

SECTION G:

Motivational Interview Rating Guide & Forms

Topic	Page
1. Interview Rating Guide	89
2. Forms - Masters.....	125
a. MI Interview Rating Worksheet	127
b. MI Adherence and Competence Feedback....	129
c. MI Skills Development Plan	130
d. MI Clinician Self-Assessment Report	131
3. References	137

MOTIVATIONAL INTERVIEW RATING GUIDE:

A MANUAL FOR RATING CLINICIAN ADHERENCE AND COMPETENCE



Adapted from the NIDA National Drug Abuse Treatment
Clinical Trials Network Protocol 0005:
*Motivational Interviewing to Improve Treatment Engagement and Outcome in
Individuals Seeking Treatment for Substance Abuse*



TABLE OF CONTENTS

Acknowledgments	92
Introduction	93
MI Supervision Guidelines	95
General Interview Rating Guidelines	99
Rating Adherence and Competence	101
Description of Rating Items	105
MI Consistent Items	
1. MOTIVATIONAL INTERVIEWING STYLE OR SPIRIT	105
2. OPEN-ENDED QUESTIONS	106
3. AFFIRMATION OF STRENGTHS AND SELF-EFFICACY	107
4. REFLECTIVE STATEMENTS	108
5. FOSTERING A COLLABORATIVE ATMOSPHERE	109
6. DISCUSSING MOTIVATION TO CHANGE	110
7. DEVELOPING DISCREPANCIES	111
8. EXPLORING PROS, CONS, AND AMBIVALENCE	112
9. CHANGE PLANNING	113
10. CLIENT-CENTERED PROBLEM DISCUSSION & FEEDBACK	114
MI Inconsistent Items	
11. UNSOLICITED ADVICE, DIRECTION GIVING, OR FEEDBACK	115
12. EMPHASIS ON ABSTINENCE	116
13. DIRECT CONFRONTATION	117
14. POWERLESSNESS AND LOSS OF CONTROL	119
15. ASSERTING AUTHORITY	120
16. CLOSED-ENDED QUESTIONS (Optional)	121
General Ratings of Client	
17. MOTIVATION – BEGINNING	122
18. MOTIVATION – END	122
Forms - Masters	
1. MI Interview Rating Worksheet	127
2. MI Adherence and Competence Feedback Form	129
3. MI Skills Development Plan	130
4. MI Clinician Self-Assessment Report	131
References	137

ACKNOWLEDGMENTS

The NIDA/SAMHSA Motivational Interviewing Blending Team members, representing participants from the NIDA National Drug Abuse Treatment Clinical Trials Network (CTN) and the CSAT Addiction Technology Transfer Centers network have adapted the MI Supervisor Interview Rating Guide from the supervisory tape rating system used in CTN Protocol 005 (*Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse*). We gratefully acknowledge the authors of the protocol's tape rating system (Samuel Ball, Ph.D., Steve Martino, Ph.D., Joanne Corvino, M.P.H., Jon Morgenstern, Ph.D., and Kathleen Carroll, Ph.D.) and all the individuals who participated in the protocol and contributed to the system's development.

We specifically would like to acknowledge Kathleen Carroll, Ph.D. who was the protocol's Lead Investigator, the CTN Node trainers who helped refine the system: Deborah Van Horn, Ph.D. - Delaware Valley Node; Chris Farentinos, MD and Kathyleen Tomlin, LPC - Oregon Node; Doug Polcin, Ed.D., Jean Obert, MFT, MSM, and Robert Wirth, MA, MFT - Pacific Node; Charlotte Chapman, MS, MAC, LPC - Mid-Atlantic Node; and William R. Miller, Ph.D. and Theresa Moyers, Ph.D. who trained trainers in the CTN protocol.

Finally, we especially thank the community treatment programs and their supervisors, clinicians and clients who participated in the protocol and the fifteen independent tape raters who rated approximately 400 protocol sessions and provided the data for fine-tuning the system. The culmination of this Guide truly has been a blended team effort to provide supervisors and mentors with a tool that promotes the best practice of MI among community treatment program clinicians.



INTRODUCTION

This manual details a system for rating a clinician's adherence and competence in using Motivational Interviewing (MI), a client-centered treatment approach that targets the development and enhancement of intrinsic motivation to change problem behaviors (Miller & Rollnick, 2002). Clinician MI adherence refers to the extent to which clinicians specifically implement MI strategies and techniques, i.e., how “much” they did it. Clinician MI competence refers to the skill with which clinicians use these MI interventions, i.e., how “well” they did it. The aim of this Guide is to provide supervisors and mentors with a systematic way for monitoring clinician MI adherence and competence and to provide clinicians with individualized supervisory feedback and coaching as a means to further develop and refine their MI skills.

The Guide is a modification of the supervisor tape rating system used in the NIDA National Drug Abuse Clinical Trials Network (CTN) MI Protocol 0005 (*Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse*) and is based on an adaptation of the Yale Adherence Competence Scale (YACS; Carroll, Nich, Sifry, Frankforter, Nuro, Ball, Fenton, & Rounsaville, 2000). In brief, YACS is a general system for evaluating therapist adherence and competence across several types of manualized substance abuse treatments. Versions of it have been used in several prior clinical trial studies, including Project MATCH in which Motivational Enhancement Treatment (MET) was evaluated (Carroll, Connors, Cooney, DiClemente, Donovan, Longabaugh, Kadden, Rounsaville, Wirtz, & Zweben, 1998). The YACS has shown high reliability and an ability to discriminate MET from other treatments (Carroll et al., 1998, Carroll et al., 2000).

The Guide details a system for identifying the ways in which clinicians implement counseling strategies that are consistent or inconsistent with MI. It also lays out parameters that supervisors may use for establishing the clinicians' quality or skill of intervention. Because

the system relies upon direct observation of the clinicians' MI practice via the use of audio recordings, it has the capacity for highly individualized supervision based on what clinicians actually say and do in sessions rather than basing supervisory feedback solely on the clinicians' self-report. This “ears-on” approach to supervision is very important given that clinician self-report is unrelated to proficiency levels of observed practice (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004).

THE GUIDE IS DIVIDED INTO FIVE SECTIONS:

- The first section, *MI Supervision Guidelines*, describes recommendations for supervisor qualifications and makes suggestions for how to supervise clinicians in a MI consistent fashion.
- The second section, *General Interview Rating Guidelines*, provides supervisors with six recommendations for how to review session recordings and obtain accurate and consistent adherence and competence ratings.
- The third section, *Rating Adherence and Competence*, describes the system for rating how often specific counseling strategies occurred during a session (i.e., Adherence: Frequency and Extensiveness) and the clinician's skill or quality in using those strategies (i.e., Competence: Skill Level).
- The fourth section, *Description of Rating Items*, is divided into three subsections. The first subsection, *MI Consistent Items*, contains 10 items that describe MI strategies or techniques clinicians may use to address a client's substance use problems. The second subsection, *MI Inconsistent Items*, contains 6 items that are inconsistent with a MI approach. For each item in these two subsections, the manual provides definitions (Frequency and Extensiveness Rating Guidelines), examples to help supervisors identify when each strategy occurs, and

guidelines for determining the level of skill or quality in which the clinician implemented the strategy. The MI consistent items also reference teaching tools the supervisor might use with the clinician to develop targeted skill areas. The third subsection, *General Ratings of Client Motivation*, contains 2 items that address the client's motivation at the beginning and end of the session.

- The fifth section, *Forms - Masters*, contains a *Motivational Interview Rating Worksheet* to tally instances when specific strategies occur and to write examples or notations about the quality of interventions. Based on the information on the worksheet, the supervisor makes his or her final adherence and competence ratings and clearly records them on the *Motivational Interviewing Adherence and Competence Feedback Form*. The supervisor and clinician should compare and discuss their ratings during supervision and then

develop a *Motivational Interviewing Skills Development Plan* for addressing the needs identified during the tape review. This section also contains a *Motivational Interviewing Clinician Session Report* that the clinician has the option to complete at the end of each session.

Other supervisory tools for helping clinicians develop and maintain proficiency in MI are included elsewhere in the MIA:STEP package. Tools that summarize important MI concepts and strategies can be found in section E. Self assessment guidelines for ten specific MI skills are included in section F. All these tools can be reproduced and used in mentoring clinicians as they work to improve their proficiency in MI skills.



MI SUPERVISION GUIDELINES

Supervisors and mentors have a very important role to play in the development of the clinician's MI skills. Ongoing feedback and coaching helps develop and maintain the skills of clinicians trying to learn MI and other evidence-based substance abuse treatments (Miller et al, 2004; Sholomskas, Syracuse, Rounsaville, Ball, Nuro, & Carroll, 2005). This Guide provides a method for supervisors to implement these standards in a manner that mirrors the supervisory process used in the CTN MI protocol.

To use this MI rating system, supervisors will need to have sufficient knowledge, experience, and support. Minimum qualifications for conducting MI supervision include: (1) completion of a 15 hour MI skill-building workshop by a MINT (Motivational Interviewing Network of Trainers) trainer, (2) interest in becoming a MI supervisor, and (3) be in a position with authority to supervise other staff members. In addition, supervisors should have the support of their clinical administrative leadership group for implementing this method of supervision at their agencies.

Before outlining a suggested format for conducting MI supervision, supervisors and mentors might benefit from reviewing the following general guidelines. These guidelines include: (1) being sensitive to the deceptive simplicity of learning and implementing MI, (2) being mindful of the complications posed by a clinician's use of MI inconsistent strategies when learning MI, (3) handling clinician performance anxiety generated by supervision, (4) practicing what you preach as a supervisor by supervising in a MI consistent fashion, and (5) considering clinician MI proficiency standards.

DECEPTIVE SIMPLICITY

MI often is harder to conduct well than clinicians may expect. When asked, many clinicians report that they commonly use many MI consistent strategies such as open-ended questions and reflections as a mainstay of how they work with clients and typically describe their work as empathic or attuned to the client's needs (Ball,

Bachrach, DeCarlo, Farentinos, Keen, McSherry, Polcin, Snead, Sockriter, Wrigley, Zammarelli, & Carroll, 2002). They may believe that the use of core MI skills is straightforward or elementary and that they can perform these strategies fairly well with little practice.

While some clinicians find learning MI quite manageable and progress in skill development readily, many clinicians struggle to grasp the client-centered spirit of MI, to reflect with increasing depth and accuracy, to appreciate the impact of questioning (open- and closed-ended) on client elaboration and counseling style, to understand the relationship between change talk and resistance, and to know how to proceed strategically with directive methods for eliciting change talk and handling resistance skillfully. Even recognizing overuse of close-ended questions and incorporating more open-ended ones into the interview may be challenging for some clinicians.

MI's deceptive simplicity poses a dilemma for supervision. If the supervisor conveys to the clinician that the clinician probably is less skilled than the clinician imagines him- or herself to be, the supervisor and clinician may get into a confrontational trap in which the supervisor becomes excessively corrective or authoritative in pointing out what a clinician has done wrong. The supervisor also might fail to address the clinician's understandable ambivalence about learning a new counseling approach if he or she is used to conducting sessions in another manner. At the same time, the supervisor's responsibility is to promote the clinician's best MI practice (i.e., increase MI consistent behaviors and decrease MI inconsistent behaviors) and to help the clinician appreciate that MI is more difficult to learn than meets the eye. The supervisor navigates this dilemma by acknowledging any familiarity the clinician has with MI techniques and inquires about the clinician's experience using these skills. The supervisor attempts to meet the clinician where he or she is both in terms of interest in learning MI and initial skills the clinician brings to the supervision. The supervisor then asks the clinician in what ways he or she might hope to develop further. In this way, the supervisor manages resistance to training and supervision, fosters a collaborative learning

environment, and sets the stage for the clinician to discover and develop his or her essential MI skills. As the supervisor provides the clinician with objective feedback from the tape ratings, the clinician may become more mindful of his or her strengths and weaknesses and appreciative of the subtleties and challenges posed by using MI. Thus, effective MI supervision incorporates many elements of being a skilled MI clinician.

MI INCONSISTENT COUNSELING BEHAVIORS

Sometimes a clinician may experience resistance to learning MI when the clinician realizes some of his or her counseling behaviors may be inconsistent with a MI approach. This type of resistance may arise when the supervisor gives tape rating feedback about the clinician's performance. As in MI, the supervisor avoids conveying that MI is the "best" or "preferred" counseling approach. Other methods might be appropriate alternatives. In fact, clinical research does not support the superiority of any one major addiction counseling approach over all others, provided that they are conducted with a high level of competence and have been empirically validated (Project Match Research Group, 1997, 1998). Instead, the supervisor presents MI on its own merits and encourages the clinician to see what he or she thinks about it by trying to learn and practice it in its purest form. The clinician's freedom to choose how to counsel clients in the end may seem obvious, but might be worth underscoring at this point. The key is that the supervisor avoids the trap of "knowing better" than the clinician and affirms his or her respect for the multitude of ways in which the clinician may counsel others. At the same time, the supervisor highlights that the aim of MI supervision is to develop the clinician's MI adherence and competence and this process entails limiting or eliminating counseling approaches or styles that do not work well with MI or that might be used after MI has been conducted. Once established, examination of how to sequence and integrate other approaches with MI (e.g., incorporating relapse prevention skills training after enhancing a client's motivation for changing substance use patterns) may become the focus of supervision.

CLINICIAN PERFORMANCE ANXIETY

Just as supervisors may not be familiar with the method of supervision outlined in this Guide, clinicians also may find the approach novel and may be surprised by the supervisors' attention to their actual performance of MI instead of relying solely on self-report. While many clinicians find the degree of specificity and targeted coaching very helpful and clearly benefit from it (Miller et al., in press), occasionally some clinicians may become anxious about the scrutiny of their work and become uncomfortable with the process. If clinicians react in this manner, the supervisor might reinforce the expectation that learning MI takes practice over time and that clinicians commonly experience some difficulties initially implementing the approach with fidelity. Supervisor efforts to recognize and affirm the clinicians' MI performance strengths often help to alleviate performance anxiety and to support the clinicians' self-efficacy in conducting MI.

PRACTICE WHAT YOU PREACH

The three prior supervisory dilemmas underscore the importance of conducting MI supervision in a manner consistent with MI. This means that the supervisor avoids presenting him- or herself as the expert fully armed with interview ratings and helpful feedback, even if well intentioned. Instead, MI supervisors ask about the clinician's view of his or her MI performance before commenting on the session. Focusing on what MI areas went well, what progress happened, what challenges occurred, what other ideas or options the clinicians might entertain retrospectively, what the client communicated, and how to proceed with the client are all fruitful areas for discussion. Woven into these areas, the supervisor presents the interview rating results to the clinician and asks for the clinician's reactions. Based on these discussions, the supervisor helps the clinician identify focal areas for performance improvement, mirroring the change planning process.

The supervisor also tries to understand resistance to learning MI as an opportunity to see how MI may best fit into a clinician's practice. Resistance to learning MI does not necessarily mean a clinician does not want to

learn and practice MI. The clinician may confront real implementation dilemmas involving agency practices that hinder proficient use of MI (e.g., heavy information gathering demands with narrow time constraints at intake, clients presenting with complicated problems and symptoms that make using MI more challenging). Listening carefully to and understanding this “resistance” is an important part of supervision. How the supervisor handles it will affect the clinician’s motivation to incorporate MI into his or her counseling approach. As in MI where the clinician shares in the responsibility of enhancing the clients motivation for change, the supervisor shares in the responsibility for how well the clinician conducts MI.

Finally, the supervisor and clinician have the discretion to use additional methods to promote the clinician’s best MI practice. Some options include:

1. Having the clinician complete the MI Clinician Session Report after sessions and discussing it with the supervisor;
2. Reviewing MI manuals, textbook chapters, or MI training tapes;
3. Listening to recorded sessions together to highlight well performed skills and to discuss what else the clinician might have said when the interview veered from proficiency;
4. Using structured role-plays targeting skills areas necessitating development or clinical circumstances in which clinicians have difficulty using MI;
5. Forming a group or peer supervision to promote wider interest and dissemination of MI within the agency.

Throughout this process, the supervisor tries to make him- or herself and other MI resources available to the clinician. The clinician maintains the freedom to choose in what additional ways he or she may enhance the supervision experience.

In summary, the style of supervising clinicians in MI mirrors the overall MI style central to the approach. MI supervision fundamentally is clinician-centered and

approaches the development of a clinician’s MI proficiency as a collaborative work in progress. By practicing what is preached, the supervisor models for the clinician a style of interaction essential to performing MI and that may dually enhance the clinician’s intrinsic motivation to learn the approach.

A SUGGESTED SUPERVISION FORMAT USING INTERVIEW RATING FEEDBACK

The Supervisor Tape Rating Guide is a method for assessing clinician MI performance and for constructing feedback that provides the basis of individualized clinician coaching. While listening to a clinician’s taped session, the supervisor rates the session using the *MI Rating Worksheet* and then completes the *MI Adherence and Competence Feedback Form*. **These ratings only are completed for the first and last 20 minutes of the session** when the clinician is using MI as part of the MI assessment sandwich. Because the middle portion of the MI assessment involves collection of information necessary for intake form completion, sometimes including a formal administration of the *Addiction Severity Index* (McLellan, Kushner, Metzger, Peters, Smith, Grissom, Pettinati, & Argeriou, 1992) or other intake assessment tool, rating this portion of the session is not useful for evaluating and supervising a clinician’s MI proficiency. In addition, the supervisor has the option of asking the clinician to complete the *MI Clinician Session Report* after conducting the counseling session to help sensitize the clinician to his or her MI efforts, increase greater MI self-evaluation skills, and foster supervisor-clinician collaboration by comparing item ratings. The supervisor may meet individually with the clinician, use a group supervision model in which clinicians rotate presentation of their work, or incorporate both means of reviewing MI performance. Individual MI supervision sessions typically require a minimum of 30 minutes to provide feedback and coaching. Group MI supervision typically requires one hour.

While the supervisor and clinician will adjust the supervision session to their needs, a suggested format is as follows:

1. Openly discuss the clinician’s perception of his or her session. Affirm the clinician’s use of the MI Clinician Session Report and, if necessary, remind the clinician that it is an optional tool available to him or her for honing MI skills.

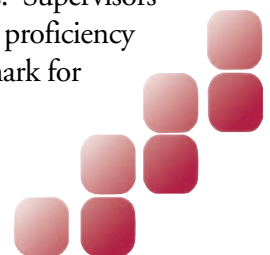
2. Reflect the clinician's main points. Look for opportunities to support the clinician's efforts to use MI in the session and to appreciate the challenges the clinician may have had in trying to adhere to MI.
3. Provide the clinician with feedback from the *MI Adherence* and *Competence Feedback Form*. Begin by focusing on areas in which the clinician performed well. Next, note areas in which the clinician struggled and provide some ideas in collaboration with the clinician about what might have contributed to these difficulties (e.g., highly resistant client or relatively silent one, basis of ambivalence not clarified during session, moved too far ahead of the client, ratio of questions to reflections was too high, etc.). Discuss ways to promote the clinician's abilities in these areas.
4. Ask the clinician to identify an area in which he or she wishes to focus. Spend time discussing this matter and, as indicated, supplement the discussion with review of MI strategies and techniques. Use of role-plays constructed to target the development of specific skills or to handle challenging client scenarios often are very useful for this purpose. Use of the MI Skill Development Plan may help clarify learning objectives and methods for both the supervisor and clinician.
5. Either with the permission or at the clinician's request, listen to a segment of the recording together and consider retrospectively what else the clinician might have said or done. This exercise may be particularly useful for providing feedback and skill development opportunities for the clinician.
6. Summarize the supervision session with a succinct review of the clinician's strengths and ongoing learning objectives.
7. Schedule the next supervision session and review with the clinician the timeframe for obtaining another recorded client session and having it rated by you.

CLINICIAN MI PROFICIENCY STANDARDS

Supervision also entails training clinicians to some standards of proficiency and using these standards to

evaluate performance. The MI Assessment protocol had proficiency standards for certifying clinicians as sufficiently competent to implement the motivational interviewing assessment. The standards were set by the protocol development team and represented a consensus decision among the team members. Miller also has proposed preliminary proficiency standards for MI (Miller & Mount, 2001) based on an alternative rating system called the motivational interviewing skills coding system or the MISC. In addition, a briefer adaptation of the MISC called the motivational interviewing treatment integrity code or the MITI is available. Supervisors interested in learning more about these systems should access the following website: <http://casaa.unm.edu>. Nonetheless, the proficiency standards for this protocol were established to provide a competency threshold that would be feasible for clinical practice among community treatment program clinicians and sufficient to ensure an adequate level of MI performance in the study in the absence of existing benchmarks (Carroll, Farentinos, Ball, Crits-Christoph, Libby, Morgenstern, Obert, Polcin, & Woody, 2002).

To be deemed sufficiently proficient in conducting the MI assessment, clinicians had to demonstrate in several sessions the use of at least half of the MI consistent items three to four times, namely, receive a "Somewhat" (4) frequency and extensiveness rating and at least an "Adequate" (4) skill level rating. In other words, the clinician had to show the capacity to use a moderate amount of MI strategies and skills and show an adequate level of performance when implementing them. After reaching these standards, supervision of the clinicians continued on a biweekly basis throughout the protocol using the method of supervision detailed in this manual to maintain or make further gains in the clinicians' MI performance. If three successive sessions occurred in which a clinician fell below proficiency standards, the clinician received additional training, feedback, and coaching until he or she demonstrated again the minimal MI proficiency standards. Supervisors may elect to use the protocol's MI proficiency standards as a supervisory benchmark for their clinicians.



GENERAL INTERVIEW RATING GUIDELINES

Rating tapes of counseling sessions and using these ratings as the basis for clinical supervision may be unfamiliar to many supervisors and clinicians. Supervisory interview rating requires a supervisor to carefully follow the system outlined in this Guide and to learn how to use it with accuracy and consistency as a primary tool of supervision. This systematic approach to supervision ensures a uniform approach for understanding what occurs within and across counseling sessions, allows comparison of MI performance across clinicians, and provides a means for the supervisor and clinician to track the clinician's performance over time. To maximize these capacities, we recommend that supervisors follow several guidelines when rating clinician MI adherence and competence:

1. RATE OBSERVABLE CLINICIAN BEHAVIORS AND FACILITATION EFFORTS:

Each item describes explicit clinician behaviors that a supervisor might observe when listening to a taped session. The supervisor rates only clear, observable instances in which a clinician implements a strategy consistent with MI or that is contraindicated by the approach. The client's behavior and responses to clinician interventions do not impact the ratings. The supervisor simply considers what the clinician actually attempted or facilitated and rates these efforts according to the items' specific definitions. The supervisor should have specific examples in mind to substantiate the ratings.

2. AVOID BIASED RATING:

This MI adherence and competence rating scale is designed for the purpose of accurately describing the clinician's behavior in the session. To obtain the highest level of accuracy, the supervisor should be mindful of potentially biased ratings and strive not to be unduly swayed by:

- other behaviors the clinician engaged in during the session;

- ratings given to other items;
- how skilled the supervisor believes the clinician is;
- how much the supervisor likes the clinician.

3. RATE EACH CLINICIAN BEHAVIOR ON ALL APPLICABLE ITEMS:

A clinician's statement or question may be relevant to several items. Because items may overlap in terms of breath of coverage, the same clinician behavior that is appropriately rated on one item may also apply to another item. Supervisors should carefully consider what they have observed and code their observation on all items that apply. For example, a clinician may ask a client at the beginning of a session, "What are some of the good and bad things you get from drinking?" This question is open-ended (Item 2 – Open-ended Questions) and related to the advantages and disadvantages of substance use (Item 8 – Pros, Cons, and Ambivalence). Supervisors should rate this one occurrence on both items.

4. USE THE SUPERVISOR'S GUIDE DURING EACH RATING SESSION:

To prevent supervisor rating drift, we strongly recommend that all supervisors regularly review the MI Supervisor Interview Rating Guide when rating a session. The Guide provides definitions, guidelines, and specific examples to promote accurate rating. Because of the complexity of the scale items, it is essential that the supervisors are completely familiar with the item definitions before rating them. If supervisors are uncertain about how to rate what the clinician has said, the supervisors should stop the tape and reference the Guide to isolate the best-matched item descriptors.

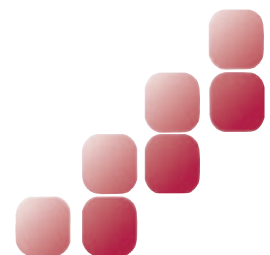
5. REVIEW THE MI PORTIONS OF THE MI ASSESSMENT SESSION, TALLY CLINICIAN BEHAVIORS, AND TAKE NOTES BEFORE MAKING A RATING:

Supervisors should listen to first and last 20 minutes of the session before making final ratings. These portions of the session capture the parts of the MI assessment sandwich where MI is used in the absence of more structured intake assessment tools. As they listen to the session, supervisors should make hash marks to indicate when an item has occurred. In addition, we recommend supervisors take notes while listening to the session. Supervisors should record all of this information on the Interview Rating Worksheet (provided in the Rating Form section of this Guide). Tallying and note taking enhance the accuracy of the ratings because they keep the supervisors focused on what actually occurred in the session and provide supervisors with information critical for making final ratings on all

the items. In particular, narrative note taking greatly helps supervisors make Skill Level ratings and individualize feedback and coaching to the unique training needs of the clinician.

6. PROTECT CONFIDENTIALITY:

All recordings and rating sheets and scores are confidential materials. To maintain confidentiality, supervisors should instruct clinicians not to write any personal information on any tape or form. In addition, clinicians will need to obtain a record consent that reviews how the recordings are handled and the purpose of recording the session. Once obtained, supervisors must listen to recordings and rate sessions in places that ensure confidentiality. In other words, supervisors should handle recordings like medical records and not leave recordings or rating material unattended.



RATING ADHERENCE AND COMPETENCE

For all items, supervisors must distinguish between the clinician’s (1) Adherence: Frequency and Extensiveness of using strategies, and (2) Competence: Skill Level of implementing those strategies. The specific system for coding the interview for adherence and competence is described below.

1. Adherence: Frequency and Extensiveness

The adherence rating blends together both the Frequency (i.e., the number of discrete times the

clinician engages in the intervention) and Extensiveness (i.e., the depth or detail with which the clinician covers any given intervention). These separate but related dimensions inform each rating interactively. In other words, the highest ratings involve clinician behaviors that are both high on frequency and extensiveness, whereas middle range scores may reflect behaviors that were done less often or with less depth. All supervisors use the following definitions to make their final Frequency and Extensiveness ratings for each item.

RATING OF:	
1 = Not at all	The variable never explicitly occurred.
2 = A little	The variable occurred once and was not addressed in any depth.
3 = Infrequent	The variable occurred twice, but was not addressed in depth or detail.
4 = Somewhat	The variable occurred one time and in some detail <u>OR</u> the variable occurred 3-4 times, but all interventions were very brief.
5 = Quite a bit	The variable occurred more than once in the session, and at least once in some detail or depth <u>OR</u> the variable occurred 5-6 times, but all interventions were very brief.
6 = Considerably	The variable occurred several times during the session and almost always with relative depth and detail <u>OR</u> the variable occurred more than 6 times, but all interventions were very brief.
7 = Extensively	The variable occurred many times almost to the point of dominating the session and was addressed in elaborate depth and detail <u>OR</u> the variable occurred briefly at such a high frequency that it became difficult to count.

For the Frequency and Extensiveness ratings, the starting point for rating each item in the scale is “1”. The supervisor should assign a rating of greater than “1” only if he or she hears examples of the behavior specified in the items. The supervisor must be able to substantiate with examples the rating assigned to every item. This guide provides many examples of clinician behaviors that would “count” or endorse each item.

To acquire accurate counts, all supervisors should use a hash or tally mark system while reviewing the recording. Using the Interview Rating Worksheet, supervisors should make a hash mark next to the item when it occurs. If the item occurs more than once there should be corresponding hash marks (i.e., item mentioned 3 times would look like this: / / /). If an item occurs in detail, the hash mark(s) can be circled to help supervisors make a final rating

determination (i.e., at the end of listening to the entire session) that includes consideration of the depth/extensiveness of counseling interventions.

Of note, the supervisors should rate all instances of an item’s occurrence. In some cases, an item will have a very large number of un-circled hash marks that indicate a high frequency of brief interventions. Sometimes, no or very few instances may have occurred. In other cases, interventions may have been delivered in detail or an extensive fashion. In the end, the supervisor must convert his/her tallies from the Interview Rating Worksheet into final ratings on the Supervisor Interview Rating Form. The hash mark system should capture the supervisor’s overall best judgment of the clinician’s style and technique used during the session. For example, corresponding rating notations might look like this:

<p>1 (Not at all) = The variable never explicitly occurred</p> (no hash marks)
<p>2 (A little) = one hash mark, uncircled The variable occurred once and was not addressed in any depth.</p> (/)
<p>3 (Infrequent) = two hash marks, uncircled The variable occurred more than once, but was not addressed in depth or detail</p> (//)
<p>4 (Somewhat) = one circled hash mark The variable occurred one time and in some detail <u>OR</u> the variable occurred 3-4 times, but all interventions were very brief</p> ((/)) (/ / /)
<p>5 (Quite a bit) = two or three hash marks, at least one circled The variable occurred more than once in the session, and at least once in some detail or depth <u>OR</u> the variable occurred 5-6 times, but all interventions were very brief.</p> ((/ /)) (/ / / /)
<p>6 (Considerably) = more than three hash marks, several circled The variable occurred several times during the session and almost always with relative depth and detail <u>OR</u> the variable occurred more than 6 times, but all interventions were very brief.</p> ((/ / / /)) (/ / / / / /)
<p>7 (Extensively) = more than five hash marks, almost all circled The variable dominated the session, occurred many times, and was addressed in elaborate depth and detail <u>OR</u> the variable occurred briefly at such a high frequency that it became difficult to count.</p> ((/ / / / / / / /)) (/ / / / / / / / / / / /)

2. Competence: Skill Level

The clinician’s competence or Skill Level refers to the clinician’s demonstration of:

- expertise and competence
- appropriate timing of intervention
- clarity of language
- responding to where the client appears to be

All supervisors use the following definitions to make their final Skill Level ratings for each item:

When rating Skill Level, the starting point for rating each item should be “4.” That is, supervisors should begin by assuming that a clinician will behave adequately or at an average level. Supervisors assigning scale scores above or below a “4,” should have examples or notations in mind to support their scores. To help supervisors with this task, the Guide provides Skill Level Rating Guidelines that describe how a specific strategy is of higher or lower quality than an “adequate” rating of 4.

A useful method for recording Skill Level ratings while listening to a session is to combine them with the hash

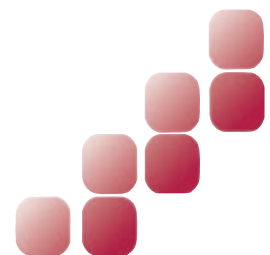
mark system. When a strategy occurs with adequate skill, the supervisor records a simple hash mark without a notation about quality (/). The absence of a notation always connotes adequate skill level. If a strategy occurs with more or less than adequate skill, the supervisor records a hash mark with a superscripted number that corresponds to the specific Skill Level rating. For example, a strategy implemented with poor skill would look like /². A strategy implemented with

very good skill would look like /⁶. The supervisors also may include a few narrative examples of higher or lower quality strategies on the worksheet. In this manner, the supervisors can organize the data efficiently and more easily cull and average the varying Skill Level ratings to

RATING OF:	
9 = Not at all	The variable was not observed (i.e., rated “1” for Frequency and Extensiveness).
1 = Very poor	The clinician handled this in an unacceptable, even unprofessional manner.
2 = Poor	The clinician handled this poorly (e.g., showing clear lack of expertise, understanding, competence, or commitment, inappropriate timing, unclear language).
3 = Acceptable	The clinician handled this in an acceptable, but less than ‘average’ manner.
4 = Adequate	The clinician handled this in a manner characteristic of an ‘average’, ‘good enough’ clinician.
5 = Good	The clinician handled this in a manner slightly better than ‘average.’
6 = Very good	The clinician demonstrated skill and expertise in handling this issue.
7 = Excellent	The clinician demonstrated a high level of excellence and mastery in this area.

determine and justify the final competency ratings for each item. These narratives also are very useful in supervision to provide specific examples.

Although there may be significant overlap between the Skill Level and its effectiveness (implied by the client's verbal response), Skill Level is not the same as effectiveness in that it does not require the client's positive response. A clinician may score highly on Skill Level for a particular item regardless of the client's response. Of equal importance, Skill Level must be distinguished from Frequency and Extensiveness. For example, a clinician's score of "6" on Frequency and Extensiveness for a particular item does not necessarily mean the Skill Level was high. Supervisors should rate Skill Level independent of Frequency and Extensiveness. Thus, it is perfectly appropriate for a supervisor to give a rating of "3" on Skill Level even if the Frequency and Extensiveness rating is a "6."



DESCRIPTION OF RATING ITEMS

This section describes in detail different counseling strategies a clinician may use during a session. Items 1 through 10 define strategies that are consistent with MI and critical to the approach (e.g., open-ended questions, affirmations of strengths and self-efficacy, reflective statements). Items 11 through 15 define strategies that are inconsistent with MI (unsolicited advice giving, directly confronting, emphasizing abstinence, emphasizing powerlessness and loss of control, asserting authority) and undercut the overall MI style or spirit. Item 16 (closed-ended questions) is an optional additional MI inconsistent item supervisors may find helpful to track in their efforts to maximize a clinician's MI proficiency. Each item includes a specific definition, frequency and extensiveness rating guidelines to help the supervisor capture all occurrences of it, specific examples, and guidelines for rating the overall skill demonstrated by the clinician in using the particular strategy. We strongly encourage supervisors to become very familiar with the rating items and to continuously refer to the definitions in order to provide clinicians with the most accurate, consistent, and individualized rating feedback and coaching.

MI CONSISTENT ITEMS

1. MOTIVATIONAL INTERVIEWING STYLE

OR SPIRIT: *To what extent did the clinician provide low-key feedback, roll with resistance (e.g., avoiding arguments, shifting focus), and use a supportive, warm, non-judgmental, collaborative approach? To what extent did the clinician convey empathic sensitivity through words and tone of voice, demonstrate genuine concern and an awareness of the client's experiences? To what extent did the clinician follow the client's lead in the discussion instead of structuring the discussion according to the clinician's agenda?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item refers to how much the clinician maintained an empathic, collaborative approach and handled resistance skillfully instead of head-on while

consistently aiming to elicit the client's motivation for change. This therapeutic style is one of calm and caring concern and an appreciation for the experiences and opinions of the client. The clinician conveys empathic sensitivity through words and tone of voice, and demonstrates genuine concern and an awareness of the client's experiences. The clinician avoids advising or directing the client in an unsolicited fashion. Decision-making is shared. As the clinician listens very carefully to the client, the clinician uses the client's reactions to what the clinician has said as a guide for proceeding with the session. The clinician avoids arguments and sidesteps conflicted discussions or shifts focus to another topic where eliciting the client's discussion and motivation for change may be more productive. In brief, this item captures the client-centered way of being with a client a clinician maintains when conducting MI.

A higher Frequency/Extensiveness rating would be achieved if the clinician consistently maintains the MI spirit and pursuit of an accurate understanding of the client throughout the session and clearly demonstrates an ability to respond without defensiveness to the client's resistance behaviors such as arguing, interrupting, negating (denial), or ignoring. The clinician appears facile in using core MI skills such as open-ended questions, reflections, affirmations, and summaries and integrates these skills with a variety of other techniques used to more directly elicit self-motivational client statements and to reduce resistance such as: Amplified reflection (reflecting the client's statements in an exaggerated manner); Double-sided reflection (restating what the client has said, but reminding them of the contrary things they have said previously); Shifting focus (changing the topic or focus to things the client is less resistant to exploring and changing); Reframing (acknowledging what the client has said, but offering a different perspective); or Coming along side (taking the side of no change as a way to foster the client's ambivalence and elicit change talk). Each of these techniques is used to reduce resistance and

facilitate the client's consideration and discussion of change-related topics. *Lower ratings* occur when clinician behaviors supporting a MI stance are absent or seldom occur or if the clinician peppers the session with several MI inconsistent interventions that disrupt or negate the MI spirit.

EXAMPLE:

Client: "Why do you keep asking me to talk about my cocaine use? My kids are driving me crazy. You'd use cocaine too if you had my problems!"

Clinician: "You have a valid point. Maybe we should think about having your family come to a session. This problem may be bigger than you alone."

SKILL LEVEL RATING GUIDELINES:

HIGHER: A clinician demonstrates a high quality motivational interviewing style/spirit when he/she establishes an overall tone of collaboration and respect. The clinician shows he/she cares about what the client is saying and strives to accurately understand and reflect the client's statements. The clinician uses any specific therapeutic strategy in the service of promoting an overall motivational interviewing style or spirit. A clinician also demonstrates higher skill when, throughout the session, the clinician deftly uses the client's reactions as a guide for formulating subsequent MI strategies and techniques. The clinician's attunement to the client is obvious.

LOWER: A low quality motivational interviewing style occurs when the clinician controls the interview process, insufficiently facilitates the client's open exploration of his/her problem areas and motivation for change, and acts inflexibly and defensively in response to client resistance. The clinician may deliver therapeutic interventions in a technically correct manner but with little facility, warmth, or engagement of the client. A clinician who does not adjust

strategies to the client's shifting motivational state or who sounds redundant in the interventions selected also may receive lower Skill Level ratings.

- 2. ASKING OPEN-ENDED QUESTIONS:** *To what extent did the clinician use open-ended questions (i.e., questions or requests that elicit more than yes/no responses) to elicit the client's perception of his/her problems, motivation, change efforts, and plans?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

Open-ended questions are questions that result in more than yes/no responses and that don't pull for terse answers or very specific pieces of information. Often these questions begin with the following interrogatives: "What," "How," "In what," and "Why" (somewhat less preferable) or lead off with the request, "Tell me..." or "Describe..." The clinician uses open-ended questions to elicit an open conversation about the client's view of his/her problems and commitment to change. In brief, by using open-ended questions, the clinician gives the client a wide range for discussing his or her life circumstances and substance use patterns.

A higher Frequency/Extensiveness rating would be achieved if the clinician asks numerous questions that invite client conversation (see Correct Examples) as opposed to asking only yes/no response questions (see Incorrect Examples). Lower ratings occur when the clinician asks very few questions or almost all closed-ended ones.

EXAMPLES:**Correct**

- So, what brings you here today?
- What are some of the ways that substance use affects your life?"
- What kinds of differences have you noticed in...?

Incorrect:

- Do you use marijuana? When was the last time you used?
- Can you tell me how heroin affects you?
- Your wife thinks you are addicted to cocaine. Are you addicted to cocaine?

SKILL LEVEL RATING GUIDELINES:

HIGHER: High quality open-ended questions are relevant to the clinician-client conversation and pull for greater client exploration and recognition of problem areas and motivation for change, without appearing to be judgmental or leading to the client. They are simple and direct, thereby increasing the chance that the client clearly understands what the clinician is asking. Usually, several open-ended questions do not occur in close succession. Rather, high quality open-ended questions typically are interspersed with reflections and ample client conversation to avoid the creation of a question-answer trap between the clinician and client. The clinician pauses after each question to give the client time to respond to each query.

LOWER: Low quality open-ended questions are poorly worded or timed or target an area not immediately relevant to the conversation and client concerns. They often will occur in close succession, giving the conversation a halting or mechanical tone rather than one that flows naturally between the clinician and client. Lower quality open-ended questions also may compound several questions into one query (e.g., “Tell me about how you felt before and after you got high and how that all affects your future risk for using cocaine.”), making them harder to understand and respond to by the client. Further reductions in Skill Level ratings may occur if the clinician seems to be leading or steering the client, uses a judgmental or sarcastic tone when asking open-ended

questions, or does not pause sufficiently after each question to give the client time to contemplate and respond.

3. AFFIRMATION OF STRENGTHS AND CHANGE EFFORTS:

To what extent did the clinician verbally reinforce the client’s strengths, abilities, or efforts to change his/her behavior? To what extent did the clinician develop the client’s confidence by praising small steps taken in the direction of change or expressing appreciation of personal qualities in the client that might facilitate successful efforts to change?

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item refers to what extent the clinician expresses confidence in the client to achieve his/her goals. The clinician may affirm the client using many different approaches: a) using compliments or praise, b) acknowledging the client’s personal qualities, competencies or abilities that might promote change, c) recognizing effort or small steps taken by the client to change. Sometimes, the clinician might use a positive reframe to affirm the client (e.g., noting how multiple treatment episodes and numerous relapses are evidence of the client’s persistence in trying to deal with his or her drug use problems and not giving up). By complimenting, positively reinforcing, and validating the client, the clinician fosters the belief in the client that there is hope for successful recovery and that the client can change his/her own substance use behaviors.

Note: Raters should not rate a clinician’s simple statements of “Good” or “Great” as affirmations. Affirmations must include direct references to something about the client.

EXAMPLES:

Clinician: “It sounds as if you have really thought a lot about this and have some good ideas about how you might want to change your drug use.”

“That must have been really hard for you. You are really trying hard to work on yourself.”

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher quality affirmations occur when the clinician affirms qualities or efforts made by the client that promote productive change or that the client might harness in future change efforts rather than being general compliments. The clinician derives these affirmations directly from the conversation. As a consequence, high quality affirmations are meaningful to the client rather than being too global or trite. A key ingredient in a high quality affirmation is the appearance of genuineness rather than the clinician merely saying something generally affirming in a knee-jerk or mechanical fashion.

LOWER: Low quality affirmations are not sufficiently rooted in the conversation between the client and clinician. The affirmations are not unique to the client's description of him/herself and life circumstances or history. The clinician may appear to affirm simply to buoy a client in despair or encourage a client to try to change when he/she has expressed doubt about his/her capacity to do so. In short, poor quality affirmations sound trite, hollow, insincere, or even condescending.

4. MAKING REFLECTIVE STATEMENTS: *To what extent did the clinician repeat (exact words), rephrase (slight rewording), paraphrase (e.g., amplifying the thought or feeling, use of analogy, making inferences) or make reflective summary statements of what the client said?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

Reflective statements made by the clinician restate the client's comments using language that accurately clarifies and captures the meaning of the client's communications and conveys to the client the clinician's effort to understand the client's point of view. The clinician uses this technique to encourage the client to explore or elaborate on a topic. These

techniques include repeating exactly what the client just stated, rephrasing (slight rewording), paraphrasing (e.g., amplifying thoughts or feelings, use of analogy, making inferences) or making reflective summary statements of what the client said. Reflective summary statements are a special form of reflection in which the clinician selects several pieces of client information and combines them in a summary with the goal of inviting more exploration of material, to highlight ambivalence, or to make a transition to another topic. Often, summary reflections receive an extensive or in depth tally mark on the worksheet.

EXAMPLES:

Client: "Right now, using drugs doesn't take care of how bad I feel like it used to. If anything, I feel worse now."

Simple Reflection

- Using drugs makes you feel worse now.

Rephrasing

- So, you have found that using drugs to deal with how badly you feel is not working well for you anymore.

Paraphrasing Using a Double-Sided Reflection

- In the past using drugs helped you feel better when you were having a hard time or feeling badly. Now, it is only making matters worse for you.

Introductions to a Reflective Summary

- Let me see if I understand what you've told me so far..."
- Here is what I've heard you say so far..."

Skill Level Rating Guidelines:

HIGHER: Higher quality reflections occur when the clinician accurately identifies the essential meaning of what the client has said and

reflects it back to the client in terms easily understood by the client. The clinician's inflection at the end of the reflection is downward. The clinician pauses sufficiently to give the client an opportunity to respond to the reflection and to develop the conversation. Well-delivered reflections typically are concise and clear. Over the course of the session, higher quality reflections usually have more depth (i.e., paraphrasing thoughts or feelings in manner that effectively brings together discrepant elements or that clarify what the client meant). If the clinician reflects several client statements, the clinician neatly arranges them in a manner that promotes further client introspection, conversation, and motivation for change. Often high quality reflections increase the time spent talking by the client, foster a collaborative tone, and reduce client resistance.

LOWER: Low quality reflections often are very inaccurate (i.e., “miss the boat”) and may contribute to the client feeling misunderstood. They can be too vague, complicated, or wordy. They also may have an upward inflection at the end and consequently function as disguised closed-ended questions. Typically low quality reflections decrease the time spent talking by the client and may increase the client's resistance. Skill Level ratings also may decrease, even with high frequency reflections, if the reflections are too spread out rather than consecutively linked over the session such that they do not increase introspection, conversation, or motivation to change. Likewise, reflections that are redundant or remain repetitively simple such that the conversation seems to go around in circles are lower in quality.

5. FOSTERING A COLLABORATIVE

ATMOSPHERE: *To what extent did the clinician convey in words or actions that the therapy is a collaborative relationship in contrast to one where the clinician is in charge? How much did the clinician emphasize the (greater) importance of the client's own decisions, confidence, and perception of the importance of changing? To what extent did the clinician verbalize respect for the client's autonomy and personal choice?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item captures any explicit effort the clinician makes to seek guidance from the client or to act as though therapy were a joint effort as opposed to one in which the clinician consistently is in control. The clinician emphasizes the (greater) importance of the client's perspective and decisions about if and how to change. Any explicit clinician statements that verbalize respect for the client's autonomy and personal choice are examples of fostering collaboration during the session.

EXAMPLES:

Clinician: “What do you think would be a good way to handle this situation in the future?”

“I would have thought you would..., but it sounds like you made a better choice by...”

“Let's look at that issue together.”

“We can spend some time talking about your situation at home.”

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher quality strategies occur in several ways. The clinician may directly and clearly note the greater importance of the client's perception about his/her drug use and related life events in contrast to what the clinician or significant others might think. The clinician may underscore the collaborative nature of the interview by

highlighting his or her interest in understanding the client's perspective without bias. Likewise, direct and clear references to the client's capacity to draw his or her own conclusions or to make personal choices about how to proceed with a plan for change receive higher Skill Level ratings. Use of these strategies when the clinician perceives that the client is feeling coerced by significant others can be especially effective and lead to higher Skill Level ratings. Emphasizing viable personal choices rather than choices that are unrealistic to the client also improve Skill Level ratings. For example, a clinician may provide a choice among treatment options within a program rather than highlight the option of program non-enrollment to a client who presents to treatment in a job jeopardy situation; this type of client most likely will see treatment nonparticipation as too risky for losing his job.

LOWER: Lower quality strategies occur when the clinician emphasizes personal choices that do not seem realistic to the client. Also, vague, wordy, or poorly timed efforts to articulate the client's personal control, autonomy, and collaborative role in the interview reduce quality ratings. Clinician advice giving in the context of seemingly collaborative statements also receives lower ratings (e.g., "You are obviously in the driver's seat, but I wouldn't do that if I were you.).

6. DISCUSSING MOTIVATION TO CHANGE: *To what extent did the clinician try to elicit client discussion of change (self-motivational statements) through evocative questions or comments designed to promote greater awareness/concern for the problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change? To what extent did the clinician discuss the stages of change, help the client develop a rating of current importance, confidence, readiness or*

commitment, or explore how motivation might be strengthened?

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item refers to the extent to which the clinician made attempts to elicit client self-motivational statements or "change talk," or any type of discussion about change. This is often accomplished through questions or comments designed to promote greater awareness/concern for a problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change. The clinician might ask the client about how other people view the client's behavior as concerning or problematic and how these concerns by others impact the client's motivation for change. The clinician also might initiate a more formal discussion of the stages of change or level of motivation by helping the client develop a rating of current importance, confidence, readiness or commitment to change and explore how any of these dimensions might be strengthened. In brief, this item captures somewhat more directive means for eliciting a client's change talk and addressing a client's commitment to change. While these strategies very often lead to "change talk" or self-motivational statements and movement toward the negotiation of specific change plans, the client does not need to respond in this fashion for this item to be rated highly.

A higher Frequency/Extensiveness rating would be achieved if the clinician attempts to elicit remarks from the client indicating either recognition of a problem, statements of concern, intention to change or optimism about change. The clinician will often use techniques that are rated on other items (e.g., open-ended questions, reflections about substance use and/or about general problem areas related to substance use) that, in this case, are meant to encourage "change talk" on the part of the client. The clinician may also explicitly assess the client's current motivation to become abstinent or decrease their substance use, especially if the client continues to use. A lower rating would be given when the

clinician seldom strategically queries or reflects the motivational issues outlined above.

EXAMPLES:

Clinician: “What concerns you about your current use of substances?”

“What are some reasons you might see for making a change?”

“What do you think would work for you if you decide to change?”

Client: “My wife really believes it is a problem, so she’s always on my back about it.”

Clinician: “How do you feel about your drug use? What are your concerns and what do you think might need to happen?”

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher ratings occur on this item when the clinician uses evocative questions to elicit a client’s change talk that are targeted to the client’s current level of motivation. For example, if a client has not recognized drug use as a problem, the clinician asks the client to explore any concerns or problematic aspects of his or her drug use. If a client has recognized drug use as a problem but is uncertain about his or her capacity to change, the clinician directly queries the client about factors that might impact intent or optimism for change. Higher ratings also occur when the clinician collaboratively explores the client’s current readiness to change in depth by combining rating scales and open-ended follow-up questions and reflections that prompt the client’s arguments for change, optimism, and self-efficacy.

LOWER: Lower ratings on motivation to change strategies occur when the clinician tries to elicit self-motivational statements that are

inconsistent with the client’s stage of change. Additionally, if a clinician’s efforts to elicit self-motivational statements or to assess the client’s readiness to change become redundant, they receive lower Skill Level ratings. Clinician efforts to assess readiness to change that pull for resistance or arguments against change also receive lower ratings. For example, a lower quality intervention would occur if after a client selects a readiness to change rating of 6 on a scale of 1 (lowest readiness, to 10 (highest readiness)), the clinician asks, “How come you said a 6 rather than a 10?”

7. DEVELOPING DISCREPANCIES: *To what extent did the clinician create or heighten the internal conflicts of the client relative to his/her substance use? To what extent did the clinician try to increase the client’s awareness of a discrepancy between where his or her life is currently versus where he or she wants it to be in the future? How much did the clinician explore how substance use may be inconsistent with the client’s goals, values, or self-perceptions?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item involves efforts by the clinician to prompt the client’s increased awareness of a discrepancy between where they are and where they want to be relative to their substance use. The clinician may do this by highlighting contradictions and inconsistencies in the client’s behavior or stated goals, values, and self-perceptions. The clinician may attempt to raise the client’s awareness of the personal consequences of substance use, and how these consequences seem contrary to other aims stated by the client. The clinician may engage the client in a frank discussion of perceived discrepancies and help the client consider options to regain equilibrium. Other common techniques used to create or develop discrepancies include 1) asking the client to look into the future and imagine a changed life under certain conditions (e.g., absence of drug abuse, if married with children), 2) asking the client to look back and recall periods of better

functioning in contrast to the present circumstances, and 3) asking the client to consider the worst possible scenario resulting from their use or the best possible consequences resulting from trying to change. Sometime double-sided reflections that bring together previously unrecognized discrepant client statements are examples of a clinician's attempt to heighten discrepancies (which may also be rated on Item 8: Pros, Cons, and Ambivalence).

EXAMPLES:

Clinician: "You say you want to save your marriage, and I also hear you say you want to keep using drugs."

"On the one hand, you want to go out to the bar every night. On the other hand, you have told me how going out to the bar every night gets in the way of spending time with your son."

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher quality efforts to develop discrepancies typically occur when the clinician attempts to make the client aware of a discrepancy in the client's thoughts, feelings, actions, goals or values based upon the client's previous statements. The clinician presents the discrepancies as legitimate conflicts or mixed experiences rather than as contradictions or judgments that prove the client has a drug problem. In addition, higher quality interventions are clear and articulate reflections that encapsulate divergent elements of what a client has said. In short, integration of the client's specific discrepant statements in well-stated terms using a supportive, nonjudgmental tone improves the Skill Level rating.

LOWER: Low quality efforts to develop discrepancies typically occur when the clinician highlights the opposite side of the client's ambivalence without sufficiently counterbalancing it. For example, a client might say he wants to continue to smoke marijuana after previously acknowledging how smoking

angers his wife and may lead to an unwanted separation. A rater would give a lower Skill Level rating if the clinician responds by saying, "Yeah, but you said you don't want to be separated," instead of saying, "So even though you've told me you are concerned your wife might leave you, you continue to want to smoke marijuana." Often this approach appears somewhat argumentative and may heighten resistance rather than develop dissonance in the client's position. Abruptness in posing discrepancies ("gotcha!") or stating discrepancies with a hint of accusation also undermines clinician-client collaboration and reduces the overall quality of the intervention. Finally, wordy, cumbersome, or overly complex reflections of discrepant client statements receive lower Skill Level ratings.

8. EXPLORING PROS, CONS, AND

AMBIVALENCE: *To what extent did the clinician address or explore the positive and negative effects or results of the client's substance use and what might be gained and lost by abstinence or reduction in substance use? To what extent did the clinician use decisional balancing, complete a cost-benefits analysis, or develop a list of pros and cons of substance use? How much did the clinician express appreciation for ambivalence as a normal part of the change process?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item focuses on the extent to which the clinician facilitated the discussion of specific consequences of the client's substance use. This may include the positive and/or negative results of the client's past, present, or future behaviors as related to active substance use. Specific techniques used include decisional balancing, a cost-benefits analysis, or listing and discussing the pros and cons of substance use. An important stylistic component accompanying these techniques should be the clinician's verbalizing an appreciation for ambivalence as a normal part of the change process?

A *higher Frequency/Extensiveness rating* would be achieved if the clinician discusses ambivalence in detail or explicitly facilitates a costs/benefits analysis with client input concerning change versus remaining the same. A high score on this item typically involves the written completion of a Pros and Cons form either during the session or detailed review of a form completed prior to the session. A *lower rating* occurs when the clinician devotes little time or effort on any of these tasks.

EXAMPLES:

Clinician: "What do you see as the positive and negative consequences of your drinking?"

"You have had a lot of chest pain after using cocaine and seem very concerned about your health, your family, and where your life is going. And you have identified many possible benefits of stopping use, such as..."

"So by getting high, you feel good and can avoid painful feelings. What are some of the downsides to using?"

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher quality efforts to discuss the pros and cons of substance use occur when the clinician approaches the task in a nonjudgmental, exploratory manner. Throughout the examination of pros and cons, the clinician prompts the client to continue detailing dimensions of ambivalence using open-ended questions or reflections about consequences previously noted by the client. Full exploration of the pros and cons of stopping substance use versus continuing use improve quality ratings. During this process, the clinician elicits responses from the client rather than suggesting positive and negative consequences as possibilities not previously mentioned by the client. Additionally, use of summary reflections within each dimension or to compare and contrast them may enhance the Skill Level

ratings, particularly when the clinician uses these discussions to tip the client's motivational balance to the side of change. The specific technique of completing or reviewing a decisional balance sheet or simply discussing the pros or cons does not directly affect the Skill Level rating.

LOWER: Lower Skill Level ratings occur when the clinician seldom provides the client with opportunities to respond freely to the pros/cons dimensions or to more thoroughly reflect upon meaningful pros and cons to the client. Instead, the clinician provides the client with likely pros and cons and asserts this view to the client in a more closed-ended fashion. Consequently, the client becomes more of a passive recipient rather than an active participant in the construction of the decisional balance or discussion of factors underlying the client's ambivalence. Lower ratings also occur when the clinician asks the client to list pros and cons one after the other without exploring details or the personal impact of substance use on the client's life. When summarizing the client's pros, cons, or ambivalence, the clinician does not involve the client in the review and simply restates the items in a mechanical or impersonal manner. The clinician makes no effort to strategically tip the client's motivational balance in favor of change.

9. CHANGE PLANNING DISCUSSION: *To what extent did the clinician discuss with the client his or her readiness to prepare a change plan. To what extent did the clinician develop a change plan with the client in a collaborative fashion? How much did the clinician cover critical aspects of change planning such as facilitating a discussion of the client's self-identified goals, steps for achieving those goals, supportive people available to help the client, what obstacles to the change plan might exist, and how to address impediments to change?*

FREQUENCY AND EXTENSIVENESS RATING**GUIDELINES:**

This item measures the extent to which the clinician helps the client develop a change plan. This process may include an initial discussion of the client's readiness to prepare a change plan. It may include a more formal process of completing a Change Planning Worksheet or a less formal clinician-facilitated discussion of a plan without completing a worksheet. In either case, the intervention typically involves a discussion that includes many of the following areas: (1) the desired changes, (2) reasons for wanting to make these changes, (3) steps to make the changes, (4) people available to support the change plan, (5) impediments or obstacles to change and how to address them, and (6) methods of determining whether the plan has worked.

A *higher Frequency/Extensiveness* rating would be achieved if the clinician guides the client through a thorough discussion of change planning. This process does not have to include review of a completed Change Planning Worksheet, but a high score requires the development of a detailed change plan during the session. A *lower rating* occurs when the clinician addresses only a few elements of a change plan and spends little time examining them in detail.

EXAMPLE:

Clinician: "So, it sounds like you have made a decision to stop using drugs and reduce your drinking. Let's spend some time figuring out a plan that will help you get started working toward that goal. What is the first thing that comes to mind?"

"What do you think might get in the way of this plan or make it hard for you to continue to make these changes?"

SKILL LEVEL RATING GUIDELINES:

HIGHER: As a prerequisite, a higher Skill Level rating for change planning requires that the clinician develop a detailed change plan that addresses most of the key change planning areas outlined above.

The clinician takes sufficient time to explore each area and to encourage the client to elaborate by using open-ended questions and reflections. Overall, the development of the change plan is highly collaborative and serves to strengthen the client's commitment to change. If the client expresses ambivalence during the completion of the plan, the clinician attempts to resolve it in the direction of change instead of pushing forward when the client may not be ready to proceed.

LOWER: Lower Skill Level ratings occur when the clinician approaches the change planning process in a cursory fashion. The clinician does not actively engage the client in change planning or individualize the plan to the unique circumstances of the client. The lowest Skill Level ratings are given when the clinician takes on an authoritative and prescriptive tone while completing the change plan with the client.

10. CLIENT-CENTERED PROBLEM

DISCUSSION AND FEEDBACK: *To what extent did the clinician facilitate a discussion of the problems for which the client entered treatment? To what extent did the clinician review or provide personalized, solicited feedback about the client's substance abuse and the evidence or indications of problems in other life areas?*

FREQUENCY AND EXTENSIVENESS RATING**GUIDELINES:**

This item involves explicit attempts by the clinician to inquire or guide a discussion about the problems for which the client entered treatment. This discussion can include both the substance use as well as the many related problems in living that are associated with substance use. The clinician facilitates the development of a full understanding of the nature of the client's difficulties. This process may involve the review of assessment results obtained during prior clinical assessments,

worksheets completed by the client, or more formally through use of specific feedback forms. The method is less important than is the task of learning about the client’s problems and providing feedback to the client about his/her problems in an objective, client-centered manner. The clinician guides this discussion and provides feedback using a non-judgmental, curious, collaborative client-centered style. If the clinician provides formal feedback, the clinician implements this strategy only when solicited by the client or when seeking the client’s permission first.

EXAMPLES:

Clinician: “I wonder if we might start by your sharing with me some of the concerns that brought you into treatment. What brought you into treatment?”

“You have given me an excellent description of some of your concerns. I would like to put this information together with some of the other information you provided when you began this study so we will both have a complete view of what might be helpful for you. Would that be alright with you?”

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher quality problem discussion and feedback occurs in several ways. Initial clinician efforts to facilitate a discussion of the client’s problems may be fairly straightforward and of “adequate” quality (e.g., What’s been happening that has led you to come see me today?). Subsequent clinician efforts may receive higher ratings if they promote the client’s further elaboration and fuller understanding of the presenting problems, particularly when efforts to promote problem discussion successively build upon each other. Regarding feedback, higher ratings may occur when the feedback is very individualized to the client’s experiences and self-report. The clinician presents the feedback in clear, straightforward, and supportive terms. Overall, the clinician is

nonjudgmental about the feedback and uses open-ended questioning, affirmations, and reflections as part of the feedback process and only offers feedback when solicited by the client or when obtaining the client’s permission to do so first.

LOWER: Lower quality ratings on this item typically occur when a clinician presents feedback to a client in a generic way. The feedback may be unclear or presented in a judgmental fashion. Lower quality feedback also occurs when the clinician seems to be lecturing the client or drawing conclusions for the client without providing the client with opportunities to respond to the feedback provided. This latter approach to providing client feedback creates the image of the clinician as expert and often decreases the amount of talking done by the client. Unsolicited feedback also reduces the Skill Level rating.

MI INCONSISTENT ITEMS

11. UNSOLICITED ADVICE, DIRECTION

GIVING, OR FEEDBACK: *To what degree did the clinician provide unsolicited advice, direction, or feedback to the client (e.g., offering specific, concrete suggestions for what the client should do)? To what extent was the clinician’s style one of telling the client how to be successful in his/her recovery?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item assesses the degree to which the clinician provides unsolicited advice, direction-giving, or feedback about a specific situation rather than drawing out the client’s intentions or plans (“I think the best thing for your sobriety is to move out of your parent’s house.”). In other words, this item should capture situations in which the clinician unilaterally offers specific suggestions, advice, direction, or feedback to the client when the client has not asked for it. This item is distinguished from other directive clinician’s

behaviors such as the provision of objective feedback in a style consistent with MI (Item 10). In general, the clinician typically adopts a prescriptive style of telling the client how to be successful in his/her recovery instead of maintaining a more collaborative, client-centered tone. The message is one of “I’m telling you what to do.”

Importantly, this item should not be scored when the client specifically asks for advice, direction, or feedback. Likewise, if the clinician has explored the client’s ideas for a solution first and seeks the client’s permission to provide feedback before offering information or suggestions, this item is not scored. The key element is that whatever was provided by the clinician was unsolicited. When the clinician’s unsolicited advice or feedback is provided in a very directive, perhaps blunt manner to help the client assess his or her circumstances in more realistic terms, it also would be scored on Item 13 (Direct Confrontation of Client). Depending on the content of the unsolicited feedback, occurrences of this item might also involve other MI inconsistent strategies.

To be *rated highly*, the clinician would give unsolicited advice, direction, education, feedback, or skills training many times throughout the session. A central feature of the session would be the clinician telling the client what he needs to know or do. *Lower ratings* occur when the clinician gives unsolicited advice or direction only once or twice.

EXAMPLES:

Clinician: “I really think you need to tell your family that you used again. You won’t be able to stay clean and sober if you are not honest with the people closest to you in your life.”

“I don’t think you should be hanging out with him. You used to get high with him, and it only will be a matter of time before you start to use again.”

“When I listen to you, it seems like you don’t have enough support from people who can help you when you feel like using. Getting a sponsor might be a good idea. How come you haven’t gotten a sponsor yet?”

SKILL LEVEL RATING GUIDELINES:

HIGHER: To be rated highly, the clinician must present unsolicited advice, direction, or feedback in a confident and clearly articulated manner. The advice and directions are very instructive or prescriptive to the client. While the client may “take it or leave it,” the advice leaves no doubt about the clinician’s recommendations to the client. Providing a rationale to the client about the value of following the advice and direction, particularly when this rationale integrates details of the client’s life into it, improves the quality of the intervention.

LOWER: Lower ratings occur when the clinician provides unclear advice, direction, or feedback or makes recommendations to the client in a tentative manner. The advice or suggestions also may not be relevant to the client and, thus, sound like a “party-line” instead of individualized to the client’s unique circumstance.

12. EMPHASIS ON ABSTINENCE: *To what extent did the clinician present the goal of abstinence as the only legitimate goal and indicate that a controlled use goal was not acceptable or completely unrealistic? How much did the clinician seek to impose his/her judgment about the goals of abstinence and emphasize that abstinence was considered to be the necessary standard for judging any improvement during treatment?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item refers to the extent to which the clinician explicitly discussed the rationale for absolute abstinence and was unequivocal in his/her recommendation of abstinence as the only acceptable goal for treatment. In this process of emphasizing abstinence, the clinician also typically articulates the disadvantages or dangers of having a treatment goal of reducing substance use. Typically, this item is meant to capture instances when the clinician seeks

to impose his/her judgment about the goals of abstinence and emphasizes that abstinence is considered the necessary standard for judging any improvement during treatment.

Although the clinician may praise smaller improvements in other areas of a client's functioning, the clinician remains much more focused on whether the client has stopped using substances completely. Likewise, the clinician may acknowledge a reduction in use or that some substances have been stopped (e.g., cocaine cessation with episodic marijuana or alcohol use), but not accept this outcome as a clear sign of progress until the client initiates complete abstinence. As a concrete example, the clinician might praise one week of complete abstinence with no change in other life areas more than a longer period of significantly reduced use accompanied by some life improvements. The clinician sees a harm reduction goal as unacceptable and dangerous because it communicates a false sense of control over addictive substances and keeps the individual in a state of being active in his/her addiction and prone to full relapse and deterioration.

EXAMPLES:

Clinician: "You cannot control your drinking by trying to drink less. If you pick up one drink, you will lose control and be right back where you started."

"It's great that you didn't smoke weed last week, but you drank beer and that concerns me because you used to smoke and drink together a lot. They're connected, and soon you will be smoking weed again unless you commit to total abstinence."

Skill Level Rating Guidelines:

HIGHER: Higher quality emphasis on abstinence occurs when the clinician provides a clear, persuasive, and confident rationale for abstinence to the client and attempts to compel the client to adopt total abstinence as the central treatment goal. The clinician's message is loud and clear: complete abstinence from substances is the

only realistic and acceptable treatment goal; controlled or reduced use is dangerous. The clinician corrects notions that controlled use, drug or product substitution (e.g., near-beer), or other harm reduction approaches are feasible treatment goals for the client. When done well, the clinician makes the point through the client's own substance use history, clinical examples or anecdotes, or references to treatment approaches and clinical consensus that emphasizes total abstinence.

LOWER: Lower ratings occur when the clinician appears to be giving "lip service" to total abstinence without conviction or a convincing rationale. The emphasis, while mentioned, is downplayed or casually suggested rather than at the forefront of the clinician's approach to substance abuse treatment. A lower rating also occurs when the rationale is more rooted in an administrative policy ("Our clinic requires sustained abstinence to complete the program and any positive urines get reported to your probation officer.") rather than based on the clinician's philosophical conviction or the client's reported pattern of uncontrolled use.

13. DIRECT CONFRONTATION OF CLIENT:

To what extent did the clinician directly confront the client about his or her failure to acknowledge problems or concerns related to substance use and other behavioral difficulties (e.g., psychiatric symptoms, lying, treatment noncompliance)? To what extent did the clinician directly confront the client about not taking steps to try to change identified problem areas?

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

For this item, confrontation is defined as any clinician statement or series of statements that involve telling the client what he or she has not acknowledged or needs to know and accept. The message of the clinician's communication is clear: "I

know better than you, and I am telling you what you haven't realized." The clinician's statement is a call to the client to see his or her situation in more realistic terms. Often, the clinician's confrontations will be blunt or, at times, dramatic, although it does not need to occur in a flamboyant manner. It may also occur in a lecturing style designed to impart information to the client. However delivered, the confrontation in essence indicates to the client how they are in ignorance or in denial about a problem or need to acknowledge and accept the problem if the client is to improve. Although an affectively charged interaction may ensue between clinician and client, in most cases, it should be clear that the clinician's assertive involvement is motivated by his/her concern over the destructiveness of the client's current behavioral pattern. Although shouting would be considered counter-therapeutic, a confrontational interaction may sound more like a controlled argument or disagreement. The disagreement often revolves around the clinician's use of a label (alcoholic, addict, dry drunk, in denial) to which the client objects. It will also often involve discussion of the client's resistance to recognizing a problem, lying, or non-compliance as indicators of denial.

A *higher score* should usually be given when the confrontation of denial or defensiveness is raised several times or for a sustained period of the session. This intervention does not need to be successful (reducing denial) to be rated high on the Frequency and Extensiveness scale. What matters more is how much the clinician uses direct confrontation as the main therapeutic tool. *Lower ratings* occur when the clinician seldom makes use of confrontational strategies.

EXAMPLES:

Clinician: "Look. Your urine screen is positive for cocaine. You say you haven't used cocaine in over a week. I think you are in denial. Denial will only continue to feed your addiction and ruin your life. If you really want to change your life, then you should start by being honest with me and, more importantly, with yourself."

"I think the reason you are giving me is just an excuse. Think about what you were willing to do for your addiction. Think about all the time, effort, and money you put into getting high. You'd do anything to get your drugs. How come you are not willing to do anything for your recovery?"

"I don't think that's quite right what you are saying."

"Let me give you some information that might help you understand what you are having a hard time seeing right now."

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher Skill Level use of confrontational strategies occurs when the clinician is clear, concise, and firm with the client about the client's defensiveness in talking about his/her substance use and related areas as problems. The clinician persists in pointing out the client's denial and tries to use the confrontation to get the client to acknowledge the problem and deal with it in more realistic terms, even if the client initially becomes more defensive. In addition, higher quality confrontational strategies involve when a clinician tries to compel the client to change his behavior in addition to his/her mind ("walk the talk" instead of "talk the talk").

LOWER: Low Skill Level confrontational strategies insufficiently challenge the client's distortions about his/her substance use and related life circumstances. Rather than persisting in confronting a resistant client, the clinician retreats from the confrontation and may adopt less confrontational approaches to resolve the resistance. Also, a clinician's reference to the client's denial or defensiveness without effort to "break through" it (e.g., "A lot of addicts get dirty urines and say the lab must have made a mistake. It's a sign that you are still in denial of your addiction.") is lower quality. In short, a lower

confrontation quality rating may be given when the clinician's statements have content that is "confrontational," but lacks the persistent or perhaps tenacious confrontational style at times necessary to change client behavior.

14. POWERLESSNESS AND LOSS OF CONTROL:

CONTROL: *To what extent did the clinician emphasize the concept of powerlessness over addiction as a disease and the importance of the client's belief in this for successful sobriety? To what extent did the clinician express the view that all substance use represents a loss of control or that the client's life is unmanageable when s/he uses substances?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item refers to the extent to which the clinician discussed the disease concept of addiction, in that the client has a chronic, progressive illness which, if not arrested, will lead to further loss of control and physical, mental, social and spiritual damage and eventually insanity or death, much like many other medical diseases. The clinician should refer to the characteristics of the disease as a progressive and predictable loss of control and the importance of accepting this loss of control as an early part of the treatment process and necessary for successful long-term sobriety. Any and all episodes of substance use are regarded as symptoms of a loss of control process in which the client's life will become progressively unmanageable when s/he uses substances.

This discussion will often involve an emphasis on abstinence (and so overlap with Item #11) as the only method of "controlling" or arresting the progression of the disease. This overlap is most apparent when the clinician provides a justification for why abstinence is the only appropriate treatment goal. It may also contain direct confrontation (Item #13) as a means of getting the concept of powerlessness across to the client. Often, the clinician will state that if a client takes even one drink or drug, he/she inevitably will lose control and have a full-blown relapse.

EXAMPLES:

Clinician: "Remember that if you use again, you most likely will pick up where you left off. Most addicts have found that they rapidly return to using as much or more than they had in the past. Before they know it, their lives fall apart very quickly and the hole they have dug only becomes deeper."

"You seem to understand very clearly that you are powerless over your addiction...that one drink is too much and a thousand are never enough. Clearly, that has been your experience time and time again and you are getting tired of it."

"Your addiction will progress. Every bottom has a trap door, except death. Are you willing to take this chance?"

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher quality ratings occur when the clinician provides a clear and convincing discussion of the disease concept of addiction. This discussion would involve a thorough detailing of how drug and alcohol addiction is a primary, progressive, and chronic process that ultimately severely damages a person's life in all areas and, if left unchecked, will lead to "jails, institutions, and death." Higher ratings also may occur when the clinician directly applies the principles to the client's history and presenting problems. In short, a clinician who persuasively "makes the case" that the client is powerless over addiction and inevitably will lose control of his/her life receives a higher Skill Level rating on this item.

LOWER: Lower Skill Level ratings occur when the clinician merely mentions (even repeatedly) the disease concept of addiction, powerlessness, or loss of control without really explaining what these principles mean or the implications of them for the client. The presentation of the concepts of

powerlessness or loss of control sounds formulaic and untied to the nature and circumstances of the client's substance use problem.

15. ASSERTING AUTHORITY: *To what extent did the clinician verbalize clear conclusions or decisions about what course of counseling would be best for the client? How much did the clinician warn that recovery would be impeded unless the client followed certain steps or guidelines in treatment? To what extent did the clinician try to lecture the client about “what works” about treatment or the likelihood of poor outcome if the client tried to do his/her own treatment? To what extent did the clinician refer to his or her own experiences, knowledge, and expertise to highlight the points made to the client?*

FREQUENCY AND EXTENSIVENESS RATING

GUIDELINES:

This item refers to the degree to which the clinician dominates the direction of the counseling session by promoting his or her treatment agenda rather than trying to elicit the client's goals for treatment. A key component to rating this item is that the clinician must somehow communicate that following the pre-established goals of the clinician or treatment program is necessary for progress to occur. Furthermore, the clinician may actually discourage the client from “writing his or her own treatment plan” and to instead stick with what is known to be effective for promoting sobriety or recovery. The clinician may lecture the client about what does and does not work in addiction treatment and warn that recovery will be impeded and outcome will be poor if the client follows their own rather than the usual guidelines in treatment. For this item to be rated, an explicit or implicit message must be communicated that the clinician is more knowledgeable about addiction and recovery and in a position of greater power or expertise relative to the client.

This item very often will be associated with high ratings on Item 11 (Unsolicited advice/direction-giving...). It might also accompany the clinician's

use of direct confrontation (Item 13). However, a clinician might not invoke therapeutic authority when providing direct advice or direction or when confronting a client. The key element for this item is the promotion of the clinician's authority via his or her position, expertise, or personal experience. For example, a clinician might say, “I start the group at 5 pm sharp. I won't allow anyone to attend the group once we begin, unless you let me know in advance.”

To be *rated highly*, the clinician must frequently control the flow of the session by introducing topics to be discussed or redirecting the client to the tasks at hand. A moderate rating might be given when a clinician is obviously following a treatment manual and makes references to what needs to be done next or which handouts, practice exercises, and homework need to be completed. A *very low rating* would be given if the clinician remains more client-centered and rarely asserts authority during the session.

EXAMPLES:

Clinician: “I know what you are going through. I've been there myself, and I had to struggle with the same feelings. But I quickly learned that I could not do it myself. I had to involve other people in recovery into my life for me to get better. That's what you need to do too.”

“Take my advice. Don't go see your parents right now. You told me you most likely will have a big argument with them and feel like getting high afterwards. Is that what you want after all the time and effort you have put into being clean and sober?”

“You really need to show up on time. A lot of other people would like to get treatment for their addictions here. If you are not able to make your treatment a priority, I will discharge you, and you can call me back in 30 days if at that time you feel you are ready to address your drug abuse in a more serious way.”

SKILL LEVEL RATING GUIDELINES:

HIGHER: To receive higher ratings, the clinician provides directives and recommendations with confidence and clarity. The clinician also may reference his or her scientific knowledge base, clinical experience, or personal recovery to fortify therapeutic authority during the session and to underscore the need for the client to follow the clinician's directions. The clinician's more prescriptive tone aims to promote the client's compliance with the clinician's recommendations and improve the client's treatment outcomes rather than merely to assert power and control over the client.

LOWER: Lower Skill Level ratings occur when the clinician softens an assertion of authority by seeking the client's input, guidance, or approval for what the clinician has said. The initially prescriptive tone yields to a collaborative one. As a result, rather than the clinician driving the treatment recommendations, the client has excessive input into their development, despite the client's potentially poor judgment about what might be best for him or her.

OPTIONAL MI INCONSISTENT ITEM

Supervisors may have an interest in tallying the number of times clinicians use closed-ended questions. Overuse of questions, and closed-ended questions in particular, tend to diminish the amount of time a client talks spontaneously by creating a question-answer trap between the clinician and client. It also limits how much a client may elaborate on his or her motivation for change in that closed-ended questions pull for terse answers. In short, by relying too heavily on closed-ended questions, the clinician teaches the client to only respond when prompted by the clinician and to only answer the specific question (Miller & Rollnick, 2002). Also, because the overall spirit of MI depends upon a highly empathic counseling style in which the majority

of the clinician's speech is dominated by reflective statements rather than questions, keeping track of the clinician's use of closed-ended questions is important. This item, however, was not included in the CTN protocol's tape rating system, although protocol supervisors commonly monitored it. The extent to which it contributes to the MI Inconsistent dimension is unknown. Nonetheless, given the clinical importance of monitoring closed-ended questions as a means to hone a clinician's MI skill, we provide it here as an optional rating item. We encourage supervisors to use this item initially with clinicians to determine if the overuse of closed-ended questions is a supervisory issue. If a clinician consistently limits his or her use of closed-ended questions and predominantly relies on open-ended ones when querying a client, the supervisor may choose not to continue to rate this item.

16. CLOSED-ENDED QUESTIONS: *To what extent did the clinician ask questions that could be answered with a yes or no response or that sought after specific details or information from the client?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item measures the extent to which the clinician uses closed-ended questions during the interview. These questions typically seek very specific answers or information. Often the client can answer them with a “yes” or “no” response. The questions leave little room for client elaboration. Often clinicians use them to “get to the point” or to acquire information the clinician deems as necessary for the purposes of evaluation and treatment. They typically begin with the interrogative stems: “Could/can you? Do/did you? Are you? Have you? Where? When?”

A higher Frequency/Extensiveness rating would be achieved if the clinician asks numerous questions that seek specific information or brief yes/no responses (see Correct Examples) as opposed to asking questions that are open-ended (see Incorrect Examples). Lower ratings occur when the clinician asks very few questions or almost all open-ended ones.

EXAMPLES:

Correct:

- Do you use marijuana? When was the last time you used?
- Can you tell me how heroin affects you?
- Your wife thinks you are addicted to cocaine. Are you addicted to cocaine?

Incorrect

- So, what brings you here today?
- What are some of the ways that substance use affects your life?"
- What kinds of differences have you noticed in...?

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher quality closed-ended questions pull the client to answer the question specifically asked rather than giving the client leeway to elaborate on a topic or area. They occur in close succession as they follow-up on one another. When performed well, closed-ended questions establish that the clinician is in control of the session and in the role of the expert trying to discern information important for clinical assessment/evaluation and treatment. High quality closed-ended questions are very clear and direct, thereby minimizing any confusion a client may have about what the clinician has asked and wants to know.

LOWER: Lower quality ratings occur if the clinician's questions are overly complex due to the clinician asking the client several matters in one question or stringing together many closed-ended questions before permitting the client to answer them. Consequently, the specificity of the client's answer may be lost in the client's inability to recall the question or in considering what part of the question to answer first.

GENERAL RATINGS OF CLIENT MOTIVATION

The aim of a MI session is for the clinician to collaboratively work with the client to build and strengthen the client's motivation for change. Helping the clinician attend to shifts in motivation over the course of the session by recognizing the relative balance of change talk and resistance is an important skill in MI. Likewise, strategically using core MI consistent skills (open-ended questions, affirmations, reflections, and summaries or the OARS) and directive methods for eliciting change talk or for handling resistance skillfully to facilitate motivation for change are additional critical MI skills. While using these MI strategies, the clinician follows the client's lead in the discussion and listens carefully for shifts in motivation as a means to guide his or her next intervention. Items 17 and 18 allow the supervisor to track how the client's motivation changes from the beginning to end of the session and provides a mechanism for giving the clinician feedback about how the clinician's use of MI strategies may have affected this process.

17. MOTIVATION – BEGINNING: *How would you rate the client's stage of change or motivation at the beginning of this session?*

18. MOTIVATION – END: *How would you rate the client's stage of change or motivation at the end of this session?*

Motivation is the readiness and commitment the client demonstrates to change his or her substance use behaviors.

RATING	DEFINITION
1	NOT AT ALL. The client does not believe he/she has a substance use problem. The client resists the clinician's efforts to identify substance use as problematic or concerning. The client believes no changes are necessary and shows no initiative to change his/her behavior

RATING	DEFINITION	RATING	DEFINITION
2	VERY WEAK. The client acknowledges a few problematic aspects of his/her substance use and considers the clinician's questions and comments. However, the client concludes substance use is relatively non-problematic and no changes are necessary. If the client has initiated any changes in substance use or related behaviors, the client made these changes under coercion or as a temporary measure to reduce the pressure from others to change.		anticipates significantly greater benefits than costs through cessation or reduction. The client makes a commit to a change plan, expresses some optimism about his/her capacity to change, and may have begun to self-initiate specific change efforts.
3	WEAK. The client is highly ambivalent about the problematic aspects of his/her substance use. The client engages with the clinician during the session, but vacillates in his/her position that substance use is a problem. If a client states a desire to change, this desire is counterbalanced with skepticism about his/her capacity to change and the options available to produce it. The client approaches any initial change efforts with only slight commitment and fluctuating willingness to follow-through.	6	VERY STRONG. The client firmly believes he/she has a substance use problem. The client shows little resistance to change and very openly and collaboratively talks with the clinician. The client sees the relative benefits of changing his/her substance use as much greater than any benefits that might accrue from continued status quo patterns of use. The client makes the argument for change with little assistance from the clinician. The client most likely has begun to change substance use behaviors and speaks positively about these initial experiences. The client is clearly hopeful and optimistic about his/her capacity to sustain a change plan.
4	ADEQUATE. The client believes he/she has a substance use problem but continues to acknowledge some significant benefits to use and anticipated difficulties in cessation. The client wants to make changes in his/her substance use patterns (abstinence or reduced consumption) and commits to an initial plan for change. While not skeptical, the client is uncertain about his/her capacity to sustain change and the outcomes of these efforts.	7	EXTREMELY STRONG. The client emphatically believes he/she has a substance use problem. The client shows no resistance to change and works very openly and collaboratively with the clinician. The client is very thoughtful and earnest in his/her assessment of prior substance use and very clear and convincing about how these experiences underpin his/her current reasons for change. The client expresses determination to change his/her behavior and has begun to initiate his/her change plans.
5	STRONG. The client believes he/she has a substance use problem. The client responds well to the clinician's efforts to manage any client resistance that arises during the session. The client cooperatively discusses both positive and negative aspects of substance use and firmly		

FORMS – MASTERS

MOTIVATIONAL INTERVIEW RATING WORKSHEET

RATING ITEM	ADHERENCE: FREQUENCY & EXTENSIVENESS	COMPETENCE: SKILL LEVEL COMMENTS
1. MI Style or Spirit (p.105)		
2. Open-ended Questions (p. 106)		
3. Affirmation of Strengths & Self-efficacy (p. 107)		
4. Reflective Statements (p. 108)		
5. Fostering a Collaborative Relationship (p. 109)		
6. Motivation to Change (p. 110)		
7. Developing Discrepancies (p. 111)		
8. Pros, Cons, and Ambivalence (p.112)		
9. Change Planning Discussion (p. 113)		
10. Client-centered Problem Discussion and Feedback (p. 114)		

RATING ITEM	ADHERENCE: FREQUENCY & EXTENSIVENESS	COMPETENCE; SKILL LEVEL COMMENTS
11. Unsolicited Advice, Direction Giving & Feedback (p. 115)		
12. Emphasis on Abstinence (p. 116)		
13. Direct Confrontation of Client (p.117)		
14. Powerlessness and Loss of Control (p. 119)		
15. Asserting Authority (p. 120)		
16. Closed-ended Questions (p. 121)		

ALWAYS CONSULT RATING GUIDE WHEN TRANSFERRING FROM WORKSHEET TO RATING FORM, ESPECIALLY WHEN UNCERTAIN.

ADHERENCE RATINGS: FREQUENCY AND EXTENSIVENESS

NOTATION	BEHAVIOR OCCURRED	RATING
None	Never occurred =	Not at all (1)
/	Once but not in depth =	A little(2)
//	More than once, but not in depth =	Infrequent(3)
Ø	Once and in some depth =	Somewhat(4)
Ø//	More than once and once in depth =	Quite a bit (5)
Ø/Ø	More than once in depth =	Considerably (6)
Ø Ø Ø / Ø Ø	Dominated session, many times in depth =	Extensively (7)

COMPETENCE RATINGS: SKILL LEVEL

BEHAVIOR	RATING
Unacceptable, unprofessional =	Very poor (1)
Lack of expertise, competence =	Poor (2)
Fair; below average =	Acceptable (3)
Average =	Adequate (4)
Above average =	Good (5)
Skill and expertise shown =	Very good (6)
High level of mastery =	Excellent (7)

**MOTIVATIONAL INTERVIEWING
ADHERENCE AND COMPETENCE FEEDBACK FORM**

MI Consistent Items	Adherence Rating*							Competence Rating**							
	1	2	3	4	5	6	7	NA	1	2	3	4	5	6	7
1 MI Style or Spirit															
2 Open-ended Questions															
3 Affirmations of Strengths & Self-efficacy															
4 Reflective Statements															
5 Fostering Collaboration															
6 Motivation to Change															
7 Developing Discrepancies															
8 Pros, Cons and Ambivalence															
9 Change Planning Discussion															
10 Client-centered Problem Discussion and Feedback															
MI Inconsistent Items															
11 Unsolicited Advice, Directions & Feedback															
12 Emphasize Abstinence															
13 Direct Confrontation															
14 Powerlessness, Loss of Control															
15 Asserting Authority															
16 Closed-ended Questions															

*ADHERENCE: 1 – Not at all 2 – A little 3 – Infrequent 4 – Somewhat 5 – Quite a bit 6- Considerably 7 – Extensively

** COMPETENCE: 1 – Very poor 2- Poor 3 – Acceptable 4 – Adequate 5 – Good 6 – Very Good 7 - Excellent

MI SKILLS DEVELOPMENT PLAN

Name:

Date:

Strengths Demonstrated in Session			
Skill Development			
MI Skill Targeted for Improvement	What specifically will be developed or improved?	How will the goal be reached?	Date of next supervision
1.			
2.			
3.			

MOTIVATIONAL INTERVIEWING CLINICIAN SELF-ASSESSMENT REPORT

INSTRUCTIONS: Listed below are a variety of Motivational Interviewing consistent and inconsistent skill areas. Please rate the degree to which you incorporated any of these strategies or techniques into your session with your client. Feel free to write comments below each item about any areas you want to discuss with your supervisor. For each item please rate your best estimate about how frequently you used the strategy using the definitions for each scale point.

1	(NOT AT ALL)	Never used the strategy
2	(A LITTLE)	Used the strategy 1 time briefly
3	(INFREQUENTLY) ..	Used the strategy 2 times briefly
4	(SOMEWHAT)	Used the strategy 3-4 times briefly or once or twice extensively
5	(QUITE A BIT) ...	Used the strategy 5-6 times briefly or thrice extensively
6	(CONSIDERABLY) ..	Used the strategy during more than half of the session
7	(EXTENSIVELY)	Use of the strategy almost the entire session

MOTIVATIONAL INTERVIEWING CONSISTENT ITEMS

1. MOTIVATIONAL INTERVIEWING STYLE OR SPIRIT: To what extent did you provide low-key feedback, roll with resistance (e.g., avoiding arguments, shifting focus), and use a supportive, warm, non-judgmental, collaborative approach? To what extent did you convey empathic sensitivity through words and tone of voice, demonstrate genuine concern and an awareness of the client’s experiences? To what extent did you follow the client’s lead in discussions instead of structuring the discussion according to your agenda?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

2. OPEN-ENDED QUESTIONS: To what extent did you use open-ended questions (i.e., questions or requests that elicit more than yes/no responses) to elicit the client’s perception of his/her problems, motivation, change efforts, and plans? These questions often begin with the interrogatives: “What,” “How,” and “In what” or lead off with the request, “Tell me...” or “Describe...”

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

3. AFFIRMATION OF STRENGTHS AND CHANGE EFFORTS: To what extent did you verbally reinforce the client’s strengths, abilities, or efforts to change his/her behavior? To what extent did you try to develop the client’s confidence by praising small steps taken by the client in the direction of change or by expressing appreciation for the client’s personal qualities that might facilitate successful change efforts?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

4. REFLECTIVE STATEMENTS: To what extent did you use reflective listening skills such as repeating (exact words), rephrasing (slight rewording), paraphrasing (e.g., amplifying the thought or feeling, use of analogy, making inferences) or making reflective summary statements of what the client says?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

5. FOSTERING A COLLABORATIVE ATMOSPHERE: To what extent did you convey in words or actions that counseling is a collaborative relationship in contrast to one where you are in charge? How much did you emphasize the (greater) importance of the client’s own decisions, confidence, and perception of the importance of changing? To what extent did you verbalize respect for the client’s autonomy and personal choice?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

6. MOTIVATION TO CHANGE: To what extent did you try to elicit client discussion of change (self-motivational statements) through evocative questions or comments designed to promote greater awareness/concern for the problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change? To what extent did you discuss the stages of change, help the client develop a rating of current importance, confidence, readiness or commitment, or explore how motivation might be strengthened?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

7. DEVELOPING DISCREPANCIES: To what extent did you create or heighten the internal conflicts of the client relative to his/her substance use? To what extent did you try to increase the client’s awareness of a discrepancy between where his or her life is currently versus where he or she wants it to be in the future? How much did you explore how substance use may be inconsistent with a client’s goals, values, or self-perceptions?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

8. PROS, CONS, AND AMBIVALENCE: To what extent did you address or explore with the client the positive and negative effects or results of his or her substance use and what might be gained and lost by abstinence or reduction in substance use? To what extent did you conduct a decisional balance activity consisting of a cost-benefits analysis or list of pros and cons of substance use? How much did you develop and highlight the client’s ambivalence, support it as a normal part of the change process, and reflect back to the client the mixed thoughts and feelings that underpin the client’s ambivalence?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

9 CHANGE PLANNING DISCUSSION: To what extent did you develop a change plan with the client in a collaborative fashion. How much did you cover critical aspects of change planning such as facilitating discussion of the client’s self-identified goals, steps for achieving those goals, supportive people available to help the client, what obstacles to the change plan might exist, and how to address impediments to change?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

10. CLIENT-CENTERED PROBLEM DISCUSSION AND FEEDBACK: To what extent did you facilitate a discussion of the problems for which the client entered treatment instead of directing the conversation to problems identified by you but not by the client? To what extent did you provide feedback to the client about his or her substance use or problems in other life areas only when solicited by the client or when you explicitly sought the client’s permission first?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

MOTIVATIONAL INTERVIEWING INCONSISTENT ITEMS

11. UNSOLICITED ADVICE, DIRECTION-GIVING, OR FEEDBACK: To what degree did you provide unsolicited advice, direction, or feedback (e.g., offering specific, concrete suggestions for what the client should do)? To what extent was your style one of instructing the client how to be successful in his/her recovery?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

12. EMPHASIS ON ABSTINENCE: To what extent did you present the goal of abstinence as the only legitimate goal and indicate that a controlled use goal was not acceptable or realistic? How much did you try to definitively emphasize a goal of abstinence or reinforce abstinence as a necessary standard for judging any improvement during treatment?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

13. DIRECT CONFRONTATION OF CLIENT: To what extent did you directly confront the client about his or her failure to acknowledge problems or concerns related to substance use or other behavioral difficulties (e.g., psychiatric symptoms, lying, non-compliance with treatment)? To what extent did you directly confront the client about not taking steps to try to change identified problem areas?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

14. POWERLESSNESS AND LOSS OF CONTROL: To what extent did you emphasize the concept of powerlessness over addiction as a disease and the importance of the client’s belief in this for successful sobriety? To what extent did you express the view that all substance use represents a loss of control or that the client’s life is unmanageable when he or she uses substances?

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

15. ASSERTING AUTHORITY: To what extent did you verbalize clear conclusions or decisions about what course of counseling would be best for the client? How much did you warn the client that recovery would be impeded unless the client followed certain steps or guidelines in treatment? To what extent did you tell the client about “what works” best in treatment or the likelihood of poor outcome if the client tried to do his/her own treatment? To what extent did you refer to your own experiences, knowledge, and expertise to highlight the points you made to the client?

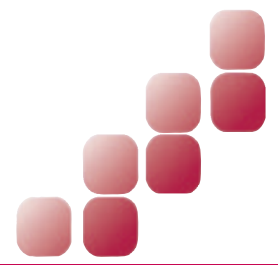
... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

16. CLOSED-ENDED QUESTIONS: To what extent did you ask questions that could be answered with a ‘yes’ or ‘no’ response or that sought very specific answers, details, or information about the client’s past or current behavior and circumstances? These questions typically begin with the interrogative stems: “Could/can you,” “Do/did you,” “Are you,” or “Have you.”

... 1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____



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