Evaluation Report

Impact of a two day 'Introduction to Motivational Interviewing' training

Chesterfield Royal Hospital

Report authors: Dr Fiona Holland and Dr Caroline Harvey
School of Psychology
University of Derby
f.g.holland@derby.ac.uk
c.harvey@derby.ac.uk

Table of Contents

1. Introduction

This report summarises the impact of a 2-day Introduction to Motivational Interviewing (MI) training that was delivered in March and April 2022. The training was designed to meet the needs of a variety of hospital staff within cancer care including roles such as occupational therapy, physiotherapy, nursing, hospice volunteering and estate management. The two training days were offered to two groups and were scheduled to allow a gap of two weeks between trainings to support the attendees to practise their skills. The training was hosted by the University at the Chesterfield Campus.

Motivational Interviewing is defined as purposeful conversation directed at a particular change goal. It is a more directive form of client-centred counselling, with a foundation built upon practitioner empathy and client autonomy. It involves practitioners having competence in a well-defined set of strategies and skills. The MI practitioner establishes rapport, pays attention to a client's speech and language, and aims to elicit a client's own arguments for change. MI skills help practitioners support people to keep moving through the natural process of resolving ambivalence towards changes they have identified [1]. MI was developed from practise in drug and alcohol rehabilitation however over the past thirty years, it has been used in a wide variety of settings including healthcare, lifestyle change (e.g., physical activity promotion, nutrition), social justice, dentistry, and education [1]. MI conversations are fruitful, particularly with clients/patients who are beginning to contemplate change as they are encouraged to own the changes and self-select doable steps towards action. MI has been employed by health care practitioners in interventions within cancer care, for example to enhance cancer screening uptake [2], to help patients adhere to therapy [3], to enhance physical activity in breast cancer survivors [4] and to help with the management of cancer -related fatigue [5].

The training and evaluation was commissioned by the Chesterfield Royal Hospital. The goal was to use an evidence-based behaviour change approach to support patients undergoing cancer treatment or cancer care. In particular, MI was considered a useful approach to support staff in employing relational and technical skills when working with patients (even those who were ambivalent about their health behaviours), to help them discuss their care, and in some cases, make decisions, and/or lifestyle changes.

The training was designed and facilitated by Dr Fiona Holland from the Psychology and Behaviour change team at the University of Derby. Fiona is a certified MI trainer and member of the Motivational Interviewing Network of Trainers. She also teaches on the MSc in Behaviour Change at the University and has a background in applied health promotion and lifestyle change. Fiona worked with Sheree Hall to create a delivery plan and evaluation strategy. The format of delivery combined two day-long workshops which included mini lectures, discussion, demonstrations, interactive group work and skills practise. Each day entailed 6 hours of learning time. Participants' practical skills were not formally assessed by the facilitator.

The course covered the foundational skills of building rapport, empathic listening, using skilful open questions, reflections, affirmations and summaries. It also included giving information in an MI-consistent way, identifying and evoking 'change talk' and strategies for planning and goal setting with clients.

There were more people interested in the training than could attend (hence the baseline survey had 20 people respond). 18 people attended in total. 15 people attended and completed both days of the training, 1 person completed 1.5 days, and 2 people attended 1 day (the first day only).

2. Evaluation methodology

The evaluation methodology design and analysis was conducted by Dr Fiona Holland and Dr Caroline Harvey. Surveys were sent out via email to participants at three time points. If people had not received the email for some reason, a QR code with a link to the survey was available at the training, so participants could complete Time 1 and Time 2 that way if needed.

Surveys were completed by those interested in attending prior to day 1 (Time 1- baseline), at the end of their second day of training (or for those who did 1 or 1.5 days, they completed this at this time too) (Time 2-immediately post training), and all were asked to complete the survey again 6 weeks after training (Time 3-follow up). The data was collected via Qualtrics, a secure online data base hosted by the university. No names or identifying features of participants were gathered.

The survey consisted of closed and open -ended questions. Closed questions asked about confidence in talking to patients about behaviour change, usefulness of MI in practise and confidence level in using MI. Open questions asked about previous training, evaluation of the training, considerations for future support, and asked attendees to respond to a case study to capture their MI-adherent responses.

3. Results

20 Participants answered the baseline survey at Time 1

19 participants answered the immediate post-training survey at Time 2

5 participants answered the post-practise survey at Time 3

Previous Experience

Participants were asked about any previous training in Motivational Interviewing- only one person reported that they had experience via an introductory training ten years ago.

Closed questions

The participants were asked three questions about their practise and utility of MI across all three time points, these were as follows:

Question 1. Overall, how confident do you feel in talking with patients about behaviour change?

Question 2. How useful do you feel MI is in your practise?

Question 3. How would you rate your overall confidence level in using MI? (Time 1)/using MI basic skills since your recent training with Fiona Holland? (Times 2 and 3).

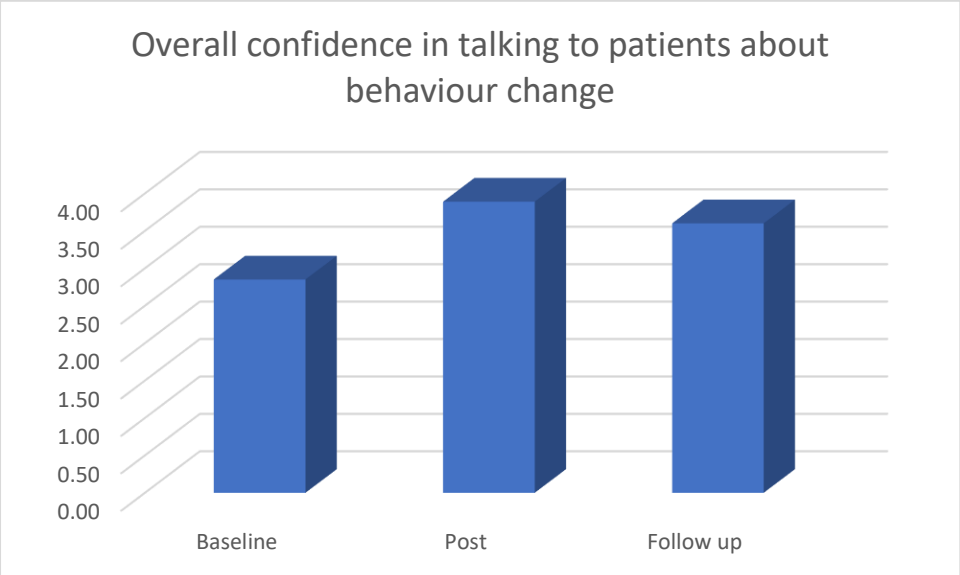
These were scored on a Likert scale, with lower scores indicating a lack of confidence or usefulness, mid points of 3 indicating 'somewhat confident'/neutral and scores of 5 indicating extremely confident/useful. Means across the group were used to track change over time. These are summarised in Table 1 below.

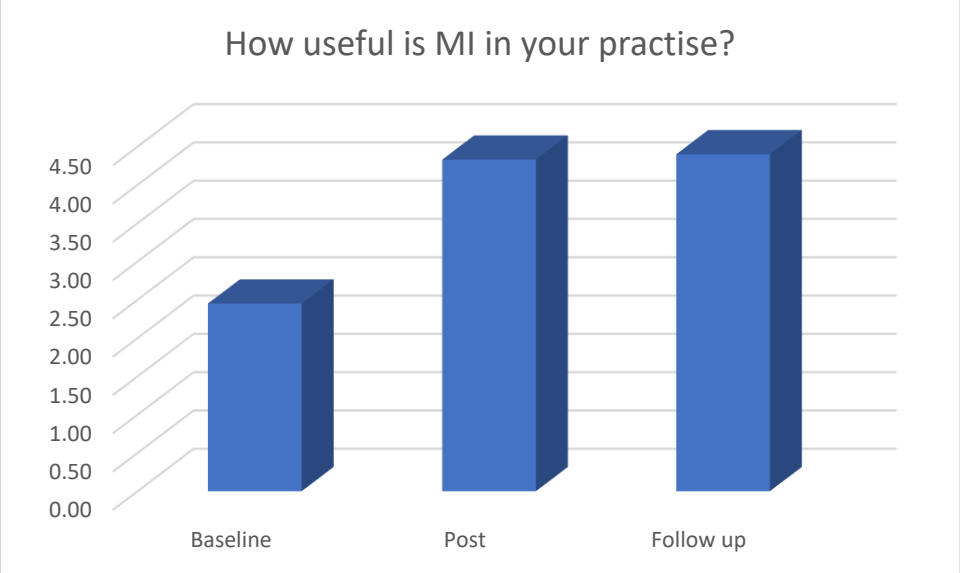
Table 1. Means across three time points for initial closed questions

	Time 1 (n=20) Mean (sd)	**Time 2 (n=9) Mean (sd)**	**Time 3 (n=5) Mean (sd)**	**Change Time 1 to Time 2** ***(Baseline to end of workshops)***	**Change Time 1 to Time 3** ***(Baseline to 6 weeks post-training)***
Overall, how confident do you feel in talking with patients about behaviour change? *1 Not at all confident, 2 Slightly confident, 3 Neutral/somewhat confident, 4 Moderately confident, 5, Extremely confident*	2.85 (0.93)	3.89 (0.78)	3.60 (1.14)	+1.04	+0.75
How useful do you feel MI is in your practise? *0, I'm not aware of MI, 1 Not useful at all, 2 Slightly useful, 3 Neutral, 4 Moderately Useful, 5, Extremely Useful*	2.45 (2.14)	4.33 (0.50)	4.40 (0.55)	+1.88	+1.95
How would you rate your overall confidence level in using MI?/MI basic skills since your recent training with Fiona Holland? *0, I'm not aware of MI, 1 Not at all confident, 2 Slightly confident, 3 somewhat confident, 4 Moderately confident, 5, Extremely confident*	2.17 (1.34)	3.67 (0.50)	3.60 (0.89)	+1.5	+1.43

Across all three questions, increases were seen from time one to time 2, and although there was a slight decrease to time 3 in two of the measures, all showed an increased from time 1 to time 3.

These changes are also demonstrated in the following graphs:





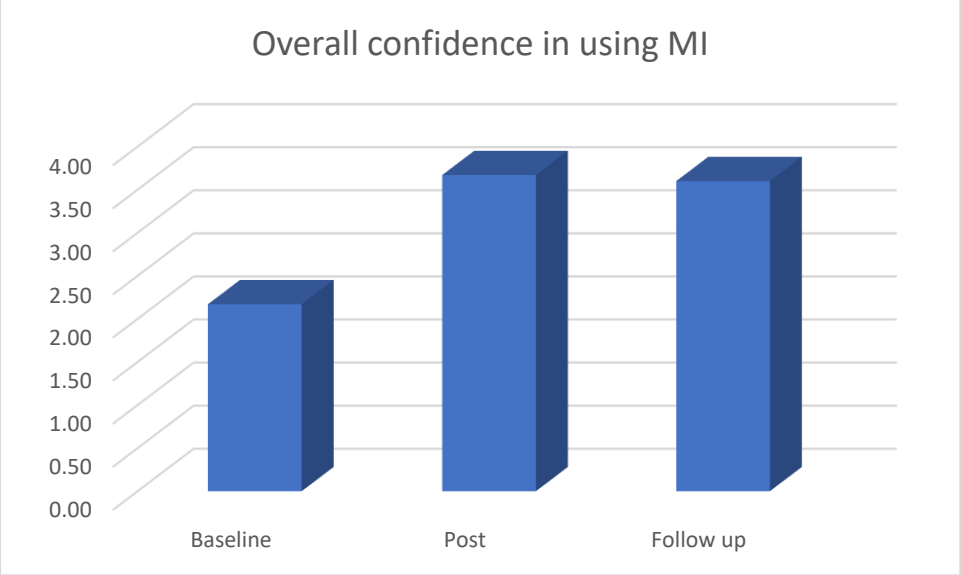


Figure 1: Graphs of mean change over 3 time points for the three closed questions

More specifically we saw participants' confidence in talking to people about behaviour change moving from the higher end of 'not at all confident' range to the higher end of the 'somewhat confident' range after their training. This confidence dropped slightly by follow up, but was still higher than their baseline levels.

There was a positive change in their perceptions of the usefulness of MI in their practise, with scores moving from the 'slightly useful' range to the 'moderately useful' immediately after the training and this mean score increased slightly further when participants were back in their work and potentially applying their new MI skills.

Their confidence in using MI skills moved from the lower end of the 'slightly confident' range to the 'somewhat confident' range and there was a very small decline in this (from 3.67 to 3.6) after the 6-week post-training period. This is unsurprising, as in the classroom the skills were practised in a supportive environment with peers. Back in the working world, the practitioners were applying their skills with real patients and without skilled supervision or feedback.

The positive changes were encouraging to see. The training was at introductory level, and the focus was not on perfecting their skills, but on introducing them to these and supporting them in trying them out with peers. The participants became aware of the complexity of MI practise, and recognised they were at the beginning point of skill development, and this was reflected in the positive movement upwards in their scoring, and their recognition that skills take time, practise and feedback to develop. This is evident in the qualitative responses highlighted later in the report.

Qualitative results: Case scenario

The participants were given a scenario and asked to respond to it. This question was based on the helpful responses questionnaire [6]:

A 40 year-old woman comes to see you. She has been struggling with stress, lacks energy, has low mood and has been recommended to join a local activity for health programme. You recap a few things on her health history form and notice she is a smoker. When you ask her for a little more detail about her smoking habits, she states:

"I don't know why I can't quit, I know it's bad for my health, but I need to smoke to manage my stress, I've got so much going on in my life – sometimes it feels like it's the only thing that helps me through the day, especially now I'm working from home. I go outside, I don't smoke inside where the kids would breathe it in. It helps to give me some thinking time, a chance to get away from work, the noise, the kids… it just feels like sometimes it's a sanity saver."

You want to say the right thing. What's the NEXT thing you'd say if you wanted to be helpful? Write only one or two sentences below.

The participants were asked to write a sentence or two that indicated what they would say straight after a client said this. Their responses were coded according to the language they used (e.g., open question, reflection) and whether the way they said it conveyed empathy, supported the client's autonomy, whether they gave information in an MI-consistent manner.

This question was designed to assess the styles of response participants used. The training should facilitate responses that are less around offering instant judgement (e.g., that's bad for you, there are other ways you could control your stress), unsolicited advice or 'fixing it' type statements (we have programmes that can help with that), and closed questions (e.g., do you want this to change?). MI-adherent practise moves to use more empathic statements, reflections, open questions and affirmations. MI adherent practise would be to offer an empathic reflection and/or an open question that encourages the client to talk more about positive change for example:

you're under pressure, and smoking offers you a much-needed break. It sounds like you'd like things to be different. What are some of the things you've thought about that could be an alternative? (Complex reflection plus open question that evokes change talk)

or

The stress is getting on top of you. You recognise that smoking isn't good for you or for your kids. How would you like things to be different? (Complex reflection plus open question that evokes change talk).

Only responses that were articulated in a way that was direct speech were coded i.e., if someone said, *" I would ask her more about how it makes her feel"* would not be coded but if someone said, *"how do you feel about your smoking?"* this would be coded as it is direct speech (an open question). Coding was done in line with the MITI 4, a valid and reliable coding tool [7]. The MITI 4 has both technical and relational elements, and coding identifies the *technical skills* employed via behaviour counts (e.g., MI consistent ones such as questions, affirmations, complex and simple reflections, and MI-non adherent ones such as persuasion and confrontation) and the *relational*

elements involved such as showing empathy, developing partnership, cultivating change talk, and softening sustain talk). The MITI 4 is designed to be used on longer conversations, however, it provided a coding template for the short responses given.

Baseline (n=17 responses)

There were 17 coded responses at baseline which showed that the majority of the participants answered in an MI consistent manner. Technically, people used reflections (mostly simple reflections), many asked open questions and relationally, they mostly conveyed empathy and some asked questions that would promote change talk. However, one response was not MI consistent, showing the use of confrontation and judgement. The majority of the participants employed open questions as their main technique for responding, and 4 used reflective statements to convey empathy. There was only 1 complex reflection.

Time 2 (n = 7 responses.)

All were MI consistent. These responses showed an encouraging use of skilful MI, with all responses having reflections, and 6 of them demonstrating the use of more advanced complex reflections which communicated empathy, highlighted ambivalence and/or promoted change talk.

Time 3 (n=4 responses)

All 4 responses again demonstrated the use of an empathetic reflection. 1 complex reflection was used (this is a more advanced skill). They were all MI consistent.

Overall, the participants arrived at day one of the training with strong empathy skills. Most worked hard to learn how to use reflections before questions in their responses. Although their baseline responses were almost all MI adherent, the responses at time 2 revealed more skilful employment of the technical and relational aspects of MI. These were maintained at time 3, although there were fewer complex reflections employed at time 3. The responses showed that they had a good basic understanding of employing reflective listening. However, more training to help them to build upon their skills to use more complex reflections and more evoking questions that elicit change talk would be ideal.

Reflections on practise

Participants were also asked to report anything they had noticed in their practise since attending the MI training at time 2 and time 3.

These are highlighted below:

Time 2 responses:

- *I no longer praise patients in the same way. I use positive statements that highlight what has been done well- more constructive. I also 'ask, offer, ask' rather than just giving my advice or opinion on a treatment method.*
- *Identifying and utilising any change talk to progress conversations*

- *Attempting to use OARS [open questions, affirmations, reflections, summaries] in conversations and to identify what is in it for the other person. Doesn't come natural yet but hoping will do so as I apply more*
- *Taking more time to listen and engage with patients. Using reflections and recognising change talk*
- *I have not yet had the chance to utilise MI but will look forward to giving this a try in my next oncology follow up clinic where weight loss is a subject we often need to discuss to reduce the risk of endometrial recurrence*
- *I am more conscious of allowing people to talk rather than asking too many questions or filling silences. I feel I am a good listener but now I am listening with the intention of using he information to support the conversation and ask an appropriate question or offer an appropriate affirmation*
- *Identifying and focusing on the change talk in order to progress conversations*

Time 3 responses

- *Allowing more time to engage with patients and listening*
- *The way in which we speak with patients about behaviour changes and recommendations*
- *Yes, I have noticed that by utilising the MI approach, patients will often initiate an action themselves without you having to 'problem solve' for them. This allows them to be more in control of the care and I have noticed that they are then more likely to pursue what action it is they have 'identified'*

They were also asked if **anyone else had noticed a change in their approach** at time two and time 3, the responses were as follows:

- *'No, not yet'*
- *students have found it really helpful to observe a different approach to assessing patients. They reflected on the importance of listening and engaging rather than asking too many questions and instructing or offering solutions.*
- *Students noticed I used a different approach to engaging and assessing patients and it helped to discuss the importance of listening in our role*

Reflections on the training and delivery

Participants were asked for feedback on their **experience at the training** (e.g., logistics, activities, trainer) and how useful they felt it was in supporting professional skills in practise. The feedback was as follows:

- *It was really useful completing role plays*
- *Very useful sessions, interactive sessions which work well for me*
- *Overall excellent sessions and useful to put into practice within my role*
- *Good to be 2 weeks apart to allow time to reflect and try out. Pace of days was good with lots of opportunities to practise*

- *The training was excellent and delivered at a comfortable pace with plenty of opportunities to practise the skills with each other. The 2-week gap between sessions was useful to give me an opportunity to put some of the skills into practise and reflect and feedback on it*
- *Lovely, relaxed environment makes you feel at ease. The trainer has a clear passion for MI which always provides a better feel for the training course, the length of the sessions was good- was not too overpowering and if it was becoming information overload the trainer would identity this and allow a break or stop for the day to allow thought processing time.*
- *The engagement was really good. I am a learner who needs to get actively involved so the role play session was helpful and the relaxed atmosphere put me a t ease with this. Lots of positive comments and constructive feedback which was helpful. We discussed multiple times how this approach can be used in general conversation also which also made me realise it is more transferable into my role than I originally anticipated.*
- *Nice safe learning environment*

Next steps for support

Finally, participants were asked if they had any thoughts and ideas for support or training that might further help them in their work with patients. The responses at time 2 and 3 are below:

- *Perhaps some peer support, hearing how well it has gone for others and time to practise*
- *Need to have a period of time of applying/using rather than additional support at the moment*
- *Keeping in touch with other attendees. Having the opportunity to have a further session with the group to reflect and feedback on how we have used MI in practise and perhaps discuss more complex/complicated patients*
- *This is a very advanced skill and whilst I will endeavour to use it in my everyday work and I hope will improve this with practise, it would be nice to look at a follow up session in 6-12 months to help with more complex patients who are more resistant to change*
- *Perhaps a follow up in future to put my attempts to use Mi into practise*
- *Having a follow up session would be helpful and give us the opportunity to discuss more challenging cases where we've used the spirit of MI*
- *I would like to see a follow up session on MI maybe in 12 months' time*
- *More in depth training on MI. The role play was really helpful.*
- *Follow up in a few months to review and move skills forward*
- *Further real-life examples of the practices taught*

The participants clearly valued the training and were keen to build upon the introductory level in the future. MI is often taught in series of workshops in which skills are introduced, then built upon progressively. Elements of MI can make a difference in practise quite quickly, while gaining competence in the approach involves integration of more advanced skills over time. MI skill development has been shown to be most successful when training via workshops is followed up by coaching, coding practice and tailored individual feedback [8].

4. Conclusions

The MI training was well received. Although two people were unable to attend the second day due to illness, those who did attend were very engaged throughout the two days and fully participated in all activities. The room at the Chesterfield campus was spacious, light and large allowing interaction and space to move between activities. The technical skills and 'spirit' of MI (compassion, acceptance, evocation and partnership) were the focus of the two days, and this was delivered to support people in understanding the ethos of this way of working with people, and the skills that support this. Skills practise was part of the training, but this was not evaluated formally during the workshops. The goal was for people to recognise and try out the skills rather than perfect them. Participants gained in confidence in applying MI skills from the training, and this continued once back into their working lives. However, their qualitative comments highlighted that they were also aware that they were still beginners as MI has a mastery arc and needs practise, feedback and mentoring, hence their mean levels of confidence remained below the top end of the Likert scales. Their application of the MI-adherent skills was evident post training, particularly immediately after day 2 as they demonstrated technical MI skills in responding to a scenario. After 6 weeks the more advanced skills were less evident, however all their responses continued to be MI adherent which was pleasing to see. All respondents valued the MI skills as being more useful in their practise after the training. Their responses to the open questions revealed examples of ways they had applied MI in their work and seen benefits for their patients. They identified that 'top up' training would be beneficial in the future to help them to consolidate their learning and apply it in more challenging situations or with more complex clients. The participants valued the training and the delivery style and were keen to build upon their knowledge in the future.

References:

[1] Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. Guilford press.

[2] Aujoulat, P., Le Goff, D., Dany, A., Robaskiewick, M., Nousbaum, J. B., Derrienic, J., ... & Le Reste, J. Y. (2022). Improvement of participation rate in colorectal cancer (CRC) screening by training general practitioners in motivational interviewing (AmDepCCR). *Trials*, *23*(1), 1-11.

[3] Malins, S., Biswas, S., Rathbone, J., Vogt, W., Pye, N., Levene, J., ... & Russell, J. (2020). Reducing dropout in acceptance and commitment therapy, mindfulness-based cognitive therapy, and problem-solving therapy for chronic pain and cancer patients using motivational interviewing. *British Journal of Clinical Psychology*, *59*(3), 424-438.

[4] Pudkasam, S., Feehan, J., Talevski, J., Vingrys, K., Polman, R., Chinlumprasert, N., ... & Apostolopoulos, V. (2021). Motivational strategies to improve adherence to physical activity in breast cancer survivors: A systematic review and meta-analysis. *Maturitas*, *152*, 32-47.

[5] Ream, E., Gargaro, G., Barsevick, A., & Richardson, A. (2015). Management of cancer-related fatigue during chemotherapy through telephone motivational interviewing: modeling and randomized exploratory trial. *Patient Education and Counseling*, *98*(2), 199-206.

[6] Miller, W. R., Hedrick, K. E., & Orlofsky, D. R. (1991). The Helpful Responses Questionnaire: A procedure for measuring therapeutic empathy. *Journal of Clinical Psychology, 47*(3), 444-448.

[7] Moyers, T. B., Rowell, L. N., Manuel, J. K., Ernst, D., & Houck, J. M. (2016). The motivational interviewing treatment integrity code (MITI 4): rationale, preliminary reliability and validity. *Journal of substance abuse treatment*, *65*, 36-42.

[8] Miller, W. R., Yahne, C. E., Moyers, T. B., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of consulting and Clinical Psychology*, *72*(6), 1050.