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Motivational Interviewing: A Qualitative Examination of Factors Impacting Adoption and Implementation in a Community-Wide Setting

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Motivational interviewing (MI) training frequently results in only minimal improvement in the proficiency of MI techniques. The purpose of this qualitative study was to examine factors influencing the adoption of MI across various substance abuse treatment settings. Twenty practitioners and administrators were interviewed using a semistructured interview focused on participants' experiences and attitudes toward MI. Content analysis revealed themes similar to the current literature such as the evidence-based practice's fit with counselor orientation and the need for ongoing training and supervision. Recommendations include consideration of MI for use by paraprofessional staff and a comparison of the program's mission and philosophy to the spirit and principles of MI.

KEYWORDS dissemination, evidence-based practices, implementation, motivational enhancement, motivational interviewing, substance abuse treatment

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Motivational interviewing (MI; see Miller & Rollnick, 2002), is an empirically supported treatment that has received considerable attention in the literature with regard to training and implementation. A systematic review of the effectiveness of MI workshops indicated that although improvement in knowledge, attitudes, and confidence occur, these factors rarely facilitated maintenance of skill acquisition over time (Walters, Matson, Baer, & Ziedonis, 2005). Several studies, for example, found that workshop training resulted in only minimal improvement in the proficiency of MI techniques (Ager et al., 2005; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004; Smith et al., 2007). Additionally, there was not a significant reduction in counselor traditional responses, such as confrontation or advice giving, which are antithetical to MI. Thus, clinicians tend to add MI techniques, rather than eliminate their old strategies that are antithetical to MI. A practitioner's theoretical orientation and conceptualization of substance use appear to influence attitudes toward adoption of MI. Ager and colleagues (2011) found that low adherence to the 12-step treatment philosophy predicted gains in knowledge, attitudes, and skills related to participation in an MI workshop. Traditional counselors, characterized by their endorsement of the disease concept, are more likely to use techniques antithetical to MI (Ball et al., 2002). Studies like these have taken a quantitative approach that focused on counselor traits or training outcomes.

Few qualitative articles address a wide range of barriers and facilitators influencing the implementation of MI. One such study by D'Ambrosio, Laws, Gabriel, Hromco, and Kelly (2006) evaluated staff perceptions of the MI implementation process. One finding was that as implementation efforts declined, the staff became cynical. Additionally, it appeared that although commitment from management is key, many believed that in the end the staff determines whether the implementation succeeds or fails. Suggestions included providing clearer identification of goals and expectations for applying MI, increasing the amount of clinician and nonclinician staff time for MI implementation, and use of videotapes of clinicians' individual and group sessions for training and supervision. Another study (Berger, Otto-Salaj, Stoffel, Hernandez-Meier, & Gromoske, 2009) used a mixed methods approach to examine barriers and facilitators to implementing MI. Barriers to implementing a new approach (MI) were identified in the practitioner focus groups. Two organizational issues arose: time and resources dedicated to learning a new approach, and an organizational climate that did not provide opportunities for staff input into organizational decisions. Survey data revealed that higher intentions to adopt, implement, and practice MI were most correlated with institutional resources (i.e., computer equipment), efficacy and job satisfaction of staff, and continued development of professional skills. The benefit of Berger et al.'s (2009) study design was that barriers expressed in the focus groups (prior to MI training) allowed the researchers to provide an intervention in the workshop to address the

concerns identified in the focus groups. Unfortunately, barriers encountered posttraining could not be identified in the study.

The purpose of this study was to provide a more in-depth understanding of the factors influencing MI adoption by substance abuse treatment providers and administrators across treatment settings. Particular attention was given to programmatic and supervisory implications and recommendations to assist individual practitioners and managers to implement MI.

BACKGROUND

This study was part of a larger project funded and sponsored by the New Orleans Practice Improvement Collaborative (NOPIC). As per the grant funded by the Substance Abuse and Mental Health Services Administration and the Center for Substance Abuse Treatment, NOPIC worked closely with the treatment community in southeastern Louisiana to improve the quality of substance abuse services (Gleghorn & Cotter, 2003). In the larger study, the NOPIC project trainers provided an intense, 2-day motivational enhancement therapy (MET)/MI training to more than 250 participants from the treatment community, followed by a 4-hour booster session 1 month later. Participants demonstrated improved MET/MI knowledge, attitudes, and behaviors, and maintained those changes for 4 months (Ager et al., 2005). Other NOPIC project activities included additional trainings on empirically support treatments and a quarterly newsletter about NOPIC activities to agencies and individuals. This packaged approach to dissemination provided a broad range of interventions to investigate as opposed to "training-only" studies.

The NOPIC used the term *motivational enhancement therapy* based on the Project MATCH manual that was distributed at the workshops (Miller, Zweben, DiClemente, & Rychtarik, 1992). For purposes of this article, we use the term *motivational interviewing* for two reasons. First, the workshop participants were essentially trained in MI (the trainer followed the recommended format from the Motivational Interviewing Network of Trainers). Second, this avoids confusion for the reader because MET is a specific adaptation of MI (as presented in the Project MATCH manual) that was not the sole focus of the qualitative interview process.

METHOD

Sample

A convenience and purposeful sample was identified, gleaned from a list of more than 440 individual providers accumulated by the NOPIC via contact lists of various licensing bodies (professional counselors, social workers, and substance abuse professionals) as well as through word of mouth and

networking efforts. The NOPIC program manager assisted in identifying opinion leaders to serve as participants—those who were thought to be vocal individuals willing to share input. Individuals were contacted by phone and recruited to participate.

The inclusion process began with identifying practitioners and administrators. Of these individuals, potential participants were identified as those who were primarily providing services to substance-involved adolescents (SIAs), postincarcerated substance-involved offenders (PISIOs), or both. Additionally, from this pool of potential participants, we identified 10 individuals who received NOPIC's MI training and 10 who were not trained in MI. The purpose was to elicit information from individuals who might be at various points in the adoption or implementation process as well as garner a broad perspective of barriers and facilitators to implementation. Potential participants were contacted for recruitment until 20 individuals representing the New Orleans metropolitan area had been identified, recruited, and interviewed.

Procedure and Data Collection

Participants received $50 compensation on completion of the 1.5-hour interview. The study protocol was approved by the Institutional Review Board at Tulane University. Recruitment and interviews were conducted by the first author, a licensed clinical social worker, between June and August 2004. A semistructured interview protocol was utilized. Interview questions focused on the participant's experiences with the NOPIC's various activities, the MI trainings hosted by NOPIC, and the application of MI in the work environment (see Table 1). Questions were structured to reflect Rogers's (2003) Innovation-Decision Process, which was chosen due to its long-standing support in the literature as a technology transfer theory

TABLE 1 Sample Interview Questions

Diffusion of innovations stage	Sample interview question
Knowledge/Awareness	What is your familiarity with NOPIC's activities? (Participants were asked about specific activities such as the newsletter.)
Persuasion	Did the MI training influence your interest in MI? Or, having looked at MI, what do you think?
Decision	Do you use MI presently? What influenced your decision to use or not use MI?
Implementation	What are the obstacles you faced trying to implement MI? What helped you implement MI? Or, what obstacles would you face if you wanted to implement MI?
Confirmation	What are the obstacles you now face trying to continue or improve implementation of MI? What has helped or might help?

Note. NOPIC = New Orleans Practice Improvement Collaborative; MI = motivational interviewing.

(Herie & Martin, 2002), and because Simpson's (2002) model was not well known at the time this study was developed. Rogers's process included five stages: knowledge, persuasion, decision, implementation, and confirmation. In the first stage, knowledge, the individual is exposed to the innovation—in this case, MI. These questions addressed the individual's knowledge and perceptions toward the NOPIC as an entity and its knowledge dissemination activities (which included the MI trainings). Stage 2—persuasion—relates to the factors that influence one's attitude toward the innovation, believed to be one of the primary predictors of adoption and implementation (Rogers, 2003). Interview questions explored the individual's attitudes toward the MI training and perceptions of MI (whether a training participant or not). For example, "Did the training influence your interest in MI?" Or for participants not trained in MI, "Having looked at what MI is about, what do you think?"

In the third stage, a decision is made regarding the adoption of the innovation. Participants were asked if MI has been adopted (according to their understanding of MI). Other questions related to the influences on that decision. For example, "What are some agency-related influences [on your decision]?" During implementation, the fourth stage, the innovation is put into practice. Interview questions explored various contextual aspects (individual, client, organizational, treatment community, and MI itself) influencing implementation. For example, "What client-related obstacles have you faced trying to implement MI?" For nonparticipants, the question was asked as a hypothetical. The final stage, confirmation, involves seeking reinforcement for the adopted innovation. These questions were structured similar to the implementation stage questions except to specify what barriers and facilitators will assist with ongoing implementation.

This study used a qualitative approach to data analysis (Denzin & Lincoln, 1994). Interviews were taped and transcribed. Content analysis of the interview transcripts and also the notes taken during the interviews was conducted to identify themes across interviews (Creswell, 1998). Tentative codes were developed based on specific themes, patterns, and categories from the data using description, classification, and interpretation (Creswell, 1998). These tentative codes were examined and compared with the data to further refine and narrow themes. To help ensure coder reliability, an outside auditor was used to compare themes with the data (Creswell, 1998). Level of agreement was 93%. Differences were discussed until consensus was reached.

RESULTS

Demographics

The sample of 20 were primarily Caucasian (70%) and female (70%), with ages ranging from 27to 66 (M = 46). Most participants had a master's

degree (70%), about one third (35%) were in recovery. Participants worked in various organizations, settings, and populations served (see Table 2).

Most (70%) participants reported spending at least 25% of their time in direct practice duties and 80% reported spending at least 25% of their time in administrative or supervisory duties. Administrators who were trained in MI spent more of their work duties in direct services than those who did not participate in the NOPIC MI workshops (see Table 3). Providers who attended the NOPIC MI workshops spent more of their time in administrative duties than providers who had not received MI training (see Table 3).

TABLE 2 Participant Demographics

Variable	Range	*M*	*SD*
Age	27–66	46	12.94
Years of experience	<1–42	7	9.37
Variable		***n***	**%**
Race/ethnicity			
Black/African American		5	25
White		14	70
Latin/Hispanic		0	0
Other		1	5
Gender			
Male		6	3
Female		14	70
Highest level of education			
High school/general equivalency diploma		3	15
Associate's degree		0	0
Bachelor's degree		3	15
Master's degree		12	60
PhD, MD, or equivalent		2	10
Recovery status			
Yes		7	35
N/A		12	60
Type of organization			
Private, for profit		4	20
Private, not-for-profit		8	40
Public (local, state, federal)		8	40
Treatment setting (provide more than one type of setting)			
Outpatient, drug-free		10	50
Outpatient, methadone		2	10
Inpatient, short-term (<30 days)		1	5
Residential, long-term (>30 days)		6	30
Other		7	35
Populations you serve			
Adolescents		11	55
Incarcerated, paroled, or probation clients		11	55

Note. $N = 20$.

TABLE 3 Participant Demographics by MI Training Received and Administrator/Provider Status

	MI participant			Nonparticipant		
	Percentage of effort spent providing direct services					
		n	%		*n*	%
Administrators	0–25%	5	50	0–25%	1	10
	26–50%	3	30	26–50%	4	40
	51–75%	2	20	51–75%	2	20
	76–100%	0	0	76–100%	3	30
	Percentage of effort spent in supervisory or administrative duties					
		n	%		*n*	%
Providers	0–25%	1	10	0–25%	3	30
	26–50%	2	20	26–50%	4	40
	51–75%	4	40	51–75%	3	30
	76–100%	3	30	76–100%	0	0

Note. $N = 20$; MI = motivational interviewing.

Themes

Five themes related to factors influencing adoption of MI were identified. Table 4 organizes the themes into barriers and facilitators.

Resources

The NOPIC offered multiple avenues of knowledge dissemination from the initial MI workshops as well as a newsletter, workshop offerings, and professional networking meetings. Respondents found the NOPIC dissemination activities valuable. Participants appreciated notification regarding upcoming trainings and the latest information on MI and other evidence-based practices. One participant stated, "Without NOPIC we wouldn't know about [MI], we wouldn't know about its effectiveness, the population that it works with. So, NOPIC has had a great impact on getting the word out on MI." For others, time was a barrier. Overwhelmingly, the participants commented on problems with scheduling training, time for supervision, or too few staff, which prohibited releasing them for training purposes.

Goodness of Fit

The individual's current therapeutic approach impacted the goodness of fit of MI and thus was critical in whether the individual was persuaded to adopt MI. MI fit with client-centered practitioners who recognized and even

TABLE 4 Barriers and Facilitators

Theme	Facilitator	Barrier
Resources	"[NOPICS] been our resource . . . that's where we've gotten all of our training and our reinforcement." "The newsletter "gives treatment information and the [MI] information out to practitioners in the field. So I like it for that, it kind of keeps everybody updated on all sorts of things."	"It's more a time thing with me than anything else . . . It's just there's so much on my plate." "To be honest with you, the determent for me is the fees. There are so many fees for different things. I have to weed out one for the other, so basically it has a lot to do with the fees."
Goodness of fit	"I like it [MI] because it . . . helps the client to come up with answers . . . which, to me, is very valuable, because if they come up with the answers . . . then they are more likely to buy into it and to actually . . . be motivated for change." "I guess basically when I first started doing what I am doing, I didn't like the idea of tearing people down and building them up in someone else's image. I like the idea of them taking the initiative to change their lives and if they don't, then it's me changing their life. If you're motivational and you give them an impetus to make a change, then it's their decision, not yours, and then it becomes their own life choice."	"MI, I feel, is a good approach for someone other than myself because it's just difficult in letting the client kind of lead the therapy and you not being assertive in their treatment . . . We're putting it in the laps of the client and I've been working with clients for a long time." "I'm still kind of good friends with a counselor who is old time [substance abuse counselor] and I don't think she'll ever go to MI. I don't know how you change that. It's almost like intrinsically culturally religious in what they believe and I don't know exactly how to change that."
Flexibility/ inflexibility	"We have no set guidelines on which treatment approach we use. We can use whatever we feel that's going to work and that's why I have embraced MI. . . . I think that's easier than being confrontational because everybody knows that being confrontational with the clients makes them draw back; gets them angry." "In my staff, I feel that they're really good, very professional and willing to try new techniques. We have staff that are looking for that extra something that may help with some people that they're running into corners	"Dealing with the agency where I work . . . dealing with the supervisors, the policy changes that would need to be made, certain rules and regulations that we do have if a certain action is done." "My coworkers have barriers. They are not in favor of MI. They like the established setup and they are going to resist if it was suggested or intended that we change our system and start to utilize MI over our current setup."

(*Continued*)

TABLE 4 (Continued)

Theme	Facilitator	Barrier
	with . . . we have a lot of younger people that are willing to look up extra information, research information, not just set into one way of doing things . . . so I feel like they would be receptive."	
Adaptability of MI	"[The MI training] helped the paraprofessional staff that I was working with, who didn't have the same advantage of the training and experience prior to that." "I've always used it [MI] in group. . . . One thing you have to watch out for is that you can't let people tell war stories. When you roll with the resistance, you can't roll where they tell war stories."	"I'm thinking of a client that I work with right now who is schizophrenic and he is on drugs and some days I can barely talk to him. And I can use all this that I have learned, but he's not even listening to me and he's in a whole other world. It's more what his basic needs are. So we do have clients at times where [MI] wouldn't work." "It's hard to know the whole idea about nondirective versus directive when you have a woman that comes in and she's in this severely abusive relationship and she wants to go on a weekend pass with him, and kind of being placed in that role to say 'yes' or 'no, you can't go' and wanting her to reach that decision on her own; but is she in a place where she is able to do that?"
Ongoing skill development	"[Training should take place] every 6 months, or even just annually, so that you can hit up . . . the new employees. Sure it was repetitive, but repetition is what's helpful to make it stick." "The main thing that might have been helpful that I found was just reminding people that this is what they are supposed to be trying to do. This is one of the concepts that we are trying to implement here and these are the reasons why and why it would be a good idea with this client as opposed to this method, or an approach that had been used and has not worked."	"Having more of the staff that would be trained in [MI]. Supervisors would probably be more open to using it. Where I work there is a huge turnover rate, so the people I was trained with are gone and we have a new staff with a huge turnover rate." "The majority of our staff is not schooled on it. We would have to train for it."

Note. NOPIC = New Orleans Practice Improvement Collaborative; MI = motivational interviewing.

emphasized the importance of allowing the client to take responsibility for his or her progress in treatment. One participant described the value of a client-centered approach: "I like it because it helps the client to come up with answers, which, to me, is very valuable because if they come up with the answers, then they are more likely to buy into it and to actually be motivated for change." Some practitioners viewed this client-centered approach as useful only with certain clients, particularly with adolescents. In working with adolescents, a participant said, "[MI] would be more effective instead of getting into a power struggle or debate with them; because that is a never ending debate. You're never right. [Adolescents] are always right." Additionally, MI was viewed to consist of common counseling techniques, and overwhelmingly was viewed as "easy to learn," although a few participants admitted that the techniques were not always easy to apply.

Conversely, MI lacked "fit" for the traditional counselor. Traditional counselors perceived confrontation to be the most effective approach to helping a client change. Participants discussed perceptions that incarcerated or postincarcerated clients can manipulate MI techniques. One participant explained, "For some reason their deep-rooted issues are just a little tough to get to. But for whatever reason they pretty much resist anything other than confrontation therapy." Many felt that the use of MI depended on the client, that some clients respond better to direct confrontation, or are not suited to the approach due to cognitive impairments. Additionally, some clinicians seemed uncomfortable with a client-centered approach. A participant who worked with incarcerated adults said, "It put more on the client side of the table and took some from this side." Another participant who worked with adolescents viewed MI as too passive: "We basically got their treatment as to 'you do this, and this is the consequences.' But with MI it's like, you gotta kind of be laid back and I can't see myself doing that."

Flexibility/Inflexibility

Flexibility was noted in the extent to which agencies restricted, accommodated, or promoted the adoption of MI. Some agencies encouraged the use of MI. One participant noted, "I was pretty much at the top of the food chain, if you will, so I really didn't have any resistance [from the agency]." Others remained neutral. One administrator stated, "I give suggestions, but I don't really control the type of therapy." Most participants viewed MI as a "tool in the tool belt" and "let everybody kind of take his own approach to it." A few participants questioned whether MI fit with their agency's philosophy and rules, thus viewing the agency as inflexible. A clinical program director commented, "I think the barriers are primarily just policies and guidelines that we have for the clients." One participant noted that counselor inflexibility was of concern, "[My coworkers] are not in favor of MI. They like the established setup and they are going to resist."

Adaptability of MI

Additionally, analysis revealed that MI was viewed as flexible in that MI was adapted to helping situations outside of individual counseling. Adaptations included use of MI in family sessions, group counseling, and particularly the use of MI as a communication style for direct-care or paraprofessional staff. An administrator/provider who runs an outpatient clinic for adolescents commented, "Now we have moved [MI] out into just using it in a normal community setting, like the gym." Participants found that MI provided a language to explain a set of communication tools that form the basis of interactions between staff and clients in the general milieu: "[It's] a very helpful conception tool . . . and [MI] made it easy for me to . . . phrase things in MI terms and they knew what I was talking about," a former supervisor stated. Only two participants did not believe or recognize that MI was useful outside of substance abuse counseling.

Ongoing skill development

Participants recognized the need for ongoing skill development posttraining due to treatment drift. Participants noted ongoing supervision through informal discussions, clinical direction in staff meetings, or formal clinical supervision. Periodic trainings or "boosters" were frequently recommended by participants. Althugh boosters are repetitive, one participant noted, "That's what makes it stick." Some specific suggestions from participants included role plays and training videos. Few barriers to ongoing supervision were explicitly stated; namely the need for more training for staff as well as supervisors, as well as the need to train staff who have not yet been trained.

DISCUSSION

Overall, the resulting themes support findings in the literature. For example, results indicated the importance of resources, including information, training, and time. The NOPIC provided information toward trainings and raising awareness about MI for the local providers and maintained visibility of MI through newsletters and workshops. The common resource barriers of time and money were clearly noted by participants (Bartholomew, Joe, Rowan-Szal, & Simpson, 2007). Additionally, agency support, openness to change, and, in some cases, permission to use MI techniques, facilitated implementation of MI. Agency support is crucial to implementation of innovative practices (Addiction Technology Transfer Centers, 2000; Simpson, Joe, & Rowan-Szal, 2007). Thus, organizational support is critical to addressing resource issues that can present significant barriers to implementation (Berger et al., 2009).

The importance of ongoing training and supervision was widely reported by participants. Participants mentioned multiple settings beyond the training room to assist clinicians in consistently applying techniques within the spirit of MI, including informal discussion, clinical direction in staff meetings, or periodic booster trainings. Much of the literature supports the use of coaching (live or via telephone) and audiotape review (Berger et al., 2009; Miller et al., 2004; Smith et al., 2007). Supervision, however, is often challenging in terms of resources, time, and supervisory skill (Burke & Early, 2003; Tomlin, 2004). Overall, an important aspect of ongoing skill development is that implementation does not stop with training.

Another finding that supported the literature was the gap between counselors who tend to use confrontation to facilitate change ("traditional counselors") and those that use client-centered approaches such as MI. Although a majority of the participants were positive toward MI, 2 of the 20 participants did not have a positive view of MI. The literature has found that belief in the disease model predicts use of skills antithetical to MI or a higher occurrence of treatment drift (Ball et al., 2002; Hartzler et al., 2007; Moyers & Yahne, 1998). Or, perhaps participants who display a more accurate understanding of MI, no matter their theoretical orientation regarding substance abuse and addiction, might predict a higher level of use of MI. For example, in this study, 7 participants discussed how MI can fit a 12-step model and be used for appropriate confrontation. An outpatient clinical director who supports MI commented, "We try to keep people on the staff understanding that everybody we deal with is an individual with a disease of addiction, whereas it's not their fault . . . [Providing] affirming thoughts from somebody who's on your side and willing to kind of mirror back the most positive aspects a person has is really important." Therefore, although practitioners who espouse the disease model might be more likely to prefer confrontational approaches to treatment (according to the research), belief in the disease model itself might not be the barrier to implementing MI.

The differences between traditionally confrontational counselors and client-centered counselors might be explained by cultural and educational differences. Toriello et al. (2005) found that nontraditional counselors (those more likely to use a cognitive-behavioral conception of substance use) were more likely to be non-African-American men with master's degrees and not in recovery. Additionally (from the same sample), Ager and colleagues (2011) found that being Caucasian, having a high practitioner self-perceived cultural competency, and being younger predicted gains in MI knowledge, attitudes, and skill.

The flexibility of MI was apparent in its application to various modalities, such as group and family sessions as well as across targeted behavioral health issues. Research on the application of MI in group settings remains limited and no systematic studies appear to be done in this area. An interesting adaptation of MI mentioned by 5 participants is the use of

MI by paraprofessional staff. Paraprofessionals are trained in motivational interviewing alongside clinical staff, and apply the skills as a general communication style in the therapeutic milieu. This finding could be an opportunity to further "legitimize" MI as a more positive and respectful approach to traditional confrontational styles. Very little research has been done with regard to the training and application of MI techniques by paraprofessionals who work on the front lines with clients in the therapeutic milieu. The techniques and philosophy of MI, however, might be beneficial for paraprofessionals who often do not have formal training in counseling and thus therapeutic forms of communication.

RECOMMENDATIONS, LIMITATIONS, AND IMPLICATIONS FOR FUTURE RESEARCH

Recommendations

Utilizing the concept of goodness of fit might be a useful approach to help traditional staff see how MI techniques can be used together with 12-step and the disease concept approaches. Particularly, it might be useful to demonstrate how to translate "confrontation" into "expressing discrepancies" (Elder & Stout, 2007). Developing discrepancy helps the client argue for change, rather than the clinician using confrontation to point out arguments for change. Helping a counselor understand what MI "is" and "is not" (Miller & Rollnick, 2009) and when to use MI will help frame it as a tool in the tool belt. Whereas the "science" of MI can be trained, the "art" of application must occur through careful supervision and coaching.

With regard to the theme of flexibility and inflexibility, agency leadership should consider what attitudes and policies might impact the counselor's ability to choose where and when to use MI. For example, programs that revolve around therapeutic community-style confrontation groups might leave counselors believing confrontation and advice giving are the only approved interventions. We suggest a review of the program's mission and philosophy by comparing the mission and other guiding principles to the spirit and principles of MI (Prescott, 2008). For example, how do the agency philosophy and the mission embody the spirit of MI: client autonomy, collaboration, and evocation?

The theme of ongoing skill development indicates that the creation of a concrete plan that weaves MI into the program structures is essential to ensure the development of professional skills that adhere to MI's spirit and principles. For example, existing meetings such as clinical staff meetings or supervision might be simple avenues to reinforce the spirit and principles of the approach by encouraging clinicians to discuss the client's stage of change and the techniques used to move the client toward the next stage of change. Some agencies implement treatment plan review forms that include

an evaluation of the client's level of motivation and engagement in treatment. Also, coaching and direct observation can offer clinical supervisors the opportunity to identify counselor strengths and areas for improvement in the skillful application of MI skills (Prescott, 2008).

Study Limitations

Limitations of the study include the small sample size as a qualitative study and therefore lack of generalizability beyond the application of MI or the context of substance abuse providers in southeast Louisiana. Additionally, the study sample resulted in a group not representative of the providers in the New Orleans metropolitan area in terms of race, gender, and education. Finally, the results are limited to practitioner self-report. Despite these limitations, this study can serve to inform the literature on barriers and facilitators facing agencies in their efforts to implement an empirically supported treatment such as MI.

Implications for Future Research

Further exploration as to whether belief in the "disease concept" is a barrier to implementing MI is needed. Clinicians who use confrontation might be more likely to adhere to the disease concept, but the reason for this association warrants further attention and might assist in identifying facilitators to increase implementation of MI.

Another area that warrants more research is the use of MI as a communication style by paraprofessional staff. This could include questions about the impact of implementing MI on the therapeutic milieu as well as the impact on skill development posttraining. From a training perspective, it would be interesting to explore how training materials intended for clinicians might be adapted to teach essential MI skills.

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