Motivational interviewing (MI) has become a core and almost indispensable skill for practitioners working in the addictions field, since it was first described by Miller (1983) and elaborated on by Miller and Rollnick (1992).

The technique is widely taught internationally, and the evidence for its effectiveness in helping people to change negative behaviours has grown (Nahom, 2005; Amrhein et al, 2003; Burke et al, 2002; Dunn et al, 2001; Noonan and Moyers, 1997).

Increasingly, however, MI has come to be seen as an intervention that can be adapted and applied to a range of problem behaviours, not just those associated with addictions (Rollnick et al, 2008; Blitt et al, 2004; Rollnick et al, 1999). Indeed, it has been described as having “common currency” among health professionals.

Although Tober and Raisrick (2007) used the term “motivational dialogue” to describe how addiction practitioners engage with service users in different settings – focusing on the critical interaction between the two parties – we know that, whatever we call it, professionals can play a crucial part in determining whether clients change or maintain their problem behaviour.

Training
Of course, training is not synonymous with accredited teaching. MI, like many other psychosocial interventions, can be and is often – delivered without requiring practitioners to demonstrate competence. Certainly, Forrester et al (2008; 2007) and Miller and Mount (2001) all had interesting things to say about the teaching of MI to professionals who are new to it as an approach for bringing about behaviour change. Raising this is not to criticise short courses, but rather, to promote accredited training wherever possible.

This article describes one course – Motivational Interviewing in Clinical Practice – that aims to appeal to a range of health and social care professionals, and equip them with the knowledge and skills they need to use the approach in everyday practice in a diverse range of clinical areas. These areas include: eating disorders; chronic pain management; diabetes; school nursing; mood disorders; obesity; and medication concordance; among others.

Importantly, this module, which stands within the CPD framework at Bournemouth University, requires students to demonstrate competence by submitting a 30-minute video recording of them using MI in a genuine clinical session, as well as writing a critical analysis of their practice. This is not entirely novel – this assessment method has been used at Leeds Addiction Unit (in association with the University of Leeds) for many years and has enabled it to...
Innovation

Nursing Practice

establish a solid reputation for excellence in its training portfolio.

Teaching MI

In 2009, Bournemouth University decided to stop running its BSc (Hons) Therapeutic Interventions for Addictions programme, which included a module on the use of MI. That module previously assessed students’ knowledge of MI through a written piece of work. This did not, and could not, assess whether they had achieved competence in its actual delivery – it was time for change.

The university decided to validate a new, standalone module that broadened its focus to include students from a range of healthcare disciplines and used video-recording as the primary method of assessment. Both these aspects were, arguably, quite radical. This was a collaborative venture between practitioners from Bournemouth University, Dorset HealthCare University Foundation NHS Trust and the Borough of Poole.

At the time, there was some uncertainty about whether the prospect of having to record themselves delivering MI with a genuine patient might deter potential students from applying for this new module. My experience, as a tutor at Leeds Addiction Unit, was that they would not be deterred; indeed, students would come to see this method of assessment as the “gold standard” and of most use in developing their clinical practice.

First cohort

The first cohort ran in 2010 and drew practitioners from the community mental health team, physiotherapy, school of nursing, occupational therapy, smoking cessation, eating disorders and addictions.

We also invited practitioners from wider fields to speak about how they used MI in their own work. For example, two spoke about their use of MI in a condition management programme, which sought to help people with long-term medical conditions return to work or training. This complemented the knowledge and skills practice components of the module.

There was some concern from students, at least initially, about video-recording themselves. They were also worried about confidentiality, being able to secure patients’ informed consent and even finding the “right” patient to record. However, none of those in the first cohort failed to deliver a recording. Indeed, it could be argued that video-recording practice, together with the ability to critically reflect on it, proved to be a most valuable learning opportunity for them.

Although most students were nurses, the completion of the first cohort proved to the module tutors that MI can be adapted and taught effectively to practitioners from a wide range of specialisms, rather than nursing exclusively. To adapt MI, we had to make the focus generic, in the sense that it was on problem behaviours generally – that is, any behaviours that were amenable to change.

One of the challenges in teaching a wider audience lies in striking a balance between different problem behaviours, while keeping the course relevant to all. The extent to which we achieved it is not for us to judge, and lessons learned from teaching this first cohort were incorporated into the review of its teaching.

Second cohort

The second cohort ran in January 2011. Again, practitioners came from a range of clinical backgrounds. What emerged from this cohort was the enthusiasm for, and confidence in using MI when facing problems with which patients (and, to an extent, practitioners) had become “stuck”. It also made them more aware of aspects of their own behaviour that were likely to be counter-productive, such as argumentation or the well-intentioned and common trap of the “righting reflex”.

We do not suggest that MI is a panacea or that it replaces, or is superior to, the knowledge and skills these practitioners use in their everyday work, but it does enhance them. However, one of the ongoing problems in developing MI lies in the absence, to a large extent, of clinical supervision frameworks.

Assessing competence

Fortunately, when it came to developing a framework for assessing competence, we were able to adopt the one used by Leeds Addiction Unit/University of Leeds for all their practice-based modules. This enabled us to identify specific behaviours that were shown by students in their clinical use of MI.

For example, the framework enables tutors to separately (sub)mark and provide written feedback about “therapist presentation”, as it is evidenced in the video-recording. Here, we are looking at the extent to which students establish a therapeutic alliance with their patients in their use of accurate empathy (Rogers, 1959) and non-verbal behaviours. It is here that the “spirit of MI” – that is to say, a “way of being with people” – is either in evidence or not. An analogy with dancing is sometimes used to identify when the practitioner achieves the spirit; this is what Rollnick and Allison (2001) described as having a “constructive conversation about behaviour change”. Conversely, wrestling is used to denote its absence, which is a practitioner problem.

The same applies to relevant content and structure of the session: was it recognisable as MI and did the session have a clear structure?

The third dimension is application of knowledge. Here, we are interested in whether the specific knowledge underpinning MI is being applied to the clinical situation in hand. Do individual students have a clear rationale for what they are doing or not?

The fourth aspect is application of skills. This is concerned with the range of

Nurses play a vital part in determining whether clients change their problem behaviour.
MI-consistent skills used and the depth in which problems were explored.

Finally, the critical analysis dimension assesses the extent to which students, in their written work (which accompanies the video-recording), are able to identify which aspects of their practice were either effective or ineffective and what – if anything – they would do differently, on reflection. It is also an opportunity for them to integrate theory with practice, highlighting the principles and core skills of MI. However, a student cannot rely on a stunningly good critical analysis of an incompetent clinical intervention.

Following the Leeds model, tutors provided detailed feedback on all these areas of practice. They commented on what students did well and identified some learning points – that is, what they might have done differently to achieve a greater shift towards change. One of the things we know, from providing such feedback, is that students value it highly, whether they fail the assignment or do well in it.

**Clinical supervision**

As we all know from learning a new skill, the likelihood of being able to develop it depends on the opportunities to use it and whether we do use it. If we don’t, the chances are we let the skill drift and begin to use behaviours that are inconsistent with a given intervention.

However, there is another aspect to this scenario – can we use clinical supervision to maintain and enhance our skills? One of the questions our students have raised (and is likely to be more widely raised) is: what mechanisms are there, particularly in the workplace, for clinical supervision in MI? This is an important question and one for which ready answers are not available, despite the expansion of MI training over the past 20 years.

One of the key learning points from the United Kingdom Alcohol Treatment Trial focused on training and the need for ongoing clinical supervision to maintain consistency in practice, as well as effectiveness (UKATT Research Team, 2005). In that case, a structured and manualised adaptation of MI – motivational enhancement therapy (Miller et al, 1995) – was compared with social behaviour and network therapy (Copello et al, 2002). Tober et al (2005) concluded:

“Supervision after initial training was critical in the acquisition of competence. Not only did we believe that supervision ensured that therapists adhered to treatment protocols over time, but also that it underpinned understanding of the treatment and its purpose.”

This makes logical sense and is therefore an important question for other psychosocial treatments.

**Conclusion**

Arguably what is needed is a network of experienced MI practitioners, in a range of settings, to provide clinical supervision regularly. This doesn’t have to be done individually, but could perhaps be undertaken in small groups.

Whether this is realistic, given the available resources, is uncertain. However, if it is not provided, it does mean that MI-trained practitioners are left to their own devices and the investment made in this training is less likely to yield consistently positive results. This is not because they are deficient in some way, but because clinical supervision is a key part of professional development, be it in MI or any other approach. That may come, in time.

In the meantime, whatever their specialism, practitioners interested in learning a new and effective clinical skill can, and should, think about accredited training in MI. NT

**References**


