



Motivational Interviewing: Applications for Path Service Providers

**An Edited Transcript of the
PATH National Teleconference Call**

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Welcome and Introductory Remarks

Tom Lorello

Welcome everyone to the PATH national meeting on motivational interviewing, applications for PATH services providers. My name is Tom Lorello from Advocates for Human Potential in Sudbury, Massachusetts. We're the technical assistance contractor for the PATH program.

There are more than 100 people participating on this call from all over the country, including staff from PATH-funded service provider agencies and representatives of state and Federal government. We're pleased to have three nationally recognized experts with us today, who have prepared a presentation specifically for the PATH audience.

PowerPoint slides of today's presentation, background text, and a link to the outreach curriculum from the National Health Care for Homeless Council website have been posted for view and download at the PATH website at www.pathprogram.com. Please contact Amy Sanborn through e-mail if you have any problems: asanborn@ahpnet.com.

We're pleased to have with us this afternoon Gail Hutchings, the Acting Director of the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services. Ms. Hutchings leads a CMHS staff of 126 individuals in addressing both the 21st century challenges and opportunities presented to the nation's system of mental health care. These challenges range from developing approaches to changing the disparities in access to services and negotiating the complexity of financing and funding concerns to building on presidential priorities such as the New Freedom initiative, the president's New Freedom Mental Health Commission, and growing support for mental health parity.

We're happy to have Gail Hutchings with us today to introduce our presentation on motivational interviewing. Gail.

Gail Hutchings

Tom, thank you so much. Good afternoon, everyone. Our history goes back to where I used to help run the National Resource Center on Homelessness and Mental Illness. PATH continues to get investments from SAMHSA and at no time is that more a testament to how important we think the program is. To those of you who are out there doing the work to serve such vulnerable people, a sincere thank you.

I also want to remark on AHP's leadership on our behalf for this and how for years that you've been doing the NTA focus calls, and that's pretty much the wave of the future. As budgets within states get more and more limited, we have got to figure out better ways to provide technical assistance via the good uses of technology.

I would like to let everyone know of what we think is a fabulously exciting opportunity. Just recently announced in *The Federal Register*, is a notice of funding availability that is a combined effort, the first time in history, with HUD, HHS and VA money. It's a \$35 million initiative that will fund community-based interventions that are trying to do a system of care approach to help people, particularly those with chronic homelessness, and frankly, so we can get ahead and end chronic homelessness.

Finally, let me turn to this presentation. As most of you know, SAMHSA takes seriously its commitment to overcoming homelessness and particularly to preventing homelessness among people with disabilities. Homelessness is clearly one of our core issues. With that, we are so pleased to be able to bring you today's National Technical Assistance presentation on motivational interviewing.

The approach was recognized as an exemplary practice for persons with co-occurring mental health and substance abuse disorders and is also mentioned in our recent report to Congress on that topic. This technique can be especially useful in homelessness and among service providers that focus on people who are homeless, and it provides practical strategies for helping people who have become stuck in negative behavior patterns taking a step towards

positive change. It's both a structure and a process for reaching out to individuals, and particularly individuals who are termed difficult to engage.

Tom Lorello

Thank you very much, Gail. Motivational interviewing can be a valuable approach for PATH-funded programs. We're going to describe the basic principles and practices of the motivational interviewing approach, with an emphasis on the application of the approach for persons who are homeless and have mental illness and substance abuse problems.

Many of you may know that motivational interventions emerged in the substance abuse field, and that the seminal text on the method is Miller and Rollnick's *Motivational Interviewing, Preparing People To Change Addictive Behavior*. The second edition was published by Guilford Press in 2002 and is currently in print, and we have adapted this approach for people with severe mental illness and co-occurring substance abuse problems. As Gail mentioned, it is featured in SAMHSA's report to Congress on co-occurring disorders as evidence-based practice. The approach can be especially useful for homeless service providers because it provides practical strategies for helping people stuck in negative behavior patterns to take steps towards positive change.

So we're going to describe the underlying principles, the conceptual frameworks, and the basic skills needed to implement the approach, and specific examples of how to apply the approach with persons who are homeless will be provided throughout. Please note that this presentation is only an introduction to the key issues, and we encourage you to download the resources listed on the PATH website, again, at www.pathprogram.samhsa.gov. In particular, we have created a bulletin board discussion on a variety of topics that are relevant to the PATH program, including the issue of motivational interviewing and behavior change, which is under the discussion on co-occurring disorders on our bulletin board page.

One way to continue today's discussion would be to join the discussion on our bulletin board after today's call, and ask a question, make a comment or an observation, or simply read what others have contributed. Our presenters for today's call will be monitoring the discussion to respond to any questions that you would post there.

So at this point, I would like to introduce our featured experts in their order of appearance. Jim Winarski is currently the Director of Homeless Programs for Advocates for Human Potential, where he provides technical assistance and training in the areas of assessment, development, and implementation of human service programs. He's the Project Director for the Projects for Assistance and Transition from Homelessness, that is the PATH Technical Assistance Program, and he was also the co-writer of SAMHSA's report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders. He also authored the PATH Technical Assistance manual on co-occurring mental health and substance abuse disorders that is available for download on the PATH website.

We also have with us Sheryl Silver, and Sheryl has worked with homeless men and women since 1987 and those with psychiatric disabilities and substance abuse issues since 1993. She's currently a team leader with Pathways to Housing in New York City, where she has applied the principles and practices of the motivational interviewing approach with persons who are homeless. She was the co-founder of the organization, Alliance for Human Potential of Denver, Colorado, where she provided HIV education and prevention services to homeless injection drug users.

Then we also have with us Ken Kraybill. Ken has over 18 years of direct care experience providing outreach, engagement, and long-term clinical case management services to people experiencing homelessness and suffering from multiple health, mental health, and substance use disorders. In addition, he has broad experience providing training, supervision and consultation in the field.

Currently, Ken is the clinician specialist on the staff of the National Health Care for the Homeless Council,

an organization that provides support, training, and advocacy on behalf of the approximately 155 Health Care for the Homeless projects nationwide. He recently developed an extensive training curriculum for outreach workers and regularly facilitates workshops around the country on this topic, and his training curriculum for outreach workers is available on-line at www.nhchc.org/curriculum/index.html.

Motivational Interviewing and PATH: An Overview

Okay, so let's get started. Jim, what is motivational interviewing and how do you see it being relevant to staff working in PATH programs?

Jim Winarski

Motivational interviewing is an approach that emerged first in the substance abuse field as a method to help people who were stuck in addictive behaviors and other kinds of negative behaviors. Also, again, I would mention the seminal text in this area, Miller and Rollnick. The second edition was just published in 2002, and that's required reading for anyone who's interested in this approach. The complete reference to the text is listed on the PATH program website.

Now the approach has been adapted as part of intervention models for people with both severe mental illness and co-occurring substance abuse problems, and it's important to us because that represents a significant portion of the population that the PATH program serves. However, I believe that the power and utility of this method and the reason it should be of interest to people providing services to homeless people is that its focus is not strictly on illness and addiction, but rather the process of change and growth that is intrinsic to all people.

Now for those of you who have downloaded the PowerPoint presentation, the first slide provides two quotes from the Miller and Rollnick text that summarize the heart of this approach. The first quote says, and this is actually the introductory sentence from the text, "Healers in all ages have sought to

understand and to create conditions that lead to beneficial change." So in motivational interviewing, we're seeking to better understand what it takes for each individual to get unstuck, to quote Miller, from a pattern of negative behaviors.

Now for us, we need to begin by relinquishing our notions of "non-compliance, treatment-resistant, not being ready for treatment," and to recognize that these labels do little to enhance our understanding or our responsiveness to the people we're serving. If we're truthful, we'd recognize that these labels are another way of saying to our clients, "Look, we haven't been able to help you. We've had enough of banging our head against the wall. We are exasperated, we're frustrated and come back and see us some time if you can get your act together because there must be something defective about you that's causing this."

But of course, these "resistant people," as we describe them, are the same people that the PATH program is charged with reaching out to and helping. The focus of motivational interviewing is on developing more accurate perceptions of these difficult behaviors and then looking at how we establish the kinds of therapeutic relationships that will help persons to take positive steps for change.

The lack of motivation to change is a challenge to your therapeutic skills. It's not a fault for which to blame your client. In fact, lack of motivation or this experience of resistance that we have with our clients should be an indicator to us that we need to change our strategies. Our goal today with the presentation is to provide you with some alternate strategies for responding to people who have had difficulty changing, who have been difficult to engage, and for whom often we feel little hope of progress.

Five Important Assumptions

Jim Winarski

Assumptions essentially make up the theoretical base of an approach, and you might wonder, well gee, why is that important? So really, the assumptions represent

the core beliefs about the people we're serving, about the problems they encounter, and about the responses that we attempt to make to solve the problems, and that are intrinsic to this approach.

I'll mention the five of them, and then I'll just briefly talk about each of them. One is that motivation is a state, not a trait. Second, that resistance is not a force that we must overcome. Third, that ambivalence is good. Fourth, our clients should be an ally rather than an adversary. And finally, that recovery and change in growth are intrinsic to the human experience.

Motivation is a state, not a trait. Eventually, what we're saying here is that people who seem to appear unmotivated, who have a lack of motivation, that this is not a function of a character trait, and certainly it is not character pathology. Motivation is an emotional state and it can change rapidly, and that it can be influenced by our interventions. Now, that's good news for us because if it were a character trait, we'd be looking at years of personality reconstruction to move somebody from an unmotivated to a motivated state. But the reality is that it can change rapidly and that our interventions can have an effect that's immediate. So that's number one.

The second assumption is that resistance is not a force that we need to overcome. That's when we have that experience of resistance when we're working with a client, things are not moving like we'd like to see them move, that should be a cue for us that we need to change our strategies. We need to take a step back and look at what we're doing and look at an alternate approach. I always think of the martial arts where rather than meeting force with force as we would in fisticuffs, we take a force or energy and try to direct it to its desired goal.

So it's an approach that's not about power struggles. Ultimately it's about shifting the struggle from an us-versus-them approach to where we're going to move to a them versus them. In other words, it's shifting from us confronting the person to helping the person to confront themselves so that they can get on with the important work of change and growth.

The third assumption is that ambivalence is good. Now those of you who might remember the movie *Wall Street* where Michael Douglas plays a character called Gordon Gekko, who is kind of a Wall Street mogul, and there was a phrase from that film that was almost like the mantra of the '80s where it was "greed, for lack of a better term, is good." Well, in this approach, ambivalence, for lack of a better term, is a good thing. People often lack clarity in making decisions. That's common, and it's also a source of frustration for us when people are on the fence and have difficulty making decisions. But really, when we're seeing somebody ambivalent, we can rejoice, because this is the stuff we work with. This is how we help people to make decisions.

The fourth assumption is that the client should be an ally rather than an adversary. This is simply the idea that developing a partnership is the key and that we need to have a respectful orientation. It's the lynchpin to the approach, and later on, Ken Kraybill is going to go into great detail about that, because it's how we develop those partnerships that will determine how successful we will be with this approach.

Then finally, the fifth assumption here is that recovery, change and growth are intrinsic to the human experience. It's a natural part of the human experience, and in the approach, consequently, the focus is on the person. It's not on the pathology. Not that we ignore the pathology, but our real focus point is the person and how they change, and we need to recognize that even persons with severe disabilities and addictions can and do change. If we don't believe that and if we don't acknowledge that, there's no way that we can expect that from our clients.

Tom Lorello

Now Jim, your next slide here is called *The Risk of Hope*. What do you mean by that? In what way does hope involve risk, and how does this relate to the process of motivational interviewing?

Jim Winarski

Yes, nothing happens without hope. People who have suffered many losses often need to relinquish hope as

a means of survival. In fact, the most profound and pervasive theme that we see in personal histories, even more than illness, addiction, poverty, is the experience of loss, and as we learned in last month's National PATH Conference that we had on trauma, trauma is also a common experience and has an effect. Now if hope for improvement is not realized over a period of many months or even years, hope itself becomes a source of great pain. Individuals who feel trapped may relinquish hope as a means to survive emotionally. So in other words, hopelessness actually is functional for people living in these conditions, but it's also a great tragedy because in giving up hope, people also relinquish what is the basis of their human dignity.

So this is critical to understand as we're beginning the approach. There're two important factors for us to realize in relationship to hope. One, hope is an absolute prerequisite for making life changes. But second, and perhaps not so obvious, is that hope risks visiting profound experiences of loss and disappointment, so it's dangerous territory for people to begin hoping again.

I don't know if those of you out there have seen the film *The Shawshank Redemption* that starred Morgan Freeman and Timothy Robbins. It takes place in a prison in Maine, and Morgan Freeman is doing life in prison for a murder and has been in the prison for some number of years. Timothy Robbins also is incarcerated for a murder, also a life sentence, and enters the prisons as this film begins. There's a scene in which Timothy Robbins gets into some trouble, and consequently has to do some time in the box, in solitary, for a month, sitting in the dark in this underground hole.

After a month, he comes out of the hole, and he goes into the canteen where they're having lunch, and he gets his tray and he sits across from Morgan Freeman, who's sitting looking over at him, and Morgan said, "Hey, how did you do?" And Timothy Robbins looks over and says, "Well, I'm keeping hope alive. I'm not going to let them break me. I'm going to keep hope alive no matter what." And then Morgan Freeman has this look of complete horror on his face, and says, "Don't you go talking about hope in here. Let me

tell you something. Hope's a dangerous thing. Hope can drive a man insane. Hope has no use on the other side."

Is that not what the experience of many of the clients I've served over the years is, that these clients are indeed people living on the other side? We need to recognize that when we're asking them to hope, and we're asking them to believe in us as helpers, we are asking a great deal indeed. How we build a trusting relationship is critical, and as we're building those relationships, we need to recognize that we're asking a great deal of people when we're asking them to hope again.

Tom Lorello

Thanks, Jim. I'm going to keep tab on the movie references. That's two so far. At this point I'd like to invite Sheryl Silver into the conversation.

The Role of Hope

Sheryl, could you comment on your experience of how the issue of hope has played out in your work generally, as well as specifically in your work with a client?

Sheryl Silver

Okay, let me tell you a little bit about this person who I'm going to be referring to throughout the call. For the purposes of this, we'll call him Charles, and Charles is a 52-year-old male, a Vietnam combat veteran. His mother committed suicide when he was 15 years old. His father died of a heart attack at age 50. He came back from Vietnam and had several different jobs, never lasting much, and that's pretty much when his drinking started and continued to escalate. When I met him in 1993, he had already been homeless for about 15 years at that point. Hope is just critical for anyone making change, but it's the thing that we oftentimes forget about when we first meet new clients, whether it be on the street, in a clinic, under a bridge, or whatever it is. At the point that we meet them, they pretty much have none, and again, that's their way of coping and dealing with

their situation. It's my job to help instill hope in them until they are able to kind of take over. I sometimes see it as like the relay races, where you have pass the baton. So I'm going to start out with the baton, and I'm going to try to do the things that I can in initially engaging with the person, which, of course, begins with kind of initiating some trust. Then I'm going to eventually pass that off, but I think it's incredibly important for us to take some responsibility in regaining that trust.

When I first met Charles, he had no desire to speak with me for any reason, and had resigned himself to the fact that his life would continue as it had been for the last 15 years. When we met, we met at a shelter, and we would spend, I'd say, probably 15-20 minutes each time I went down there just sitting on the bench next to each other with no words being spoken. That went on for a while, and then sooner or later we started speaking, and that's when I started getting to know him slowly. But it was clear when I first met him that he had pretty much given up all hope of his life ever changing, and again, what Jim was saying is just right on that hope would bring him back to revisiting some of the trauma that he has endured throughout his life.

Tom Lorello

Thanks Sheryl.

Readiness to Change

Jim, are there specific factors that influence a person's readiness to change?

Jim Winarski

Yes, and basically it's understanding a person's personal history as it relates to their experience of change. We take histories on people's mental health and substance abuse and various problems, but we should also be thinking about their history with changes and how that might influence their ability to take steps in the future.

Miller and Rollnick described readiness to change as factors that contribute to shaping the person's internal perceptions about change and their overall motivational state.

Now, I'm going to mention four factors. Each of them represent areas that are shaped by the person's individual history with life changes. The four I will describe are perception of need, a belief that change is possible and can be positive, the person's sense of self-efficacy, and a stated intention to change. And again, for those who have the Power Points, it would be slide number 5 in the presentation.

First, the perception of need, this is the person's experience of a discrepancy between the pain in the present and the potential for future improvement. Essentially this is saying that no lasting change in human behavior is possible unless the person feels the need to change from within. It can't come from us. It's got to come from within the person. Now, people are generally motivated to avoid pain and to change a painful situation and to seek something more positive. The level of comfort or discomfort with where you are compared to where you want to be has a significant effect on the perception of your need to change and the experience of "hitting bottom." This can help some people overcome denial.

Now on the surface, one would think that the experience of homelessness, poverty, addiction, mental illness, would be sufficiently painful to be a strong motivator to want to change. When we're doing outreach, you would think people would just be lining up to want to talk to us because they're in such painful conditions. However, the long histories of deprivation and abuse that are common to homeless individuals have a significant impact on how they perceive pain and on the actions that they will take to avoid that pain. So people who live in conditions that are perpetually distressing learn to be tolerant of even extremely uncomfortable conditions, and as we discussed, individuals who feel trapped may relinquish hope as a means of emotional survival, so they may seem to be content even in difficult conditions.

So we might conclude that these individuals prefer to be homeless, and this is the basis of some of the myth that people actually want to be homeless. But our challenge here is that we really want the person to feel some level of dissatisfaction with their current conditions, while at the same time we explore genuine options for improvement in the future.

The second readiness factor is the belief that change is possible and can be positive. Now, people feel little motivation to change behaviors unless a positive outcome is perceived as achievable within a reasonable period of time. Everybody knows that. Most people who are homeless have experienced change as a negative force, so histories of unstable housing, unstable work experiences, and disruptions in key relationships, all of these are common. So people who perceive change as a threatening and negative experience may be reluctant and uncomfortable with practitioners who are suggesting a strategy for change. Also if the desired outcome of these changes appears to be unlikely, if there have been a lot of previous disappointments or if it's only possible in the distant future—in other words you've got to wait 18 months for your apartment—commitment is a lot less likely.

So it's vitally important for practitioners to be aware of the person's recent experiences with life changes, and it's especially important with homeless individuals who have core disorders and are living in unstable conditions. Strategies for behavior change need to include a support relationship that begins by targeting short-term, achievable kinds of goals.

The third factor is a sense of self-efficacy, an internal belief by the person that he or she can take an action to make a change to make a difference. Now, people are more willing to change, one, if the obstacles are not perceived as overwhelming, and two, if the locus of control is internal rather than external. In other words, does the person see themselves as a person who can take action and make a change in their environment or do they see themselves as being acted upon by the forces of the world?

Clients in PATH programs often have lost control over their living environments and may, indeed, view themselves as being acted upon by external forces. If a person has suffered many losses, the obstacles can seem overwhelming. So our goal is to help people regain a sense of their own ability to effect a positive change. We can help them get this sense of self-efficacy by creating experiences that provide opportunities for success that develop confidence. In addition, we should ensure that the person is involved with their treatment plans, and that the pace and the intensity of our interventions are sensitive to the person's ability. That's critical, especially when people are dealing with both mental health and substance abuse disorders.

Then the final readiness factor, which is also critical, has to do with stated intentions to change. It's not uncommon for persons, even our "unmotivated" clients to make statements about their intentions to change: "I intend to stop drinking, I'll take my medication, I'll keep my appointment with you, and I intend to do all of these things." And as you all know, it's also not uncommon for them not to follow-up with any of these statements. So consequently, it's also not uncommon for practitioners to ignore these statements, especially if the person has stated multiple intentions without following up on some sort of action.

So the key point for us in the motivational interviewing approach is that any statement that the person makes related to the need to change indicates the developing readiness to start to take some actions. We need to acknowledge these statements and be prepared to explore their significance with the individual. These statements often represent a window that's opening up, a window of opportunity that we want to follow up on, and that's the key point here.

Tom Lorello

Thanks Jim. I'd like to invite Sheryl to come in, and I'd like to ask again, Sheryl, if you would comment on how these factors played out with Charles.

Sheryl Silver

I will just go through each one of them. In terms of the perception of need, when I first met Charles there, he would not state in any way, shape, or form that his situation was difficult or painful for him. In fact, he would say how strong he was and what a survivor he was. Any implication that his situation was not a good place for him to be in would have kind of broken all of that armor that he had built up to protect himself, that he was strong and he could do this. That's how he had survived for the amount of time that he was living on the street. I know at that point that he was not able to see into the future for any kind of improvement.

The next one is the belief that change is possible and can be positive. For the most part, I think, the system that Charles was a part of for so long, both as a veteran and then as someone who had been homeless for the amount time he had been, kind of crushed the belief that change was possible and could be positive. He fell in line with so many of the people that we work with in just accepting that belief that has been instilled by the greater systems that they're a part of.

Then the sense of self-efficacy. I think he felt that he had strength in what he was doing at the time when I first met him in terms of being a survivor, and he took pride in taking care of other people. He spoke about that quite a bit, that he looked after the folks when they were drinking in the alley. At that point there was at least a glimmer of him identifying a strength within him, and I knew at some point I would be able to kind of go back and draw on that.

Then in terms of the stated intention to change, he actually never spoke that, but I knew that something was happening when he came to the clinic. He hadn't been in probably since I met him, and it was probably eight months before he came. So the day that he walked in, I said, "Okay, I think we're ready to do something different here." He didn't say it, but he just came in.

Tom Lorello

Thanks Sheryl. Jim, let's talk a little bit more about how to apply this information. I'm looking at slide

number 6, and in that slide you outline the stages of behavior change model, and that adds a new perspective to the issue of motivation. Can you talk a little bit about the model and how it relates to motivational interviewing?

Jim Winarski

This model creates a conceptual framework to understand behaviors and how to build our strategies in responding to people and how to interact with people in a way that is going to help them move through a process of change.

Because we do have limited time, we're just going to walk through this and provide an overview, and Ken Kraybill is going to focus on kind of the interactions that are at the heart of the approach. We made the assumption that a lot of people are already familiar with the stages of change model. For those of you who are not or those of you want to know more about it, please feel free to e-mail me, and also to engage in discussion on our bulletin board at www.pathprogram.samhsa.gov, because we can talk about it in depth and spend all the time that you would like in learning more about it.

To summarize it, it's a model that is based on the work on the work of Prochaska and DiClemente, and it describes stages through which people pass in the course of changing a problem. It's great in that it provides a useful framework for understanding how change occurs. Now, they describe six specific stages. It's significant in that each stage reflects an internal state that can be influenced by external factors, and so it's a way for us to build strategies to help the person change.

So the stages are pre-contemplation, contemplation, determination, action, maintenance, and relapse. Now those of you, again, who have the PowerPoint presentation, there are actually slides number 6, 7, 8, and 9.

The first stage, pre-contemplation is essentially the place where the person has no perceived need to change. So essentially, changing is not a blip on the screen at all. They're not yet considering the possibility of change. They're not seeing the

relationship between the substance abuse and the fact that they're having problems with their life, no connection between the fact that I've lost my job, I've lost my marriage, I've lost my home, and no connection between that fact and the fact that I have a cocaine problem.

What we have to do is try to create some level of dissatisfaction with where they're at to facilitate that confrontation within the person. We need to do that by exploring the consequences of their behaviors and to explore desirable options, because I know from personal experience when I was doing outreach in New York with people who were real street dwellers for a number of years, many had no interest of connecting at all.

I'll never forget the person whom we took on a van ride to an apartment, who walked into the apartment and said, "You mean I can have this?" And I said, "Yes, that's what we've been talking about for the last three months." But there was the moment when he moved from pre-contemplation to contemplation, because at that point, the desirable option created a sense of dissatisfaction with where he was. All of the sudden, there was an option that was real to him, made him view life in the doorway as something that was less desirable than maybe what he could have, the fact that I could have this.

Tom Lorello

Jim, could you touch on the other stages in the model quickly, and then also, comment on how to apply this to people experiencing multiple, complex problems, especially those who are more disabled than under the influence of substances.

Jim Winarski

Well, the next stage, and then we're moving, to contemplating a problem; this is the point where there is this initial awareness, that feeling of ambivalence, which is great. When people are ambivalent, they're going to have difficulty coming to a clear decision, and that's where we explore with them the pros and cons of their experience. When they're looking at changing, from their point of view, they might

be saying, "Hey, I could do what you say and take my psychiatric medication, give up getting high" They might be looking at, "Okay, I could either get high with my friends, have a good time, or become impotent, have a dry mouth," and that's kind of part of their decisional balance. So we need to establish some clarity.

Then eventually, we go to determination, which is basically the time when people make a decision. That's when people might start making statements about change, and we want to help people move to the next stage, which is to make some actions based on that decision, and that's when it's ripe to work on treatment plans. Often people are at a pre-contemplation stage, and we're talking to them about treatment plans, which is a little further down the line. That's often an error we make.

The maintenance stage is looking at the steps for long-term change, which is different than the initial steps of change. We have to be aware of the triggers that get people in trouble—biological, psychological, social triggers—and the kinds of expectations they bring into the change process which affect people. Trying out a 9:00–5:00 job and staying sober may not be everything they dreamed it would be, and we need to prepare for that and deal with that.

And of course, the relapse stage, is recognizing that long-standing change involves set-backs and our goal is to help a person overcome discouragement and recognize that relapse is a normal part of achieving goals that endure, and helping them get back up again and learn from the experience.

So that's the central model. It's important to recognize, too, that this is something that is circular, not linear, and people can go around this and enter it and exit it in many different ways.

Tom Lorello

Thanks Jim. Sheryl, were you aware of Charles moving through these stages?

Sheryl Silver

Yes, definitely. The time frame for all of these stages is so incredibly individual. Don't expect two people, to maneuver through these stages at the same rate. It's not realistic, and so the onus is on us to continually evaluate where our clients are and where we are.

When I first met Charles the idea of change had been taken out of his consciousness, so in his mind, there was no need to change. He had this position where he was, and people respected him. He felt some level of strength coming from that he took care of people in the street, and along with this, he had actually never been treated for depression, which is what he wound up being treated for, a major depressive disorder. So my initial inclination would have been to start talking about that from the start, and I'm glad I didn't, because that probably would have chased him away.

Then, we moved to contemplation, and I would throw things out there at him, and he maybe would think about them, maybe wouldn't, but start realizing that, "I'm not sure how comfortable I am in this, that the shelter is getting worse. It's getting more dangerous." There were younger people coming to the shelter, and so there tended to be a little more violence going on with the younger kids. He was about 50 when I met him, and so the younger kids, the 28- and 30-year olds, were starting to come in, and that was becoming a problem for him.

Sheryl Silver

The determination stage was when he started coming to the clinic a little bit more, and that's probably when I started talking a little bit about speaking to one of our psychiatrists and seeing if treatment for what I perceived to be a serious depression—and I didn't quite use those words, I more described the symptoms that I observed in him—if possibly treatment would enable him to reduce his alcohol intake.

Then the action is when he did start seeing the psychiatrist, and he did not stop drinking, but his drinking was reduced a little bit initially, and then a little bit more, and the times that he went to detox had longer periods in between. That was about the time

that we started talking, or actually, the determination stage is when we started talking about housing as well. So that was the stream in our conversation as well throughout.

Then the maintenance stage for Charles was when we actually were able to get him a place to live, an apartment, and that was probably one of the most difficult times for him because he had been so part of a community that he was feeling uncertain about himself. He had been feeling good in the determination and action, and then once he got to the maintenance, once he got an apartment and he had to redefine his life from the streets, he didn't have people around him all the time. He was nervous about having people in the apartment, because he didn't want them to ruin it for him, but he wanted them around and he didn't want to hurt their feelings. Throughout this journey, Charles didn't stop drinking, but it certainly was reduced.

The Interpersonal Interactions of Motivational Interviewing: GRACE

Tom Lorello

Thanks Sheryl. At this point, I'd like to bring Ken Kraybill into the discussion. Ken, Jim has provided an overview of the motivational interviewing approach and the stages of change model. Now let's shift gears to the interpersonal interactions that are at the heart of motivational interviewing, especially as they are applied to working with people who are homeless. My question to you is, what specific principles should PATH workers keep in mind while working with individuals in the shelters and on the streets?

Ken Kraybill

I want to just start by saying that as care providers, we talk a lot about providing client-centered care, and we use those descriptors of being accepting and respectful and empathetic and compassionate and all that, and I think we have to ask ourselves what does that mean. The mystics say that we're not human

beings who are trying to become more spiritual, we're all spiritual beings trying to become more human. I think that motivational interviewing is a tool that helps us become a lot more human. The beauty of this whole way of being with people and working with people is that it allows us to operate with integrity and with a sense of being all of those things we want to be: accepting, respectful, empathetic, etc.

Motivational interviewing is based on these principles, which endorse and embody some of our best human qualities. Miller and Rollnick claim that motivation is an interpersonal process. It's not just an intrinsic thing, but it's actually something much related to the dynamic that occurs in a relationship. So I'm going to focus on that relational piece here as we talk about that, because our presence in people's lives as providers clearly does make a huge difference, especially as we were talking about hope and some other things.

The underlying messages of motivational interviewing are: "I want to learn to know who you are; I want to hear your story as it is; You don't have to prove yourself worthy or deserving of receiving help from me; I want to be a resource to you, but I don't want to control you or your choices; I want to be able to laugh with you and also be able to enter into your suffering."

One of the notations that fits nicely here with motivational interviewing is the concept of offering the gift of hospitality to people as defined by Henri Nouwen, who says that hospitality is creating a free and friendly space for the stranger. If we get the part that we're there not to help people so much as to create the conditions for help to occur, for people to discover what they need to do for themselves with our support, we've gone a long way towards grasping motivational interviewing.

So, in many respects for us as providers, we also have to recognize that we have a lot of power, but it's a power that we exercise by letting go, not by forcing, but instead by empowering others, by letting go of our power over them, if you will.

In motivational interviewing, most of these messages are communicated nonverbally, through our attitudes and actions. Another way of saying that, is that motivational interviewing is not a euphemism for, "How can I subtly coerce you into doing what I think you should do," which is oftentimes a trap.

What I'm offering here is an acronym called GRACE. This isn't precisely the way that Miller and Rollnick present these principles, but I wanted to stay with the GRACE principle because it's easy for me to remember, and it works well.

The first principle is what I call *generating a gap*. This is also known as developing discrepancy. We've been talking a lot about that. As much as we want to be with people and be respectful and caring and compassionate, that doesn't preclude the fact that we also want to stir them a little bit. We want to actually permit people to be a bit ill at ease, because that, indeed, is what helps us to make change.

Basically, if there is no discrepancy, there is no motivation, and if there is no discrepancy, there is also no ambivalence. For many people, the first step towards change is to become ambivalent. I also want to just point out that this is not the same as guilt tripping. We need to think about how we approach this and recognize that we're not trying to make people feel guilty. We're just trying to help them see reality as best as possible from their perception.

Sheryl, do you have anything you want to add about your experience with Charles?

Sheryl Silver

Yes, actually, there are a few things I just wanted to mention. Miller and Rollnick mention the idea of psychological reactance and that the rate and attractiveness of a problem behavior, if a person perceives that his or her personal freedom is being infringed upon or challenged, it will be more difficult for them to make the change.

So often with the clients that I have worked with, with Charles, with the many, many, many others that I've worked with, we need to be where they are and

realize that there's a lot of things that we're willing to give up in our lives to toe the line, and there are things that Charles experienced, that he wasn't willing to give up that kind of freedom that he had. So I always try to keep that in mind.

The other thing is working with as opposed to against. Motivational interviewing is more like a dance than a wrestling match. As in dancing, you might step on your partner's toes once in a while. But then you step off and you keep going, and then eventually, you get better at the dance, and toes aren't being stepped on any more. That is just all part of how we can develop the positive relationship with our clients so that we can work with them, not for them.

Ken Kraybill

I want to add that not everybody we work with needs to be prompted to sense the discrepancy in their lives. Many people are stuck in that ambivalence, and stuck in a state of inertia. Our job there is not so much to create a whole lot more sense of dis-ease, but to work with it and explore it with people to help them override that inertia.

The second principle of motivational interviewing is *rolling with resistance*. Resistance can be positive as well as can have negative. Resistance is a human strength. It's often self-protective. It involves people taking principled stands. It's a sign of being alive. If there is no resistance, then you haven't got much to work with.

Resistance in motivational interviewing is interpersonal. It takes two to tango or to dance or to wrestle, for that matter, and resistance will happen for various reasons. I think usually it's related to the fact that people simply are not ready. They're not in that stage of change readiness, if you will, to hear or think about something, so that when resistance happens, it's not a sign of failure. It's information to the provider. It's a signal, perhaps, that one should shift one's approach or perhaps just back away from what's being explored, and recognize that you're planting seeds.

How a provider responds to client resistance will influence whether it increases or diminishes. Too often we can actually help cultivate resistance just by being dogged in our views or not taking into account the other person's perceptions.

Three effective ways to roll with resistance are one, to continually seek to understand the person's perspective. A second is to invite the person to consider new information or perspectives. The invitation is critical because once a person has said yes, you may do that, and then it gives you a freedom that otherwise you don't have. Then a third way to think about this is to *avoid argumentation*. This is turning to our third principle. (Miller and Rollnick actually combine these two together in the second edition of their book.)

In the spirit of motivational interviewing, it's not the provider's job to convince, control or fix. Our job is to help somebody shed light on their situation, to help them identify the discrepancies between where they are and where they want to be, and then consider options towards change. Our work is also about helping people discover that which is hidden in plain sight, so just putting it out there and naming it, is an important way to help people uncover things.

There is no place for argumentation for or against anything in motivational interviewing. That's the client's job, and I think it's important to remember that if we find ourselves arguing for change, and God knows I've been there, and we have the client voicing arguments against change, then we're all in the wrong roles. As Sheryl was saying, it does become more of a wrestling match, when it should look more like a dance with the partners moving together and one gently leading.

I'm going to move ahead to the fourth principle. Sheryl, is there something you want to interject?

Sheryl Silver

What I try to do with my clients is to ask them, as you were saying, to try to understand. I want to understand more. Can you tell me more? And open it up for them to share with me as they see fit and as

they choose to over time, to share a little bit more of their experiences with me so that I have a greater amount of information to be able to work with them.

Ken Kraybill

Exactly. The beauty of motivational interviewing is that it highlights the need for us to be grounded as practitioners, as providers, so that we don't keep spilling our agenda into the interchange.

Sheryl Silver

Yes. The more resistance we're getting from our client, the more we need to look at what we're doing to elicit that kind of resistance.

Ken Kraybill

All right, I'm going to move to the fourth principle, which in the GRACE acronym is called *can do*. This is also called supporting self-efficacy. This is about hope, what we were talking about before. They might even know exactly what needs to be done, but if they don't perceive that there is a possibility for change, then no effort will be made. So instilling hope in people is a critical issue, and of course, among chronically homeless people with dual disorders and triple disorders, it's even more so.

Supporting self-efficacy is giving people a sense of personal power to make changes to maintain them, and there are a variety of ways we can go about doing that. One of the things that I think we need to think a lot about is not only instilling hope within the individual or seeing it as something that is theirs to own, but also the fact that we know from research, that the provider who has hope, who has expectations that a person can change—that *that* has a tremendously powerful affect on what happens. Oftentimes, I know by experience and I'm sure many of you have experienced, too, that we providers will lose hope. Not just in a particular individual, but losing hope—that nothing we're doing is working or making sense. I just want to come back to the fact that not only do we want to instill hope in others; we have to instill it in ourselves.

There's a wonderful quote by Vaclav Havel that I like a lot, and he says that hope is not believing that we change things, but hope is believing that what we do makes a difference.

Sheryl, you've talked about that some already. Do you want to say anything?

Sheryl Silver

Pathways to Housing is our Housing First model, so our belief is that everyone can live in an apartment on their own, in an independent apartment with the right kind of support. What we consistently get from other providers is, well, is this person appropriate, are they ready, or I don't think this person can. So even if they are not saying that to their clients, certainly their clients are getting that message. From the beginning when we meet a new client, we make it clear with them that we believe you can do this, we want you to do this, and we're going to help you do this, and their faces change.

When I meet so many of my clients, they are drained of hope and drained of the idea that they can make a change in their life. That is because of the system that they have been in for so long. So I feel initially that it's our responsible to pump them up with a little bit of our hope, which means we have to have a little extra to give to them, and eventually, that will become assimilated into their being, and they will then believe themselves that they can make a change and move from there.

Ken Kraybill

That's great. As a shift has occurred over the years, many of us have thought about getting people to be "housing ready" before we could help them, and now we're starting to talk about housing first. What a tremendously hopeful message that is for people. It's not easy, but hopeful for many.

Sheryl Silver

Yes, as Jim was saying earlier, it's amazing to bring someone to an apartment for the first time and have

them look back and look forward and look back and say, “Wait, is this—is this mine?” It’s amazing.

Ken Kraybill

The fifth principle that I’ll refer to is *expressing empathy*. This is one that permeates motivational interviewing. Miller and Rollnick make the statement that client-centered and empathic style is one fundamental and defining characteristic of motivational interviewing, and it’s employed throughout the interaction. Empathy is defined as a deep understanding of the feelings, thoughts, and motives of another. We say that we need to be able to walk in a person’s shoes. We don’t have to have been there, we don’t have to have experienced the same things that people do, but we have to be able to try to deeply understand it as best as we can.

Empathy, of course, is expressed verbally as well as nonverbally, and I would say more so through attitude and manner oftentimes, than through words. Through skillful reflective listening, also known as accurate empathy, the provider can seek to understand the client’s feelings and perspectives without judging, criticizing or blaming, and this we call acceptance.

I’ll just make a note here that acceptance of a client is not the same as agreement or approval. It’s possible for us to be accepting of someone without endorsing, perhaps, certain ideas or behavior. Acceptance also does not preclude the provider from expressing differing views. I think we get caught sometimes in the myth that client-centered care means that our views don’t count, and Miller and Rollnick point out that this is a directive, client-centered approach as opposed to the more classical Rogerian approach in that we are there as a resource, we’re there as a guide, we’re there in many ways to direct traffic. But again, we make that distinction between not controlling, but being there as a resource.

In the motivational interviewing view, reluctance to change a behavior is not seen as uniquely pathological or the client as being incapable, but just that there are understandable reasons why people have arrived where they are or have developed perspectives that they have.

Sheryl Silver

We often think that the behavior that our clients have is somehow different than our own. For me, motivational interviewing has been incredibly humbling, because it forces me to look at myself and my communication with clients. A big thing that I say to clients now, which certainly wasn’t something that I learned in social work school was, “I don’t agree with you, but I will support you in your decision”. It’s amazing to see the relief in someone’s face, and they’re, “Oh, okay, so you’re going to let me do this?” And it’s not about me letting them. It’s about them making the decision to do it. Based on the relationship that we develop, they know that if it doesn’t work out, we’ll be here, and we’ll move along from there.

The Skills of Motivational Interviewing: OARS

Ken Kraybill

Which moves us right into the OARS, another nice little, tidy acronym. These are basic skills of motivational interviewing, and indeed, these are ones that you can try at home, in the office, anywhere. They are foundational ways of relating effectively with people, and this is not rocket science. Human relationships are more complicated than rocket science, but these skills are not complicated. They’re ones that unless we are thinking about practicing them, we often fall out of practice of doing so.

One of my current favorite sayings is by an author named Madeline Hunter, and she says, “They say you can lead a horse to water, but you can’t make him drink. But I say you can salt the oats.” We are in the position as providers to use these micro skills to salt the oats, to create a thirst for people to change, and that’s another way of talking about creating the conditions for change to occur.

I would highly recommend that you practice these skills with each other in your office, at home. I recommend that maybe you get into groups of three at some convenient time, one person plays the provider,

one plays a client, and the other is an observer. You have a three to five-minute interview in which the provider attempts to use all of these different OARS skills, and then after that period of time, I would urge the three of you to talk about it. The provider might talk about what it was like to use the skills, the client might speak to what it was like to have the skills utilized, if you will, with them, and the observer, of course, can of take a tally and see how the skills were actually used.

Sheryl Silver

What was incredibly helpful for me when I first started learning about motivational interviewing was to sit down and have someone observe my technique in working with someone else. And then looking at this tally and seeing, “What, did I say that? Did I use that many close-ended questions?”

Ken Kraybill

There’s nothing like practice. The other thing that can be useful is to watch videotape of effective use of these skills, and I know that Miller and Rollnick have developed a series of tapes, some of which are quite good.

The first skill is the use of *open-ended questions*. Basically, these are questions that encourage people to talk about whatever is important to them. They are the kind of questions that help establish rapport, to gather information, increase understanding. They are the opposite of questions that require a yes or no answer, or some kind of fairly brief answer. The beauty of open-ended questions is it’s a way of inviting others to tell their story in their own words, in their own pace. The key, of course, when we use an open-ended question, is we have to be in a position and have the time to be willing to listen. This whole method is listening and listening effectively.

There are times when we do need to use close-ended questions, and it’s not inappropriate. Often we find ourselves not offering enough open-ended ones. So just as an example and to contrast the two, if I were to ask you, did you have a good relationship with your parents, or I asked you, tell me about your

relationship with your parents, I’m basically asking you about the same topic, but I think the likely responses would be different, because one invites a rather closed answer, and the other allows you to elaborate.

So some great examples of open-ended questions are things that we do naturally use, but there might some here that you don’t. Would you tell me about, ta da, ta da? Or how would you like things to be different? Or, here’s a great motivational interviewing question, what are the positive things about this particular behavior, about drinking, and what are the less good things about the drinking? Or what will you lose if you have to give up whatever you tried before? These are all ideas that are ways. There are a myriad of open ended questions we can ask. There’s no right or wrong. These are just put here as samples.

It’s powerful to ask somebody an open-ended question, and I do want to say, however, that not everybody will respond openly and elaborately. That’s just the way some people are. Some people are a little more introverted and are not going to offer as much information. But what I found is that over time, as trust and rapport are built, that people do find it so freeing to have the ability to respond to an open-ended question without being guided in a particular direction.

The “A” part for the second micro skills is *affirmations*. They have to be absolutely genuine. It doesn’t work to give affirmations for the sake of giving affirmations. These are basically statements and gestures. They’re not just words, but they are also ways of just glancing at people or smiling at them, that recognize client strengths and acknowledge behaviors that lead in the direction of change, no matter how big or small.

What’s so useful about giving affirmations is that they do build confidence in one’s ability to change, even if they’re totally unrelated to the topic of change being worked on. Some of these are as simple as saying, “Thank you for coming in to the drop-in center to see me today,” or “That’s a great idea,” or “You kept your cool when that guy started yelling at you. That shows a lot of courage.” Or you might say, in the spirit of harm reduction, “That’s great that you remembered

to take your medicines four out of the past six days.” But these are all ways of reframing things in a way that people can recognize that maybe their behaviors aren’t totally strength based, maybe there are things that they are not doing properly, but there are pieces that they are trying to do properly, and we need to acknowledge that and not be so focused on problems only.

Sheryl, any comments there?

Sheryl Silver

In some ways it seems simple. In other ways it seems more complicated, but the difference in the response and the interactions and the relationships that you can develop with clients using this kind of language is amazing. You become much more sensitive to hearing other people around you speak in ways that may not be as positive or may not elicit more information. You realize the difference in how people can interact. So it works, it does.

Ken Kraybill

On the affirmations, many times it has nothing to do with the words that we use. It might be that we just share a chuckle over a word play, or it might be that we just find something humorous or whatever, but there are many ways to affirm people. If we come into these interactions as being genuinely interested in people and interested in understanding them, we can’t avoid giving affirmative kinds of gestures and comments.

Reflective listening is, I suppose if anything, the real heart of all of this. Listening is much more than just paying attention. It’s also suspending judgment. Listening means that we’re trying to understand as opposed to getting ready to reply to the next remark. There’s a great saying that we were born with two ears and one mouth. We should listen twice as much as we speak. I think it should be even more than that in our work with folks.

Listening reflectively seems simple, but it’s not easy. We need to do a lot of practicing. The whole point of reflective listening is that we want to close

the loop in communication, because we know that communication can be problematic, and we’ve all experienced that, whether it’s verbally or by e-mail or by letter or whatever. The problems that come up, of course, are that perhaps the speaker themselves doesn’t say what they meant to say, or perhaps the listener doesn’t hear it correctly. Maybe there’s a word that trips them up or they have a different interpretation.

In reflective listening you create an immediate feedback loop, and so a person makes a statement and you reflect back to them what you’ve heard. There are different levels of doing this, and I’m just going to just quickly outline three basic levels of reflection. One is to simply say back what you heard. This is not intended to be a parroting exercise, which I think is rather demeaning if you just repeat back the same words, but it’s a way of saying back what the person said, maybe changing a word or two.

A more amplified level of reflection is to actually paraphrase. I said rephrase before, this is paraphrasing now. You test the meaning of what is going on below the surface, and so you’re actually making some conjecture about what the person is trying to say. This might take the form of like a double-sided reflection in which you hear somebody saying something that sounds ambivalent, and you might say, “Now on the one hand, it sounds to me like you do want to, such and such, but on the other hand, ta da, ta da.” So that’s one way of providing that reflection.

A third level of reflection is getting at the feeling. What happens oftentimes is we operate in a cognitive way with people, but once we try to grasp the feeling underneath it all, then we can engage people in an in-depth conversation.

It’s obviously a case that we don’t always use reflective statements when people are talking, but I think that we need to be conscious about using these things as much as possible. It does allow people to know for one thing that they have been heard, and it also allows them to hear their words or some semblance of their words in another form, which is instructive to them.

The “S” part of the OARS is *summarizing*, which is just another form of reflective listening. Summarizing is an expanded reflective statement in which you take a topical area that someone has been talking about for five to ten minutes or so, and you might say, “Let me see if I understand so far what you’ve been saying,” or “Here is what I’ve heard. Tell me if I’ve missed anything,” or something along those lines. So when you do this, it’s powerful to have somebody actually indicate that they’ve been listening to you by giving you a brief synopsis of what you’ve just said. It’s powerful in the sense that their mind wasn’t wandering and they were paying attention. Now you might be wrong or it might not be the same perception that the client has when you summarize, so it is also another opportunity to close that feedback loop.

How about if I just move on here, and I’m just going to make a brief commentary on the question of whether motivational interviewing with dually diagnosed individuals works. This is slide 22. I’ll just say that it’s not like there has been a whole slew of research done, but there has been a lot of pilot research done with dually diagnosed people, not necessarily who are homeless, but this pilot research has shown a lot of positive results. In particular, the research has been done on compliance with appointments

Medication adherence is a huge issue. We all know that ambivalence is high in this area for good reason. Not all studies have shown that motivational interviewing makes a difference, but a number have, and just as an example, there was a study done in the United Kingdom with 47 male and female patients, half of whom received motivational interviewing sessions while in the hospital. At a six month follow-up, their particular intervention group, as compared to the control group, had 23 percent higher rates of compliance with medications than the control group.

I think the bottom line is that there is still plenty of research to be done, but because we’ve learned that motivational interviewing is effective with substance use in general and in health care and other settings, we are reasonably confident that this clearly works here as well.

Question and Discussion

Tom Lorello

Ken, at this point, I think we do want to move into the question and answer part of our presentation.

Q. My question is how the approaches that you shared with us sound like things that we might be able to apply in more clinical or therapeutic environments. Could you talk about how of these approaches or skills could be offered in service environments that are characterized by short staffing or rapid staff turnover or different staff interacting with the same kinds of client?

Sheryl Silver

I’ve used this. I was doing outreach on the street, outreach in the shelters, and in our free clinic, and I think what you’re saying is actually something that a lot of people believe about motivational interviewing, that it’s done in a clinical setting, with a door, and two chairs sitting across from each other. But really, if the spirit of motivational interviewing is infused into the work that you’re doing on a daily basis and into the staff, and the language is used as best that it can be on a regular basis, then the results will be equally, if not more positive than in a clinical, face-to-face, two-chair, shut door setting.

Ken Kraybill

In the outreach and engagement phase of the work that we do, this is the approach that works, whether we call it motivational interviewing or not. But the spirit and these ways of listening to people are the only way to go.

Jim Winarski

I know it sounds like one of Bob’s concerns or a concern in your question is that it takes time to talk to people, and if your case load is so high that it doesn’t give you a great deal of time to listen, it could be problematic. I think regardless of the time available, that quality of the interaction with the time you have can be enhanced significantly by this approach, but

you also do need to take time to listen. If that time is impinged upon, it is a challenge, but it doesn't preclude you from applying the approach.

Ken Kraybill

I think it's possible for a whole staff to use this approach without it being just a one-on-one situation, and by that, I mean in a drop-in center setting or something like that, if the whole staff interacts with people consistently using these methods, I think that in itself can be impactful.

Tom Lorello

Ken, did you have anything else you wanted to elaborate on in regards to the research?

Increasing Engagement and Adherence

Ken Kraybill

I could spend a little time talking about some strategies for increasing engagement and adherence if you want. The effective ingredients that seem to make a difference in motivational interviewing are the fact that we elicit 'change talk,' and we haven't talked about that, but we elicit the kind of commentary from people that indicates that maybe they're more and more ready to make change, and we have to attend to that. Other effective ingredients include the fact that we emphasize giving people personal choice and control and that they feel respected and valued and deeply understood, all fundamental issues, but that's what this approach is about.

I'll just comment briefly on some strategies for increasing treatment engagement and adherence. One is pretty straight-forward, addressing the hierarchy of needs, but I would say it's not addressing the hierarchy of needs as you and I perceive it necessarily or as Maslow perceives it, but as it is perceived by the client. This is central to the notion of meeting a person where they're at versus where you want them to be. This doesn't preclude that we can raise

suggestions or even make recommendations, but if a person whom we encounter, whether it's out under the bridge or in a shelter or wherever, says to us that they want to get ID or they need shoes, and we see that there is maybe some other need that we think they should be attending to. This is a little dance that we have to do with folks to kind of sort out which direction we're going to go, and it's always incumbent upon the provider, however, to start with the client's perceived hierarchy of needs and try to address those as best as possible.

The reality is we can't always address people's needs, and that is just part of the honesty of this relationship that's being developed. Maybe we want to get somebody into housing right now, but that's not possible in our particular environment. So we have to be up front about that.

Another area is to increase engagement and adherence by raising awareness of non-adherence. This is particularly helpful, I think, after a crisis situation, a good example being a hospitalization or maybe an arrest. This is an opportunity to take the time to just help clients make a connection between non-adherence to the treatment—let's say to medications—and the resulting crisis. It's a time to explore the person's reasons for not staying on the meds, to explore the client's role in what they can do to improve their situation, to discuss treatment options, these sorts of things. We can ask, "How do you think things might have been different if you had, for example, stayed in treatment, or had you kept on your meds, or if you had not smoked crack? This also an opportunity then for us to provide information, and again, I would just emphasize the need to ask for an invitation to share that information. "May I share some information with you that might be helpful in making your decision?" Then share your expertise or some written materials.

A third way is to elicit pros and cons of non-adherence. This is where that decisional balance comes in that we didn't talk a lot about. We raise the kinds of questions, like what are the benefits of not taking medications, because, certainly, there are some, and what are the costs? And then we turn that

around and say, and what are the benefits of taking medications and what are the costs?

Then, I'll just comment on some special issues that we all have with disordered people. A big one continues to be harm reduction or abstinence, and I would frame that differently at this point and say harm reduction and/or abstinence. We know that even a small amount of substance use for people who are seriously mentally ill can have a dramatic negative impact on their mental disorder. However, we also know that clients are not necessarily looking to change their substance use behaviors in the early stages of treatment. Since we know that clients often will continue using, this is an opportunity for us to increase their motivation to at least reduce frequency, reduce harm, as an option. This never precludes aiming for abstinence. I think it's most helpful to think about this in a continuum, where we go from utter refusal and pre-contemplation to a harm reduction approach, a risk reduction approach, to the possibility of that leading towards abstinence.

The where-to-begin question is a variation of what came first, the chicken or the egg, and this has historically been asked in regard to mental disorders and substance abuse. The reality is that there are many answers to that question, and also what we know is that we have people, particularly when homeless, who have many more than two disorders. The big question is where do we intervene initially. Again, the focus in this approach would be that it's ultimately the client's responsibility to choose how to proceed, and of course, that's determined by their readiness for action. So outside of a real emergency situation, when clearly we have to step in and intervene, we have to be client-centered in that approach.

Then the question comes up about the presence of cognitive impairment. A lot of our folks have some serious difficulties with abstract reasoning, with concentration, with working memory, and the important thing to remember is that we have to adapt our interventions. So things we can do are to slow down our pace in working with people. Oftentimes we need to write things down for people. We need to repeat them over and over. Maybe we make lists for

clients, and there are concrete ways to explore more abstract ideas.

For instance, there's an example in Miller and Rollnick's book about exploring the pros and cons of a particular behavior. Maybe you want to use colored cards, green ones being reasons to continue using alcohol, for instance, and red ones reason to stop using, and have the person carry those with them. Or maybe you want to make a stack of blocks or use other visuals. I was just thinking, sitting in a little café, you could even take sugar and salt packets, and you could create a little division of the sugar being reasons to do something and the salt being reasons not to, or the pepper or whatever. But you can be creative there.

The other thing that I would mention about cognitive impairment is that often we need to simply accommodate people to appointments or to get things taken care of.

Then I'll just mention one other brief issue, and that is, do we intervene with people at an individual level or groups or both, and again, this depends on the person and their readiness. What is clear is that some people are ready to meet individually with somebody, a provider, but they're not ready to benefit from a group. But it's also true in the other direction, that some people won't meet one to one, but they would sit in with a group. Then there are many people who would benefit from both individual and group interventions to the extent that those are made possible by your program.

Then there are issues around the heterogeneity of the population, so you might form groups based on gender or on drug of choice or type of mental disorder, or you may also base it on stages of change, like pre-treatment, treatment group, and after care group, and things like that. So I just lift those up for you to think about, that there are many different ways to intervene with people that will help retain them in care.

I guess I'll just say that one thing we know about people with substance abuse disorders and mental disorders is that the longer we keep them in care, the

better they get, and often just focusing on adherence and coming back is the key issue.

Questions and Answers

Q. I'm an outreach worker, and I work with quite a few, probably 60 percent right now, people with co-occurring disorders and I have a few guys who like group stuff, and I have a few guys who are reluctant to do the group stuff but will talk to somebody. I've taken Stan McCracken's course several times on motivational interviewing, and I've realized to get out there and just to be straightforward and honest. I think that's what's helped them, and they actually tell me that this is what they like. I'm honest and straight up: I'm not here to judge you, you're going to use, and I'm not going to be able to stop you. I hope that you don't.

But on the other hand, I'm wondering why I have two guys who are so reluctant, even though I believe they are practicing their sobriety very well, they are so reluctant to get sponsors. They haven't disclosed why, and I did ask the open-ended questions, and they're just kind of laid back with their answers. Why somebody would be reluctant to find a sponsor when they're so into their sobriety?

Ken Kraybill

Well, it's a question that probably has many, many answers to it. It's probably important not to assume that everyone's sobriety depends on them having a sponsor, even though in a 12-step model, that's a critical point. Maybe they feel like those sponsorship activities are already occurring with some person or other people in some way or another, but it might also be, there might be some interesting dynamics to explore about what they think a sponsor is all about, because it might suggest a hierarchical difference that they're not ready to embrace. But I wouldn't necessarily assume that one has to have a sponsor to maintain sobriety. Others might want to talk to that.

Jim Winarski

Yes, I would wonder what it means to that person. That's the first question that comes to my mind is that this notion of a sponsor has some meaning and has some implications to him, and it would be interesting to explore exactly what that is.

Ken Kraybill

I think the pros and cons question would be helpful in working with somebody like this.

Q. As a motivator, is it helpful or harmful to share personal reflections with the patient? With any person that you're talking to, whether they're an alcoholic or mentally ill or whatever, if you as the counselor honestly have alcoholism in your family or mental illness in your family, do you find that helpful to share that with the client?

Sheryl Silver

I think that goes to the question of self-disclosure in general, and that is probably relevant in all forms of treatment and interactions with our clients. That, for me, is something that is individual with the counselor or with the outreach worker or with the social worker and their level of comfort in self-disclosure. I think that motivational interviewing and the spirit of motivational interviewing is a level of honesty and sincerity, and I think a little bit of self-disclosure can be helpful. It's just something that needs to be thought about prior to disclosing, depending on what it is and the situation, and your relationship with the person, what your supervisor and your agency supports and doesn't support. I think there's a lot of factors involved in it.

Jim Winarski

I would agree completely. The issue of supervision is important, because with self-disclosure, it should always help the person. So you have to ensure that it's in service of the person in some way. I think it's a good policy in general to strategize with the supervisor about the use of it for this particular

person and what is it you hope to achieve by that self-disclosure and to be clear before doing it.

Ken Kraybill

The timing is a critically important piece of that. I do think that not only are we client and provider in our relationships with people, but at some level we're human to human, we're neighbors, and we're all of these other things. It's one of those boundary issues that have to be looked at carefully, as both of you have said, it's the motivation for doing it. But it can be very effective. Generally speaking, the timing of that kind of disclosure is well into the point where the relationship is well established usually.

Tom Lorello

Okay, well, then I think we can wrap up the teleconference. I'd like to encourage everyone to visit the PATH program website at pathprogram.com. Special thanks to Margaret Lassiter and our colleagues at Policy Research Associates. Special thanks, once again, to Gail Hutchings and to Dr. Michael Hutner at the Center for Mental Health Services, and thank you so much, Jim; thank you, Sheryl; thank you Ken. This concludes today's national presentation. Thank you all for participating.

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