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Counselor competence for telephone Motivation Interviewing addressing lifestyle change among Dutch older adults

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ABSTRACT

Counselor competence in telephone Motivation Interviewing (MI) to change lifestyle behaviors in a primary care population was assessed using the Motivational Interviewing Treatment Integrity (MITI) rating system. Counselor behavior was evaluated by trained raters. Twenty minutes of a random sample of 336 MI sessions were coded representing 232 counselees. Ninety-four sessions (28%) were double coded to assess inter-rater agreement. The MI fidelity was examined by comparing the MI fidelity scores direction, empathy, spirit, % open questions, % complex reflections, reflections-to-questions ratio, % MI-adherent responses with the matching beginner proficiency MITI threshold.

The inter-rater agreements for the MI fidelity summary scores were good (spirit, reflections-to-questions ratio), fair (empathy, % open questions, % MI-adherent responses) or poor (direction, % complex reflection). The MI fidelity scores for direction, empathy, spirit and the percentage of complex reflections exceeded the MITI threshold, but lower scores were found for the percentage of open questions, the reflections-to-questions ratio and the percentage of MI-adherent responses.

In conclusion, evidence that MI was implemented was revealed. However, the inter-rater agreements scores and some fidelity scores leave room for improvement indicating that raters and counselors may need more ongoing training and feedback to achieve and maintain adequate competence. These findings apply to more complex skills (as rating complex reflections) in particular.

1. Introduction

Motivational interviewing (MI) is a collaborative, person-centered form of guiding to elicit and strengthen a person's own motivation for and commitment to change in order to achieve a specific goal (Miller & Rollnick, 2012). There is much evidence for MI to address lifestyle behaviors such as, physical activity or nutrition, using face-to-face counseling (e.g., Lee, Choi, Yum, Yu, & Chair, 2016; Söderland, Madson, Rubak, & Nilsen, 2011; McKenzie, Pierce, & Gunn, 2015; Spencer & Wheeler, 2016), and some support for its effectiveness using telephone-based MI (e.g., Garrett et al., 2013). The overall spirit of MI describes a relationship between a counselor and a client that is collaborative rather than that the counselor takes on the role of an expert; the style of the counselor is one that searches for intrinsic motivation within clients and evokes it rather than giving advice or insight, and the responsibility for change is left with clients so it can arise from within them through a corresponding increase in intrinsic motivation (Miller & Rollnick, 2012).

Five techniques appear to be useful throughout the MI process of change: asking open questions, listening reflectively, affirming and summarizing, and eliciting change talk. Change occurs in two phases, first by building intrinsic motivation for change, and second – when the client is willing and able to change – by strengthening the commitment to change and developing a change plan.

Literature reviews have shown that MI in primary care settings may lead to modest improvements in physical activity, fruit consumption and vegetable intake (e.g., Morton et al., 2015; O'Halloran et al., 2014; Morton et al., 2015). Similar changes were found using *telephone-based*

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MI, which is one of the options to conduct motivational conversations (e.g., Tuccero, Railey, Briggs, & Hull, 2016). Telephone-based MI interventions have been used to address a diversity of issues to mention improvement of fatigue and depression in individuals with multiple sclerosis (Turner et al., 2016), support of decision making in genetic counseling (Geus de et al., 2016), adherence improvement of patients (with diabetes) to an internet intervention (Ingersoll et al., 2015), adherence improvement to medication (Teeter & Kavookjian, 2014), counseling adolescent on smoking cessation (Kealey et al., 2009), counseling drug users (Borges Bortolon et al., 2017) and also lifestyle modification (Draxten, Flattum, & Fulkerson, 2016; Garrett et al., 2013; Keulen van et al., 2011; Lilienthal, Pignol, Holm, & Vogeltanz-Holm, 2014, Lin et al., 2016). Articles on the evaluation of the quality of telephone-based MI counseling are less common although assessment of counselors' competence is strongly recommended (Madson & Campbell, 2006; Moyers, Martin, Manual, Miller, & Ernst, 2007). Only a couple of telephone-based MI studies reported findings on counselors 'competence to date (Ingersol et al., 2015). Today the most commonly used tool to evaluate counselor MI skills is the Motivational Interviewing Treatment Integrity Code (MITI) (Moyers, Rowell, Manuel, Ernst, & Houck, 2016), which is viewed as the gold standard (Forsberg, Berman, Kallmén, Hermansson, & Helgason, 2008). This paper contributes to the limited knowledge so far on counselor fidelity by evaluating the competence of (newly-trained) counselors' in conducting telephone-based MI to address lifestyle behavior changes (e.g., increase physical activity, increase fruit and vegetable intake) using the MITI (3.0) as structured observation guide. It is anticipated that counselors who received an MI training will at least show beginner proficiency in providing MI.

2. Materials and methods

Ethics approval for the RCT to compare the effect of a web-based intervention to a telephone-based MI intervention on changing lifestyle behavior was obtained from the Medical Ethics Committee of Maastricht University and the University Hospital Maastricht. The Dutch Trial Register identifier is NTR1068. Details on design, participants, and measurements of the RCT are described elsewhere (Keulen van et al., 2008).

2.1. Participants

Participants were counselors and raters. Counselors (n = 16; 14 women, mean age 22.7 years (SD = 2.1)) were master students of Health Sciences or Psychology at Maastricht University, who responded to an advertisement in the university newspaper and who were trained in MI (see MI training). The raters (n = 7; 6 women, mean age 25.5 years (SD = 2.9)) were master students or graduates of Health Promotion at Maastricht University.

2.2. MI training

The counselors were trained in six three-hour training sessions by two trainers. The length of the training in hours was based on the most common approach, which appeared to be a two-day MI workshop, in other words 18 h (Dunn, Deroo, & Rivara, 2001; Hettema, Steele, & Miller, 2005; Lundahl et al., 2013). In the training videotapes (Miller, Rollnick, & Moyers, 1998) were used to demonstrate MI, and the development of MI skills was guided by practice in small groups. The first session dealt with the philosophy, principles, and techniques of MI and the use of agenda setting. The second session addressed asking open questions and reflective listening, while the third focused on affirming, summarizing and eliciting change talk by assessing and enhancing the importance of change. The fourth session dealt with eliciting change talk by evaluating and reinforcing confidence, and recognizing and rolling with resistance. The fifth session briefly overviewed the first phase of MI (developing intrinsic motivation for change) and addressed the transition to and the second phase of MI (strengthening readiness for change and developing an action plan). Finally, in the sixth session, the trainees together practiced MI using telephone protocols adapted for the study and based on those used successfully in the Healthy Body Healthy Spirit trial (Resnicow et al., 2005). These protocols were pretested with experts and participants from the study population. Trainees who attended all six sessions performed a trial telephone MI session with a real client using the study's semi-scripted protocols and were assessed with the OnePass rating tool for MI (Resnicow, 2002, Resnicow, Davis, & Rollnick, 2006). OnePass is a multiple-item user-friendly measure to assess MI competency on a 7-point scale capturing similar dimensions of MI as the MITI (McMaster, & Resnicow, 2015). This tool was fine-tuned to the telephone protocols used. Sixteen counselors who obtained an adequate OnePass score (average score ≥ 5) were contracted to work as counselor in the study.

2.3. Training in using the MITI

The raters (n = 7) were master students or graduates of Health Promotion at Maastricht University, with at least 40 h of training following recommendations from the MITI 3.0 (Moyers et al., 2007). Readings (Miller & Rollnick, 2002) (pp.1–175), videotapes (Miller et al., 1998) and brief discussions were used to familiarize the raters with MI. The initial materials used to practice rating were transcripts for which expert-rating information was available and which were used to give feedback to trainees after they had coded the transcripts. This way they practiced rating MI techniques separately and combined, starting with open and closed questions and then simple and complex reflections, and finally MI-adherent and MI-nonadherent responses and information giving. They also practiced with rating MI principles and, eventually, they coded complete interviews from the present study with subsequent group-based debriefing. There was one session halfway the rating activities to check on the rating agreement.

2.4. Assessment of MI fidelity

The fidelity of MI delivery was examined by analyzing computer-recorded, telephone-based counseling sessions with the Motivational Interviewing Treatment Integrity Code (MITI 3.0, available at http://casaa.unm.edu/download/miti3.pdf).The assessment included the MI summary principle *spirit* score: the average (scale 1 = low to 5 = high) of the scores for evocation, collaboration, and autonomy/support. Besides *Spirit*, the MITI 3.0 assessed the principles *empathy* and *direction*, measured with a scale as used for spirit. Furthermore, four MI summary techniques (i.e., the percentage of open questions, the percentage of complex reflections, the reflections-to-questions ratio and the percentage of MI-adherent responses) were based on counting the counselors' responses on the following categories, i.e. questions (open versus closed), reflections (simple versus. complex), MI-adherent responses (as asking permission, emphasizing control, affirming, or supporting) and MI-nonadherent responses (i.e. advising without permission, confronting, or directing). In addition, the category 'giving information' was measured; because no summary MI fidelity measure was available for this technique, it was only used to determine inter-rater agreement. The fidelity of MI delivery was examined by comparing these MI fidelity scores with the corresponding MITI thresholds. Scores above the threshold indicate adequate fidelity. Because the counselors in the study were new to MI, we used beginner proficiency values of the MITI 3.0 summary scores for evaluating the fidelity of their MI delivery.

In total, 1472 computer–recorded counseling sessions were conducted by the 16 counselors. There were four different sessions in total. From each session, 25% were randomly selected using online software (GraphPad) to code at least 20% of the available sessions (as

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