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A Collaborative Approach to Learning Motivational Interviewing (MI): One MI Learning Community and its "MI Learning Day"

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A Collaborative Approach to Learning Motivational Interviewing (MI): One MI Learning Community and its "MI Learning Day"

Abstract

The inaugural year of one Motivational Interviewing Learning Community (MILC) in one counselor education program is described, along with its capstone project, “MI Learning Day,” that involved simulated clients and external consultants to measure MI skill performance. The MILC’s faculty, student, and counselor composition exemplifies professional collaboration, peer supervision, and ongoing professional development. Recommendations are provided for establishing and maintaining extracurricular MI Learning Communities in other counselor education programs and with community-based partners.

Keywords

motivational interviewing, learning community, collaboration, simulated clients, counselors-as-clients

Author's Notes

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Collaboration with fellow counselors and other professionals is an expectation of counselors introduced in graduate education. Programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015) must provide all students with instruction in "the multiple professional roles and functions of counselors across specialty areas," including "interagency and interorganizational collaboration and consultation" (Standard D.1.b.).

Interprofessional collaboration is now an integral component of health care delivery in the United States. The driver of this is the Patient Protection and Affordable Care Act (PPACA) of 2010 (see Manderscheid, 2014). The PPACA requires integrated care, meaning that primary care physicians and behavioral health care providers work in tandem to coordinate care. This coincides with an ever-increasing emphasis in health care today on evidence-based practices (EBPs), methods demonstrating efficacy and effectiveness in research trials.

The current transformation of health care in the United States – one that involves the adoption of EBPs and interprofessional collaboration – has significant implications for the preparation and ongoing professional development of behavioral health care providers, including professional counselors. This transformation has begun to affect methods of teaching and learning for health care professionals. Clay et al. (2013) suggested that the tradition of learning first and then teaching can no longer continue for health profession faculty, stating, "Many faculty find themselves in the awkward position of teaching concepts they have yet to master themselves" (p. 1215). This is true for counselor educators in CACREP-accredited programs expected to introduce students to "evidence-based counseling strategies and techniques for prevention and intervention" (CACREP, 2015, Section 2, F.5.J.). Faculty who teach specific EBPs may not have received extensive training in these EBPs, let alone practiced them under supervision or some form of monitoring with feedback.

To provide accurate and credible instruction in EBPs, it behooves counselor education (CE) faculty to participate in formal training in one or more EBPs. Because EBPs in behavioral health are not exclusive to one discipline, training in one or more EBPs is likely cross-disciplinary, thereby promoting inter-professional collaboration at the training level. We believe such training must include opportunities to practice an EBP and receive feedback on one's work (e.g., supervised practice). This can take place by attending an intensive days-long professional seminar on a given EBP. However, very few seminars offer post-training monitoring of attendees' skill performance in their natural work setting.

Rather than leave campus to receive ongoing training in an EBP, CE faculty can establish an on-campus extracurricular learning community, a gathering of other professionals to promote continuous learning and ongoing professional development in that EBP. Doing so seems consistent with the mission of an institution of higher education. Bosch et al. (2008) described "meaningful learning cultures" as those "not merely created in the classroom, but…a product of the overall environment of the institution" (p. 91). They argued that a culture of learning is "best accomplished through a collaborative effort between faculty members and students" who use "the essential skills of inquiry, creativity, problem solving, and reflection…" (p. 90). This resembles the situated learning theory proposed by Lave and Wenger (1991) wherein learning in higher education is characterized as a social process situated within a community of practice.

This article describes the development and operations of one extracurricular learning community dedicated to promoting skill development in one EBP, motivational interviewing (MI). The first four authors are members of the inaugural MI Learning Community (MILC) in one CACREP-accredited program. We selected MI because of its person-centered basis, its extensive and evolving research base, and its wide application in health care and counseling (see Miller &

Moyers, 2017). We each had completed formal training in MI and wanted to preserve and enhance what we had learned. The developers of MI (Miller & Rollnick, 2013) and other proponents (e.g., Rosengren, 2018) recommend establishing learning communities and this collaborative form of learning – a type of peer supervision – was appealing to us.

At the conclusion of our first year as a learning community, we wanted to evaluate our progress. We scheduled a full day of training with MI consultants and practice with simulated clients (i.e., counselors-as-clients). This capstone project, "MI Learning Day," served as our "report card" of our MI skill performance. It also is described in this article. The purpose of this article is thus to describe the inaugural year of our MILC, including MI Learning Day and our qualitative and quantitative report card. We offer recommendations for organizing and maintaining a collaborative learning community in other CE programs and in the community. Suggestions for research opportunities also are provided.

Motivational Interviewing

MI (Miller & Rollnick, 2013) is an EBP for substance use disorders (SUDs) now implemented in the majority (68%) of U.S. addiction treatment facilities (Rieckmann, Abraham, & Bride, 2016). MI is not exclusive to SUD treatment, however. It is applied to a wide variety of health issues such as diabetes, nutrition, and anxiety and depression. MI can thus be regarded as an integral style and skillset for professionals working in integrated health care settings.

MI is a specific style of communication intended to evoke and strengthen another person's motivation for change. It is a way of being with another person. Applied to counseling, MI is the manner a counselor takes when interviewing clients about their motivation for change. There is the assumption that clients are motivated toward something salutary. Essential MI skills are thus listening for and responding to that which is important and valuable to the client, promoting the

client's own resources toward change. Rather than comprising a set of techniques, MI is a skillful method of helping that employs selective and purposeful listening to gently guide clients toward their self-selected behavior change. It is a collaborative and a strategic endeavor in that MI practitioners do not tell clients what to do (not even covertly) and they do not permit conversations to wander aimlessly. MI gives prominence to what the client wants and believes is necessary for change and uses that insight to help shape movement toward healthy change.

MI is not easy to learn or practice (Miller & Rollnick, 2009). It is a responsive style learned from repeated interactions with clients. It is crafted from therapeutic conversations that purposefully attend to and cultivate the client's natural language. Because it is an alternative to customary practice in most health care settings and by most helping professionals, MI requires intentionality and an openness and receptivity to alter certain ingrained behaviors. In many ways, MI is about restraint, what not to do, such as not swaying a client toward a particular decision or action (even subtly so) and not questioning a client's sincerity. Unless one's work is observed (live or recorded) and evaluated, coercive and patronizing behaviors can go undetected.

Learning MI with Simulated Clients

One method to assess MI skill level during and following formal MI training is to practice with simulated clients (SCs). This practice resembles the use of standardized patients (SPs) in medical education that is standard in medical schools and teaching hospitals in the United States (Passiment, Sacks, & Huang, 2011). The use of SPs has been found to be a reliable means to evaluate medical students' MI performance (Childers et al., 2012; Haeseler et al., 2011; Martino, Haeseler, Belitsky, Pantalon, & Fortin, 2007). After completing MI training, pharmacy students who interviewed a SP demonstrated higher MI skills than pharmacy students who practiced only with their peers (Lupu, Stewart, & O'Neil, 2012). SPs also have been used to assess MI skills

among clinical staff (e.g., social workers) at trauma centers after formal MI training (Darnell, Dunn, Atkins, Ingraham, & Zatzick, 2016).

Feedback and Evaluation in MI

Whether practicing with SPs or working with actual clients, MI performance is often evaluated by using a coding scheme such as the Motivational Interviewing Treatment Integrity (MITI) 4.2 coding manual (Moyers, Manual, & Ernst, 2014). The MITI is used in research to code clinician behaviors (observed live or recorded) and to determine clinician adherence to MI. The MITI also is used to provide formal feedback to improve practice in non-research settings (Moyers et al., 2014), such as counselor supervision.

MITI coding entails global scores and behavior counts. Global scores measure an overall impression of the session in terms of cultivating change talk, softening sustain talk, partnership, and empathy. Behavior counts include behaviors such as questions, reflections, persuading with permission, and giving information. Coders tally behaviors to determine question-to-reflection ratios and degree of MI adherence. A coded sample needs to be a minimum of 20 minutes (Moyers et al., 2014) and have a definitive target behavior the client hopes to change.

Collaborative Learning

Miller and Rollnick (2013) contend that a MI Learning Community (MILC) is peer-supported learning. “Learning together is often more fun than learning alone” (p. 227), they state. We have found this to be true in our own MILC and regard our collaborative work as resembling peer supervision, defined by Wilkerson (2006) as

> a structured, supportive process in which counselor colleagues (or trainees), in pairs or in groups, use their professional knowledge and relationship expertise to monitor practice and

> effectiveness on a regular basis for the purpose of improving specific counseling, conceptualization, and theoretical skills. (p. 62)

Wilkerson clarified that peer supervision takes place among or between equals (i.e., non-hierarchical) without an evaluative component (i.e., not evaluating one another's work), although peers monitor and provide one another feedback. The primary focus is the professional development of members. In this way, peer supervision is counselor-centered more than client-centered.

The MILC we established also resembles the practice of the learning circle. Lynam, Grant, and Staden (2012) described the learning circle as an Aboriginal or indigenous form of community dialogue, "an informal, cooperative, collaborative approach to fostering engagement and dialogue within a community" (p. 95). It promotes "horizontal communication" so that all members' viewpoints are heard and validated and is positioned to create "a culturally safe environment for engagement" (p. 96). This form of communication was our intent in our collaboration of learning MI. And we believe such collaboration is foundational for interprofessional collaboration in today's integrated health care system.

Development and Operations of One MI Learning Community

As stated, our MILC was developed to enhance and refine the MI skills of counseling students and professionals who had completed formal training in MI. A CES faculty member (i.e., the first author) established the MILC after extensive training in MI and membership since 2002 in the MI Network of Trainers (MINT; see https://motivationalinterviewing.org/). After returning from a sabbatical that included time spent in the MI coding lab at the University of New Mexico (i.e., assessing MI-consistent skills by listening to audio recordings of counseling conversations), she established a course in MI and one year later founded the MILC. The MILC was structured in

similitude to the MI coding lab with peers (e.g., counseling students who completed the MI course) who listen to their practice (live and to audio recordings) and offer structured feedback to develop competency and proficiency (see Madson, Loignon, & Lane, 2009). The first author designed the MILC in part to foster her own MI skills, desiring to surround herself with others who had completed training in MI and who could observe and evaluate her own practice. Rather than establishing a learning community off-campus, she envisioned an MI practice lab in the CE program for graduate students and licensed professional counselors who had at least 15 hours of prior MI training (e.g., completing the MI course), an opportunity for collaborative learning beyond the classroom. Such a gathering included the second, third, and fourth authors.

The second author began her CE doctoral studies when the MILC was launched. She is a licensed professional counselor and worked closely with the first author to schedule and plan each meeting. She served as the MILC co-facilitator in its first year. The second author was introduced to MI in her master's degree program where it was integrated into the counseling techniques course. She has used MI in her work with chronic pain patients and clients with substance use disorders. She co-instructed an MI workshop at a university in Southeast Asia and has conducted several state workshops. In our first year as a MILC, the third author was an advanced CE doctoral student and an independently licensed professional clinical counselor. She has since graduated and is now clinical director of a counseling facility. The fourth author was a master's counseling student during the MILC's inaugural year and is now a licensed professional counselor and a CE doctoral student.

The four of us met biweekly for 1.5 to 2 hours (12 times total) our first year. Research has demonstrated that MI skills diminish after formal training in MI (e.g., attending a 2-day workshop) without further or additional training, such as receiving supervision or coaching on ongoing

practice (Baer et al., 2009; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). We regarded our meetings as booster sessions and "ongoing support…needed for acquisition and retention of proficiency" (Miller et al., 2004, p. 1060). Each of us served as an MI champion or coach for one another (a designation used in MI training; see Rosengren, 2018) to assist in continued learning of MI.

Initial meetings of the four-member MILC consisted of agenda setting and defining learning objectives, such as using intentionality when practicing MI, becoming proficient in MI skills, and applying MI to specific client concerns. In each MILC meeting, one of us volunteered to be a speaker (or client) and another volunteered as helper (or counselor). We referred to "speaker" and "helper" in our MILC practice sessions so as not to confuse our work as providing actual counseling. The speaker presented a topic she felt two ways about (i.e., ambivalence), such as reducing coffee consumption or engaging in physical exercise. The conversations were either role-played (i.e., speaker portraying a counseling client) or real-played (i.e., speaker discussing something true to her life). The helper practiced responding in an MI-consistent manner. The other two MILC members observed the 20-minute interaction to provide feedback. All practice conversations (approx. 9) were audio recorded and subsequently transcribed and coded using the MITI 4.2 coding manual (Moyers et al., 2014) described earlier.

In addition to MITI coding practices, MILC activities during our first year included viewing professionally produced MI training videos, listening to earlier audio-recorded MILC practice conversations, and coding corresponding transcripts for helper MI-consistency. MI consultants in other disciplines (e.g., psychology) were utilized to gain additional feedback from experienced professionals with MI proficiency. An MI researcher and psychologist practicing in a Veterans Administration hospital was consulted by telephone regarding questions developed by

MILC members, such as clarifying the global scales on the MITI, identifying target behaviors, applying MI to existential concerns, and integrating MI into clinical supervision.

MI Learning Day

To evaluate our MI skills at the conclusion of the first year of the MILC, a full day of intensive practice was scheduled. The first four authors named this "MI Learning Day." We had practiced with one another throughout the year; it was now time to practice our skills with guest counselors in the client role, similar to the use of standardized patients described earlier. Two professional counselors were enlisted to help us practice, both having already portrayed clients in several courses in our CE program. Internal funding supported these two counselors-as-clients (CACs), as well as two MI consultants: an MI consultant who observed our live practice on MI Learning Day, and an MI consultant at the University of New Mexico who listened to and then coded our practice conversations using the MITI. We received an exemption from our university's institutional review board to conduct MI Learning Day.

MI Learning Day took place in our CE program's on-site counseling center and training lab and its two conference rooms, A and B. The lab is equipped to video record and live stream video from one room to the next. Practice conversations – or individual interviews – between each member of the MI Learning Community (MILC) and each CAC took place in room A and live viewing of these conversations took place in room B. All interviews were audio and video recorded and CACs signed release forms for their participation. MILC members took turns individually interviewing each CAC for 30 minutes. Because three MI members gathered in room B were observing live the interviews in room A, the second interview with each CAC picked up where the first interview left off. This allowed for the conversation begun with one MILC member and each CAC to continue with each of the three other MILC members. In this way, each CAC was

interviewed four times. The first CAC (CAC1) was interviewed in the morning and the second CAC (CAC2) in the afternoon. CAC1 is a middle-aged Caucasian male and CAC2 is a middle-aged African American female. The faculty member of the MILC conducted the first interview with each CAC. She requested that each CAC develop their own client case and not share this prior to their visit in order to provide MILC members a fresh, non-biased perspective of the client.

The MI consultant, and fifth author, is a doctoral level counselor with extensive clinical counseling and supervisory experience, as well as MI training. He has been a member of the MINT, has conducted numerous MI trainings, and now teaches part-time in the CE program that houses the MILC. During MI Learning Day, he observed from room B the interviews of CACs that took place in room A. After each MILC member interviewed each CAC and left the room, the MI consultant conducted a brief (5-minute) interview with each CAC about their interaction with each MILC interviewer. The purpose of these brief interviews was to: (1) elicit each CAC's perceptions of the interview, with special emphasis on change potential; (2) identify specific salient events from the interview that impacted the potential of change; and (3) assess the CAC's likelihood of returning for an interview using an adapted Change Ruler question (see Miller & Rollnick, 2013). These comments along with his own observations of the MILC interviews were analyzed for recurring themes and MI-consistent behaviors identified in the MITI 4.2.

After each round of CAC interviews, the MI consultant met with the four MILC members as a focus group for about 45 minutes to provide overall and specific feedback. The purpose of these group sessions was to elicit MILC members' perceptions of CAC interviews regarding potential for change, identify moments of MI-consistency and missed opportunities, and assess MILC members' confidence in implementing MI skills. The MI consultant encouraged MILC members to provide one another feedback, consistent with peer supervision. He also combined his

general and targeted feedback with occasional MI-based instructional information, consistent with the role of an MI coach (Rosengren, 2018).

Feedback and Evaluation of MI Skills on MI Learning Day

MILC members received feedback on MI skills from three sources on MI Learning Day: the two CACs, the on-site MI consultant, and an expert MI coder who coded all eight interviews using the MITI. The varied types of feedback (e.g., live, delayed, audio-recorded, quantitative, qualitative) from three different sources was intended to enhance the quality and credibility of the evaluations received.

Counselor-as-Client Feedback

Counselor-as-client (CAC) feedback, solicited at the end of each MILC interview, exemplified the recommended practice of systematically soliciting client feedback to improve counseling services and client outcomes (Lambert, 2013). The on-site MI consultant asked CACs two scaling questions: (a) "On a scale of zero to 10, zero being 'There is no evidence at all' and 10 being 'It was absolutely there,' how strong(ly) do you feel accepted and that this relationship was safe?" and (b) "On a scale of zero to 10, zero being 'Absolutely not' and 10 being 'Absolutely would,' how likely would you come back to engage with [MILC interviewer] as your therapist?" MI is commonly used to increase client retention (Carroll et al., 2006) and the engagement scaling question was used to assess the likelihood of client retention. The acceptance and safety scaling question was intended to explore each CAC's perception of relational characteristics measured by the global scales on the MITI (i.e., empathy and partnership).

In response to the first scaling question (acceptance and safety), CAC1 rated his initial comfort at nine, and it decreased across the next three interviews to seven, six, and then eight. CAC1 explained that his decrease in comfort was not due to the MILC interviewers, but to the

nature and intensity of the topic (i.e., alcohol use). CAC1's average rating on the second scaling question (likelihood of returning) across four interviews was seven. CAC2 reported a slight increase in comfort (on the first scaling question) ranging from six to seven across the four interviews. The MI consultant did not ask CAC2 the second scaling question and his interviews with her were shorter than those with CAC1. This inconsistency is a limitation in comparing the two CAC cases.

MI Consultant Feedback

As mentioned, the MI consultant met with the four MILC members twice as a group on MI Learning Day to provide them with general and individualized feedback. The first group feedback session took place in the morning, after all four of CAC1's interviews; the second in the afternoon, following CAC2's interviews. General feedback themes included the need to summarize at the beginning of each interview, performance anxiety, high reflection-to-question ratios, difficulty focusing or identifying the target behavior(s), and "spoiled" reflections. A reflection was "spoiled" (see Miller & Rollnick, 2013) if it was used as a question at the end of a statement such as "Is that right?" or if there was up speak. Up speak is a linguistic term describing a higher tone of voice at the end of an utterance that indicates a question. Additional general feedback themes included the use of empathy, affirmations, and emphasizing autonomy (all MI-consistent skills). Across MILC members, the MI consultant identified strong empathic tendencies that promoted CAC autonomy, and the frequent use of affirmations to encourage change talk and self-efficacy. He noted the use of complex reflections and metaphoric language to increase CAC change talk.

Individualized feedback was influenced by the order of interviews. For example, the faculty member was the first interviewer of both CACs and engaged in the process of focusing to identify goals and provide a foundation for subsequent interviews. The MI consultant provided

general feedback that she was warm and focused on building the relationship. Specific feedback revolved around her attempt at focusing CAC1 by asking: “What’s one thing you can get today before you leave to make it worth it?”

The MI consultant noted an overall concern: difficulty focusing each CAC and the focus shifting from one interviewer to another. Discussion ensued in the focus group about the difficulty focusing CACs – and clients in general – due to ambivalence on a number of topics and uncertainty about how long a counselor should acknowledge a client’s sustain talk before cultivating change talk. The MI consultant recommended developing a focus sooner by summarizing each CAC’s ambivalence and seeking collaboration. He also advised to eliminate “I” statements as part of affirmations and to substitute “You” instead. He described this as a continuum of focusing on the self (“I”) to focusing on the client (“You”). During both focus groups on MI Learning Day, MILC members discussed gentle confrontation as it relates to cultivating change talk, the need to work consistently with a CAC over the course of three sessions, and consulting with an MI coder.

MITI Coding Feedback

A professional MI coder and psychologist from the MI coding lab at the Center on Alcoholism, Substance Abuse, and Addictions (CASAA) at the University of New Mexico was enlisted to code the interviews from MI Learning Day. She listened to all eight audio recorded interviews with the two CACs and coded one 20-minute segment of each interview using the MITI 4.2 coding manual. MILC members received their MITI coding sheets, along with handwritten examples and explanations of codes. Several months after the MI Learning Day and having interviews coded, MILC members participated in a 2-hour telephone conference call with the professional coder to review the coding sheets and her explanations.

Table 1 presents each MILC member's average scores on the relational (partnership and empathy) and technical (cultivating change talk and softening sustain talk) global scales of the MITI, as well as behavior counts for eight of the ten verbal behaviors coded with the MITI. These are the score categories recommended in the MITI coding manual for reporting competency (fair) and proficiency (good) thresholds and are the threshold scores included in Table 1. As depicted in Table 1, the majority of MILC members met one or both thresholds on the global scales with one or both CACs. Thresholds also were met on two of the behavior count categories for all but one MILC member with one CAC.

Qualitative feedback received from the professional MI coder was consistent with MI consultant feedback provided on MI Learning Day. One example was difficulty clarifying the target or goal behavior in all CAC interviews. One member received feedback that focusing on CAC1's eating habits was premature. It was unclear if CAC1 was interested in focusing on his eating habits or if it was symptomatic of a larger behavioral change, such as overall health. A similar concern happened with CAC2. The MI coder informed one member that too much of CAC2's interview focused on current behaviors (i.e., generating sustain talk) rather than behavioral change (i.e., intended to generate change talk). Difficulty focusing is reflected in the lower MITI global technical scores in Table 1 that two members received. Softening sustain talk scores decreased especially in the case of CAC2, and difficulty focusing led to an increase in questions in reflection-to-question (R:Q) ratios.

Table 1

Four MILC Members' MITI Codes for Interviews with Two Counselors-as-Clients (CACs)

MITI 4.2 Codes	MITI 4.2 Thresholds:		MI Learning Community (MILC) Member and CAC Pairings							
			A		B		C		D	
	Fair	Good	CAC1	CAC2	CAC1	CAC2	CAC1	CAC2	CAC1	CAC2
Global Scores: Relational										
Partnership and Empathy	3.5	4	5	5	3	2.5	5	5	4	5
Global Scores: Technical										
CCT and SST	3	4	3	3.5	3	2.5	4.5	5	4.5	4
Behavior Counts:										
% CRs	40	50	48	61	28	55	72	62	82	75
R:Q	1:1	2:1	23:3	28:13	18:7	18:35	25:6	13:15	17:4	20:11
Total MIA	-	-	4	4	5	3	4	5	7	7
Total MINA	-	-	0	0	5	3	0	0	0	0

Note. MITI codes determined by professional MI coder, based on the MITI 4.2 coding manual. MITI 4.2 thresholds are for fair (competent) and good (proficient). Global scores rated from 1 (low) to 5 (high); average scores presented. CCT=cultivating change talk. SST=softening sustain talk. CR=complex reflection. R=reflections (simple and complex combined). R:Q ratios for MILC members are presented in raw number counts. Q=questions (closed and open combined). MIA=MI-adherent behaviors (combined behavior counts for affirmations, seeking collaboration, and emphasizing autonomy). MINA=MI-non-adherent behaviors (combined behavior counts for confront and persuade without permission).

Reflections on Our MI Learning Community

Several months after MI Learning Day and MILC members' telephone consultation with the professional MI coder, the first four authors reflected on their involvement in the inaugural year of the MILC. Each MILC member responded in writing and separately to several questions the first author posed, questions to which she also responded. The first and third authors reviewed and synthesized all responses.

Overall, the MILC was an empowering, non-hierarchical, safe, and risk-supportive "consciousness-raising community" for us. Advanced MI skill development, exploration, and feelings of connection and confidence stemmed from learning and practicing with those who understood the language and "spirit" of MI. We believe the MILC has improved our practice of MI in several ways: we are more attuned to change talk, responding to feedback from clients, determining target behaviors (even if those changed), and viewing the engaging and focusing processes of MI as "key."

MI Learning Day was “nerve-wracking” and challenging, but “comforting” and “eye-opening.” We realized how “drowning in compassion” might hinder engagement, therapeutic rapport, the counseling process, and one’s ability to identify and focus on target behaviors. The impact of subjectivity on evaluation, MITI coding, and feedback was an additional theme. We appreciated the MI coder’s “candor and vulnerability” during consultation as her engagement and provision of detailed feedback (and not just numbers) about the importance of purposefully “valancing complex reflections toward change talk” shifted our perceptions and left us feeling “guided and encouraged.” Questions arose about coding limitations (i.e., nonverbal cues are not considered in MITI coding) and overall counseling style versus “pure MI.” MI Learning Day and consultation with the MI coder affirmed the importance of “consistent practice,” that learning never ceases with regard to practicing, teaching, and coding MI; and that demonstrating MI when training, teaching, and sharing feedback with others is essential.

Recommendations for Developing and Maintaining an MI Learning Community

Professional development opportunities for counselors and counselor educators seem to rely primarily on self-study, attending professional conference sessions, and one-day workshops. Achieving competence and pursuing proficiency in an EBP, however, requires more than didactic and sporadic training. What has demonstrated improved skillfulness in an EBP, such as MI, is ongoing practice observed and evaluated by others (Miller et al., 2004). This includes the MI practice of CE faculty observed and evaluated by graduate students and professional counselors as part of an ongoing extracurricular learning community or community of practice.

MI Learning Day reinforced for us the importance of continued and semi-structured practice of MI witnessed by peers and evaluated (quantitatively and qualitatively) by those with expertise in MI. We learned that practice is not simply repetition or merely experience. Rather, for

practice to lead to competency and proficiency (characterized as fair and good, respectively, in the MITI manual; see Table 1), it must move beyond the routine or what is comfortable (e.g., practicing among ourselves) to increasingly challenging opportunities (e.g., interviewing simulated clients as a team). Another lesson learned is that improved skillfulness in MI takes shape in a supportive learning environment, one in which fellow members and expert consultants adopt the style or spirit of MI.

Use of Simulated Clients and Counselors-as-Clients in Training

Interviewing counselors as clients (CACs) on MI Learning Day – and doing so as a team – proved an appropriate measure of our MI skills. We had practiced MI as a team; it was fitting to test our skills as a team. We learned, however, that to practice MI, we should have prepared CACs better for their role, such as asking them to present as a client feeling two ways about something (i.e., arriving in a state of ambivalence). It also may have been helpful, especially in the morning interviews of CAC1, for us to have received in advance some information about the client, whether developed by the CAC or one of us interviewers. This would provide interviewers and the MI consultant with preliminary and shared understanding of the client prior to the first interview, a practice consistent with MI training methods in medical education in which standardized patients are used (e.g., Childers et al., 2012). For advanced practice sessions, however, it seems reasonable to ask CACs to arrive as a "clean slate" or without a known "backstory" to further challenge interviewers.

Three additional recommendations for using CACs in team-based MI training are first, to recruit counselors or other helping professionals with formal training in MI who can then provide interviewers with feedback specific to MI once out of their client role. Second, debrief CACs after their portrayal/interviews and request their overall feedback. This will ensure that persons

portraying clients are not leaving the interview in a vulnerable state and it models ethical counseling practice. We have implemented these first two recommendations in several meetings of our third year of the MILC. Our third recommendation is to have the same CAC interviewed twice by each MILC member, the second interview occurring after receiving targeted feedback, such as MITI scores. The second interview with the same CAC could be a "do-over" for the interviewer and a measure of incorporating feedback.

Developing and Maintaining an MI Learning Community

The rapid and vast dissemination of MI in a variety of helping professions (see Carroll, 2016), including counseling, warrants its inclusion in counselor preparation curriculum. Its study and practice, however, should not be confined to the classroom. An extracurricular MI Learning Community comprised of faculty, students, and professional counselors in the community who gather on a regular basis to practice the skills and style of MI symbolizes a commitment to relevant and meaningful collaborative learning. It also resembles professional collaboration essential in today's integrated health care system. Our MILC is now in its fourth year and we have more than doubled in size to nine members. Most of these members are program graduates who are now licensed professional counselors in the area. The MILC thus fosters a connection between the CE program and its alumni, as well as connections between MILC student members and alumni. We offer a few recommendations for developing and maintaining a MILC.

For a MILC to be sustainable, we believe someone with extensive training in MI should be the facilitator. Rosengren's (2018) three criteria of an MI coach apply to the role of facilitator: be knowledgeable and passionate about teaching and learning MI, set high expectations, and provide high levels of support. The facilitator can shift from MILC session to another, but who will facilitate each gathering needs to be determined in advance. We recommend that membership in a

MILC be by invitation only, inclusive of persons who have had some standard MI training and who wish to improve their MI understanding and skills. Although not a closed group (i.e., persons can join and attend at any time), it is an exclusive group in the sense that members share the common language of MI and want to learn in a supportive environment. Our MILC has developed the feel of a support group, but support only has not been our focus.

We have learned the benefit of scheduling meeting days and times in advance, such as for the entire semester. Honoring each meeting's start and stop time and identifying a topic specific to MI for each gathering may help to keep members involved. We have met in the same location for the past 3 years (e.g., on-campus conference room), but plans are underway to partner with a community counseling facility and meet periodically as an MILC at the agency's site, in the company of clinical staff trained in MI. This type of town-gown collaborative has been enhanced with recent requests from community agencies in the area for MILC members to offer MI training to their multidisciplinary staff (e.g., case managers).

A successful MILC is practice-focused. This is consistent with Miller and Rollnick's (2013) advice for MILCs. This means engaging in role-play or real-play conversations with one another or interviewing invited CACs with training in MI to offer feedback. In supervision, modeling practices and role-play strategies have been found to increase supervisee implementation of recommended practice more so than supervisor-supervisee discussion (Bearman et al., 2013). Similarly, talking about MI does not lead to MI skill proficiency. In our MILC we incorporate learning activities that are creative, fun, and involve all members present. We routinely use props (e.g., dice, hand-held colored paper "flags") for activities described in the MI literature (e.g., Rosengren, 2018) and at MINT-sponsored gatherings and on the MINT website. We recommend an audio recording device be available at each MILC to record practice conversations for future

review (e.g., MITI coding). We have asked members to audio record practice conversations outside of our meetings for all members to review at a future gathering. We have developed an audio recording release form for non-MILC members when interviewed as CACs. We specify that practice conversations not be conducted with current or former clients, close friends, or family members.

One final recommendation is to consult periodically with persons external to the MILC who have MI expertise, including professionals from other disciplines, such as psychology and medicine. These consultations can serve as calibration for members by keeping their understanding of MI current and their skills consistent with MI. As we did on MI Learning Day, a professional MI coder can be enlisted to code sample audio recordings as an external evaluation of MI skills. The MITI scores we received from MI Learning Day, presented in Table 1, provided that type of "report card" for us. We recommend that consultations focus on a specific aspect of MI and be conducted by phone or in-person. Prospective consultants can be with MINT members at other CE programs, on campus (e.g., in nursing, medicine), or in the community. For these consultations, continuing education credit can be pursued for MILC members, a tangible benefit of participating in the MILC.

Closing Thoughts and Future Directions

Among faculty across disciplines in higher education, Spiller, Byrnes, and Ferguson (2013) observed a culture of reluctance to engage in professional development activities. They described faculty who prioritize their autonomy and think they maintain "a sophisticated and rigorous command of an academic discipline" (p. 836). Such a stalwart mindset can lead to overconfidence and an insular and rigid understanding of a particular topic. It also can reinforce professional silos, the antithesis of interprofessional collaboration necessary in today's integrated health care. This

isolationist mindset and practice does not model healthy inquiry for students, nor does it encourage interprofessional consultation. Furthermore, it does not signify professional development as perpetual learning.

Extracurricular learning communities comprised of students, counselors, CE faculty, and perhaps helping professionals from other disciplines who meet on a regular basis to promote their learning of a given topic simulate one aspect of integrated health care in the United States today: interprofessional collaboration. They also represent one aspect of implementation or dissemination science (Thomas et al., 2017), the study of how research findings and EBPs can be translated into actual and routine practice. It is noteworthy that the EBP of MI originated in part from its disciplined practice among clinicians from a variety of disciplines in an atmosphere of genuine curiosity and inquiry (see Miller & Moyers, 2017). It therefore seems fitting for a team of counselors, students, and faculty to gather on a routine basis to study, practice, and promote their implementation of an empirically supported counseling method.

Learning communities can be implemented in other CE programs on topics related to trauma care, suicide assessment and prevention, and culturally affirming practices, to name a few. Their purpose is to extend organized learning beyond the classroom; exemplify to students and others the perpetual nature of learning and professional development; foster collaboration among faculty, students, and professionals (the latter who may include CE program alumni); and enhance practice fidelity, a key feature of EBPs.

Although our MILC has yet to venture into online or distance collaboration (other than consultation with experts via video conferencing), conducting a virtual learning community is feasible with the proper digital platform and member connectivity. Members could submit practice audio recordings with non-clients via a digital platform for review and feedback. Another option

is for members to practice in real-time. Virtual practice may consist of the speaker receiving comments and MITI codes during a mock session and adapting MI skills in-the-moment using video conferencing. A virtual learning community would increase access for counselors to engage in ongoing MI training in the midst of scheduling and time constraints. Increased virtual access may assist in the development of legitimate peripheral participation, a concept in which individuals joining a group progress into experts by learning and adopting group practices (Jan, Vlachopoulos, & Parsell, 2019; Lave & Wenger, 1991). A virtual MI learning community aligns with a Communities of Practice (CoP) online framework in which mutual engagement, joint enterprise, and a shared repertoire are present (Wenger, 1988; Wenger, White, & Smith, 2009). Members' previous MI training lends to a shared repertoire easily accessible in an online platform. Members may also take turns facilitating or contributing to online practice, thus effectively contributing to the joint enterprise of a CoP and increasing mutual engagement.

Research specific to any learning community includes measuring skills that are the focus of that learning community (e.g., MI-consistent skills) over time and from more than one source (e.g., self-report, peer review of sample audio recording). Internship supervisors could evaluate the skill level of supervisees who are and who are not members of a learning community. Health care facilities (e.g., hospitals) sponsoring a learning community might evaluate staff outcomes in light of staff members participating in a learning community. Results might be comparable to practicing as part of a regular treatment team or consultation team. Assertive community treatment (ACT), for example, is a multidisciplinary team-based EBP for persons who are homeless and severely mentally ill. Participating on ACT teams is associated with reduced staff burnout, increased job satisfaction, and low staff turnover (see Boyer & Bond, 1999). The supportive nature of professional learning communities might offer similar benefits to staff.

Practice with feedback is an essential element in assessing implementation fidelity of any EBP (Bearman et al., 2013; Carroll, 2016). A collaborative learning community that maintains its mission of supported and shared learning among diverse professional helpers, remains focused on the topic selected (e.g., MI), and welcomes the periodic evaluation and feedback of "external reviewers" exemplifies professional collaboration and development at its best. Such practice also is consistent with expectations in today's health care system of provider accountability. We recommend that CE faculty and practicing counselors establish extracurricular (and perhaps community-based) learning communities to prepare counseling students for effective practice in today's integrated health care system and to promote their own skill repertoire.

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