



## MOTIVATIONAL INTERVIEWING COMPETENCY ASSESSMENT

CODING & COACHING TOOL, version 3.2

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### Recommended citations:

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## Purpose of MICA

Does the communication method of this practitioner demonstrate a level of competency representative of motivational interviewing (MI)? The Motivational Interviewing Competency Assessment (MICA) addresses this question in a way that upholds integrity to the intent of MI by drawing upon a variety of evidence-informed and evidence-based tools, theories and practices. There are well-respected and established assessment tools, such as the MISC<sup>1</sup> and MITI<sup>2</sup>, that are used to effectively evaluate clinical samples for fidelity to MI for research projects, as well as to explore the underlying dynamics of MI. As MI continues to evolve, there is an increasing demand for a coding tool solely focused on providing practical feedback to professionals in multiple service fields on how to build their skill-set in MI. (See Appendix B for the evidence of how to learn MI.)

The MICA relies on the principles, strategies and approach as presented in Miller & Rollnick's *Motivational Interviewing: Helping People Change*, Third Edition.<sup>3</sup> We developed the MICA to evaluate a sample of a practitioner's clinical conversation to assess baseline competence in MI from a quality assurance perspective. In addition, we wanted to provide a quality improvement process for practitioners who want to move from beginning use of MI to a more proficient application of the MI approach. Ultimately, our goal is that MICA will provide professionals with easily digestible, structured and specific feedback regarding their effort to use MI with their clients.

Any professional conversation can be coded (i.e., assessed) using MICA whether it is a brief, yet complete, conversation (i.e., 8-10 minutes in length), or a selected 20-minute sample from a longer conversation. MICA is designed to assess a session where there is a targeted behavior and the interaction with the client addresses lifestyle management, behavior change or treatment adherence. MICA is not intended to be used in sessions where a formal structured script is used (e.g., using an intake assessment form) or during a decisional balance activity (e.g., no influence towards target behavior).

## MICA Coding Process

The MICA is designed to be a one-pass system. While other tools are amenable to non-MI trained coders, coding sessions using MICA requires an intimate knowledge of MI. It is designed to work hand-in-glove with mentoring based on the MI proficiency and experience of the coder. The primary focus is to provide readily applicable feedback to the practitioner. MICA was also designed with the goal of providing clear instructions and decision tree processes for coders to ensure a standardized, validated and efficient coding experience.

There are two categories coded in the MICA: Verbal Interventions (microskills and MI strategies) and MI Intentions. The microskills in the Verbal Interventions are tallied each time they occur. The two MI strategies and the five MI Intentions each are structured with a Definition, Indicator and Further Detail (see Figure 1).

## MICA Coding Training

The MICA Manual is provided to the MI community with no licensing fee. We respectfully request that you receive adequate training from one of the co-developers of the tool to ensure that the coding system can be applied appropriately, as it was intended. For more information on training or results from our reliability and validity testing, go to [www.micacoding.com](http://www.micacoding.com) or email one of us: Casey Jackson at [casey.jackson@ifioc.com](mailto:casey.jackson@ifioc.com); Ali Hall at [mi.consult.ahall@gmail.com](mailto:mi.consult.ahall@gmail.com); Susan Butterworth at [butterwo@qconsulthealthcare.com](mailto:butterwo@qconsulthealthcare.com); John Gilbert at [john.gilbert@ifioc.com](mailto:john.gilbert@ifioc.com).

## Guidelines for Samples for MICA Coding

Any professional conversation can be coded using MICA whether it is a brief (yet complete) conversation of 8 – 10 minutes in length, or a selected 20-minute sample from a longer session. The MICA was designed to assess a session where there is a possibility of lifestyle management or behavior change based on a referral, a presenting problem, a target behavior or a topic of concern. There may be less utility of its use in sessions where a formal structured script is used (e.g., during a standardized assessment or completing an intake form) or where there is no particular behavior change or treatment plan indicated.

Additional guidance can be provided during MICA coding training; however, here are basic guidelines regarding appropriate samples for MICA coding:

- Ideally, the session should be a full session at least 8 minutes in length. While there is not limit on length, the coder may set limits such as coding the first 12 minutes and last 8 minutes of a session in order to maintain needed concentration.
- MICA is validated for a one-on-one session between one practitioner and one client; it is not validated for a group session or discussion with a caretaker (unless the caretaker is the one in charge of the choices/actions/decisions, in which case the caretaker would be consider the client)

<p><b>Definition</b>—This is the description and the scope of the item to be rated. →</p> <p><b>Indicator</b>—This is where the coder derives a representative score based on observations over the course of the session. →</p> <p><b>Further Detail</b>—This is where specific aspects of the Definition are considered and provide additional descriptions to delineate between Indicators. →</p>	<b>GUIDING</b>		
	<p>This measures the practitioner Intention to navigate the conversation towards the goal or topic of concern. The client is the captain whose ship may be stuck, off course, strug course. The client provides information, feedback and insights while the practitioner he course by skillfully navigating the conversation towards a path of insight/solution/resolu.</p>		
	<b>Fundamentally Inconsistent</b>	<b>Generally Inconsistent</b>	<b>Client-Centered</b>
	<b>1</b> <b>Primarily directing, controlling, or mandating the client goals</b>	<b>2</b> <b>Primarily wandering around, following, or subtly directing client goals</b>	<b>3</b> <b>Attempts a shared approach to the client's goals with instances of wandering, following or directing</b>
	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• subtly or overtly sets the targets or goals irrespective of the client's interests or agenda</li> <li>• is in the expert role and leads or pushes the client</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• listen to client's goals, then shift to their own agenda</li> <li>• makes few, if any, attempts to establish a shared approach to the client's</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• elicit the client's agenda, but may promote a secondary agenda they are trying to insert into the conversation</li> <li>• allow the conversation</li> </ul>

Figure 1. Structure of MI Strategies and Intentions

## Coding MI Strategies and Intentions

We advise that the coder review all Definitions each time a new session is coded. To uphold coding integrity, the coder grounds, reorients and refocuses on each Definition prior to coding the session. This cues the coder's listening and provides a contextual framework for the conversation. This is the coding protocol regardless of the coder's experience in coding, coaching or training MI.

The coder listens to the session, takes notes and gathers an impression of the overall sessions while tallying the microskills (questions and reflections) as they occur. The coder should listen to the session and consider it as a whole. There is no one verbal exchange between the practitioner and the client that determines a score. Yes, the coder may jot down timestamps and take specific notes throughout, which may be shared during feedback. Once the session is done, the coder should refer to the MICA Manual and review the scoring sections.

The five Intentions and two Strategies each have a Definition, Indicator and Further Detail. The coder moves through each of the Definitions and provides a score based on the Indicators. The protocol is to read the Definition, then identify which of the Indicators most accurately reflects the practitioner's demonstration of that MI Strategy or Intention. If it is difficult to determine a score based off of the discrete Indicators, the coder then reads the Further Detail provided in the bulleted section below each Indicator. While the Indicators for each Definition are tailored to that specific Intention, it is helpful to have a base understanding of the target threshold of each Indicator. These are the fundamental thresholds to distinguish each score for each global:

- 1 **Fundamentally inconsistent with MI.** Absence of MI Intentions and skills. Missing or inconsistent with most elements of MI, and the conversation being coded has no Indicators representing a client-centered approach.
- 2 **Generally inconsistent with MI.** Attempts toward MI are missing the underlying Intentions and skills. May naturally, intentionally or unintentionally hit some elements of MI, yet the conversation coded does not represent a client-centered approach.
- 3 **Client-Centered.** Consistencies and inconsistencies demonstrating aspects of MI. Notable attempts to align with MI Intentions and skills. Naturally, intentionally or unintentionally hit some elements of MI. The conversation being coded represents a client-centered approach.
- 4 **Competent MI.** Primarily consistent with MI Intentions and skills. Intentionally and purposefully focuses on and demonstrates elements and strategies of MI, beyond a client-centered approach.
- 5 **Proficient MI.** Clearly consistent with MI Intentions and skills. Deftly demonstrates advanced and skillful elements of MI. The conversation coded embodies an empowering, client-centered approach.

### MICA Coding Sequence

1. Review Definitions of MI strategies and MI Intentions prior to coding session
2. Listen to audio session.
3. For each Strategy and Intention:
  - a. Read Definition
  - b. Ask yourself if interaction is client-centered
    - (1) If yes, start at #3 for baseline scoring and adjust higher on scale accordingly
    - (2) If no, start at 2.5 and adjust lower on scale accordingly
4. If unable to assign score solely based on the Indicator, read Further Detail

## Coding Differentials

There are instances where it is difficult to distinguish the most accurate Indicator score. We provide Further Detail to help clarify and distinguish the quality of the Indicator. If the coder cannot distinguish with relative certainty between two Indicator scores that appear to have equal merit, then a .5 decimal may be added to the score to increase accuracy. For example, if there are elements of Further Detail of a “2” Indicator that are accurate and Further Detail of a “3” Indicator that are also accurate, then the coder can assign a score of a “2.5”. This allows the practitioner to see that they are beyond the elements of a “2”, although not quite to the elements of a “3”. This can be helpful feedback to the practitioner as well as helpful insight and targets for improvement from a coaching perspective. It is not appropriate to assign a .5 decimal because a coder does not want to mark a score too low or as a default.

## Coding Verbal Interventions

MI continues to explore and expand linguistics and the impact on behavior change. An MI practitioner is mindful as to the words being used and the immediate impact on the client. Each time the practitioner chooses to speak, there is an awareness of potential impact on the client’s perspective. In the MICA, those skills and strategies are called “Verbal Interventions.” Verbal Interventions include the skills of mindful questions and strategic reflections used by the practitioner to facilitate an effective and efficient exchange. MI strategies focus on the types of language and selective responses that promotes the client’s progression toward a goal or preferred change. Both microskills and specific MI strategies are the two types of Verbal Interventions coded in the MICA.

## Coding Microskills

Microskills coded in the MICA include reflections and questions. These microskills are basic communication skills that practitioners intentionally apply when working with clients. Miller and Rollnick (2002) found that clinicians asked questions significantly more than they used reflective statements in traditional therapy sessions. Reflections were markedly outnumbered by questions with a ratio of one to ten (1:10). They found a notable contrast with clinicians skilled in MI who tend to reflect more often than ask questions. Those skilled in MI had a reflection to question ratio of 3:1.

Over the length of the segment of audio session being coded, the coder listens to and tallies both questions and reflections coming from the practitioner. There is no differentiation of types or quality of questions or reflections in tallying the microskills section of MICA, although quality and intentions of these skills are captured in the Intentions and Strategies. The microskills count should be presented as feedback to the practitioner in the form of a reflection to question ratio. (See *MICA Feedback Report*, p. 11)

## Coding Questions

There is no distinction between open and closed questions; however, coders can take note of the quality of the questions to provide feedback to the practitioner (i.e., primarily closed questions, predominantly fact-finding, exploratory, evocative, etc.). If the practitioner starts out with a statement, yet the voice inflection turns the statement into a question, the Verbal Intervention is coded as a question. This includes when there is that questioning or inquisitive tone, or a tone of checking for accuracy. Coders distinguish voice inflections and hear differences when these responses are read out loud:

*“You are worried about how you will explain it to him?”* versus *“You are worried about how you will explain it to him.”*

*“There was nothing you could do?”* versus *“There was nothing you could do.”*

This is a crucial distinction, and a primary reason to code audio sessions rather than coding transcripts. Coders assess what the practitioner provides, not how the client responds.

It is common that a practitioner may ask a series of questions in one Verbal Intervention. Here are common types of examples where there are two or more questions in the Verbal Intervention:

*Question: "What are you planning for the weekend? There is a group of people going out to the lake to have a BBQ and go boating, is that something you would be interested in?"*

*Question: "What are you planning for the weekend? You feel depressed on weekends and disconnected and alone. What thoughts have you had to increase your activity on the weekends?"*

*Question: "What are you planning for the weekend? Are you going to the lake? Spending time with your family? Going to a show?"*

These examples would receive only one question tally. The client typically responds to the overall thought, question or concept, and most likely will not respond to each of the questions independently. This protocol increases inter-rater reliability by preventing over-coding. There would be two distinct codes if the practitioner asks a question, the client responds, and another question is asked.

*Question: "What are you planning for the weekend?"*

*Response: "We are heading out to the lake with some friends."*

*Question: "Are you going to be spending time with your family?"*

This example would receive two separate question tallies.

### **Coding Reflections**

"The essence of a reflective listening response is that it makes a guess about what the person means."<sup>3, p. 52</sup> A reflection – whether simple, complex, or a series in one intervention – is coded as one reflection. Reflections are statements and, as detailed above, the voice inflection at the end does not go up. If reflections are summarizing, long, wordy or even convoluted, they still receive one reflection tally if it is part of one Verbal Intervention. It should also be coded as one reflection if there is a series of reflections along with a question or giving information scattered throughout the Verbal Intervention.

*Practitioner: "It sounds like you have been struggling with this for a while... and still aren't sure what you might do, since your children are involved, and the court has their agenda, it all seems so overwhelming. It's normal for people in your situation to feel stuck. It sounds like you are not quite sure of your next step."*

*Practitioner: "It sounds like you've been struggling with this for a while... Is that right? That's pretty normal. And it seems like you're not sure of your next steps."*

In each of these examples, there is one Verbal Intervention, therefore the coder would tally one reflection code (the last example would also receive one

question code). If there is a response by the client, and a new reflection by the practitioner, then there would be two separate codes.

*Practitioner: "It sounds like you have been struggling with this for a while... and still aren't sure what you might do, since your children are involved, and the court has their agenda, it all seems so overwhelming, which is why you are feeling so stuck right now."*

*Client: "It is overwhelming. I don't think anything I do will make a difference."*

*Practitioner: "You're not quite sure of your next steps."*

Each of these Verbal Interventions would receive a separate tally as a reflection. If there is a clear and obvious pause and there appears to be a separate and distinct Verbal Intervention, then there would also be two separate reflection tallies.

*Practitioner: "It sounds like you have been struggling with this for a while... and still aren't sure what you might do, since your children are involved, and the court has their agenda, it all seems so overwhelming, which is why you are feeling so stuck right now."*

*Client: (long pause)*

*Practitioner: "Yet you do have some ideas of possible next steps from here."*

If there are two clearly notable Verbal Interventions, they would receive two separate codes. If it is unclear, the default is to code a singular reflection code.

Reflections versus Affirmations: Affirmations are an important part of MI; however, they are not coded as a reflection in our microskills count. Instead, they are noted and acknowledged directly in the Supporting Autonomy and Activation intention. Additionally, they will also influence Partnership and Expressing Empathy intention scores in a positive way. See examples below:

*Coded as reflection:* You have been busy at work, but you were able to walk almost every day for the past four weeks, and you have lost some weight as a result.

*Affirmation; not coded as reflection:* Your persistence and efforts have really paid off – you made it happen!

*Affirmation; not coded as reflection:* Your success with this goal in the face of having so much going on is a great testament to your commitment and is just an amazing effort!

Spoiled Reflections: Even If the intent of a practitioner is to provide a reflection, if the voice inflection goes up at the end as in a question, it is coded as a question. This is referred to as a "spoiled reflection".

## Coding MI Intentions

Working from a clinical perspective, we want to assess if a practitioner is operating with the intention of MI. Beyond the necessary technical skills, a practitioner should embody the purpose or Intention of an MI- based conversation. We recognize that there is no way to objectively access and measure what is actually going through a practitioner’s mind by listening to a recording. The MICA fosters a naturally prospective approach to coding and coaching based on comprehensive MI training. The MI coach guides the practitioner in having clear intentions with foresight heading into an MI-based session. The baseline measures are derived from the simple and powerful question:

“When we began teaching MI in the 1980s we tended to focus on technique, on how to do it. Over time we found, however, that something important was missing. As we watched trainees practicing MI, it was as though we had taught them the words but not the music. What had we failed to convey? This is when we began writing about the underlying *spirit* of MI, its mind-set and heart-set (Rollnick & Miller, 1995).”<sup>3</sup>, p. 14

“Is the practitioner operating from a client-centered approach?” If a practitioner fundamentally operates from a client-centered approach, then it reinforces Dr. Terri Moyers’ expression: “There is definitely more than one right way [to get there].” Feedback based on the MICA helps practitioners become aware of multiple ways stylistically that they can facilitate a successful MI session versus feeling bound by an overly structured and technical goal of making sure they are hitting specific verbal marks and phrasings. As the above quote aptly expresses, MICA focuses as much on the “spirit” as the technique. MICA was designed to capture this mindset and heart-set, along with more concrete, active ingredients in MI; i.e., MICA attempts to capture these components more qualitatively and holistically with an emphasis on proactive intentionality by the MI practitioner. This point further clarifies how the MICA is positioned as a coaching and feedback tool intended for guiding practitioners towards accurate and improved MI.

Much has been written about the “Spirit of MI” and the concerted efforts of many individuals (most notably Moyers, Martin, Manuel, Miller and Ernst) who produced a method to measure MI Spirit. Spirit in MI is currently comprised of Partnership, Acceptance, Compassion and Evocation<sup>3</sup>. They surmise that practitioners can be highly skilled at the technical components of MI, yet still not be proficient in the Partnership aspect of MI. As research has progressed, the measurement of Spirit has shifted, been modified and condensed. The Definitions of the Intentions in MICA represent aspects of the original MI Spirit plus those supported by Self-Affirmation Theory<sup>4</sup>, Self-Determination Theory<sup>5</sup> and Patient Activation Model<sup>6</sup> which are all invaluable in constructing a client-centered approach. While the MICA does not capture all of those perspectives in their entirety, it does focus on measurable elements that flesh out a quality MI approach. Once coders assess microskills and MI strategies, they then assess the extent to which the overall conversation embodies the key inter-relational aspects of MI.

The coding structure and protocol of the MI Intentions is identical to the MI Strategies in terms of Definitions, Indicators, and Further Details (see diagram on p. 3), distinguishing Indicator thresholds (p. 4), and coding differentials (p. 4).



## Coding MI Strategies

In 1983, William Miller hypothesized a relatively straightforward implicit causal chain: Behavior change would be promoted by causing clients to verbalize arguments for change. This was specifically designated as “change talk” by William Miller and Stephen Rollnick in 2002.<sup>7</sup> Conversely, evoking sustain talk would favor behavioral status quo. This is a technical hypothesis regarding the efficacy of MI – proficient use of the techniques of MI will increase clients’ in-session change talk and decrease sustain talk which, in turn, will predict behavior change.<sup>8</sup> Since this early theorizing, there has been much research that supports the importance of responding to sustain talk and change talk in strategic ways (see Appendix A.)

Beyond questions and reflections, it is an MI skill to distinguish types of client language, and a more advanced strategy to respond to them effectively. The crux of distilling out ambivalence is identifying client language expressing why change is difficult as well as identifying client language explaining why change may be beneficial. Resolving ambivalence toward change is the focal point of MI. MI identifies the change half of ambivalence as Change Talk (CT), and the unwilling/stuck half of ambivalence as Sustain Talk (ST).<sup>3</sup> If a client initially only presents the ST half of the ambivalence, MI makes an assumption that CT still exists – the flip side of the ambivalence. Based on that assumption, CT can be reflected even if not explicitly stated by the client. Coders assess the skill and strategy of how practitioners respond to either or both sides of ambivalence to most effectively assist clients toward their desired outcome/goal.

When the coder listens to client speech, they listen for and may hear a multitude of types and strength of CT. There is Preparatory CT: desire for change, ability to change, reasons for change, or need for change. Coders may also hear Mobilizing CT which is stronger: commitment to change, activation for change and specific steps that the client is currently taking toward change. This is now taught to MI students as “DARN CAT”.<sup>3</sup> When identifying CT, the coder assesses how the practitioner responds and strengthens this client language.

Conversely, in coding an MI-based conversation, the coder can also readily identify ST in hearing a client’s desire for status quo, the client’s belief in an inability to change, their reasons for feeling stuck, their need for status quo, or their lack of commitment and activation for change. Essentially, this is the mirror image of the DARN CAT CT. The coder listens for any form of ST in the conversation and assesses how the practitioner responds and moves the client to the other side of their ambivalence. It is NOT required nor expected that a coder would identify the specific types of ST or CT; although it is helpful for the coder to actively listen for and identify language (i.e. I don’t know, I want to, need to, should, have been thinking about, I will). This is the foundation for scoring how the practitioner responds.

Every time a client provides ST and/or CT, the practitioner has a choice of how to respond. Fundamentally, MI practitioners facilitate movement toward the client’s desired change over the course of the conversation. If there is discord or limited engagement between the client and practitioner, there should be more initial focus on engaging the client to get a better sense of their feelings, barriers, sense of “stuckness” or reluctance to change. Once the client feels heard and understood, practitioner efforts and emphasis should shift toward moving forward in the direction of change and “chasing change talk”. See Figure 2 below for examples that illustrate a basic decision tree of how a coder may assess the practitioner’s skillfulness in responding to types of client talk.

## CHANGE TALK

### Preparatory Change Talk

Desire for change

Ability to change

Reason for change

Need for change

### Mobilizing Change Talk

Commitment to change

Activation for change

Taking steps of change

## Strategically Responding...

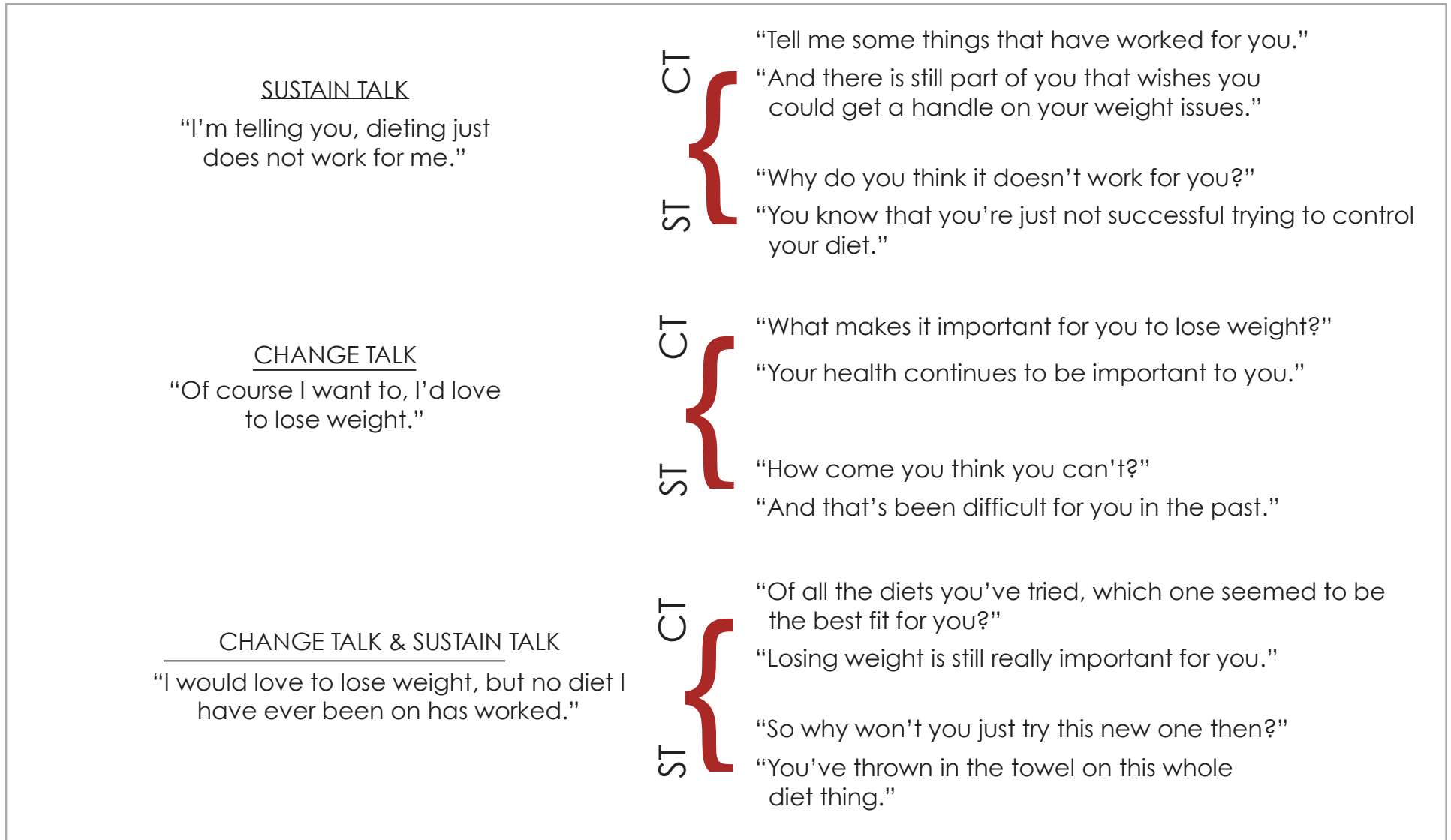


Figure 2. Examples of Responding to Either Sustain Talk or Change Talk

## MICA Feedback Report

There is no standardized MICA coding worksheet or feedback report at this time. MICA coders and/or organizations using the MICA are free to develop their own worksheet and report. Alternatively, they are also free to gather ideas from MICA co-developers.

There are standardized calculations for determining the Reflection to Question Ratio and the MICA Composite Score.

**Reflection to Question Ratio:** This is the number of reflections divided by the number of questions. See page 5-7 for how to code these microskills.

$$R:Q = (\# \text{ of Reflections}) / (\# \text{ of Questions})$$

*Example: if the clinician had 5 reflections and 10 questions, the R:Q ratio would be 5/10 or .05*

**MICA Composite Score:** This score reflects the overall competence of the practitioner in MI for this session. It is the average of the two Strategies added to the average of the five Intentions. To determine the meaning of this score as presented by the thresholds 1-5 used for the individual scores (see p. 4), simply divide this number in half.

$$\text{AVE (2 Strategy Scores)} + \text{AVE (5 Intention Scores)}$$

*Example: if the clinician had the scores in the table below, the MICA Composite Score would be: AVE(3 +3) + AVE (3 + 2.5 + 3.5 + 3.5 + 3) = 3 + 3.1 = 6.1*

*A 6.1 composite score would be considered Client-Centered per thresholds on p. 4 as we would halve it and get 3*

Strategy/Intention	Score
Strategically Responding to Sustain Talk	3
Strategically Responding to Change Talk	3
Partnership	3
Evoking	2.5
Guiding	3.5
Expressing Empathy	3.5
Supporting Autonomy & Activation	3

## MICA Strategies & Intentions: Definitions, Indicators & Further Detail

Pages 12 – 18 are the foundational MICA guidelines that should be used for each coding.

## STRATEGICALLY RESPONDING TO SUSTAIN TALK

This scale is intended to measure how well the practitioner understands the role of sustain talk (ST) in the change process and strategically responds to it during the conversation. There are situations where the client has a need to explore/explain the reluctance to change, obstacles related to change, concerns regarding change, ‘stuckness,’ or desire for status quo. The practitioner responds to ST to express empathy, provide validation or build engagement/rapport so that the client feels heard, seen and understood. When managed successfully, the amount, strength and duration of ST decreases or diminishes, the client transitions towards CT, and there is significantly less (if any) response to ST other than as a source to find/identify and cultivate change talk (CT).

*NOTE: This Intention can be coded ‘NA’ in the rare instances where the client provides zero Sustain Talk and practitioner has no opportunity to strategically respond to it*

<i>Fundamentally Inconsistent</i>	<i>Generally Inconsistent</i>	<i>Client-Centered</i>	<i>Competent</i>	<i>Proficient</i>
<b>1</b> <b>Predominantly elicits, explores, mines for or deepens sustain talk OR invalidates relevant sustain talk</b>	<b>2</b> <b>Elicits, explores and deepens sustain talk OR ignores, minimizes or is unaware of relevant sustain talk</b>	<b>3</b> <b>Emerging efforts to respond to sustain talk</b>	<b>4</b> <b>Successfully responds to sustain talk to the extent necessary for validation and rapport</b>	<b>5</b> <b>Skillfully responds to sustain talk to express empathy, build engagement and to cultivate change talk</b>
<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• use approach that builds, expands or increases amount, duration or strength of ST</li> <li>• continue to push agenda that generates ST or discord which otherwise wouldn’t be generated</li> <li>• discount or negate client desire or need to explain challenges, barriers or stuckness</li> <li>• communicate that client identified challenges or barriers are invalid or illegitimate excuses</li> <li>• install ST where it didn’t previously exist</li> <li>• offer no validation, empathy or acknowledgement of ST</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• use approach that maintains or slightly strengthens ST over course of conversation</li> <li>• be unaware that approach generates ST that otherwise wouldn’t be generated</li> <li>• mine for, focus unduly on and/or linger on reasons not to change</li> <li>• ignore or be oblivious to the client’s desire or need to explore/explain challenges, barriers or stuckness</li> <li>• consistently try to fix or correct client perceptions about challenges &amp; barriers to change</li> <li>• offer little validation, empathy or acknowledgement of ST</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• linger in, gives preferential attention to or reinforce ST in attempt to express empathy or build rapport</li> <li>• acknowledge barriers and challenges when brought up by client but not in meaningful way that allows client to feel understood</li> <li>• try to fix or correct client perceptions about challenges and barriers to change in attempt to be supportive</li> <li>• have awareness ST is being generated but seems unsure how to respond to it at times</li> <li>• use approach that does not help in lessening ST over course of conversation</li> </ul>	<p>The practitioner is client centered, plus:</p> <ul style="list-style-type: none"> <li>• consistently reflects ST in genuine manner to validate and engage client</li> <li>• does not proactively evoke nor linger in ST</li> <li>• is aware if response generates ST and responds/shifts conversation accordingly</li> <li>• uses approach that decreases and weakens ST over course of conversation</li> </ul>	<p>The practitioner is competent, plus:</p> <ul style="list-style-type: none"> <li>• Is comfortable when ST emerges and addresses it to enhance client engagement, encourage self-exploration and/or facilitate consideration or insight regarding change</li> <li>• is aware if response generates ST and is able to leverage it towards CT</li> <li>• strategically shifts away from ST when appropriate, which results in decreased ST and increased CT over course of conversation</li> </ul>

## STRATEGICALLY RESPONDING TO CHANGE TALK

This scale is intended to measure how well the practitioner understands the role of change talk (CT) in the change process and strategically responds to it during the conversation. The practitioner strategically listens for, responds to, evokes and strengthens client statements of desire, ability, reasons, need, commitment or movement towards change. There is curiosity and exploration about why change would/could occur which increases the exploration of and readiness for change. As a result, CT increases, strengthens and deepens over the course of the conversation, and may be shifted into commitment talk over the course of the conversation.

<i>Fundamentally Inconsistent</i>	<i>Generally Inconsistent</i>	<i>Client-Centered</i>	<i>Competent</i>	<i>Proficient</i>
<b>1</b> <b>Clearly oblivious to or ignores CT OR predominantly tries to install CT</b>	<b>2</b> <b>Sporadic or tepid efforts to elicit and respond to CT OR tries to persuade client to change</b>	<b>3</b> <b>Emerging efforts to elicit and respond to CT</b>	<b>4</b> <b>Successfully elicits and responds to CT</b>	<b>5</b> <b>Skillfully elicits, responds to and advances CT</b>
<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• focus on information-gathering, fact finding and giving information/advice</li> <li>• seem unaware of importance of CT and does not evoke it</li> <li>• show no interest/curiosity in identifying CT or client motivations for change</li> <li>• not respond to CT when initiated by client</li> <li>• Actively mine for ST instead of CT</li> <li>• push, provide or try to install reasons or need for change in patronizing tone</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• have little awareness/ demonstrate little skill in identifying CT</li> <li>• lack curiosity and exploration about client motivations for change</li> <li>• miss multiple opportunities to respond to CT initiated by client</li> <li>• ask questions that incidentally elicit CT</li> <li>• unintentionally mine for ST instead of CT</li> <li>• provide reasons for change in effort to persuade</li> <li>• randomly respond to CT with no conscious or deliberate effort</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• seem aware of the importance of exploring the benefits of change</li> <li>• ask some questions to elicit CT</li> <li>• respond to some CT but is inconsistent</li> <li>• miss multiple opportunities to explore and deepen CT</li> <li>• give equal time to ST</li> <li>• default to giving solutions or reasons for change when stuck</li> <li>• skip over evoking/exploring preparatory CT and go right to exploring/evoking mobilizing CT</li> </ul>	<p>The practitioner is client centered, plus:</p> <ul style="list-style-type: none"> <li>• actively demonstrates awareness of the importance of evoking and exploring CT</li> <li>• elicits preparatory (DARN) CT</li> <li>• elicits mobilizing (CAT) CT if appropriate</li> <li>• consistently responds to CT</li> <li>• when offered by client validates ST but gives preference to CT</li> <li>• may miss occasional opportunity to explore and deepen CT</li> </ul>	<p>The practitioner is competent, plus:</p> <ul style="list-style-type: none"> <li>• proactively works to evoke and explore CT</li> <li>• elicits and cultivates preparatory (DARN) CT first; then, if appropriate, elicits and cultivates mobilizing (CAT) CT</li> <li>• consistently responds to and deepens CT when offered by client</li> <li>• rarely misses opportunities to explore and deepen CT</li> <li>• leverages ST to advance movement towards change</li> </ul>

## PARTNERING

This scale measures the extent to which the practitioner fosters a collaborative process with the client as two equal partners who are working together towards the client's goals. The client is the acknowledged decision-maker regarding their life and is supported in the lead role. The MI practitioner is the key consultant who provides relevant and appropriately timed knowledge, expertise, insights and observations that support and advance the client outcomes.

<i>Fundamentally Inconsistent</i>	<i>Generally Inconsistent</i>	<i>Client-Centered</i>	<i>Competent</i>	<i>Proficient</i>
<b>1</b> <b>Exerts the expert role by defining the client problem and prescribing/developing the goals and/or plan</b>	<b>2</b> <b>Leans towards expert role and consistently misses or is unaware of opportunities to collaborate</b>	<b>3</b> <b>Emerging efforts to collaborate and support client decision making</b>	<b>4</b> <b>Successfully collaborates with client in lead role</b>	<b>5</b> <b>Skillfully collaborates as key consultant, advancing client goals</b>
<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• take hierarchical approach</li> <li>• show no attempts to build rapport</li> <li>• rely on dominance, expertise or authority</li> <li>• push their advice or suggestions</li> <li>• assume role of fixing problem</li> <li>• relegate client to following their lead</li> <li>• exhibit righting reflex in condescending and patronizing way</li> <li>• be indifferent or unaware they are generating or perpetuating discord</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• build some rapport</li> <li>• talk at client more than talk with client</li> <li>• seem unaware client can legitimately contribute to conversation and process/outcome</li> <li>• have a tendency to give advice or suggestions without permission</li> <li>• try to persuade client</li> <li>• exhibit the righting reflex in desire to direct or fix</li> <li>• be aware of discord or resistance, but has little, if any, recognition how their approach influences it</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• build good rapport</li> <li>• have a sense the client can contribute to the process</li> <li>• provide knowledge, expertise or stall when client is unsure where to go or what to do</li> <li>• ask permission before giving advice or suggestions</li> <li>• attempt to persuade with permission</li> <li>• show efforts to manage the righting reflex</li> <li>• seem to take turns with client rather than structure a collaborative process</li> <li>• be aware of discord or resistance with some attempts to reduce it</li> </ul>	<p>The practitioner is client centered, plus:</p> <ul style="list-style-type: none"> <li>• seeks and values client contribution</li> <li>• engages client perspective in mutual problem-solving</li> <li>• asks permission before giving advice, suggestions, or sharing insights</li> <li>• consistently resists righting reflex</li> <li>• manages any discord that surfaces, shifting the focus back towards collaborative resolution</li> </ul>	<p>The practitioner is competent, plus:</p> <ul style="list-style-type: none"> <li>• defers to client as expert on their own life</li> <li>• acts as a key consultant working towards client goals</li> <li>• appears to effortlessly resist righting reflex</li> <li>• actively elicits/evokes client insights and ideas</li> <li>• augments client process with relevant knowledge and expertise when client is truly stuck</li> <li>• re-engages client in problem-solving if they stall</li> </ul>

## EVOKING

This scale measures the extent to which the practitioner elicits the client’s perspective on their own thoughts, barriers, knowledge, feelings, ideas, motivators, goals, values and solutions regarding the target behavior and change. The practitioner operates both from a place of genuine curiosity and from a belief that the motivation for change and the ability to change exists within the client. The practitioner skillfully elicits, explores and expands these client perspectives on change.

<i>Fundamentally Inconsistent</i>	<i>Generally Inconsistent</i>	<i>Client-Centered</i>	<i>Competent</i>	<i>Proficient</i>
<b>1</b> <b>Absence of curiosity and little/no exploration of client perspective</b>	<b>2</b> <b>Minimal curiosity and efforts to elicit client perspective</b>	<b>3</b> <b>Emerging efforts to elicit and explore client perspective</b>	<b>4</b> <b>Successfully elicits and explores client perspective</b>	<b>5</b> <b>Skillfully elicits, explores and expands client perspective</b>
<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• be focused on gathering facts</li> <li>• give information and unsolicited advice</li> <li>• try to instill their professional/ personal perspective</li> <li>• try to instill their agency/ clinic perspective</li> <li>• adhere to a standardized intake, assessment process or follow a predetermined script</li> <li>• make no attempt to elicit or explore client perspective</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• seem intermittently interested in client perspective</li> <li>• demonstrate little effort to elicit client perspective</li> <li>• seem inattentive to/ uninterested in perspective offered by the client</li> <li>• rarely expand or explore what client offers.</li> <li>• inquire about client perspective but fail to follow up and explore OR respond with information, opinions or problem solving</li> <li>• rely on the question and answer approach</li> <li>• primarily elicit information in relation to own agenda</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• seem interested in client perspective</li> <li>• attempt to follow up in a superficial or fleeting manner</li> <li>• have instances of exploring or expanding on client perspective</li> <li>• miss opportunities to follow up</li> <li>• seem unsure how to follow up</li> <li>• fall into the question and answer trap at times</li> <li>• may elicit information in relation to their own agenda</li> <li>• ask questions about importance or confidence but they seem rote/scripted and there is no follow up</li> </ul>	<p>The practitioner is client centered, plus:</p> <ul style="list-style-type: none"> <li>• is consistently interested in client perspective</li> <li>• is curious and often follows up in order to deepen or draw out client perceptions</li> <li>• does not fall into the question and answer trap</li> <li>• explores/expands relevant sustain talk and change talk</li> <li>• rarely misses an opportunity to follow up</li> <li>• explores and identifies readiness, importance and confidence of client to tackle different areas of change</li> </ul>	<p>The practitioner is competent, plus:</p> <ul style="list-style-type: none"> <li>• is deeply interested in client perspective</li> <li>• is curious with active and consistent efforts to follow up in order to deepen or draw out client perceptions</li> <li>• explores client ideas, insights, solutions and next steps towards change.</li> <li>• does not miss significant opportunities to explore/ expand on relevant client perspective</li> <li>• explores and helps client identify sticking point (importance, confidence, readiness) for change</li> </ul>

## GUIDING

This scale measures the practitioner’s Intention to navigate the conversation towards the goal of the referral, presenting problem, target behavior or topic of concern. The practitioner works with the client to elicit insights, ideas, motivations, resources and potential next steps in an efficient and productive manner that keeps the session moving forward towards a solution or resolution. The practitioner helps the client remain/regain focus on the long-term goals while effectively moving through current and relevant issues, struggles, situations or barriers.

<i>Fundamentally Inconsistent</i>	<i>Generally Inconsistent</i>	<i>Client-Centered</i>	<i>Competent</i>	<i>Proficient</i>
<b>1</b> <b>Primarily directing, controlling or mandating client goals</b>	<b>2</b> <b>Primarily wandering around, following or subtly directing client goals</b>	<b>3</b> <b>Emerging attempts to establish and focus on client goals</b>	<b>4</b> <b>Successfully establishes and focuses on client goals</b>	<b>5</b> <b>Skillfully navigates multiple issues while maintaining clear focus on client goals</b>
<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>not work at all towards establishing a shared approach to client goals</li> <li>subtly or overtly set targets or goals irrespective of client interests</li> <li>take the expert role and lead or push client</li> <li>have overt or underlying expectations regarding compliance</li> <li>discount or diminish client targets or goals</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>start the session with assumption that client is onboard with practitioner agenda</li> <li>listen to client goals, then shift to their own agenda</li> <li>make few, if any, attempts to establish shared approach to client agenda or goals</li> <li>may be overly passive in their approach</li> <li>fail to elicit and shape the conversation toward an agenda or goal</li> <li>may allow the conversation to wander off topic with client telling stories, discussing history or sharing random events or information</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>have instances of wandering, following or directing</li> <li>elicit client agenda, but promote secondary agenda they are trying to insert into conversation</li> <li>allow conversation to wander away from presenting problem or target behavior</li> <li>attempt to sporadically or awkwardly shift conversation back on course</li> <li>grasp to find direction or default to interrupting or giving information to get back on topic</li> </ul>	<p>The practitioner is client centered, plus:</p> <ul style="list-style-type: none"> <li>helps client identify their priority or primary focus from presenting problem or target behavior</li> <li>consistently maintains focus on solution/ resolution of primary focus that client has chosen</li> <li>may have brief episodes of wandering with no instances of directing</li> <li>regains appropriate focus and shapes discourse towards intended goal if conversation loses course</li> <li>does not seem to have secondary agenda</li> </ul>	<p>The practitioner is competent, plus:</p> <ul style="list-style-type: none"> <li>may respectfully follow, but has no instances of wandering or directing</li> <li>is adept at shaping conversation towards insights/ solutions/ resolution based on client needs and preferences</li> <li>assists client in finding a clear path or approach that aligns with client ultimate goals or interests</li> <li>clarifies potential paths or approaches if presented with multiple or complex goals, or additional issues arise</li> <li>is committed to finding and supporting client ultimate destination beyond target behavior</li> </ul>



## EXPRESSING EMPATHY

This scale measures the practitioner's Intention to: actively listen without judgment; grasp the client's thoughts, feelings, experiences, and perspective; and to convey that understanding to the client. Strategies include reflective listening, validation of the client's reality, and all of the efforts the practitioner makes to understand the client's inner experience and effectively communicate that to the client.

*NOTE: Do not include practitioner self-disclosure or agreement with client stance, sympathy, warmth or advocacy when assessing this measure.*

<i>Fundamentally Inconsistent</i>	<i>Generally Inconsistent</i>	<i>Client-Centered</i>	<i>Competent</i>	<i>Proficient</i>
<b>1</b> <b>Dismisses, ignores or has little interest in client perspective</b>	<b>2</b> <b>Random, sporadic or tepid efforts to understand client perspective</b>	<b>3</b> <b>Emerging efforts to understand client perspective</b>	<b>4</b> <b>Successfully communicates understanding of client perspective</b>	<b>5</b> <b>Skillfully conveys a multifaceted understanding of client perspective</b>
<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• make no real effort to understand client</li> <li>• actively dismiss client perspective</li> <li>• not leave own world view</li> <li>• have no grasp of client perspective</li> <li>• be indifferent, annoyed or irritated with client reality or perspective</li> </ul>	<p>The practitioner: may</p> <ul style="list-style-type: none"> <li>• make a few shallow efforts to understand client reality</li> <li>• make minimal attempts to access client world view</li> <li>• have little grasp of client perspective</li> <li>• use efforts that appear shallow, halfhearted or generated from a sense of obligation</li> <li>• provide reflections that tend to miss the mark, be inaccurate or manipulative, or detract from client implicit meaning</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• attempt to grasp client reality throughout the session with sporadic success</li> <li>• use some accurate reflections and other inaccurate reflections</li> <li>• have a tendency to parrot back client statements or reflect explicit content rather than add significant meaning</li> <li>• exhibit some grasp of client perspective but never goes deeply enough to elicit and understand client inner experience</li> </ul>	<p>The practitioner is client centered, plus:</p> <ul style="list-style-type: none"> <li>• demonstrates accurate understanding of client reality</li> <li>• provides multiple complex reflections that add significant meaning</li> <li>• provides reflections that effectively communicate client thoughts, feelings and explicit world view</li> <li>• exhibits solid grasp of client perspective that resonates with client</li> </ul>	<p>The practitioner is competent, plus:</p> <ul style="list-style-type: none"> <li>• consistently communicates deep understanding of client reality</li> <li>• reflections effectively convey client's explicit experiences, perspectives, and implicit inner experience/world view</li> <li>• reflections often go beyond content to unspoken emotions, values, desires and meanings</li> <li>• exhibits thorough grasp of client perspective that obviously resonates with client</li> </ul>

## SUPPORTING AUTONOMY & ACTIVATION

This scale measures the extent to which the practitioner encourages and supports the client’s autonomy and freedom to choose, as well as empowering, addressing and affirming the client’s self-efficacy (confidence) and personal agency (belief in ability to effect change by their actions). The practitioner works from an assumption that individuals have an innate desire and capacity for evolution and growth. The practitioner operates from a strength-based approach that draws out and supports the client in putting their goals, values and choices into action. The practitioner moves beyond praise and actively provides meaningful affirmations that support and empower the client.

<i>Fundamentally Inconsistent</i>	<i>Generally Inconsistent</i>	<i>Client-Centered</i>	<i>Competent</i>	<i>Proficient</i>
<b>1</b> <b>No evident interest in client choice/control and little to no efforts to affirm/empower client</b>	<b>2</b> <b>Superficial attention to client choice/control and cursory efforts to affirm/empower client</b>	<b>3</b> <b>Emerging efforts to acknowledge client choice/control and to affirm/empower client</b>	<b>4</b> <b>Successfully supports client autonomy/control and affirms/empowers client</b>	<b>5</b> <b>Definitively enhances client sense of choice/control and markedly affirms/empowers client</b>
<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• establish agenda for session without input from client</li> <li>• drive interaction by predetermined or standard goals of practitioner or agency/clinic</li> <li>• express or convey client has no choice</li> <li>• use potential consequences as tool to eliminate client sense of choice or options</li> <li>• focus on what client is not doing or doing incorrectly, ignoring strengths</li> <li>• not offer any affirmations or statements of support</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• lean on their own agenda</li> <li>• incidentally elicit client goals/interests but give it little/no value or merit</li> <li>• genuinely seem to want to help, but exhibit a paternalistic or expert approach that undermines client autonomy</li> <li>• passively or tacitly undermine any sense of control or choice</li> <li>• provides information or advice in a way that seems coercive or condescending</li> <li>• provide instances of superficial praise but limited to when client has been following agency/treatment guidelines or prescription</li> </ul>	<p>The practitioner may:</p> <ul style="list-style-type: none"> <li>• exhibit awareness that client goals/interests have merit</li> <li>• seem to struggle between pushing own agenda/insights while attempting to provide client with sense of control/choice</li> <li>• imply/express that client has choice, but provides little exploration or follow-up</li> <li>• provide affirmations, although mostly limited to more superficial approval or praise</li> <li>• have a supportive approach/tone but miss multiple opportunities to affirm knowledge, insights, commitment or efforts</li> <li>• express desire for client to be in driver seat but then fail to relinquish the position</li> </ul>	<p>The practitioner is client centered, plus:</p> <ul style="list-style-type: none"> <li>• clearly acknowledges that client goals/interests are critical for sustained behavior change</li> <li>• evokes client agenda/ideas first before sharing their own</li> <li>• asks for permission before giving advice and may also offer a menu of options</li> <li>• focuses on and verbally identifies client strengths</li> <li>• provides genuine affirmations, even when client has not been successful</li> <li>• consistently offers expressions of support regardless of client choices</li> </ul>	<p>The practitioner is competent, plus:</p> <ul style="list-style-type: none"> <li>• clearly embraces client goals/values and agenda in the change process</li> <li>• works to activate client desire for growth &amp; evolution</li> <li>• skillfully reinforces client thoughts, choices, behaviors, actions that embody client values &amp; advance client goals</li> <li>• verbalizes support of client autonomy in concrete and genuine manner</li> <li>• consistently focuses on strengths and provides multiple statements of support</li> <li>• expresses meaningful affirmations that address client mastery, self-efficacy and personal agency</li> </ul>

## References

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- <sup>5</sup> Ryan, R. M. Deci, E. L. (2019) Brick by brick: The origins, development, and future of self-determination theory. In A. J. Elliot (Ed.), *Brick by brick: The origins, development, and future of self-determination theory*. , 6 (pp. 111-156) Cambridge, MA.: Elsevier Inc.. doi: 10.1016/bs.adms.2019.01.001
- <sup>6</sup> Mosen, D.M., Schmittiel, J., Hibbard, J., Sobel, D., Remmers, C., Bellows, J. (2007) Is patient activation associated with outcomes of care for adults with chronic conditions? *J Ambul Care Manage*;30(1):2109.
- <sup>7</sup> Miller, W.R., Rollnick S. (2001) *Motivational Interviewing: Preparing People for Change*. 2<sup>nd</sup> Edition. New York: Guildford Press.
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Appendix A: Change Talk Research

Finding	Evidence
Change Talk during a session is predictive of positive clinical outcomes; commitment strength language towards the end of the session has the most direct correlation	Amrhein et al., 2003; Martin & Moyers, 2007; Gaume et al., 2008; Campbell, Adamson & Carter, 2010; Gaume et al., 2013; Lindqvist et al., 2017; Magill et al., 2018; Magill et al., 2019
Ability language and self-efficacy have a unique and strong correlation with outcomes	Bandura A, 2004; Martin, Christopher, Houck, Moyers, 2011; Lorig et al., 2014; Yu et al., 2019
Reflection of Change Talk directly or indirectly correlated to more Change Talk and/or positive clinical outcomes. Complex reflections are more effective.	Barnett et. al, 2014; Lindqvist et al., 2017; Magill et al., 2018; Laws et al., 2018; Villarosa-Hurlocker, O’Sickey, Houck, Moyers, 2019
Interventions geared to increase clinician evocation of Change Talk results in higher levels of Change Talk during patient sessions	Glynn & Moyers, 2010; Lindqvist et al., 2017, Kitzmann, Ratka-Krueger, Vach, Woelber, 2019

Finding	Evidence
<p>“This indicated that trainees need more than a one-time workshop to improve skillfulness in this complex method. Two common learning aids seemed good candidates for improving training: progressive individual feedback on performance, and personal follow-up coaching.”</p>	<p>Miller &amp; Rose, 2009</p>
<p>“It is unlikely that 75% of clinicians can achieve beginning proficiency in MI spirit after training unless competency is benchmarked and monitored and training is ongoing.”</p>	<p>Hall et al., 2016</p>
<p>“Evaluating clinician adherence and competence will not only help ensure that clinicians are following the tenets of an intervention appropriately but also have the potential to facilitate skill development. Although these evaluations have traditionally relied on clinical judgment, the increasing complexity of interventions combined with the call for accountability suggests that evaluators will be helped by the guidance of empirically sound evaluation tools.”</p>	<p>Madson &amp; Campbell, 2006</p>
<p>“On average, three to four feedback/coaching sessions over a 6-month period sustain skills among trainees for motivational interviewing, mainly for substance use disorder treatment. However, high rates of attrition from feedback/coaching contributes to post workshop skill erosion...</p> <p>The results of this study suggest that the level of post-training expert supervision needed to sustain MI skills is somewhat modest—approximately three to four contacts totaling at least 5 hours of contact time over a 6-month period was sufficient for the average study to sustain training effects over a 6-month window...</p> <p>Previous research indicates that motivational interviewing (MI) skills decline over time among participants in training workshops when post-workshop feedback and coaching are not provided.</p> <p>Most MI scholars and trainers recognize that reading the MI literature (e.g. manuals) and participating in training workshops are not sufficient to sustain training gains for most human service professionals. Rather, evidence from practitioner training in evidence based behavioral interventions [1], along with experimental studies from the MI training literature [2], support a multi-modal training approach...</p> <p>Several studies have demonstrated this empirically, showing diminished skills among workshop participants at</p>	<p>Schwalbe et al., 2014</p>

<p>follow-up times as short as 2 months [2,6,7]...Usually, training workshops include a mix of didactic presentation, demonstrations and practice delivered over 1–3 days [4]. To sustain skills over time, a training workshop needs to influence mediating processes that provide ongoing support to counselor skillfulness, such as organizational support and counselor acceptance [8–10].”</p>	
<p>“When a complex method disseminates as widely and rapidly as has happened with MI, it is not surprising that its boundaries become unclear. With the diffusion of any complex innovation (Rogers, 2003) there is a natural process of “reinvention” whereby practitioners adapt the innovation to their own understanding and style. Some such modifications may improve the innovation or render it more accessible for a particular population (Miller, Villanueva, Tonigan and Cuzmar, 2007). It is also possible that reinvention removes some critical elements of the innovation, “active ingredients” in its efficacy. It is therefore important to understand what the essential elements are, and what components can be altered without disrupting the defining nature of a method. Good progress is being made in understanding what makes MI work (Amrhein, Miller, Yahne, Palmer and Fulcher, 2003; Moyers, Miller and Hendrickson, 2005), but clearly there is still a long way to go... It also sometimes happens that an innovation is altered so fundamentally that it no longer resembles, or is even contradictory to its pristine form...</p> <p>MI is not a trick or a technique that is easily learned and mastered. It involves the conscious and disciplined use of specific communication principles and strategies to evoke the person’s own motivations for change...</p> <p>In short, the workshop convinced clinicians that they had acquired MI skillfulness, but their actual practice did not change enough to make any difference to their clients (Miller &amp; Mount, 2000)...</p> <p>A practical challenge in training clinicians in MI, then, is to help them persist in behavior change past an initial workshop exposure that may erroneously convince them that they have already learned the method...</p> <p>Clinicians’ self-reported proficiency in delivering MI has been found to be unrelated to actual practice proficiency ratings by skilled coders (Miller &amp; Mount, 2001; Miller, Yahne, Moyers, Martinez &amp; Pirritano, 2004) and it is the latter ratings that predict treatment outcome.”</p>	<p>Miller &amp; Rollnick, 2009</p>
<p>66% of the 12 systematic reviews of MI in healthcare, including meta-analyses have the minority of their studies providing treatment fidelity information. 33% of the 12 studies have the reviews have the majority of studies reporting fidelity information. Of these systematic reviews that have over 50% of studies reporting fidelity information, the percentage of the studies in the review does not go far beyond 50% (at 55-64%), except for one study that had 71% reporting fidelity.</p> <p>“Further research may benefit from a greater focus on clinician proficiency, and a greater emphasis on the effectiveness of MI when delivered by a range of clinicians. Future research also needs to include treatment fidelity</p>	<p>McKenzie et al., 2015</p>

<p>measures [37] to ensure the intervention being studied is indeed MI.”</p>	
<p>Despite the clear need, exceedingly few studies explicitly report assessment of treatment delivery fidelity [5, 6, 9]. One review found only 30% of 287 published studies over a 10-year span included mechanism by which to assess treatment delivery and only 6% assessed the presence of non-treatment specific effects (e.g. empathy) in delivery [9].”</p>	<p>Damschroder et al., 2016</p>
<p>“The MI research is well-aligned with the research and best practices in the field of learning and organization development, including the American Society of Training and Development (ATSD), that emphasize the limitations of legacy stand-alone training programs that do not provide sufficient attention to competency development and assessment, transfer of new learning to the job and return on investment (ROI) of training costs [8]...</p> <p>Self-assessed proficiency in MI is statically unrelated to actual proficiency in MI as measured via standardized validated tools...</p> <p>Instead, proficiency [in MI] typically requires an immersion experience, such as a two-day workshop first followed by regular practice with feedback coaching over time.”</p>	<p>Butterworth &amp; Andersen, 2001</p>
<p>“The Treatment Fidelity workgroup of the NIH Behavior Change Consortium recommends fidelity monitoring strategies to ensure that counselors meet criteria for skill proficiency, monitoring be conducted throughout the intervention to prevent “drift” in adherence to manual protocol, and training be adapted to meet the needs of diverse trainees (Bellg et al., 2004)</p> <p>Yet a recent review of more than 400 publications describing behavioral interventions found that only 12% of publications could be said to have followed a “gold standard” for measuring and maintaining treatment fidelity by reporting the use of a treatment manual, measures of protocol adherence, or strategies to improve the competency of treatment providers (Borrelli et al., 2005).”</p>	<p>Koken et al., 2012</p>