clinician is tasked with identifying strategies to prevent relapse.

*Relapse/recurrence* often occurs. Most people do not immediately sustain the new changes they are attempting to make and return to substance abuse after a period of abstinence. Most patients usually revert to an earlier stage of change—often to contemplation.

Events (internal or external) trigger an individual’s return to previous behaviors and cycling through the process again. Patients may have had unrealistic goals, used ineffective strategies, or put themselves in environments not conducive to successful change.

After a return to substance abuse, patients often feel demoralized about change, temporarily unwilling or unable to change soon. However, a recurrence of symptoms does not necessarily mean a patient has abandoned a commitment to change.
Learning Exercise

Ask trainees: At what stage does a patient consider the possibility of change?

a. Precontemplation
b. Contemplation
c. Preparation
d. Action

Discuss how the clinician’s understanding of the stages of change is useful in practice (e.g., adjusting expectations). It is crucial to remember that a patient’s “readiness to change” is a state of mind, not a trait.

Remind trainees that nearly all patients come to us at precontemplative or contemplative stages.

Change Talk
Slides 13–16 (5 minutes)

Slides 13–14

Increasing Change Talk

Change talk is at the heart of MI. When patients increase their change talk, their commitment to change increases too.

Through our conversations, we evoke and affirm desire, ability, reasons, and need. To remember, use the acronym DARN.

Slide 15

What Is Change Talk?

Change talk occurs when the patient expresses motivation to change.

An example of change talk—

“I wish I could stop drinking so much because I don’t want that to be an example for my children.”
As change talk emerges, the clinician wants to affirm and reinforce it. Gently reflect and summarize consequences of use, most importantly those that have been identified by the patient.

For example—

“I hear you are quite concerned about the effects your drinking may be having on your family and that being a good parent and partner is important for you.”

**Slide 16**

*Exercise*

Identify the statements that reflect change talk:

a. “I have to cut down on my drinking so I can make it to work on time.”

b. “My spouse wants me to give up cigarettes.”

c. “The doctor thinks it is important for me to decrease my alcohol intake.”

d. “I want to stop taking my pain meds, but the pain won’t go away.”

Ask the class for examples as to how the clinician might reinforce change talk.

Ask participants how they might respond to and strengthen the patient’s change talk.

*Example*: “Work is important for you and it sounds like you are recognizing that drinking is interfering with your work.”

*Selectively reinforce*: “Sounds like you are recognizing that drinking is interfering with your work, and you are wanting to make a change.”
MI Tools (15 minutes)
Slides 17–23

Slides 17–18

**MI Strategies Most Commonly Used in Brief Intervention**

The MI strategies most commonly used in brief intervention are—

- Decisional balance
- Readiness ruler
- Personalized reflective discussion

Slides 19–20

**Conducting a Decisional Balance Discussion**

The decisional balance highlights an individual’s ambivalence (maintaining versus changing a behavior). It leverages the costs versus the benefits.

A decisional balance is in effect a type of double-sided reflection in which you identify the good and the not-so-good aspects of substance use. It is always best to start with discussing the positives about use of substances. This often is experienced by the patient as novel and disarming. It also gives the clinician a better understanding of why the patient uses substances.

The second part of this discussion is to talk about the down side of use. It is generally better to ask the question, “What are some of the not-so-good things about use?”—rather than the bad things about use. At the conclusion of this conversation, the clinician summarizes using a double-sided reflection to characterizing a decisional balance....on the one hand the pros of use are.... And on the other hand..... This provides valuable feedback to the patient regarding potential ambivalence about changing substance use behavior. The clinician subtly emphasizes the not-so-good aspects of use in support of motivation for change. Simple work sheets are available to support this conversation.
**Conducting a Decisional Balance Discussion**

- When conducting a decisional balance discussion, accept all answers. Do not argue with answers given by the patient.
- Explore your patient’s answers. Be sure to note both the benefits and costs of current behavior and change.
- Explore costs and/or benefits with respect to your patient’s goals and values.

**Slide 21**

**Exercise 3, the Decisional Balance**

*Small Group Exercise:* In twos or threes, with roles of patient, clinician, and observer, complete a decisional balance discussion with Camilla or Marcus. The information below has been previously collected during screening.

*Optional:* Show and discuss video demonstration first.

**Camilla**

Camilla, a 24-year-old waitress, hurt her back falling from a ladder at work 2 years ago. With a herniated disc and left leg sciatica down to her foot, she reports a pain level of 9 on a 10-point scale, loss of sleep, and loss of income. Her disability payments ended after 12 months. She was prescribed Percocet for 2 months and tried to refill prescriptions with different doctors with no success. She started buying opiates off the Internet and on the street. She tried detox three times last year but never fully succeeded. Every time the pain gets too great, she either drinks till she passes out or finds opiates. She drinks wine during the week and martinis on the weekends but states she is not an alcoholic. She’s never had a DUI, but she has had inappropriate relations when drinking and has slapped men in anger. She and her boyfriend of 2 years plan to get married when she can get her act together.

**Marcus**

Marcus, a 24-year-old carpenter, hurt his back falling from a ladder at work 2 years ago. With a herniated disc and left leg sciatica down to his foot, he reports a pain level of 9 on a 10-point scale, loss of sleep, and loss of income. His disability payments ended after 12 months. He was prescribed Percocet for 2 months and tried to refill prescriptions with different doctors with no success. He started buying opioids off the Internet and on the street. He tried detox three times last year but never fully succeeded. Every time the pain gets too great, he either drinks till he passes out or finds drugs. He drinks beer during the week and hard liquor on the weekends but states he is not an alcoholic. He’s never had a DUI, but he has had bar fights. He and his girlfriend of 2 years plan to get married when he can get his act together.
**Readiness Rulers: I-C-R**

Readiness rulers can be used to address—

1. Importance
2. Confidence
3. Readiness

Instructions for the readiness ruler are simple. Show the patient the readiness ruler and ask, “On a scale of 1 to 10, how ready are you to make a change in your ____?”

If the patient answers with 5, the suggested followup question would be—

- That’s great. You’re 50 percent there. So, why are you a 5 and not a 3?
- Summarize and reflect change talk.

The strategy of the readiness ruler may seem counterintuitive. If the patient says, “I am at a 5,” rather than asking why not a higher number, you should respond with affirmation; for example, “Great, it sounds like you’re 50 percent of the way there.”

Asking the patient why the number is not lower invites him or her to articulate reasons and motives for considering change. If you ask why the number is not higher, it elicits barriers and reasons for staying the same. In effect, it showcases resistance talk rather than change talk.

**Note:** Trainees will have opportunity to practice this later.

Show video demonstration and discuss (optional).

Role-play exercise (optional).
MI Strategy: The Personalized Reflective Discussion  
Slides 24–32 (20 minutes)

Slides 24–26

*The Personalized Reflective Discussion*

This MI strategy facilitates—

- Finding personal and compelling reasons to change
- Building readiness to change
- Making commitment to change

Within screening and brief intervention, the use of MI strategies facilitates a personalized reflective discussion with the goals of increasing a patient's readiness and commitment to change.

*Personalized Reflective Discussion Steps*

- Initiate reflective discussion, asking permission of patients to have the conversation
- Provide feedback based on the screening data
- Evoke personal meaning and concerns of patient
- Enhance motivation
- Negotiate commitment

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*Initiating Reflective Discussion*

Brief motivational intervention is a unique personal and reflective discussion between clinician and patient. It begins usually following other conversation. The clinician asks permission of the patient to have the conversation. Asking permission shows respect for the person’s autonomy.

*Example:* “Would it be all right with you to spend a few minutes discussing the results of the wellness survey you just completed?”
Slide 28

Providing Feedback

After being invited to discuss findings, the clinician can review the results of the screening, including score, level of risk, any identified behaviors, and normative behavior.

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Evoking Personal Meaning

To evoke personal meaning from your patient, you should use open-ended and evocative questions. This will give you a better understanding of how the patient views his or her health and behavior.

For example, you might ask any of these questions, beginning with, “From your perspective....”

- “What relationship might there be between your drinking and ____?”
- “What are your concerns regarding your use of ____?”
- “What are the important reason(s) for you to choose to stop or decrease your use?”
- “What are the benefits you can see from stopping or cutting down?”

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Summarizing (May Use a Double-Sided Reflection)

- Acknowledges the patient’s perceived benefits of use
- Elicits the “personal and important” problems or concerns caused by use
- Elicits, affirms, and reinforces motivation to change
- Helps resolve ambivalence and reinforces motivation
Slide 31

*Enhancing Motivation*

The use of a readiness ruler following the summary can further enhance a patient’s motivation to change.

Linking MI strategies would sound like this:

“So on one hand, you enjoy hanging with your friends and having a few drinks after work. However, sometimes a few drinks become a lot of drinks. It makes it unsafe for you to be on the highway and often affects your work the next day. In light of that, on a scale of 1 to 10, how ready are you to make a change to reduce your drinking to a lower level of risk?”

Slide 32

*Negotiating Commitment*

A plan does not need to be overly complicated, but it needs to be realistic and specific, and one the patient is willing to follow. It is equally important the clinician builds followup into the plan. Followup is usually scheduled 4 weeks (or sooner) after the plan is conceived to see how the plan is working for the patient.

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*Personalized Reflective Discussion Demonstrated*

- Use the MI demonstration video or demonstrate live in front of class.
- Use case studies and personalized reflective discussion worksheet (handout).
- In groups of three, assign roles of interviewer, interviewed, and observer. Practice skills in 5-minute rotations, then exchange roles. Discuss briefly after each rotation. Report out after completion.

Slide 34

Summary benefits of using MI—

- Evidence based
- Patient centered
- Provides structure to the consultation
- Readily adaptable to a variety of health care settings
Slide 35

Remember:

- Motivation is an intrinsic process.
- Ambivalence is normal; all behaviors have pluses and minuses.
- Motivation arises out of discrepancy and resolving ambivalence.
- “Change talk” facilitates change.

Conclusion

*Slide 35 (5 minutes)*

Between-session challenge is to review MI video clips and practice skills with friends, colleagues, or at practice site.

In closing—

- Ask any additional questions that seem appropriate at this time.
- Ask participants if they have any questions or issues they would like to discuss related to SBIRT in any remaining time.
- Thank participants for their time and remind them of their next scheduled SBIRT training session.

*Resources*

- Training agenda
- Copy of PowerPoint slides
- Any program-specific materials
- Copies of readiness ruler and decisional balance
- Case studies
- Personalized reflective discussion guide
- MI demonstration videos