MOTIVATIONAL INTERVIEWING

TRAINING MANUAL

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MOTIVATIONAL INTERVIEWING

Training Manual

A Comprehensive Guide for Frontline Practitioners,
Trainers and Healthcare Professionals
in UK Drug and Alcohol Settings

Tony D'Agostino

TD Consultancy | 2026

Based on the evidence-based practice of Miller & Rollnick (2023, 4th edition)

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This manual is intended for professional training purposes. All clinical scenarios are fictitious. This manual does not constitute clinical advice. Practitioners should always work within their organisational policies, professional competency frameworks, and relevant NICE guidelines.

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FOREWORD

Motivational Interviewing (MI) has transformed how practitioners in drug and alcohol services engage with people who are ambivalent about change. Since William Miller first described the approach following his clinical work in 1983, it has evolved into one of the most extensively researched psychosocial interventions in the field.

This manual has been written for the full range of practitioners working in UK drug and alcohol services — from specialist keyworkers and nurses in residential settings to social care professionals, criminal justice workers, and community health workers in primary care. This resource provides a structured, evidence-based pathway through the core skills, principles, and applications.

The manual is grounded in the fourth edition of Motivational Interviewing: Helping People Change & Grow (Miller & Rollnick, 2023). The key changes from the third edition that have been integrated throughout this manual include:

- Empowerment replaces Evocation in the Spirit of MI — reflecting a shift from practitioner technique to client capacity and strengths
- The Four Tasks (replacing Four Processes) — emphasising the fluid, non-sequential, everyday nature of MI's core activities
- Updated terminology throughout: Ask-Offer-Ask (AOA), Choosing a Path, Planting Seeds, Fixing Reflex, Pendulum Technique
- New content on remote and digital delivery of MI — essential for UK drug and alcohol services in a post-2020 practice landscape
- Deliberate practice — intentional, feedback-informed skill development as the most effective route to sustained MI competency
- Complex affirmations and strategic OARS — framing core skills as directional, purposeful tools, not just general good listening
- Practitioner self-disclosure — explicitly recognised as an MI-consistent practice when used briefly and purposefully

Throughout, you will find clinical examples, case studies, and dialogue illustrations drawn from fictitious UK practice contexts.

Capability Framework for the Drug and Alcohol Treatment and Recovery Workforce

This training resource aligns with the Capability Framework for the Drug and Alcohol Treatment and Recovery Workforce (NHS England / Office for Health Improvement and Disparities, 2024), which underpins the 10-Year Strategic Plan for the Drug and Alcohol Treatment and Recovery Workforce 2024–2034. The framework provides guidance on the knowledge, skills, and behaviours required for core roles within LA-commissioned drug and alcohol treatment and recovery services. This manual supports workforce development towards those capabilities and is intended to be used as part of a broader training, supervision, and professional development plan. See Appendix F for a full mapping of manual sections to framework competency tiers.

Tony D'Agostino

TD Consultancy, 2026

MODULE 1: FOUNDATIONS OF MOTIVATIONAL INTERVIEWING

1.1 Introduction to Motivational Interviewing

Definition and Core Philosophy

Based on Miller & Rollnick (2023, 4th ed.)

"Motivational Interviewing is a particular way of talking with people about change and growth to strengthen their own motivation and commitment." (Miller & Rollnick, 2023)

Two aspects of this definition are significant. First, the addition of "and growth" signals a broadening of MI beyond problem-focused behaviour change toward longer-term personal development. For practitioners in drug and alcohol services, this is a meaningful shift: MI is no longer solely a crisis-response tool but a framework for supporting recovery, wellbeing, and human flourishing over time. Second, "commitment" now appears explicitly alongside motivation, reinforcing that MI aims not just to explore ambivalence but to help consolidate a person's own resolve to move forward.

MI is not a technique in the narrow sense — it is a clinical style, a way of being with people. At its heart lies a profound respect for client autonomy and a belief that the motivation for change lives within the person, not in the practitioner's persuasive skill. The practitioner's role is to draw out that motivation, not to install it.

Three key ideas underpin the MI philosophy:

- Ambivalence about change is normal, not pathological. Most people seeking help for substance use simultaneously want to change and do not want to change. MI takes this seriously.
- People are more likely to act on arguments they make themselves. When clients articulate their own reasons for change, those reasons carry more weight than when a practitioner provides them.
- The practitioner-client relationship is inherently collaborative. MI moves away from the expert-patient hierarchy and towards a partnership of equals exploring change together.

Historical Development

MI originated in the work of William R. Miller, an American psychologist who developed the approach while conducting alcohol treatment research in Norway in 1983. Surprised by the outcomes he was achieving through a client-centred, non-confrontational approach, Miller published the first formal description of MI in Behavioural Psychotherapy (1983).

The collaboration between Miller and British clinical psychologist Stephen Rollnick, which began in the late 1980s, produced the landmark first edition of Motivational Interviewing: Preparing People to Change Addictive Behaviour (1991). This text formalised MI for a clinical audience and launched decades of research and training worldwide.

Subsequent editions (2002, 2013, 2023) have expanded the model, refined its theoretical underpinnings — incorporating Self-Determination Theory (Deci & Ryan, 2000) and neuroscience of change — and broadened its applications beyond substance use to health behaviour, criminal justice, mental health, and beyond.

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Year	Milestone
1983	Miller publishes first description of MI in Behavioural Psychotherapy
1991	Miller & Rollnick: Motivational Interviewing (1st edition)
1995	FRAMES model articulated; brief intervention research expands
2002	2nd edition; MI Network of Trainers (MINT) established
2013	3rd edition; refined processes model, DARN-CAT framework formalised
2014	NICE recommends MI in substance misuse guidelines (CG115, NG58)
2023	NICE TA934 (Contingency Management) references MI as foundational element
2023	Miller & Rollnick: Motivational Interviewing: Helping People Change & Grow (4th ed.) — updated definition, Empowerment, Four Tasks, remote delivery, deliberate practice

Evidence Base and Effectiveness

MI has accumulated one of the strongest evidence bases in the psychosocial interventions literature. Key findings include:

- Meta-analyses (Hettema et al., 2005; Lundahl et al., 2010) consistently demonstrate medium-effect-size improvements in substance use outcomes when MI is compared to no treatment or treatment as usual.
- A Cochrane review (Smedslund et al., 2011) found MI to be superior to no treatment for reducing substance use and more effective than brief advice alone.
- MI produces outcomes comparable to cognitive-behavioural therapy (CBT) in many contexts, with a faster time to engagement and higher treatment retention.
- Effectiveness has been demonstrated across alcohol, opioids, stimulants, cannabis, and tobacco, and across settings including primary care, criminal justice, residential treatment, and mental health services.
- Brief MI interventions are particularly effective in primary care and A&E settings, making them highly applicable to UK health services under resource pressure.

NICE GUIDANCE

NICE Guideline CG115 (Alcohol Use Disorders, 2011, updated 2019) recommends brief motivational interventions for people who misuse alcohol in primary care and acute settings.

NICE Guideline NG58 (Drug Misuse in Over 16s, 2017) recommends that all drug treatment services provide motivational enhancement approaches as part of the care pathway.

NICE Quality Standard QS23 (Drug Use Disorders, 2012) includes motivational interviewing as a core competency for drug treatment practitioners.

NICE Technology Appraisal TA934 (Contingency Management, 2023) references MI as a foundational

element in the drug treatment pathway.

Applications in Drug and Alcohol Services

In UK drug and alcohol services, MI is applied across the care pathway:

- Brief interventions in GP surgeries, A&E departments, and community pharmacies
- Initial engagement and assessment in community drug and alcohol services (CDAS)
- Motivational enhancement within structured treatment programmes
- Harm reduction conversations (e.g., discussing safer drug use, naloxone uptake)
- Pre-treatment engagement for residential rehabilitation
- Support during relapse and re-engagement
- Criminal justice settings: Drug Rehabilitation Requirements (DRR), RECONNECT (prison-to-community liaison)
- Dual diagnosis services: navigating the complexity of mental health and substance use
- Remote and digital delivery contexts: telephone keywork, video appointments, digital support platforms

1.2 The Paradigm Shift

From Coercion to Intrinsic Motivation

Traditional approaches to substance misuse treatment often rested on confrontation: the assumption that clients were "in denial" and needed to be challenged, confronted, or broken down before they could accept help. This approach has been largely discredited. Research demonstrates that confrontational interventions increase resistance and reduce treatment retention (Miller & Rollnick, 2023; Moyers & Miller, 2013).

MI represents a fundamental shift in orientation — from external coercion to eliciting internal motivation. The key insight is this: intrinsic motivation is more durable and more effective than externally imposed pressure. When a client articulates their own reasons for change, those reasons stick.

This does not mean abandoning structure, challenge, or honesty. MI practitioners can and do challenge discrepancies, provide information, and hold clients accountable. The difference lies in how: always with the client's autonomy and perspective as the starting point.

Replacing the Fixing Reflex

The "Fixing Reflex" (formerly called the "Righting Reflex" in the 4th edition of Miller & Rollnick, 2023) is the practitioner's instinctive urge to correct, advise, persuade, or solve when a client expresses a problem. The name change is deliberate: it better captures the instinct to fix — to jump in with solutions before the client has been heard. In drug and alcohol settings, where practitioners witness genuine harm and suffering, the fixing reflex is particularly powerful and understandable.

The problem is that acting on the fixing reflex — however well-intentioned — typically produces the opposite of the desired effect. Clients who feel advised, corrected, or pushed will defend their current position. This is not stubbornness; it is a predictable psychological response. The MI practitioner recognises the fixing reflex, acknowledges it internally, and redirects it into curiosity.

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> 💡 **PRACTICE TIP**
>
> Notice when you feel the urge to argue, correct, or persuade. That feeling is the fixing reflex. Acknowledge it, then ask yourself: "What open question could I ask instead that invites this client to explore their own perspective?"
>
> The fixing reflex is not wrong — it comes from caring. But in MI, we redirect that care into curiosity.

Client-Centred vs. Expert-Driven Approaches

Expert-Driven Approach	Client-Centred (MI) Approach
Practitioner as authority	Practitioner as guide and collaborator
Diagnosis and prescription	Exploration and empowerment
Confronting denial	Exploring ambivalence
Information-giving as primary tool	Listening as primary tool
Client resistance seen as pathological	Client resistance as natural and informative
Motivation as prerequisite for treatment	Motivation as outcome of good conversation

1.3 The Spirit of MI

The "Spirit of MI" describes the underlying mindset and values from which MI techniques flow. Without the spirit, MI techniques become hollow tools. With it, even imperfect technique produces genuine therapeutic movement. In the 4th edition (Miller & Rollnick, 2023), the spirit has four components: Partnership, Acceptance, Compassion, and Empowerment.

Spirit Component	Core Meaning in Practice
Partnership	Collaboration over hierarchy; two experts working together
Acceptance	Absolute worth, accurate empathy, autonomy support, affirmation
Compassion	Actively promoting the client's welfare and best interests
Empowerment	Recognising and activating the client's own capacity, strengths, and resources

Partnership (Collaboration Over Hierarchy)

MI is a partnership between two experts: the client, who is the expert on their own life, values, and circumstances; and the practitioner, who brings expertise in change facilitation, health information, and treatment options. Neither alone has all the answers.

Partnership means the practitioner and client explore together, rather than the practitioner leading and the client following. The practitioner's role is to create the conditions in which the client's own wisdom about change to emerge.

Acceptance

Acceptance in MI has four dimensions (Miller & Rollnick, 2023):

- Absolute worth: An unconditional positive regard for the client as a person of inherent value, regardless of their behaviour.
- Accurate empathy: A genuine effort to understand the client's perspective, not to project assumptions onto it.
- Autonomy support: Active affirmation of the client's right to make their own choices, including the choice not to change.
- Affirmation: Noticing and acknowledging the client's strengths, efforts, and capabilities.

Acceptance does not mean approval of harmful behaviour. It means the practitioner engages with the whole person, not their presenting problem.

Compassion

Compassion means prioritising the client's welfare — actively promoting their interests and needs. A compassionate MI practitioner asks: "What is actually in this person's best interest right now?" not "What would make this encounter easier for me?"

Compassion distinguishes MI from techniques that might appear similar but serve the practitioner's agenda rather than the client's needs. The focus is always on client wellbeing, not practitioner performance.

Empowerment (Updated in 4th edition — replaces Evocation)

The 4th edition of Miller & Rollnick (2023) replaces "Evocation" with "Empowerment" as the fourth component of the MI spirit. This is a clinically significant change. In earlier editions, Evocation emphasised the practitioner's technique—the act of drawing out the client's motivation. Empowerment shifts the emphasis to where it belongs: the client's inherent capacity, strengths, and resources.

The assumption behind Empowerment is that the resources and motivation for change already exist within the client. The practitioner's job is not to generate motivation but to recognise, activate, and strengthen what is already there. This is not merely a semantic change: it reframes the entire therapeutic encounter. The practitioner is not a skilled extractor; they are a witness and facilitator of the client's own growth.

In drug and alcohol settings, where service users often arrive with histories of coercion, stigma, shame, and disempowerment, this framing is especially meaningful. A stance of empowerment — "You have what it takes; let's find it together" — is fundamentally different from one that positions the practitioner as the holder of the client's motivation.

Note: The task of evoking remains unchanged in name and function. Evoking as a task describes what the practitioner does during sessions; Empowerment as a spirit component describes the underlying stance and belief about clients that makes evoking authentic.

PRACTICE TIP

Before a session, ask yourself: "Do I genuinely believe this person has the capacity to change? Do I see them as a partner?"

If not, your technique may be technically correct but the spirit will be missing. Clients often sense when practitioners are going through the motions. The spirit of MI — including Empowerment — is not something to perform: it is a genuine stance of curiosity and respect for the person's own wisdom.

1.4 The Four Principles of MI

The four operating principles of MI guide practitioners in specific ways. These principles are unchanged in the 4th edition and remain the practical expression of the MI spirit in action.

1. Express Empathy

Empathy in MI is active, reflective, and precise. It is not sympathy (feeling sorry for someone) but accurate empathy — the effort to understand the world through the client's eyes and communicate that understanding back. The primary tool is reflective listening (see Module 3).

"Ambivalence is normal": a core empathic assumption in MI. When clients express ambivalence, the MI practitioner treats it as understandable and worthy of exploration, not as resistance to be overcome.

2. Plant Seeds (formerly Develop Discrepancy)

The 4th edition renames "Developing Discrepancy" as "Planting Seeds". The new term better captures the gentle, non-confrontational nature of the technique: rather than forcing the client to confront an uncomfortable gap, the practitioner lightly raises awareness of inconsistency between current behaviour and stated values, and allows the client to draw their own conclusions.

Change is more likely when clients recognise a gap between their current behaviour and their core values or goals. Crucially, this awareness should be drawn from the client's own stated values, not the practitioner's values imposed on the client. "You've told me that being there for your children is the most important thing in your life. What connection do you see between that and your alcohol use?"

3. Roll with Resistance (now: Dance with Discord)

The original formulation used the phrase "roll with resistance." The third edition of Miller and Rollnick (2013) replaced this with "dance with discord" — acknowledging that what might appear as resistance is often ambivalence or a signal that the practitioner is pushing too hard. The appropriate response is to slow down, reflect, and reorient rather than push harder.

Arguing, confronting, and persuading in the face of discord only increase discord and reduce change. Stepping alongside, reflecting, and affirming autonomy often resolves it.

4. Support Self-Efficacy

Self-efficacy — the belief that one can succeed — is a crucial predictor of change outcomes. MI practitioners actively reinforce clients' belief in their own capacity to change by:

- Eliciting and reflecting change talk (especially ability and confidence language)
- Affirming past successes and current strengths
- Exploring what has worked before, even partially
- Using the confidence ruler to surface existing capabilities

🤔 **REFLECTION QUESTIONS**

1. Think about a recent clinical encounter. Did you notice the fixing reflex? How did you manage it?

_____

2. Which component of the Spirit of MI do you find most natural? Which do you find most challenging? How does the updated concept of Empowerment (replacing Evocation) change how you think about your role?

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3. How would you describe the difference between empathy and sympathy to a colleague?

_____

✅ **KEY TAKEAWAYS**

- MI is a collaborative, person-centred communication style designed to elicit and strengthen intrinsic motivation for change and growth.
- The 4th edition (2023) definition adds "and growth" and emphasises "commitment" — broadening MI beyond problem-focused behaviour change.
- The Spirit of MI (Partnership, Acceptance, Compassion, Empowerment) underpins all techniques. Without the spirit, techniques become hollow.
- The 4th edition (2023) introduces "Empowerment" in place of "Evocation" in the Spirit of MI, shifting emphasis from practitioner technique to client capacity and strengths.
- The Fixing Reflex (updated term from Righting Reflex, 4th edition) — the urge to correct, persuade, or warn — is the practitioner's most significant obstacle in MI.
- Ambivalence about change is normal and should be explored with curiosity, not challenged or pathologised.
- MI has a strong evidence base across substance use settings, mental health, and health behaviour change.
- NICE (CG115, NG58, QS23, TA934) and the UK drugs strategy (From Harm to Hope, 2022) all endorse MI as a core competency for drug and alcohol practitioners.

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MODULE 2: UNDERSTANDING CHANGE AND AMBIVALENCE

2.1 Reframing Ambivalence

Ambivalence as Normal, Not Pathological

Ambivalence — simultaneously wanting and not wanting change — is one of the most common psychological states in which people seek help for substance use. Yet traditional treatment models often pathologised ambivalence as "denial," a sign of insufficient motivation or readiness.

MI reframes ambivalence as a normal, understandable response to any significant life change. People do not use substances without reason. Their use serves functions — managing anxiety, numbing emotional pain, social connection, pleasure — that are real and important to them. Asking someone to give those up, even for compelling health reasons, understandably produces mixed feelings.

The MI practitioner's response to ambivalence is curiosity, not confrontation. Exploring both sides of the ambivalence — what the person values about their use and what concerns them — creates the conditions for the client's own motivation for change to emerge.

Decisional Balance: Exploring Both Sides

The decisional balance exercise invites clients to map out the costs and benefits of changing and not changing. This is not a persuasion tool — it is an exploration tool. The practitioner holds both sides with equal respect, reflecting and affirming the client's own perspective.

In the 4th edition (Miller & Rollnick, 2023), this approach is associated with Planting Seeds (previously known as Developing Discrepancy, updated in the 4th edition). Rather than confronting the client with the gap between their values and behaviour, the practitioner gently raises awareness of inconsistency and invites the client to make meaning of what they discover.

	Benefits (What I Like / What I'd Gain)	Costs (What's Difficult / What I'd Lose)
Continuing current use	e.g., "It helps me relax", "I enjoy it with friends"	e.g., "My health", "Arguments at home"
Making a change	e.g., "I'd feel better", "More energy for the kids"	e.g., "I'd have to find another way to cope"

PRACTICE TIP

When using decisional balance, always start by asking about the positives of current behaviour — "What do you like about your drinking?" — before moving to concerns. Starting with positives demonstrates genuine acceptance and reduces defensiveness.

After completing the balance, ask: "Looking at all of this, what do you make of it?" Let the client draw their own conclusions. This is the essence of Planting Seeds: raising awareness without arguing for a conclusion.

CASE STUDY: Decisional Balance — Mark, 38, Alcohol

Setting: Community Drug and Alcohol Service, first appointment after GP referral.

Mark attends reluctantly, having been referred by his GP following elevated liver function tests. He

describes himself as a "social drinker" and questions why he is there.

Practitioner (using decisional balance):

"Mark, before we talk about anything else, I'm interested in understanding your drinking from your perspective. Can I ask — what does drinking do for you? What do you value about it?"

Mark: "Honestly? It helps me wind down after work. I work long shifts and I need something to help me switch off. It's also how me and my mates socialise — I'd feel left out if I wasn't having a drink with them."

Practitioner: "So it's both a personal thing — a way of decompressing — and a social connection thing." [Reflection] "What else?"

Mark: "I suppose it's just normal, isn't it? Everyone drinks."

Practitioner: "And is there anything about your drinking that concerns you, or that you've noticed has become a bit tricky?"

Mark: (pause) "I suppose the GP thing worried me a bit. And I have been drinking more than I used to."

[Analysis: The practitioner has elicited both sides of the balance non-judgementally. Mark has produced his first piece of change talk — "that worried me a bit." This is the seed of motivation to be nurtured in subsequent sessions. Note how the decisional balance has functioned as a Planting Seeds exercise — the practitioner has not argued for change, but has created the conditions for the client to begin noticing it himself.]

2.2 Stages of Change (Transtheoretical Model)

Overview

The Transtheoretical Model (TTM), developed by Prochaska and DiClemente (1983) through research on smokers who changed without formal treatment, describes change as a process that occurs through a series of stages rather than a single event. While it has limitations as a predictive model, it remains a valuable clinical heuristic for matching the depth and focus of MI conversations to where a client currently is.

The 4th edition of Miller & Rollnick (2023) maintains the Transtheoretical Model as a useful heuristic while cautioning against rigid application. Practitioners should treat the model as an approximate guide, not a fixed diagnosis. In remote and digital services, stage fluctuation between contacts may be more pronounced: a client who presented in preparation at a face-to-face appointment may have returned to contemplation by the time of a follow-up telephone call a week later. Remote practitioners should reassess the stage at the start of each contact rather than assuming continuity.

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Stage	Description	Client May Say...	MI Focus
Precontemplation	No intention to change in the foreseeable future. May be unaware of problem or resistant to change.	"I don't have a problem."	Explore concerns gently; raise awareness without pressure; plant seeds
Contemplation	Aware that a problem exists; ambivalent about change. Weighing pros and cons.	"I know I should cut down, but..."	Explore ambivalence; plant seeds; tip the balance toward change
Preparation	Intending to take action in the near future; may have made small changes.	"I've been thinking about calling a service..."	Strengthen commitment; help develop a realistic plan
Action	Actively modifying behaviour. Change visible to others.	"I haven't had a drink in two weeks."	Support and affirm; problem-solve barriers; reinforce self-efficacy
Maintenance	Working to sustain change and prevent relapse. Change consolidated.	"I've been sober for six months."	Reinforce coping strategies; prepare for high-risk situations; identity development

The 40-40-20 Distribution

In population samples, Prochaska and DiClemente's research suggested approximately:

- 40% of people presenting to a drug and alcohol service are in precontemplation
- 40% are in contemplation
- 20% are in preparation or action

This distribution has significant implications for service design and practitioner expectations. If most clients are not "ready to change" in the conventional sense, then interventions designed only for those in action will fail the majority. MI is particularly well-suited to working with people in precontemplation and contemplation — the groups who most often disengage from traditional advice-giving approaches.

Limitations of the Stage Model

The Transtheoretical Model is a useful clinical map, but it should not be applied rigidly. Research has shown that:

- People do not always move through stages in a linear sequence — "relapse" often returns people to earlier stages, and movement back and forth is common.
- Stage assignments can be unreliable in practice; people often straddle multiple stages depending on the day, context, and substance in question.
- The model can be misused to justify withholding services from people judged "not ready" — MI explicitly rejects this application.

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⚠ **ALERT**

The Stages of Change model should never be used to gatekeep services. People in precontemplation need — and deserve — skilled engagement, not referral elsewhere until they are "more motivated." Motivation is not a prerequisite for MI; it is the hoped-for outcome.

2.3 Why Direct Persuasion Fails

The Psychological Reactance Effect

When practitioners argue directly for change — listing reasons why a client should stop using, issuing warnings, or providing unsolicited advice — clients commonly respond by defending their current behaviour. This is not stubbornness or pathology; it is a predictable psychological response known as reactance (Brehm, 1966).

Reactance occurs when people feel their freedom is being threatened. The greater the perceived threat, the stronger the defensive response. In practice, this means that confrontational interventions often produce more arguments against change, not fewer. Research by Moyers and Miller (2013) demonstrated that practitioner confrontational behaviour directly predicts client "sustain talk" and resistance — and that this effect is immediate, occurring within the same session.

The 4th edition of Miller & Rollnick (2023) adds an important observation about the Fixing Reflex in digital and remote delivery contexts: practitioners may be more prone to over-advising on telephone or video call due to the absence of visual cues. Without the ability to read non-verbal signals of discomfort or disengagement, practitioners may inadvertently fill silences with advice, escalating the fixing reflex response without realising it. This makes explicit awareness of the fixing reflex even more important in remote settings.

Fluctuation Across Time and Context

A person's position on the change continuum is not fixed. It fluctuates depending on:

- Their physical state (withdrawal, intoxication)
- Recent life events (job loss, relationship change, health scare)
- The quality of the therapeutic relationship in the room — or on the call
- How the conversation is being conducted

This means that motivation is not a stable trait to be assessed and then worked around — it is a dynamic state that practitioners actively influence, for better or worse, with every intervention they make.

CASE STUDY: Precontemplation — Donna, 52, Crack Cocaine

Setting: Community Drug and Alcohol Service. Donna has been referred via the criminal justice system following a possession offence.

Donna has not self-referred and does not consider her crack cocaine use a problem.

Non-MI Response (high risk):

Practitioner: "Donna, I need to be honest with you. Crack cocaine is destroying your health. You've been using heavily for ten years. Your blood pressure is dangerously high, and you're at risk of a stroke. You really need to take this seriously."

Donna: "I don't see what any of this has to do with you. I came here because the probation service told me to, not because I think I have a problem."

[Result: Donna disengages. Practitioner's fixing reflex has increased resistance and damaged the alliance.]

MI Response (collaborative):

Practitioner: "Donna, I appreciate you coming in today — I know it wasn't exactly your idea. [Affirmation] I don't have any agenda here. What I'd like to do is just get to know you a bit and understand your life. Can you tell me a bit about what's been happening for you recently?"

Donna: (slightly less defensive) "Yeah... I suppose things have been a bit stressful."

[Result: Engagement is preserved. Donna begins to open up. The practitioner has created the conditions for a genuine conversation. No change talk yet — but the seeds are planted.]

🤔 REFLECTION QUESTIONS

1. Think of a client you have worked with who appeared to be in precontemplation. How did you engage with them? What do you wish you had done differently?

_____

2. How do you respond when a client says they do not have a problem? What does the MI approach suggest you should do?

_____

3. What are the risks of categorising clients by stage and adjusting your service offer accordingly?

_____

4. How might your use of the fixing reflex change in a telephone or video session compared to face-to-face? What strategies could you use to stay aware of it in remote contexts?

_____

✅ KEY TAKEAWAYS

- Ambivalence is a normal response to significant change. Exploring it collaboratively is more effective than confronting it.
- Planting Seeds (updated term for Developing Discrepancy, 4th edition) is a gentle, non-confrontational way of raising awareness of inconsistency between values and behaviour.
- The Transtheoretical Model provides a useful framework for matching MI conversations to where clients currently are — but should never be used to gatekeep services.
- The 4th edition cautions against rigid stage assignment; in remote services, stage fluctuation between contacts may be more pronounced.
- The 40-40-20 distribution suggests that most people presenting to drug and alcohol services are in precontemplation or contemplation — not in action.
- Direct persuasion triggers psychological reactance, increasing resistance. Practitioner confrontation directly predicts client sustain talk.
- The Fixing Reflex is heightened in remote/telephone delivery — practitioners should pay deliberate attention to it in digital contexts.
- Motivation is a dynamic state, not a stable trait. Practitioners influence it, for better or worse, in every interaction.

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MODULE 3: CORE SKILLS — OARS

OARS — Open Questions, Affirmations, Reflections, and Summaries — are the four core micro-skills of MI. They are not unique to MI; they draw on person-centred counselling, active listening, and communication research. What makes them specifically motivational is how they are deployed.

The 4th edition of Miller & Rollnick (2023) frames OARS as directional and purposeful tools, not just general good-listening habits. Each skill is deployed with intentionality: the practitioner chooses which tool to use, when, and why, in service of the change conversation. A reflection can be used to amplify emerging change talk; an open question can be used to steer away from sustain talk; a summary can be used to "stack" change talk before a transitional moment.

> 💡 **PRACTICE TIP**
>
> Strategic OARS: Before using each OARS skill, ask yourself: "What am I hoping this will do in the change conversation right now?" If your reflections, questions, and summaries are not being deployed with that intentionality, you may be doing "nice listening" rather than motivational work. OARS without direction is active listening; OARS with direction is MI.

OARS Skill	Primary Function	Strategic Intent in MI	Remote/Digital Adaptation
Open Questions	Gather information; invite elaboration	Directed to elicit change talk; steer away from sustain talk	Use more explicitly on telephone; fewer visual cues mean open questions carry extra weight
Affirmations	Build self-efficacy; acknowledge strengths	Complex affirmations are more likely to elicit change talk than simple praise	Particularly important on remote calls where relational warmth is harder to convey non-verbally
Reflections	Demonstrate listening; deepen exploration	Amplify change talk; hold ambivalence; redirect when sustain talk dominates	Name emotions explicitly on telephone; "I want to sit with that a moment before we continue"
Summaries	Organise; structure; transition	"Stack" change talk statements before planning conversations	Use transitional summaries to manage session pacing remotely; helps compensate for lost non-verbal cues

3.1 Open Questions

Characteristics of Effective Open Questions

An open question is one that cannot be answered with "yes," "no," or a single word. It invites the client to elaborate, to share their perspective, to think out loud. Open questions create space. They signal that the practitioner is interested in the client's experience, not just gathering information.

The 4th edition frames open questions as directional: they should be used to move the conversation toward change talk, not simply to gather information. A well-timed open question can shift the entire trajectory of a session.

Closed Question (Avoid)	Open Question (Better)	Why It Works
"Do you want to stop using heroin?"	"What are your thoughts about your heroin use at the moment?"	Opens up exploration without presupposing an answer
"Have you thought about reducing?"	"What would reducing look like for you, if you decided to try it?"	Hypothetical framing reduces threat; invites imagination
"Is your drinking causing problems?"	"Tell me what role alcohol plays in your life right now."	"Tell me" invites narrative, not yes/no
"Are you motivated to change?"	"What brings you here today?"	Neutral and curious; avoids presupposing motivation
"Did that help?"	"What was useful about that for you?"	Open version elicits specifics and affirms the client's perspective

The Question-Answer Trap

One of the most common MI pitfalls is what Miller and Rollnick call the "question-answer trap" — a pattern in which the practitioner asks a series of questions and the client provides brief answers, producing an exchange that resembles an interrogation rather than a therapeutic conversation. This pattern places the practitioner in the "expert" role, suppresses client elaboration, and often results in minimal change talk.

The solution: after asking an open question and receiving the client's answer, respond with a reflection rather than another question. This demonstrates genuine listening, encourages elaboration, and avoids the interrogation dynamic.

💬 CLINICAL DIALOGUE EXAMPLE

Practitioner: *"What brings you in today?"* *[Open question — good start]*

Client: *"My GP sent me. Said my liver is playing up."*

Practitioner: *"Your doctor is worried, and that's brought you here."* *[Reflection — demonstrates listening]*

Client: *"Yeah... I suppose I've been a bit worried too, if I'm honest."*

Practitioner: *"You've got your own concerns as well, not just your GP's."* *[Reflection — amplifying emerging change talk]*

Client: *"Yeah. It's been a stressful year and the drinking has crept up."*

[Analysis: The practitioner has used reflections rather than further questions to deepen the conversation. Change talk has emerged naturally.]

3.2 Affirmations

Building Self-Efficacy and Confidence

Affirmations are statements that recognise and acknowledge a client's strengths, efforts, abilities, or positive qualities. They are one of the primary tools for building self-efficacy — the belief that one can change. Self-efficacy is a robust predictor of treatment outcomes across addictions research

(Bandura, 1997). When clients believe they are capable of change, they are more likely to attempt it and persist when it is difficult.

Genuine vs. Empty Praise — and Complex Affirmations

There is a critical distinction between genuine affirmation and empty or hollow praise. Empty praise ("Well done for coming in today!") can feel patronising or formulaic, particularly to clients who have experienced judgement from services. Genuine affirmation is specific, personal, and grounded in something the client has actually said or done.

The 4th edition of Miller & Rollnick (2023) introduces a formal distinction between simple affirmations and complex affirmations. Complex affirmations are more likely to elicit change talk than simple praise, because they engage directly with the client's character, values, and efforts rather than offering a generic observation.

Type	Description	Example	Effect
Simple (Empty)	Generic, non-specific praise	"Well done for coming in today!"	Can feel patronising; minimal therapeutic effect
Simple (Genuine)	Specific acknowledgement of what the client did	"You came in today despite being ambivalent about it — that took something."	Builds self-efficacy; feels authentic
Complex: Strength-Based	Acknowledges a core character quality evidenced in what the client said	"You've shown real persistence in coming back after what happened last year — that's not nothing."	More likely to elicit change talk; engages with identity
Complex: Values-Consistent	Reflects the client's own stated values back as a strength	"You said being a good parent matters more than anything — and here you are, doing exactly that by being honest about this today."	Connects current behaviour to deep motivation; activates Empowerment
Complex: Effort-Recognition	Acknowledges the difficulty of the client's situation or the courage of their actions	"A lot of people would have walked out of that conversation. You stayed."	Validates struggle; deepens alliance

A note of caution: complex affirmations must be genuine and specific. A forced or formulaic complex affirmation is worse than a simple one — clients will sense inauthenticity immediately. Affirmations should always be grounded in something the client has actually said or done in the session.

💬 CLINICAL DIALOGUE EXAMPLE

Client: *"I nearly didn't come today. I almost rang and cancelled."*

Practitioner: *"But something made you come."* *[Simple reflection]*

Client: *"My daughter, I suppose. I keep thinking about her."*

Practitioner: *"You've told me before that being there for her is everything to you. And even when it was hardest — when you nearly cancelled — you showed up. That's not just a word. That's who you are."*

[Complex affirmation — values-consistent: connects the client's action to their stated core value; likely to elicit further change talk]

Client: *"(pause) Yeah. I suppose it is."*

[Analysis: The complex affirmation does not simply praise attendance; it connects the client's behaviour to their deepest stated motivation. This is more likely to activate change talk than a generic "well done."]

Timing and Delivery

Affirmations are most effective when:

- They are specific and grounded in what the client has actually said or done
- They are delivered without qualification ("You're doing well, but..." negates the affirmation)
- They focus on client qualities rather than practitioner approval ("You managed to..." rather than "I'm really pleased that you...")
- They are timed to support a moment of vulnerability, ambivalence, or expressed difficulty

3.3 Reflections

The Power of Reflective Listening

Reflective listening is the central skill in MI. A reflection is a statement — not a question — that offers back to the client something of what they have just said, capturing the meaning, emotion, or implication. Reflections demonstrate that the practitioner is genuinely listening, not just waiting to respond.

The guiding image is that of a mirror held at a slight angle: the reflection should mirror what the client has said, but at an angle that highlights what is most important, most emotionally loaded, or most directly relevant to the change conversation.

In remote and digital delivery, reflective listening requires adaptation. On telephone calls, the absence of visual signals means reflections must work harder to communicate understanding. Practitioners can use explicit verbal acknowledgements, such as "I want to sit with that for a moment before we continue" or "That sounds significant — tell me more." When emotions would normally be acknowledged through body language, they need to be named explicitly in remote contexts.

Type	Description	Example
Simple reflection	Repeats or slightly rephrases what the client said. Demonstrates listening.	Client: "I don't think I'm dependent." Practitioner: "You see your use as under control."
Complex reflection	Adds meaning, feeling, or implication not explicitly stated. Demonstrates empathy.	Client: "I drink every night, but it helps me sleep." Practitioner: "You've found something that helps, even if it comes with other costs."
Double-sided reflection	Reflects both sides of the ambivalence, often joined by "and" not "but."	"You enjoy the social side of drinking and you're worried about what it's doing to your health."
Amplified reflection	Exaggerates slightly to invite the client to pull back and qualify — not sarcastically.	Client: "I'm never going to be able to stop." Practitioner: "It sounds completely impossible to you right now." Client: "Well... not

		completely impossible..."
Understated reflection	Slightly undersells to invite elaboration.	Client: "I've been drinking a bottle of vodka a day." Practitioner: "Sounds like you've been drinking quite a bit."

PRACTICE TIP

Use "and" rather than "but" in double-sided reflections. "But" signals that the second half of the sentence is more important; "and" holds both sides with equal weight.

End reflections with a falling intonation (making a statement), not a rising one (asking a question). Turning a reflection into a question reduces its power and re-enters the question-answer trap.

3.4 Summaries

Types of Summaries

Summaries collect, organise, and offer back the key content of the conversation. They serve multiple purposes: demonstrating listening, structuring the conversation, highlighting change talk, and creating transitional moments.

The 4th edition of Miller & Rollnick (2023) specifically frames summaries as a strategic tool for "stacking" change talk — collecting change talk statements in sequence to create momentum before a planning conversation. When a practitioner gathers three or four pieces of change talk together in a transitional summary, the cumulative effect is greater than any single reflection would achieve.

Summary Type	Purpose	When to Use
Collecting summary	Gathers together several things the client has said, particularly change talk statements.	After a productive exploration; "Let me see if I've got this right..."
Linking summary	Connects the current conversation to previous sessions or to key themes.	At the start of a session; when a theme recurs
Transitional summary	Marks the end of one focus and prepares to move to another — often used to "stack" change talk before planning.	Between the engaging and focusing tasks; before developing a plan

CLINICAL DIALOGUE EXAMPLE

Practitioner: *"Let me try to pull together what you've shared with me today. You came in because your GP was worried about your liver, but you've also mentioned that you've been noticing changes yourself — drinking more than you intended, mornings feeling rough. At the same time, your drinking has been a way of managing the stress of the last year, and you're not sure yet what you'd do without it. You're worried about your health, and you care a lot about being there for your kids. Does that capture it?"*
[Transitional summary — stacking change talk ("worried about my health", "being there for my kids") alongside sustain talk in preparation for a planning conversation]

Client: *"Yeah. That's... pretty much it. When you put it like that, it does sound a bit much."*

[Analysis: The summary has "stacked" the change talk, creating the conditions for a natural shift toward

evoking or planning. The client's response ("it does sound a bit much") represents emergent change talk.]

🤔 REFLECTION QUESTIONS

1. Record a role-play conversation and count your OARS: how many open questions, affirmations, reflections, and summaries did you use? What was your ratio of reflections to questions? Were your OARS strategic — deployed with a specific intent in the change conversation?

_____

2. Practise writing five genuine affirmations for a client you currently work with. Can you make each one specific and grounded in something they have actually said or done? Can you develop one simple and one complex affirmation for the same client?

_____

3. Choose one type of reflection (complex, double-sided, amplified) and practise using it in a real or role-play session this week.

_____

4. Think about a summary you have used recently. Was it a collecting, linking, or transitional summary? Could it have been used more strategically to stack change talk?

_____

✅ KEY TAKEAWAYS

- OARS (Open Questions, Affirmations, Reflections, Summaries) are the building blocks of MI. Reflections are the most important.
- The 4th edition frames OARS as directional and purposeful tools — deployed strategically in service of the change conversation, not simply as good listening habits.
- The question-answer trap is one of the most common MI pitfalls. Counter it by following questions with reflections.
- Complex affirmations (strength-based, values-consistent, effort-recognition) are more likely to elicit change talk than simple praise. They must be genuine and specific.
- Different types of reflection serve different purposes: simple reflections demonstrate listening; complex reflections add empathy; double-sided reflections hold ambivalence.
- Summaries can be used strategically to "stack" change talk before transitional moments in the conversation.
- Remote delivery requires explicit verbal adaptations to OARS — name emotions, use verbal pauses, and use summaries more deliberately to compensate for lost non-verbal cues.

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MODULE 4: RECOGNISING AND ELICITING CHANGE TALK

4.1 The DARN-CAT Framework

Change talk is any client speech that favours movement toward change (Miller & Rollnick, 2023). It is the verbal signal that motivation is stirring. Research by Moyers, Martin, Houck, and colleagues demonstrates a robust relationship between the frequency of change talk in sessions and subsequent behaviour change outcomes. Simply put: more change talk = better outcomes.

The DARN-CAT framework organises change talk into two broad categories:

- Preparatory change talk (DARN): language that suggests the client is warming up to the idea of change
- Mobilising change talk (CAT): language that indicates movement is actually occurring

Preparatory Change Talk (DARN)

Type	Description	Client Examples
Desire	What the client wants, wishes, or hopes for	"I wish I could get my drinking under control." / "I want to be there for my kids."
Ability	What the client believes they could do or is capable of	"I could probably cut down if I really tried." / "I've done it before."
Reasons	Specific reasons or arguments for change	"If I stopped, I'd feel so much better physically." / "My relationship would improve."
Need	A sense of necessity or urgency about change	"I need to do something about this." / "I should cut down — this can't carry on."

Mobilising Change Talk (CAT)

Type	Description	Client Examples
Commitment	Language indicating a decision or promise to change	"I'm going to stop drinking." / "I promise myself I'll cut down this week." / "I will do this."
Activation	Language indicating readiness, willingness, or preparation to change	"I'm ready to think about cutting down." / "I'm willing to give it a go." / "I'm prepared to try something different."
Taking Steps	Report of actions already taken in the direction of change	"I went to an AA meeting last week." / "I threw away the bottles in the house." / "I rang the GP."

> 💡 **PRACTICE TIP**
>
> Commitment language is the most powerful predictor of behaviour change outcomes. When a client says "I will" or "I'm going to," this is a critical moment — respond with a reflection and encourage elaboration rather than moving too quickly to practicalities.

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Taking Steps change talk is particularly significant: the client has already started. Affirm this and build on it.

4.2 Sustain Talk vs. Change Talk

What is Sustain Talk?

Sustain talk is the "other side of the coin" — speech that favours maintaining the status quo or argues against change. Like change talk, it can be organised using the DARN-CAT framework: Desire to stay the same, Ability to maintain current behaviour, Reasons not to change, Need to keep things as they are, Commitment to not changing, and so on.

Sustain talk is not resistance, denial, or opposition to the practitioner — it is the client's genuine ambivalence finding expression. The appropriate response is empathy and exploration, not counter-argument.

Change Talk	Sustain Talk
"I want to cut down." (Desire)	"I don't want to give up drinking." (Counter-desire)
"I could probably stop if I tried." (Ability)	"I'm not sure I'm able to stop." (Counter-ability)
"My health would improve." (Reason)	"It helps me cope with stress." (Counter-reason)
"I need to do something." (Need)	"I don't see why I have to change." (Counter-need)

Responding to Sustain Talk

The key principle: respond to sustain talk with a reflection or exploration, not an argument. The 4th edition of Miller & Rollnick (2023) provides clearer guidance on the ratio of reflecting sustain talk versus change talk — the practitioner should not over-reflect sustain talk to the point of amplifying it. The balance is to acknowledge it once, then redirect toward the change talk that is also present.

- Reflect it simply: "You feel like your use is working for you in some ways."
- Explore it with curiosity: "What is it about your cocaine use that you'd be most reluctant to give up?"
- Use a double-sided reflection to hold it alongside change talk: "You value the way it helps you socialise, and at the same time you've described some costs to your health."
- Shift to the other side of the balance: "You've told me what you value about your use. I'm also curious — are there any things you'd like to be different?"

⚠ **CLINICAL ALERT**

Research by Moyers & Miller (2013) shows that practitioner responses to sustain talk are critical. Arguing against sustain talk increases it. Reflecting and exploring sustain talk tends to reduce it over the course of the conversation.

If a session contains predominantly sustain talk, this is a signal to slow down, reinforce the therapeutic alliance, and check that the practitioner is not pushing too hard. Do not over-reflect sustain talk — acknowledge it and redirect.

4.3 Evoking Strategies

Evocative Questions

Evocative questions are open questions specifically designed to elicit change talk. Examples include:

- "What concerns you most about your drug use?" (elicits Reasons)
- "What would you most like to be different about your life in a year's time?" (elicits Desire)
- "What do you think you'd be able to do, if you decided to make a change?" (elicits Ability)
- "If things carried on as they are, what do you think might happen?" (elicits Need / reasons via looking forward)
- "Tell me about a time when your drinking was less of a concern for you." (elicits Taking Steps / Ability via looking back)

Importance and Confidence Rulers

The ruler technique uses a 0–10 scale to assess and elicit motivation. It has two main applications: the Importance Ruler and the Confidence Ruler.

Ruler	Ask First	Follow-Up (Critical)	Purpose
Importance	"On a scale of 0–10, how important is it to you to change your drinking?"	"Why did you say [their number] and not a 0 or 1?"	Elicits the client's own reasons for change (change talk)
Confidence	"On a scale of 0–10, how confident are you that you could change if you decided to?"	"What would need to happen to move your confidence from a [x] to a [x+2]?"	Identifies barriers and resources; builds self-efficacy

PRACTICE TIP

The critical follow-up question for the Importance Ruler is always about why their number is NOT lower — not why it is not higher. "Why a 6 and not a 2?" elicits change talk. "Why not an 8?" invites them to argue against change.

If a client gives a low importance score (e.g., 2), reflect it without alarm: "So at the moment, it's not feeling very important to change. Tell me about that."

Looking Forward and Looking Back

Two evocative strategies that leverage the client's own narrative:

Looking Forward: "If things carry on as they are, what do you think your life might look like in five years?" This invites the client to imagine the trajectory of their current behaviour and often elicits need-based and reason-based change talk.

Looking Back: "Tell me about a time before your drug use really took hold — what was your life like then?" This invites comparison between the client's current state and a past or imagined future self, often evoking desire and reasons for change talk.

The Pendulum Technique

The Pendulum Technique (formerly known as Running Head Start in earlier editions; updated in the 4th edition of Miller & Rollnick, 2023) is a strategy for exploring both sides of ambivalence to invite

reflection. Rather than pushing toward change, the practitioner invites the client to explore first one side of their ambivalence, then the other, allowing the natural weight of each to emerge. The image is of a pendulum — the practitioner helps the client swing from one side to the other, inviting reflection at each end rather than forcing resolution.

This technique is particularly useful when a client appears stuck in sustain talk or when the conversation has become polarised. By genuinely exploring and validating the case for not changing first, the practitioner demonstrates authentic acceptance, which paradoxically tends to reduce the client's need to defend that position.

CLINICAL DIALOGUE EXAMPLE

Practitioner: *"I'd like to try something a little different, if that's OK with you. I've noticed we've been talking a lot about the reasons you don't want to change your cocaine use. Can we spend a few minutes really exploring that side of things properly?"* *[Requesting permission; introducing Pendulum Technique]*

Client: *"Sure. It helps me relax after work. I feel like myself when I'm using. My mates are all doing it."*

Practitioner: *"So it's got real value for you — it's relaxation, identity, connection. Let's hold that. [Pause] Now — and only if you want to — can you tell me if there's any other part of you? Any part that has a different view?"* *[Double-sided reflection; inviting the other side of the pendulum]*

Client: *"(long pause) I suppose... there is a part of me that's tired of it. The comedowns. The money."* *[Emerging change talk following genuine exploration of sustain talk]*

Practitioner: *"That part has been there too. Tell me more about that."* *[Amplifying change talk through reflection and open question]*

[Analysis: The Pendulum Technique has created the conditions for genuine change talk to emerge by first fully honouring the sustain talk, rather than dismissing or arguing against it.]

CASE STUDY: Evoking Change Talk — Jamal, 26, Cocaine

Setting: Community Drug and Alcohol Service. Jamal is in contemplation — he acknowledges his cocaine use has increased but is not sure he wants to stop.

Practitioner: "Jamal, I'd like to try something with you. If I asked you to imagine your life in two years — if things carry on exactly as they are with your cocaine use — what do you think that might look like?"

Jamal: (pause) "I don't know... I suppose I'd probably still be doing it. Maybe more. My mates are using more than me now."

Practitioner: "Mm. That picture worries you a bit." [Reflection]

Jamal: "Yeah. I don't want to be... I don't know, one of those guys who's still doing it at 40."

Practitioner: "Tell me about the person you want to be at 40. What does that look like?" [Evocative question — looking forward toward desired self]

Jamal: "Someone who's got their life together. Got a decent job. Maybe a family."

Practitioner: "That matters a lot to you." [Simple reflection]

Jamal: "Yeah, it does."

[Analysis: The practitioner has elicited clear Desire and Need change talk by inviting Jamal to articulate his own values. No arguments for change were provided by the practitioner. This is the Empowerment principle in action: the motivation already existed within Jamal; the practitioner created the conditions for it to surface.]

🤔 REFLECTION QUESTIONS

1. Listen back to a recorded session (with consent). Count the instances of change talk and sustain talk. What is the ratio? What might this tell you about the session?

_____

2. Practise using the Importance Ruler with a colleague. Ask the follow-up question — "Why not a lower number?" — and notice what kind of language it produces.

_____

3. Write five evocative questions specific to your client group (e.g., alcohol, opioids, dual diagnosis). Practise using them in supervision.

_____

4. Try using the Pendulum Technique in a role-play or supervision scenario. What happened when you genuinely explored the sustain talk side first? How did the client (or colleague) respond?

_____

✅ KEY TAKEAWAYS

- Change talk (DARN-CAT) is the client's verbal expression of motivation for change. Its frequency predicts outcomes.
- Preparatory change talk (DARN) signals warming up; mobilising change talk (CAT) signals movement. Commitment language is the strongest predictor.
- Sustain talk should be reflected and explored, not argued against or ignored — but the practitioner should avoid over-reflecting it to the point of amplifying it.
- Evoking strategies — evocative questions, rulers, looking forward/backward — are designed to draw out the client's own change talk, not to persuade them.
- The Pendulum Technique (4th edition updated term) explores both sides of ambivalence to invite reflection, and is particularly useful when clients are stuck in sustain talk.
- The critical follow-up to the Importance Ruler is "Why not a lower number?" — this reliably elicits the client's own reasons for change.

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MODULE 5: HANDLING DISCORD AND RESISTANCE

5.1 Rethinking Resistance

Traditional models of addiction treatment often conceptualised resistance as a client trait — something inherent to the client that needed to be overcome. The confrontation-denial cycle was considered almost inevitable: the practitioner confronts the client's denial, the client resists, and the practitioner escalates confrontation.

MI reframes this entirely. Discord in a therapeutic relationship is not primarily a client trait; it is an interpersonal event, arising from the interaction between practitioner and client. Research consistently shows that practitioner behaviour directly predicts the level of "resistance" clients exhibit (Miller & Rollnick, 2023; Moyers & Miller, 2013). When practitioners push, clients push back. When practitioners slow down, explore, and affirm autonomy, discord typically diminishes. The client's "resistance" is often a signal that the practitioner is going too fast or too hard.

⚠ **CLINICAL ALERT**

If you are experiencing high levels of client resistance or discord in multiple sessions, this is worth bringing to supervision — not because the client has a problem, but because there may be something in your approach that is inadvertently increasing it.

Resistance is data, not defeat. It tells you something important about where the client is and how the relationship is functioning.

5.2 The Fixing Reflex vs. Evocative Stance

The Fixing Reflex (updated term from "Righting Reflex" in the 4th edition of Miller & Rollnick, 2023) is the practitioner's instinct to correct, advise, or solve. It produces a predictable pattern: the practitioner argues for change; the client defends the status quo. Both parties may escalate. The end result is typically more discord and less change talk.

Fixing Reflex Response	Evocative MI Response
"But you've told me your drinking is affecting your relationship." (Counter-argument)	"It sounds like you're not convinced your drinking is causing problems at the moment." (Simple reflection)
"I really think you need to consider rehab." (Prescribing)	"What do you think would be most helpful for you right now?" (Open question)
"That's denial." (Labelling)	"You see things differently from how your family sees them." (Reflection)
"You have to take this seriously." (Warning)	"You're not feeling the urgency right now." (Reflection)
"Have you thought about cutting down?" (Unsolicited advice)	"What, if anything, have you been thinking about your use?" (Open question)

5.3 Strategies for Dancing with Discord

The following eight strategies provide a practical toolkit for responding to discord. Each is appropriate in different contexts; developing facility with all eight is the mark of an experienced MI practitioner.

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1. Simple Reflection
Often the most effective response to discord is the simplest: reflect what the client said without adding an agenda. This communicates that you have heard them and reduces the feeling of being pushed.

"So you feel like you don't really need to be here."

2. Amplified Reflection
Slightly exaggerate what the client has said so that they naturally pull back and qualify their position. Use with care — this must be done genuinely, not sarcastically.

"So this is something you're not worried about at all." / "Change is completely out of the question for you."

3. Double-Sided Reflection
Acknowledge both sides of the client's ambivalence, holding discord alongside any change-oriented statements.

"You resent being here, and you've also mentioned that things haven't been quite right lately."

4. Shifting Focus
Move the conversation away from the point of contention to something less threatening, while keeping the door open to return later.

"I can see this isn't feeling very relevant right now. I wonder if we could set that aside and talk about what you'd like to get out of our time together."

5. Emphasising Autonomy
Explicitly remind the client that they are in control of their choices. This directly addresses the reactance that underlies much discord.

"I want to be clear — nobody here is going to force you to do anything. What happens from here is entirely your decision." / "You know yourself far better than I do. If you decide this isn't for you, that's your right."

6. Reframing
Offer a new frame for the client's expressed concern, one that shifts its meaning without dismissing it.

Client: "I just can't seem to stop, even when I want to." (Expressed as failure)

Practitioner: "You've been trying to manage this on your own for a long time. That takes real determination."

7. Agreeing with a Twist
Partially agree with the client, then add a slight reframe.

Client: "Everyone I know drinks like this. It's normal."

Practitioner: "You're right that many people do drink at that level. And you're someone who's been noticing it's affecting you."

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8. Coming Alongside

When all else fails, join the client's perspective entirely, expressing genuine curiosity about it.

"I'm not going to try to convince you. Tell me — what would have to happen for you to decide that change was worth considering?"

Practitioner Behaviour	Client Response	MI Strategy
Direct confrontation	Increased resistance, disengagement	Avoid — this is the fixing reflex in action
Simple reflection of resistance	Slight softening, elaboration	Safe default when unsure
Emphasising autonomy	Reduced reactance, re-engagement	Effective when client feels controlled
Amplified reflection (carefully)	Client qualifies or contradicts the exaggeration	Can produce change talk quickly, but requires skill
Coming alongside	Genuine engagement, often change talk emerges	Best for highly resistant or mandated clients

5.4 Practical Application Scenarios

Client Anger or Frustration

When a client arrives angry — perhaps frustrated by the system, feeling stigmatised, or experiencing withdrawal — the temptation is to defend services, explain policies, or counter-argue. The MI response should first reflect the anger.

💬 **CLINICAL DIALOGUE EXAMPLE**

Client: *"This is a waste of time. The last keyworker I had never listened to me. Why would you be any different?"*

Practitioner: *"You've been let down before, and you're not going to assume I'll be different until you see it."* *[Simple reflection — does not defend services; acknowledges the experience]*

Client: *"...Yeah. Pretty much."*

Practitioner: *"That's fair. I'd feel the same. I'm not going to ask you to trust me on the basis of nothing. How about we see how today goes, and you can judge for yourself?"* *[Autonomy support and reframe — invites engagement without demanding trust]*

Mandated Clients

Clients who are required to attend by criminal justice, social care, or other bodies present particular challenges. Key MI principles for mandated contexts:

- Acknowledge the situation directly, without pretending that voluntary attendance is the norm.
- Differentiate clearly between what is required (attendance) and what the client can choose (how they engage, what they talk about).
- Express genuine curiosity about the client's perspective on their situation.
- Avoid spending the session focused on compliance — find the person behind the referral.

"I know you're here because the court has asked you to be. That's the reality. But how we use our time together — that's something you get to shape. What would feel most useful to you?"

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Low Motivation Presentations

When a client presents with very low motivation — minimal change talk, flat affect, minimal engagement — avoid the trap of working harder to motivate them. Working harder often generates more resistance. Instead, slow down, broaden the focus, explore what is happening in the client's life beyond their substance use, and look for seeds of motivation in unexpected places. Even the smallest ambivalence is an entry point.

5.5 Practitioner Self-Disclosure in MI

The 4th edition of Miller & Rollnick (2023) explicitly recognises practitioner self-disclosure as an MI-consistent practice when used appropriately. This is a new area of guidance in the 4th edition, and it is particularly relevant in UK drug and alcohol services, where the workforce increasingly includes practitioners with lived experience of substance use and recovery.

When Self-Disclosure is MI-Consistent

Appropriate self-disclosure in MI is characterised by three qualities:

- Brief: Self-disclosure is not an extended personal narrative. It is a sentence or two at most.
- Purposeful: It is used deliberately and in service of the client's change process — not to fill silence, demonstrate relatability, or process the practitioner's own experience.
- Client-focused: It is immediately bounced back to the client. The moment after disclosure, the focus returns entirely to the client's own experience.

Self-disclosure that does not meet these criteria risks derailing the conversation, creating an unhelpful equivalence between the practitioner's and the client's experiences, or subtly shifting the focus of the session away from the client's needs.

Examples of MI-Consistent Self-Disclosure

In drug and alcohol settings, MI-consistent self-disclosure might include:

- Sharing a personal observation about the process of change: "In my own experience, the hardest part of making a change has sometimes been letting go of what I thought it would look like."
- Reflecting on one's own experience of ambivalence (without claiming equivalence): "I know for myself how difficult it can be to want two things at once. What does that feel like for you?"
- Using lived experience where the practitioner has it — and has the organisational permission and reflective framework to use it: "I've been in recovery myself, and I remember... [brief, purposeful reference]. But I'm more interested in what it means for you."

Boundaries of Self-Disclosure

Self-disclosure should be brief and bounced back to the client immediately. It is not therapy for the practitioner. The following guidance applies:

MI-Consistent	Not MI-Consistent
Brief (one or two sentences)	Extended personal narrative
In service of the client's process	Filling silence or demonstrating relatability
Returned to the client immediately	Shifting the session's focus to the practitioner
Purposeful and considered	Spontaneous or reactive
Used sparingly	Used frequently or routinely

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Peer Workers and Lived Experience Practitioners

Peer workers and practitioners with lived experience of substance use occupy a unique position in UK drug and alcohol services, and the question of self-disclosure is especially salient for this workforce group. Specific guidance:

- Lived experience is a significant clinical asset — but only when used with purpose and within a reflective framework.
- Peer workers should receive explicit training and supervision support on when and how to use self-disclosure in MI contexts.
- The same MI principles apply: brief, purposeful, bounced back. The difference is that peer workers may have more material to draw on, which increases both the opportunities and the risks.
- Peer workers should work within their organisation's lived experience disclosure policy and regularly bring questions about self-disclosure to supervision.

💬 CLINICAL DIALOGUE EXAMPLE

Client: *"I just don't know if I can do it. I've tried before and it never sticks."*

Practitioner: *"I hear that. I've noticed in my own life that change often looks different from what I expected — less like a straight line, more like... finding your footing again after a stumble. But that's me. What does "not sticking" look like for you?"* *[Brief self-disclosure — shared observation about change; immediately returned to client. Not claiming equivalence; not an extended narrative.]*

Client: *"I always do well for a bit and then something goes wrong and I'm back to square one."*

Practitioner: *"So there's a pattern you've noticed. Something goes wrong — and then what happens?"* *[Open question following up on the client's own language]*

[Analysis: The self-disclosure was brief (one sentence), purposeful (modelling that change is non-linear), and immediately returned to the client. It did not shift the session's focus or claim equivalence between practitioner and client experience.]

💡 PRACTICE TIP

Before using self-disclosure in a session, ask yourself three questions:
1. Is this for the client or for me?
2. Can I say it in one sentence?
3. What question will I ask immediately afterwards to return focus to the client?

If you cannot answer all three clearly, it may not be the right moment for self-disclosure.

🤔 REFLECTION QUESTIONS

1. Think of a recent encounter where you felt the fixing reflex strongly. What did you do? What would you do differently using an MI strategy?

_____

2. Which of the discord-dancing strategies (amplified reflection, coming alongside, autonomy emphasis, reframing) do you find most natural? Which is most outside your comfort zone?

_____

3. How do you currently approach mandated clients? How might MI change your approach?

_____

4. Have you ever used self-disclosure in a session — intentionally or unintentionally? How did it affect the conversation? What does the MI framework suggest about when and how to use it?

_____

✅ **KEY TAKEAWAYS**

- Discord is an interpersonal event, not a client trait. Practitioner behaviour directly predicts levels of client resistance.
- The Fixing Reflex (updated term from Righting Reflex, 4th edition) — the urge to argue, correct, or persuade — is the primary driver of therapeutic discord.
- Eight strategies for dancing with discord: simple reflection, amplified reflection, double-sided reflection, shifting focus, emphasising autonomy, reframing, agreeing with a twist, and coming alongside.
- With mandated clients, differentiate clearly between what is required (attendance) and what the client can choose (engagement, topics).
- Low motivation is a signal to slow down and widen the focus — not to work harder at persuasion.
- Practitioner self-disclosure is MI-consistent when used briefly, purposefully, and in service of the client's change process — immediately bounced back to the client.
- Peer workers and lived experience practitioners should receive explicit supervision support around self-disclosure boundaries within MI.

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MODULE 6: THE FOUR TASKS OF MI

In the 4th edition of Miller & Rollnick (2023), the four "Processes" of MI have been renamed the four "Tasks" of MI. This is not a trivial change. The word "tasks" was chosen for its everyday, non-clinical feel. More importantly, it better reflects how MI actually works in practice: the four elements are not a rigid linear sequence but a set of ongoing activities that a practitioner returns to throughout a conversation. You may be engaging and re-engaging, focusing and refocusing, across a single session. The tasks model is fluid, overlapping, and non-sequential.

Task	Key Question for the Practitioner	Primary MI Activities
Engaging	Have we established a trusting, collaborative working relationship?	OARS; affirmations; managing traps (expert, assessment, premature focus)
Focusing	Are we clear about what direction this conversation is heading?	Choosing a Path; agenda negotiation; identifying target behaviours
Evoking	Am I drawing out the client's own reasons and motivation for change?	Eliciting change talk; responding to sustain talk; rulers, looking forward/back
Planning	Are we working together on how change could happen?	Commitment strengthening; SMART goals; barrier anticipation; change plan

6.1 Engaging

Building Rapport and Trust

The Engaging task is the foundation of everything that follows. Without a genuine working relationship — one characterised by trust, non-judgement, and genuine curiosity — the other tasks cannot operate. This is not a separate "phase" completed before MI begins; it is an ongoing activity that practitioners return to throughout each session and with every new contact.

Engaging is particularly challenging in contexts where clients have been let down by services, where attendance is mandated, or where the client is in crisis or intoxication. In these contexts, the practitioner may need to spend the majority of a session purely in the Engaging task — and that is appropriate clinical work, not a failure to progress.

PRACTICE TIP

In remote and digital delivery, explicit verbal engagement signals are more important than in face-to-face sessions. Without body language, eye contact, and proxemics to communicate presence, practitioners must use words. Name what you are noticing: "I want you to know I'm fully with you here." Use silence deliberately but sparingly — silence is much harder to hold productively on a telephone call, and prolonged silences can be misread as disconnection or technical failure.

Common Traps in Engaging

Miller & Rollnick (2023) identify several common traps that derail the Engaging task:

Trap	What It Looks Like	MI Solution
Assessment trap	Session becomes a structured information-gathering exercise; client feels interrogated	Intersperse questions with reflections; use OARS throughout assessment
Expert trap	Practitioner takes the role of knowledge-provider from the start; client becomes passive	Ask-Offer-Ask (AOA): ask first, offer briefly, ask again — see Module 7.2
Premature focus trap	Practitioner focuses on change before engagement is established	Stay in Engaging until genuine rapport is present
Labelling trap	Practitioner attaches a diagnosis or category before exploring the client's own frame	Use person-first language; explore the client's understanding first
Blaming trap	Practitioner (or system) communicates that the client's problems are their own fault	Empathy and acceptance; avoid moralising
Chat trap	Session becomes social conversation without therapeutic purpose	Gently introduce focus when rapport is established

6.2 Focusing

Choosing a Path

Focusing is the task of establishing a shared understanding of what the conversation is about and where it is heading. In the 4th edition (Miller & Rollnick, 2023), "Agenda Mapping" has been renamed "Choosing a Path". The new term better captures the collaborative, directional nature of the activity: practitioner and client are not merely mapping topics; they are choosing together where this particular conversation will go.

PRACTICE TIP

Choosing a Path: "Today we have some time together. There are a number of things we could explore — your drinking, the impact it's having at home, your health, or anything else that's on your mind. What feels most important to you to talk about today?"

This approach respects client autonomy while allowing the practitioner to note clinical priorities. It sets the collaborative tone for the rest of the session.

Identifying Target Behaviours

Once a path has been chosen, the Focusing task involves clarifying what, specifically, the conversation is about. In drug and alcohol settings, clients often present with multiple concerns — poly-substance use, mental health difficulties, relationship problems, housing, and criminal justice involvement. Focusing helps both practitioner and client agree on what to prioritise, without losing sight of the whole person.

The practitioner may have a clinical or organisational priority (e.g., a required assessment, a care plan review) that needs to be incorporated. Choosing a Path allows this to be introduced transparently, without the practitioner simply imposing it.

💬 **CLINICAL DIALOGUE EXAMPLE**

Practitioner: *"You've mentioned a few different things today — your drinking, the situation with your probation officer, and how you're feeling about your housing. They're all connected, I imagine. If you had to pick one to start with today, where would you want to begin?"* *[Choosing a Path — collaborative focus-setting]*

Client: *"The probation thing is stressing me out the most. That's what's making my drinking worse."*

Practitioner: *"So the stress of the probation situation is feeding the drinking. Let's start there."* *[Reflection and focus confirmation]*

6.3 Evoking

Drawing Out Intrinsic Motivation

The Evoking task is the heart of MI: listening selectively for change talk, reflecting it back, and using evoking strategies to draw out more. "Evoking" as a task describes what the practitioner does; "Empowerment" as a Spirit component describes the underlying belief that makes it authentic — the conviction that the motivation already exists within the client.

This distinction is important: the task of Evoking (what the practitioner actively does in sessions) remains unchanged from earlier editions. It is "Evocation" as a Spirit component that has been replaced by "Empowerment" in the 4th edition. The two serve overlapping purposes but describe different aspects of the MI framework.

Strengthening Change Talk

During the Evoking task, the practitioner:

- Listens for change talk and responds to it with a reflection, elaboration question, or affirmation
- Does not over-reflect sustain talk — acknowledges it and redirects
- Uses evoking strategies (rulers, looking forward/back, Pendulum Technique) to draw out more change talk
- Watches for signals that mobilising change talk (CAT) is emerging — this signals readiness to transition to the Planning task

⚠️ **CLINICAL ALERT**

Avoid moving to Planning prematurely. Jumping to problem-solving before sufficient change talk is present typically produces plans that do not hold. Watch for commitment language ("I will...", "I'm going to...") as the signal that the client is ready to plan.

6.4 Planning

Knowing When to Move to Planning

The transition from Evoking to Planning is a clinical skill in itself. Indicators that the time is right include:

- The client is producing consistent mobilising change talk (CAT), especially commitment language
- The client is asking practical questions ("What services are available?", "How would I do that?")
- The decisional balance has clearly tipped — the client has articulated more reasons to change than to stay the same
- The client explicitly raises the idea of a plan

Developing SMART Goals

When the transition is right, the Planning task involves developing a concrete, client-authored change plan. SMART goals (Specific, Measurable, Achievable, Relevant, Time-bound) provide a useful structure, but they should emerge from the client's own language and values rather than be imposed by the practitioner.

SMART Element	Question to Ask	Example
Specific	"What exactly do you want to do differently?"	"Drink no more than 4 units on any one day"
Measurable	"How will you know if it's working?"	"I'll keep a drink diary for two weeks"
Achievable	"Is this realistic, given everything else in your life?"	"Start with weekdays only — that's where the problem is"
Relevant	"Does this connect to what matters most to you?"	"Being able to be present for my children"
Time-bound	"By when, and what is the first step?"	"Starting Monday; I'll call the GP tomorrow"

Strengthening Commitment

Commitment-strengthening conversations support the transition from intention to action. Useful questions include:

- "On a scale of 0–10, how committed are you to this plan?"
- "What might get in the way? How would you handle that?"
- "Who in your life could support you with this?"
- "What will you do in the first 24 hours to start?"

In remote and digital settings, digital tools can support the Planning task: shared-screen decision-making balance exercises, emailed change-plan summaries, and app-based goal tracking (e.g., Drink Less, BreakFree) can help maintain momentum between sessions. For clients with digital access, a change plan sent by encrypted email immediately after the session can serve as a powerful reinforcer. Practitioners should be mindful of digital exclusion (see Module 7.4).

CASE STUDY: Planning — Aaron, 33, Alcohol Dependent

Setting: Community Drug and Alcohol Service, fourth appointment.

Aaron has been producing consistent change talk over three sessions. Today, he arrives and says: "I've been thinking about this a lot. I want to make a proper plan."

Practitioner: "That sounds like something has shifted for you. Tell me about what you've been thinking." [Reflection and open question]

Aaron: "I want to try cutting down. Not stopping completely. Just to a sensible level."

Practitioner: "What does 'sensible level' look like for you?" [Open question — specificity]

Aaron: "The government guidelines. 14 units a week. That feels manageable."

Practitioner: "And when would you start?" / Aaron: "This week. Monday."

Practitioner: "What might make that harder? What could get in the way?" [Barrier anticipation]

Aaron: "Friday nights. We always go out. I could stick to soft drinks for the first round."

[Analysis: The Planning task has begun with the client's own words and commitment. The practitioner has not set the goal, the timeline, or the strategy — Aaron has authored all of these. The barrier anticipation question prepares him for realistic obstacles.]

🤔 REFLECTION QUESTIONS

1. In a recent session, which of the Four Tasks occupied most of the conversation? Was that appropriate for where the client was?

_____

2. Have you ever moved too quickly to the Planning task? What were the signs that it was premature?

_____

3. Try using Choosing a Path at the start of a session this week. What do you notice about the client's engagement when you give them that choice?

_____

4. How do you navigate the Four Tasks differently in a remote or telephone session compared to face-to-face? What adaptations have you found most effective?

_____

✅ KEY TAKEAWAYS

- The 4th edition (2023) replaces "Four Processes" with "Four Tasks" to emphasise their practical, everyday, non-sequential nature.
- The Four Tasks (Engaging, Focusing, Evoking, Planning) are fluid and overlapping — practitioners may revisit earlier tasks throughout a single session.
- Engaging is the foundation — without genuine rapport and trust, the other tasks cannot operate.
- Choosing a Path (updated term for Agenda Mapping, 4th edition) is a collaborative tool for negotiating focus, respecting client autonomy while allowing clinical input.
- In Module 6.3, Evoking as a task remains unchanged; Empowerment replaces Evocation in the Spirit — these are distinct but related concepts.
- Do not move to Planning until mobilising change talk is present and consistent. Premature planning

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undermines motivation.

- Remote delivery requires explicit verbal engagement signals, deliberate use of silence, and digital tools to support the Planning task.

MODULE 7: SPECIALISED APPLICATIONS

7.1 MI with Drugs & Alcohol

Alcohol

Alcohol is legal, deeply embedded in social culture, and its risks are frequently normalised or underestimated by clients and their families. MI conversations about alcohol often need to:

- Explore the social and cultural dimensions of drinking without moralising
- Provide accurate information about the health consequences of alcohol at higher consumption levels, using Ask-Offer-Ask (AOA) — see Section 7.2
- Navigate the medical complexity of withdrawal: alcohol withdrawal can be life-threatening, and reduction must be medically supervised in dependent drinkers
- Explore the function alcohol serves (sleep, anxiety, pain management) and what the client's life would look like without those functions
- Address stigma: many alcohol-dependent people experience shame and self-blame that inhibits engagement

⚠ CLINICAL ALERT

CLINICAL ALERT: Alcohol withdrawal is a medical emergency. People who are physically dependent on alcohol should never be advised to stop abruptly without medical supervision. If a client is consuming large quantities daily (e.g., >15 units/day), refer to a GP or specialist service for assessment before any reduction plan is agreed.

Wernicke's encephalopathy and Korsakoff syndrome are serious neurological complications of severe alcohol use. If a client presents with confusion, eye movement problems, or ataxia, treat as a medical emergency.

NICE GUIDANCE

NICE CG115 (Alcohol Use Disorders, 2011/2019): Community-based medically assisted withdrawal is recommended as the first-line intervention for people with moderate-severe alcohol dependence.

Acamprosate and naltrexone are recommended as pharmacological adjuncts to psychosocial interventions including MI. Disulfiram is available for selected patients with appropriate support.

Brief motivational interventions are recommended for hazardous and harmful drinkers in primary care and acute settings.

Opioids

Opioid use — including heroin, nitazenes, fentanyl, and prescription opioids — carries the highest risk of overdose mortality in UK drug treatment statistics. MI in opioid contexts must navigate:

- The neurobiological reality of opioid dependence: cravings, withdrawal, and the powerful reinforcing properties of opioids make change more complex than a simple decision.
- The availability and evidence base for opioid substitution therapy (OST) — methadone and buprenorphine — which should be offered as the first-line treatment (NICE NG58).
- Naloxone access: MI conversations about harm reduction should include offering take-home naloxone to all opioid users and their families.

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- Fentanyl and nitazene contamination: drug checking services and test strips should be discussed in harm reduction contexts.
- The meaning of OST: for many clients, medication feels like "swapping one drug for another." MI using the AOA framework can help explore what OST would actually offer.
- MI's specific role in pharmacotherapy conversations: use the AOA framework (see Section 7.2) to discuss naltrexone, buprenorphine, or methadone dosage — ask first, offer information neutrally, ask what the client makes of it.

NICE GUIDANCE

NICE NG58 (Drug Misuse in Over 16s, 2017): Methadone or buprenorphine is recommended as the first-line pharmacological treatment for opioid dependence. OST should be offered within a care plan including psychosocial interventions.

Take-home naloxone should be offered to all people at risk of opioid overdose and to family members, carers, and significant others.

Stimulants (Cocaine and Crack Cocaine)

No pharmacological treatment is currently licensed for cocaine or crack cocaine dependence in the UK. The evidence base sits predominantly with psychosocial interventions including MI, CBT, and Contingency Management (NICE TA934, 2023). MI considerations for stimulant use:

- Stimulant use is often episodic (binge use, "runs") rather than daily — this can make it harder for clients to see it as a problem.
- The crash following stimulant use (depression, exhaustion, dysphoria) can be significant and is often a driver of continued use to avoid withdrawal.
- Chemsex contexts require specific sensitivity around sexual identity, shame, and the intertwining of drug use with sexual and social life.
- Crack cocaine use is disproportionately associated with poverty, trauma, and social marginalisation — these contexts must be acknowledged and respected in MI conversations.
- Contingency Management (CM), which uses positive reinforcement to reward abstinence, is now recommended by NICE TA934 (2023) and is highly compatible with MI as a foundational engagement approach.

7.2 Ask-Offer-Ask (AOA) (formerly Elicit-Provide-Elicit)

In the 4th edition of Miller & Rollnick (2023), Elicit-Provide-Elicit (EPE) has been renamed Ask-Offer-Ask (AOA). The new name is more intuitive and captures the three steps more clearly: Ask what the client already knows or wants to know; Offer information neutrally and concisely; Ask what the client makes of it.

The repositioning of AOA in the 4th edition is significant. Information-giving is not contrary to MI when done within this framework. The AOA approach acknowledges that practitioners have clinical knowledge that clients need — but insists that this knowledge is offered in a way that respects autonomy, invites the client's own interpretation, and does not position the practitioner as an authority imposing conclusions.

Step	What the Practitioner Does	Example	MI Function
Ask (first)	Elicit what the client already knows; ask permission	"What do you already know about how alcohol affects the liver? Can I share something with you?"	Respects existing knowledge; requests autonomy
Offer	Provide information neutrally, briefly, without argument	"Regular heavy drinking over time can cause fatty liver, then hepatitis, and eventually cirrhosis — that's permanent scarring. It doesn't always have symptoms until it's advanced."	Provides accurate clinical information without moralising
Ask (second)	Elicit the client's response, interpretation, or meaning	"What do you make of that in terms of your own situation?"	Returns control; elicits change talk; avoids expert trap

PRACTICE TIP

The second Ask is the most important and most commonly omitted step. Without it, AOA collapses into a one-way information dump — indistinguishable from the expert trap.

After offering information, always return to the client: "What do you make of that?" or "Does any of that land differently given what you've told me about your situation?"

AOA in medication-assisted treatment conversations: practitioners discussing pharmacotherapy options — naltrexone, acamprosate, buprenorphine, methadone — should always use the AOA framework. These are conversations where the fixing reflex is particularly strong (the practitioner knows what is clinically best; the client may be ambivalent or misinformed). AOA provides the structure for offering accurate information while preserving the client's role as the decision-maker.

Clinical Context	AOA in Practice
Sharing AUDIT-C results	Ask: "What do you make of your score?" → Offer: brief, neutral explanation of what it indicates → Ask: "How does that fit with how you see your drinking?"
Harm reduction advice	Ask: "What do you already know about safer use?" → Offer: specific, non-judgmental information → Ask: "Is any of that new information for you? What do you think about it?"
Naltrexone discussion	Ask: "What do you know about naltrexone?" → Offer: mechanism, evidence, practicalities → Ask: "What are your thoughts? Does this feel like something worth exploring?"
Methadone vs. buprenorphine	Ask: "What have you heard about both medications?" → Offer: brief comparison → Ask: "What feels most aligned with what you want?"
Contingency Management referral	Ask: "Have you heard of Contingency Management?" → Offer: brief explanation of the approach and

	evidence → Ask: "What are your initial thoughts about trying it?"

7.3 MI in Brief Interventions

MI principles are well-suited to brief intervention contexts, where time is limited, and practitioners cannot rely on sustained therapeutic relationships. The FRAMES framework (Feedback, Responsibility, Advice, Menu, Empathy, Self-Efficacy) provides a useful structure for brief MI-informed interventions.

Brief MI interventions have a strong evidence base in primary care, A&E settings, and community health contexts (Hettema et al., 2005; Lundahl et al., 2010). Even a single well-conducted MI conversation can shift motivation and increase treatment engagement.

Brief MI via telephone or digital platforms: there is emerging evidence that brief MI delivered remotely is non-inferior to face-to-face brief MI in several settings (Moyers et al., 2020). Specific adaptations for brief remote MI include:

- Spend proportionally more time on Engaging — rapport is harder to establish remotely and is even more important in brief contacts.
- Use AOA proactively — practitioners can follow up with digital contacts after A&E attendances or GP appointments, sharing screening results (e.g., AUDIT-C) while preserving autonomy.
- SBIRT (Screening, Brief Intervention, Referral to Treatment) can be delivered effectively by telephone or secure messaging. Practitioners should be trained in adapting SBIRT materials for digital formats.
- Closed-loop safety checking is more important in remote brief interventions — always end with a clear summary of agreed next steps and a safety check.

NICE GUIDANCE

NICE CG115 and NG58 both recommend brief motivational interventions as part of the care pathway for hazardous/harmful alcohol and drug use.

NICE recommends that brief interventions should be delivered by appropriately trained practitioners across all clinical settings — not only specialist drug and alcohol services.

7.4 MI via Remote and Digital Platforms

The 4th edition of Miller & Rollnick (2023) explicitly addresses MI delivery via video call, telephone, and digital platforms for the first time. This is a timely addition: following the shift in UK drug and alcohol services post-2020, remote delivery has become a standard component of the treatment pathway — not an exception.

Evidence Base for Remote MI

Emerging research indicates that MI delivered via telephone and video call is non-inferior to face-to-face delivery across several settings, including substance use, health behaviour change, and mental health (Moyers et al., 2020; Sucala et al., 2012). The therapeutic relationship — the most important predictor of outcomes — can be maintained in remote formats, but it requires deliberate adaptation. Fidelity to the MI spirit (Partnership, Acceptance, Compassion, Empowerment) is the strongest predictor of remote MI effectiveness.

Practical Adaptations for Remote MI

The following adaptations apply across the Four Tasks when delivering MI remotely:

OARS Skill	Face-to-Face	Remote/Digital Adaptation
Open Questions	Enhanced by non-verbal curiosity signals	Use slightly more open questions to compensate for reduced relational warmth; name your intention: "I'm genuinely curious about..."
Affirmations	Supported by tone, eye contact, body language	Make affirmations more explicit and verbal. Complex affirmations are especially important remotely. Say what you'd normally show.
Reflections	Tone and posture add meaning	Name emotions explicitly: "That sounds like it hit you hard." Use verbal pauses: "I want to sit with that a moment before we continue."
Summaries	Can use physical cues to signal transition	Use transitional summaries more frequently to create structure and signal shifts in direction. On telephone, the summary is your only structural tool.
Silence	Productive silence can be held naturally	Silence is harder to hold on telephone — briefly name it: "I'm just giving you some space to think." On video, silences are more manageable.

Managing Engagement Without Physical Presence

The absence of physical co-presence in remote MI creates specific challenges for the Engaging task:

- Technical disruption (poor signal, frozen video, background noise) can interrupt rapport and must be managed without embarrassment.
- Non-verbal distress signals may be missed — practitioners should check in verbally more frequently: "How are you doing right now?"
- Clients who are in unsafe or unstable environments when they take a call (e.g., using substances while on the phone, in public) may need the session to be rescheduled.
- Distractions on both sides need to be managed — practitioners should create a distraction-free environment for remote sessions and invite clients to do the same where possible.

Digital MI Tools

A growing range of digital tools can support MI-consistent conversations:

- Online decisional balance tools: shared-screen or app-based versions of the decisional balance exercise
- Confidence and importance rulers: digital slider tools available via apps and web platforms
- Change talk journalling apps: apps that invite clients to record their own reasons for change between sessions

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- Remote change plan completion: shared documents or encrypted email summaries of change plans
- App-based monitoring: drink diaries (e.g., Drink Less app), drug use trackers, mood journals

Supervision and Fidelity in Remote Delivery

Remote delivery should be explicitly included in competency frameworks and MITI-style fidelity coding. Supervisors should review recordings of both remote and face-to-face sessions and code for additional competencies specific to digital delivery (e.g., explicit engagement signals, management of digital silence, use of digital tools).

💡 PRACTICE TIP

Digital Exclusion: Not all clients have access to or confidence with digital technology. OHID guidance on digital access in drug and alcohol populations identifies digital exclusion as a significant health equity issue. Practitioners should:
— Never assume digital access or literacy
— Always offer telephone as an alternative to video
— Assess digital access as part of care planning
— Avoid digital-only pathways where face-to-face or telephone remains accessible

MI on telephone remains MI. The principles do not change; only the delivery channel does.

⚠️ CLINICAL ALERT

Remote MI does not reduce safeguarding obligations. Practitioners must have clear protocols for managing risk and safeguarding concerns identified during remote sessions — including how to access emergency services for a client whose location may not be known.

💬 CLINICAL DIALOGUE EXAMPLE

Practitioner: *"Thanks for joining the call today. Can you hear me clearly? Good. I just want to make sure you're in a reasonably private space — is now a good time?"* *[Explicit engagement check — replaces physical welcome in remote setting]*

Client: *"Yeah, I'm at home. Kids are at school."*

Practitioner: *"Good. So we've got about 45 minutes. Last time we spoke you'd been trying to cut back on the weekends — how has that been going?"* *[Linking to previous session; open question]*

Client: *"Mixed. Did well Wednesday and Thursday. Friday was a write-off."*

Practitioner: *"Two good days, and then Friday broke the pattern. That takes honesty to say."* *[Complex affirmation — effort-recognition; naming what non-verbal signals can't convey on a call]*

Client: *"I suppose. I just feel like I always fail on Fridays."*

Practitioner: *"Friday has its own pull for you. Tell me what Friday looks like when it starts to go wrong."* *[Reflection followed by open question — staying in Evoking]*

🤔 REFLECTION QUESTIONS

1. Using the AOA framework, how would you share AUDIT-C results with a client who describes themselves as "not a big drinker"? Write out the three steps.

_____

2. What specific adaptations do you make (or would you make) when delivering MI via telephone rather than face-to-face?

_____

3. Think about a client who might face digital exclusion barriers. How would you adapt your approach?

_____

4. Have you encountered a situation where the remote format made it harder to maintain the MI spirit? What did you do?

_____

✅ **KEY TAKEAWAYS**

- Ask-Offer-Ask (AOA) — updated term for Elicit-Provide-Elicit — is the framework for sharing information in an MI-consistent way.
- The second Ask is the most important step: it returns control to the client and invites their own interpretation.
- AOA is especially important in pharmacotherapy conversations (naltrexone, buprenorphine, methadone, acamprosate) where the fixing reflex is strong.
- The 4th edition (2023) explicitly addresses remote MI delivery for the first time — a timely addition for UK drug and alcohol services.
- Remote MI is non-inferior to face-to-face in several settings when the MI spirit is maintained and deliberate adaptations are made.
- OARS require explicit verbal adaptation in remote/telephone contexts — name emotions, use verbal pauses, and deploy summaries more deliberately.
- Digital exclusion is a health equity issue — never assume digital access or literacy; always offer telephone alternatives.

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MODULE 8: PRACTICE DEVELOPMENT

8.1 Self-Assessment and Reflective Practice

The MI Competency Framework

Sustained MI competency requires regular self-assessment, not just initial training. The following competency framework invites practitioners to rate themselves across the core domains of MI practice. This is not a performance tool — it is a reflective one. Use it to identify where your practice is already strong, and where intentional development would make the most difference.

Competency Domain	Developing (1–2)	Established (3–4)	Advanced (5)
Spirit of MI (Partnership, Acceptance, Compassion, Empowerment)	Uses technique without consistent spirit; may feel transactional	Spirit generally present; occasions of drift into fixing reflex	Consistently embodied; clients experience genuinely collaborative relationship
OARS	Predominantly closed questions; minimal reflections	Uses all four; ratio improving; some strategic deployment	Deploys OARS strategically and with intentionality; complex affirmations used appropriately
Change Talk Recognition	Misses most change talk; does not distinguish DARN from CAT	Recognises most change talk; responds to mobilising talk	Responds differentially to all DARN-CAT types; uses evoking strategies to draw out more
Responding to Sustain Talk	Counter-argues or ignores; fixing reflex dominant	Reflects and explores sustain talk; some redirecting	Manages ratio deliberately; redirects without dismissing
Four Tasks Navigation	Moves linearly or stays stuck in one task	Navigates tasks fluidly; mostly appropriate task for client	Returns to earlier tasks when needed; transitions are client-led
AOA (Ask-Offer-Ask)	Shares information without framework; expert trap common	Uses AOA sometimes; second Ask sometimes omitted	Consistently uses AOA; second Ask is natural and client-focused
Discord Management	Engages fixing reflex when discord arises; escalates	Uses one or two discord strategies; sometimes effective	Full toolkit available; selects strategy purposefully
Remote/Digital MI Delivery	Does not adapt for remote format; equivalent to face-to-face	Makes some adaptations; explicit engagement signals used	Fully adapted OARS delivery; uses digital tools where appropriate

Reflective Practice Exercises

Reflective practice is most powerful when it is structured and regular. Recommended exercises include:

- Recording sessions (with client consent) and listening back for change talk, sustain talk, and OARS use

- Using the Motivational Interviewing Treatment Integrity (MITI) scale or a simplified version to code your own sessions
- Bringing specific moments from sessions to supervision — not just summaries
- Writing a reflective note after each session: "What was the most significant piece of change talk? Did I respond well to it? What would I do differently?"

8.2 Common Pitfalls and Solutions

Pitfall	What It Looks Like	Solution
Expert trap	Practitioner provides information or advice without using AOA; client becomes passive	Ask-Offer-Ask (AOA) — see Module 7.2; ask before offering; return control with second Ask
Question-answer trap	Session becomes a series of questions; client gives brief answers; no elaboration	Follow questions with reflections; aim for 2:1 reflection-to-question ratio
Premature focus	Practitioner introduces a change agenda before the client is engaged	Stay in Engaging until genuine rapport is established; use Choosing a Path
Premature planning	Practitioner moves to goal-setting before mobilising change talk is present	Return to Evoking; watch for CAT language as the signal
Hollow affirmations	Generic praise ("Well done!") that feels formulaic or patronising	Use complex affirmations — specific, strength-based, values-consistent
Fixing reflex in action	Practitioner argues for change; client argues against; discord escalates	Recognise the fixing reflex; use discord strategies; reflect sustain talk
Over-reflecting sustain talk	Practitioner amplifies sustain talk by reflecting it repeatedly	Acknowledge once; redirect; use double-sided reflection to hold both sides
Digital distancing	Remote format leads to reduced relational depth; practitioner becomes clinical or transactional	Explicit engagement signals; named pauses; regular relational check-ins; complex affirmations used verbally

8.3 Integrating MI into Your Practice

Starting Where You Are

MI integration is a gradual process. The 4th edition's emphasis on deliberate practice (see Section 8.4) suggests that the most effective route is not to "do MI" from session one, but to choose one micro-skill and practise it intentionally — watching what happens, getting feedback, and building from there.

Suggested starting points for practitioners new to MI:

- This week: follow every question with a reflection rather than another question.
- Next two weeks: practise complex affirmations — one per session, grounded in something the client actually said.
- Following month: introduce AOA into every conversation where you need to share information.

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Organisational Implementation

Sustained MI implementation requires more than individual training. Research consistently shows that without organisational support structures, MI skills decay within six months of training (Miller & Moyers, 2021). Effective implementation requires:

- Regular MI-specific supervision (not just caseload management)
- Fidelity monitoring (e.g., MITI coding of recorded sessions)
- A culture of reflective practice and peer learning
- Leadership that models MI-consistent values in how it manages staff
- Access to ongoing training, booster sessions, and deliberate practice communities

Combining MI with Other Approaches

Approach	Compatibility with MI	Key Consideration
Cognitive-Behavioural Therapy (CBT)	High — both are structured and goal-directed	Use MI to establish motivation before introducing CBT tools; MI maintains engagement when CBT is challenging
Contingency Management (CM)	High — MI provides the relational foundation	Use MI to explore the client's readiness for CM and to debrief ambivalence about receiving rewards
Trauma-Informed Practice	High — both prioritise safety, collaboration, and empowerment	Pace carefully; attend to windows of tolerance; MI's acceptance stance is deeply compatible with trauma-informed values
Harm Reduction	High — both are non-judgmental and autonomy-respecting	AOA is essential for harm reduction conversations; avoid moralising about safer use choices
12-Step Facilitation	Moderate — different philosophical stances on powerlessness	Use MI to explore what 12-Step would offer; avoid prescribing attendance; respect client's own conclusion
Digital/Remote Practice	High — MI framework is the same	Deliberate attention to relational depth and explicit engagement signals required in remote delivery; use AOA and complex affirmations proactively

8.4 Deliberate Practice and Skill Development

The 4th edition of Miller & Rollnick (2023) emphasises practice as the most effective route to sustained MI competency. Deliberate practice, as described by Chow et al. (2015) and Miller & Moyers (2021), refers to intentional, repetitive skill-building through supervised feedback — not the passive accumulation of experience through practice alone.

The distinction is clinically important. Research by Chow et al. (2015) on feedback-informed treatment demonstrated that therapist effectiveness is not simply a function of years of experience — it is a function of the quality and intentionality of practice and feedback received. Practitioners

who engage in deliberate practice significantly outperform those who rely solely on experience, regardless of seniority.

What Deliberate Practice Looks Like in MI

Deliberate practice in MI involves:

- Micro-skill rehearsal: practising one OARS component at a time — e.g., spending a week focused only on complex affirmations, or only on double-sided reflections
- Role-play with immediate feedback: practising with a colleague or supervisor, stopping after each exchange to receive specific behavioural feedback
- MITI coding of recorded sessions: using the Motivational Interviewing Treatment Integrity scale to systematically assess adherence to MI across a session
- Coaching triads: three-person practice structures (practitioner, client-role, observer) that allow real-time feedback
- Reflective journalling: structured post-session reflection on specific skills targeted for development

Contrast with passive learning: reading manuals and attending workshops alone does not produce sustained skill change (Miller & Moyers, 2021). This manual is a starting point, not a substitute for deliberate practice.

Alignment with NHS England Capability Framework

The NHS England Capability Framework for the Drug and Alcohol Treatment and Recovery Workforce (2024) includes continuing professional development (CPD) requirements and supervision hour expectations that align directly with deliberate practice principles.

NICE GUIDANCE

NHS England Capability Framework (2024): CPD requirements specify ongoing skill development through supervision, reflective practice, and peer learning. Deliberate practice activities as described in this section directly meet these requirements.

Practitioners should document deliberate practice activities as part of their CPD portfolio, including the skills targeted, feedback received, and development outcomes.

What to Bring to MI Supervision

Effective MI supervision is not caseload management. It is a deliberate space for skill development. Useful things to bring to MI supervision:

- A recording of a session (with consent) — ideally coded in advance using a simplified MITI framework
- A specific moment where you felt stuck, or where the conversation went in an unhelpful direction
- A piece of change talk you noticed — and your reflection on how you responded to it
- A question about one of the Four Tasks: "I wasn't sure whether to stay in Engaging or move to Focusing — what would you have done?"
- Your deliberate practice focus for the week — and what you actually did

PRACTICE TIP

Supervisors using fidelity feedback constructively: start with what went well (genuine, specific affirmations — not generic praise). Then identify one specific moment for development. Agree one focus for the following week. Keep the feedback session MI-consistent: it should feel empowering, not evaluative.

12-Week Deliberate Practice Plan

The following table provides a structured 12-week deliberate practice plan for practitioners new to MI, or for those seeking to refresh their skills following this training. Adapt it to your own context and role.

Week	Focus Skill	Deliberate Practice Activity	Supervision/Feedback Focus
1	Spirit of MI — Empowerment	Pre-session check-in: "Do I genuinely believe this client has the capacity to change?" Record one example from each session.	Discuss: when was the spirit fully present? When did it drift?
2	Open Questions	Count your open vs. closed questions in one session. Aim for 70% open.	Listen to a recorded segment: were questions directive toward change talk?
3	Simple Reflections	Practise following every client statement with a reflection before the next question.	Feedback on reflection-to-question ratio
4	Complex Reflections	Practise complex and double-sided reflections in role-play with a colleague.	Supervisor identifies one double-sided reflection that could have been stronger
5	Simple Affirmations	Write three specific affirmations per session — genuinely grounded in client behaviour.	Were affirmations specific? Did they feel authentic?
6	Complex Affirmations	Practise one complex affirmation (strength-based, values-consistent, or effort-recognition) per session.	Supervisor identifies the most powerful moment of affirmation in the session
7	Change Talk Recognition (DARN)	After each session, write down three pieces of preparatory change talk you noticed.	MITI coding: how did you respond to DARN language?
8	Change Talk Recognition (CAT)	Practise responding to mobilising change talk with elaboration rather than moving to planning.	Discussion: did you move to planning prematurely this week?
9	Ask-Offer-Ask (AOA)	Use AOA every time you share information this	Was the second Ask genuinely open? What

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		week. Debrief after each use.	did the client say?
10	Choosing a Path	Introduce Choosing a Path at the start of three sessions this week.	How did clients respond? Did it change the session's direction?
11	Discord Strategies	Identify one moment of discord per session and choose a strategy deliberately.	Review: was the strategy matched to the context?
12	Integration and Review	Record and self-code a full session using simplified MITI framework.	Full session review: Four Tasks, OARS, AOA, spirit — where are you now?

🤔 REFLECTION QUESTIONS

1. Using the competency table in Section 8.1, rate yourself honestly in each area. What are your two biggest development priorities?

_____

2. What organisational barriers exist to integrating MI into your practice? What could you do about one of them this week?

_____

3. Who in your workplace could become an MI practice partner — someone to practise with, give feedback, and keep each other accountable?

_____

4. Using the 12-week deliberate practice plan template in Section 8.4, identify one micro-skill to focus on in your next four supervision sessions. Write your plan here.

_____

✅ KEY TAKEAWAYS

- Sustained MI development requires regular practice, supervision, and ongoing learning — not just initial training.
- The 4th edition (2023) emphasises deliberate practice — intentional, repetitive, feedback-informed skill development — as the most effective route to sustained MI competency.
- Common pitfalls include the expert trap, question-answer trap, premature focus, premature planning, hollow affirmations, and digital distancing.
- MI combines well with CBT, Contingency Management, trauma-informed practice, harm reduction, and other evidence-based approaches.
- Organisational implementation requires more than training — it requires supervision frameworks, fidelity tools, and leadership commitment.
- The NHS England Capability Framework (2024) aligns directly with deliberate practice principles — use it to guide your CPD focus.
- Starting small is better than not starting. Choose one MI skill this week and practise it intentionally.

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MODULE 9: RESOURCES AND REFERENCES

9.1 Evidence Base: Key Research and Policy Sources

Foundational Texts

- Miller, W. R., & Rollnick, S. (2023). Motivational Interviewing: Helping People Change & Grow (4th ed.). Guilford Press.
- Miller, W. R., & Rollnick, S. (2013). Motivational Interviewing: Helping People Change (3rd ed.). Guilford Press.
- Miller, W. R., & Rollnick, S. (2002). Motivational Interviewing: Preparing People for Change (2nd ed.). Guilford Press.
- Miller, W. R., & Rollnick, S. (1991). Motivational Interviewing: Preparing People to Change Addictive Behaviour. Guilford Press.
- Rollnick, S., Miller, W. R., & Butler, C. (2008). Motivational Interviewing in Health Care. Guilford Press.
- Miller, W. R., & Moyers, T. B. (2021). Effective Psychotherapists: Clinical Skills That Improve Client Outcomes. Guilford Press.

Key Research Studies

- Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. Psychotherapy, 52(3), 337–345.
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- Bandura, A. (1997). Self-Efficacy: The Exercise of Control. W. H. Freeman.
- Brehm, J. W. (1966). A Theory of Psychological Reactance. Academic Press.

NICE Guidelines

- NICE CG115 (2011, updated 2019). Alcohol Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence.
- NICE NG58 (2017). Drug Misuse in Over 16s: Opioid Detoxification.
- NICE QS23 (2012). Drug Use Disorders in Adults.
- NICE TA934 (2023). Contingency Management for Substance Misuse.

UK Policy Frameworks

- HM Government (2022). From Harm to Hope: A 10-Year Drugs Plan to Cut Crime and Save Lives.

- NHS England / Office for Health Improvement and Disparities (2024). Capability Framework for the Drug and Alcohol Treatment and Recovery Workforce.
- Office for Health Improvement and Disparities (OHID). Digital access and digital exclusion in drug and alcohol populations. OHID guidance.

9.2 Further Learning and Development

The Motivational Interviewing Network of Trainers (MINT) is the international body for MI training and practice. MINT has updated its training curricula to reflect 4th edition terminology and content. MINT UK provides access to trained supervisors, trainers, and practice communities.

- MINT: www.motivationalinterviewing.org
- MINT UK resources and trainer directory: available via the MINT website
- MINT has updated its training materials to reflect 4th edition terminology — ensure any external training you access references Miller & Rollnick (2023)
- MITI coding resources: www.motivationalinterviewing.org/training_resources
- Drink Less app: evidence-based digital tool aligned with MI principles for alcohol monitoring
- BreakFree app: digital support for substance use behaviour change

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APPENDICES

Appendix A: Glossary of MI Terms

Motivational Interviewing (MI): "Motivational Interviewing is a particular way of talking with people about change and growth to strengthen their own motivation and commitment." (Miller & Rollnick, 2023). MI is a collaborative, person-centred communication style, not a set of techniques. The addition of "and growth" in the 4th edition signals a broadening beyond problem-focused behaviour change.

Spirit of MI: The underlying values and attitudes from which MI flows. Four components: Partnership, Acceptance, Compassion, and Empowerment (4th edition). Without the Spirit, MI techniques become hollow.

Empowerment: The fourth component of the Spirit of MI in the 4th edition (2023), replacing Evocation. Empowerment focuses on the client's inherent capacity, strengths, and resources — the belief that motivation for change already exists within the person. See also: Evocation (3rd edition).

Four Tasks of MI: The four ongoing activities of MI: Engaging, Focusing, Evoking, and Planning. Updated in the 4th edition from "Four Processes" — the term "Tasks" reflects their non-sequential, fluid, everyday nature. Practitioners may return to earlier tasks throughout a session.

OARS: Open Questions, Affirmations, Reflective Listening, and Summaries — the four core micro-skills of MI. In the 4th edition, OARS are framed as strategic and directional tools, deployed purposefully in service of the change conversation.

DARN-CAT: Framework for classifying change talk. DARN = Preparatory Change Talk (Desire, Ability, Reasons, Need). CAT = Mobilising Change Talk (Commitment, Activation, Taking Steps). Commitment language is the strongest predictor of behaviour change outcomes.

Change Talk: Any client speech that favours movement toward change. Frequency of change talk in sessions predicts behaviour change outcomes.

Sustain Talk: Client speech that favours maintaining current behaviour. Should be reflected and explored, not argued against. The practitioner should not over-reflect sustain talk to the point of amplifying it.

Fixing Reflex: The practitioner's instinct to correct, advise, or solve (previously "Righting Reflex," updated in the 4th edition of Miller & Rollnick, 2023). The primary driver of therapeutic discord. See also: Righting Reflex.

Ask-Offer-Ask (AOA): The framework for sharing clinical information in an MI-consistent way (previously "Elicit-Provide-Elicit" or EPE, updated in the 4th edition). Three steps: Ask what the client knows; Offer information neutrally; Ask what the client makes of it. The second Ask is the most important step. See also: Elicit-Provide-Elicit (EPE).

Choosing a Path: The collaborative process of selecting what to focus on in an MI conversation (previously "Agenda Mapping," updated in the 4th edition). The term better captures the activity's directional, collaborative nature.

Planting Seeds: Gently raising awareness of inconsistency between a client's stated values and current behaviour (previously "Developing Discrepancy," updated in the 4th edition). Less confrontational than "discrepancy" — the image is of planting rather than confronting.

Pendulum Technique: A strategy for exploring both sides of ambivalence to invite reflection (updated term in the 4th edition). The practitioner explores the sustain talk side genuinely first, then invites the client to consider the other side. Previously referred to as Running Head Start.

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Complex Affirmation: New in the 4th edition. Affirmations that acknowledge a person's specific character strengths, values, or significant efforts, rather than offering generic praise. Three types: Strength-based, Values-consistent, and Effort-recognition. More likely to elicit change talk than simple affirmations.

Deliberate Practice: Intentional, repetitive skill-building through supervised feedback — as distinct from passive skill accumulation through experience alone. The 4th edition identifies deliberate practice as the most effective route to sustained MI competency (Chow et al., 2015; Miller & Moyers, 2021).

Remote/Digital MI: MI delivered via telephone, video call, or digital platforms. Explicitly addressed in the 4th edition. Requires deliberate adaptation of OARS skills — particularly explicit verbal engagement signals, named pauses, and proactive use of complex affirmations. Evidence indicates non-inferiority to face-to-face in several settings when the MI spirit is maintained.

Reactance: A psychological response to perceived threat to personal freedom. When clients feel pushed to change, they typically push back — defending their current position. The fixing reflex triggers reactance.

Discord: A signal that the therapeutic relationship is under strain — often caused by the practitioner moving too fast or too hard. Discord is an interpersonal event, not a client trait.

Motivational Interviewing Treatment Integrity (MITI): A fidelity coding instrument for assessing MI adherence in recorded sessions. Used in supervision to provide specific, behavioural feedback on MI skills.

Appendix B: Quick Reference Card — OARS and Change Talk

Skill/Tool	What It Does	Example	Remote Adaptation
Open Question	Invites elaboration; cannot be answered yes/no; directed toward change talk	"What concerns you most about your drug use?"	Use more explicitly to compensate for reduced non-verbal warmth
Affirmation (Simple)	Acknowledges strength or effort, specific and genuine	"You came in today despite being ambivalent — that took something."	Make verbal and explicit — say what you'd normally show
Affirmation (Complex: Strength)	Acknowledges core character quality evidenced in client behaviour	"You've shown real persistence in coming back after what happened last year."	Particularly important on telephone; compensates for lost non-verbal warmth
Affirmation (Complex: Values)	Reflects client's own stated values back as a strength	"You said being a good parent matters most — and here you are, doing exactly that."	Use before and after reflective summaries remotely
Affirmation (Complex: Effort)	Recognises difficulty of situation or courage of actions	"A lot of people would have walked out. You stayed."	Name what you'd normally convey through body language
Simple Reflection	Demonstrate listening; invite elaboration	"You're feeling like things are out of control."	Falling intonation important on telephone to avoid question-trap
Complex Reflection	Add meaning, feeling, or implication	"Part of you wishes things could be different."	Name emotions explicitly: "That sounds like it really hit you."

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Double-sided Reflection	Hold ambivalence with "and" not "but"	"You value what it does for you, and you're worried about the costs."	Use "and" deliberately on telephone — tone carries less nuance
Collecting Summary	Gather change talk; structure the conversation	"Let me pull together what you've shared..."	Use more frequently remotely to provide session structure
Importance Ruler	Elicit reasons for change	"Why a 6 and not a 2?"	Can be used verbally or via shared digital tool
Confidence Ruler	Build self-efficacy; identify barriers	"What would move you from a 4 to a 6?"	Can be delivered via telephone without adaptation
Looking Forward	Evoke need change talk	"Where do you see yourself in five years if things stay the same?"	Unchanged; works equally well remotely
Ask-Offer-Ask (AOA)	Share information without undermining autonomy	Ask → Offer → "What do you make of that?"	Particularly important on remote calls where fixing reflex is heightened
Pendulum Technique	Explore both sides of ambivalence; invite reflection	Explore sustain talk side genuinely first; then invite the other side	Unchanged; works well via telephone

Appendix C: MI Stages of Change — Clinical Matching Guide

Stage	Key Presentation	MI Task Focus	Key Techniques
Precontemplation	"I don't have a problem"; absence of change talk	Engaging; raise awareness; plant seeds	Open questions; reflections; normalise ambivalence; avoid confrontation
Contemplation	"I know I should, but..."; mixed change and sustain talk	Focusing; explore and resolve ambivalence; plant seeds	Decisional balance; evocative questions; DARN reflections; Pendulum Technique
Preparation	Increasing commitment language; planning questions	Evoking → Planning; strengthen commitment; develop a plan	SMART goals; barrier exploration; AOA; Choosing a Path
Action	Active change efforts; reports of taking steps	Planning; Support; affirm; problem-solve	Affirmations of action; troubleshoot barriers; confidence ruler
Maintenance	Sustained change; concern about relapse	Engaging and Planning; reinforce; identity development	Reflections on identity; values exploration; "what helps you stay on track?"

Note: The Transtheoretical Model is retained in the 4th edition as a clinical heuristic. Practitioners should avoid rigid stage assignment and should never use the stage to gatekeep services. In remote

services, stage fluctuation between contacts may be more pronounced — re-assess at the start of each contact.

Appendix D: Sample Reflection Questions for Supervision

1. What change talk did you notice in the session? How did you respond to it?

2. Where did you notice the fixing reflex in yourself? How did you manage it?

3. Which of the Four Tasks (Engaging, Focusing, Evoking, Planning) occupied most of this session? Was that appropriate for where the client was?

4. Was there a moment of discord? How did you respond, and what effect did it have?

5. How would you describe the Spirit of MI in that session — present, intermittent, or absent? Was the Empowerment component visible in how you engaged?

6. What would you do differently if you could repeat the session?

7. What was the client's most significant piece of change talk? Did you explore it fully?

8. Did you use Ask-Offer-Ask (AOA) when sharing information? How did the client respond?

9. Was there any moment where a complex affirmation would have been more powerful than a simple one? What would it have looked like?

10. If the session was conducted remotely: what adaptations did you make? What was harder or easier compared to face-to-face?

11. What is your deliberate practice focus this week? What will you do differently in your next session?

Appendix E: Client and Practitioner Worksheets

E1: Decisional Balance Worksheet

	What I Value / What I'd Gain	What Concerns Me / What I'd Lose
My current use		
If I made a change		

E2: Importance and Confidence Rulers

Question	0 — Not at All	10 — Extremely Important/Confident
How important is it to me to make a change? (Circle a number)	0 1 2 3 4 5 6 7 8 9 10	Why this number and not lower? ___
How confident am I that I could change if I decided to? (Circle a number)	0 1 2 3 4 5 6 7 8 9 10	What would raise my confidence? ___

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E3: My Change Plan

Section	My Response
The change I want to make:	
The most important reasons for me:	
The steps I plan to take:	
What might get in the way and how I will handle it:	
Who can support me:	
How I will know if things are working:	
I will review my plan on (date):	

E4: My Deliberate Practice Log

For practitioners: use this log to record your weekly MI deliberate practice focus, track your progress, and prepare for supervision.

Date	Skill Practised	Context (session/role-play/supervision)	What Went Well	What to Adjust	Next Week's Focus

Appendix F: Mapping to NHS England Capability Framework (2024)

The table below maps this manual's key sections to the NHS England Capability Framework for the Drug and Alcohol Treatment and Recovery Workforce (2024), by tier level.

Manual Section	Capability Framework Domain	Tier 2	Tier 3	Tier 4
Module 1: Foundations of MI	Knowledge of evidence-based approaches	✓	✓	✓
Module 2: Change and Ambivalence	Understanding of behaviour change theory	✓	✓	✓
Module 3: OARS + Strategic Use	Core communication and engagement skills	✓	✓	✓

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Module 4: Change Talk	Motivational enhancement skills		✓	✓
Module 5: Discord + Self-Disclosure	Managing complex presentations; use of self		✓	✓
Module 6: Four Tasks of MI	Structured intervention delivery		✓	✓
Module 7: Specialised Applications + AOA	Substance-specific competencies; information sharing		✓	✓
Module 7.4: Remote/Digital MI	Digital and remote service delivery	✓	✓	✓
Module 8: Practice Development + Deliberate Practice	CPD; reflective practice; supervision engagement	✓	✓	✓
Appendix D: Supervision Questions	MI supervision competencies		✓	✓

"This manual draws on the conceptual framework of Miller & Rollnick (2023) and is an independent training resource not endorsed by or affiliated with the authors or Guilford Press."

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