



Wisconsin
Department of Health Services

Division of Mental Health and Substance Abuse Services

**Opening Avenues to Reentry Success (OARS)
Annual Report**

(this is an excerpt of a [larger report](#))

**Fiscal Year 2014 (FY14)
July 1, 2013 – June 30, 2014**

P-00572A (12/2014)

From the Director

The Office of Community Forensic Services was created in October, 2014 in recognition of the varied and important work performed by staff within the community forensics unit of the Department of Health Services Division of Mental Health and Substance Abuse Services.

Our mission is to ensure community safety and assist Wisconsin's judiciary in the efficient and effective processing of forensic cases in the criminal justice system.

We are committed partners with Wisconsin's judiciary and our mental health and criminal justice colleagues in the mission of making our communities safer, reducing jail, prison and mental health institution populations and saving tax dollars by providing evidence-based, client centered treatment to the clients served through the Community Forensic Programs.

I wish to thank all the dedicated individuals who contribute their expertise, passion, and hard work to make these important community programs successful.

The *Office of Community Forensic Services Annual Report* serves as a review of our program goals and performance in an effort to promote accountability and a continuous cycle of quality improvement.



Glenn Larson,
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Opening Avenues to Reentry Success Program

PROGRAM STATEMENT

The Opening Avenues to Reentry Success (OARS) Program, modeled after the Department of Health Services Conditional Release Program, is a joint venture of the Departments of Health Services and Corrections. Its mission is to fund, coordinate, and administer quality reentry services to mentally ill individuals as they prepare for their release from prison and transition to the community.

The individuals served by the program include the most seriously and persistently mentally ill releasing from the prison system that are assessed at a moderate or high risk for reoffending. Recidivism and revocation rates for this target population are higher than average and the need for crisis intervention services (i.e. detoxification facilities, emergency detentions, emergency room visits, psychiatric hospitalization, law enforcement intervention, etc.) pose a financial burden to local governments and state taxpayers. Furthermore, members of this population that return to prison typically require far greater institutional resources than the average inmate.

The individuals who choose to enroll in this program are provided an array of comprehensive, individualized services specific to their needs and risk factors. The OARS program employs a team approach involving institution treatment staff, contracted forensic case managers, community corrections agents, Department of Health Services program specialists, and community treatment providers.

OARS team members carefully manage risks by employing evidence-based practices, including Motivational Interviewing, an emphasis on medication compliance, and a hybrid of other models.

Strong team relationships have been developed across Departments and with private contractors in order to manage risk, maximize efficacy, and provide quality service to individuals in the pre-release and post release phases of the Wisconsin correctional system.

The OARS program strives to develop and share innovative ideas, program successes, resources, and comprehensive outcome data for the betterment of statewide correctional services and national forensic programs.

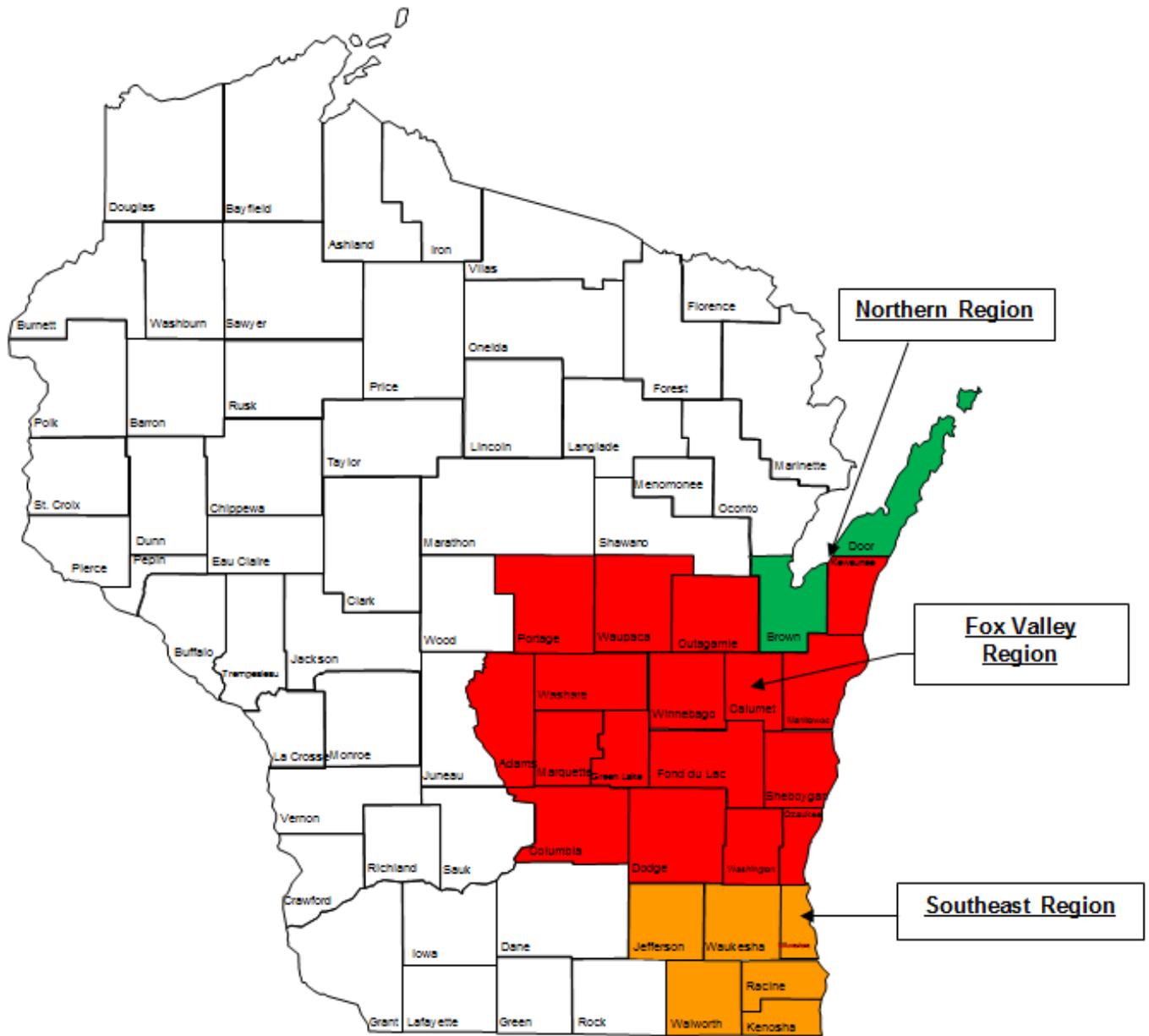
MISSION

To reduce recidivism and revocation rates through specialized supervision and individualized case management.

VISION

To enhance public safety by supporting the successful transition, recovery, and self-sufficiency of participants with mental health needs as they reintegrate into the community.

OARS PROGRAM COVERAGE MAP



DHS OARS Contact for Southeast Region: Boon Coleman, (608) 266-3878
DHS OARS Contact for Fox Valley and Northern Regions: Lila Schmidt, (608) 261-9314

FY14 GOALS AND OUTCOMES

The goals below strive to bolster the program's quality, effectiveness, and efficiency.

- **Implementing the OARS Exit (Satisfaction) Survey.**

Deferred. Rather than an exit survey, the program is reviewing a survey which would be administered prerelease, three months and six months after the client is placed in the community and then again near the program discharge date. It is believed this will not only provide useful programmatic information, it would also provide more formal individual case feedback which could be useful in adjusting how services are delivered to the individual.

- **Focus on researching/improving meaningful, healthy activities.**

Among the activities the case management providers engaged in included;

The use of a tracking system of the financial costs that the OARS program spends on clients. The goal is to help case managers better understand their client's financial picture and then they, in turn, can help their clients to understand it. This will help the client recognize what they need to do in order for them to be financially independent in the community without dependence on the OARS program. This budget form will be used by case managers with clients at least every 3 months or more frequently if needed. The form helps to show all expenses and identifies if the client is paying for that expense or the program or both. The form clearly shows a client their income, what they are able to pay for, and helps the client identify what expenses they may need to start paying for on their own in the future. In addition, the case management supervisor reviews monthly bills with case managers to assure that the program is paying for necessary items only.

Case managers were provided with presentations by the Aging and Disability Resource Center (ADRC) on eating healthy on a budget and program information, Rent Smart, Budgeting a fixed income, AODA, and Trauma Informed Care.

In the pre-release phase, staff worked with clients to identify hobbies and ensure tools/equipment were available upon release. It is important to assist the client in identifying evening and weekend activities. Additionally collaborating with prison social workers to identify natural supports/leisure activities/hobbies prior to release will be a focus.

Continued emphasis on natural supports, volunteer and employment areas were targeted and improved.

- **Focus on increasing accessibility to quality medical care and benefits (patient assistance measures); which will also improve cost savings.**

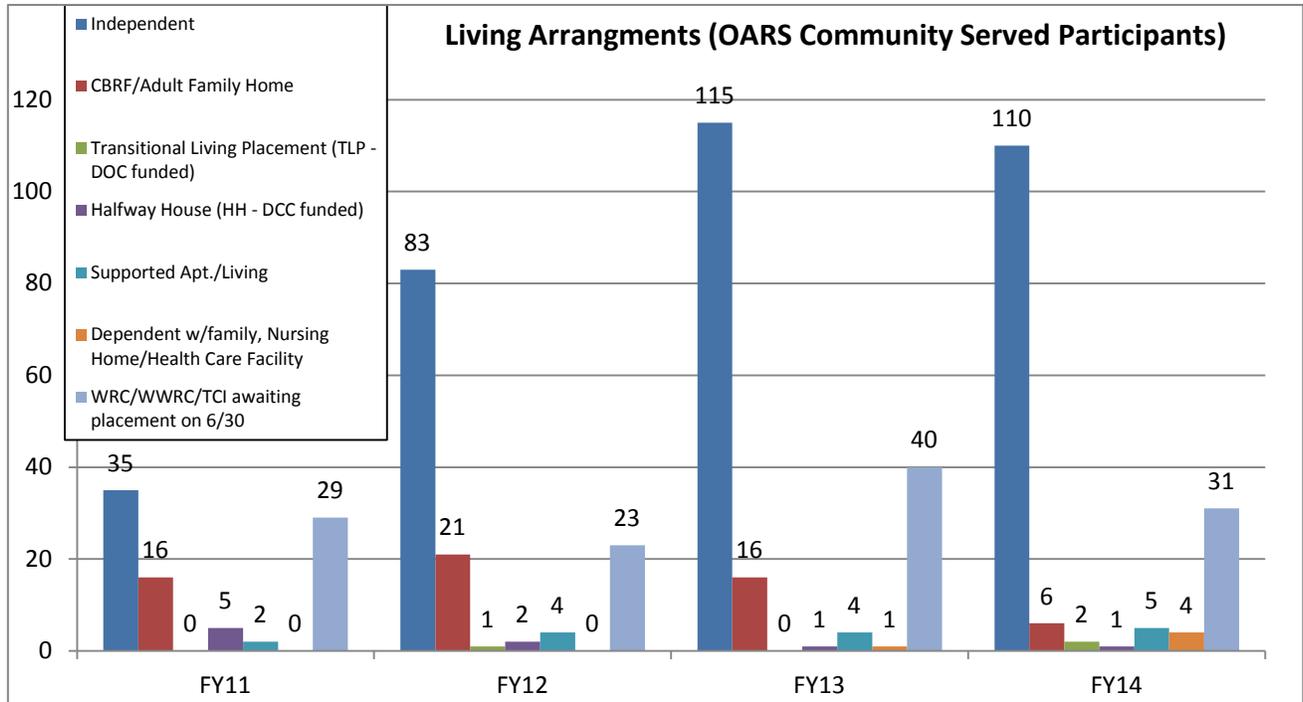
Provider program assistants participated in a Medicaid teleconference hosted by the state of WI. The training focused on Medicaid and programs that exist using Medicaid funds. All participants are assigned a DOES attorney (Disabled Offenders Economic Security provided by the Legal Action of Wisconsin in partnership with DOC) whom assists them in applying for SSI/SSDI. About 50% of OARS participants received SSI/SSDI benefits. The remainder were eligible for applying for insurance through the Market Place.

FY14 DATA

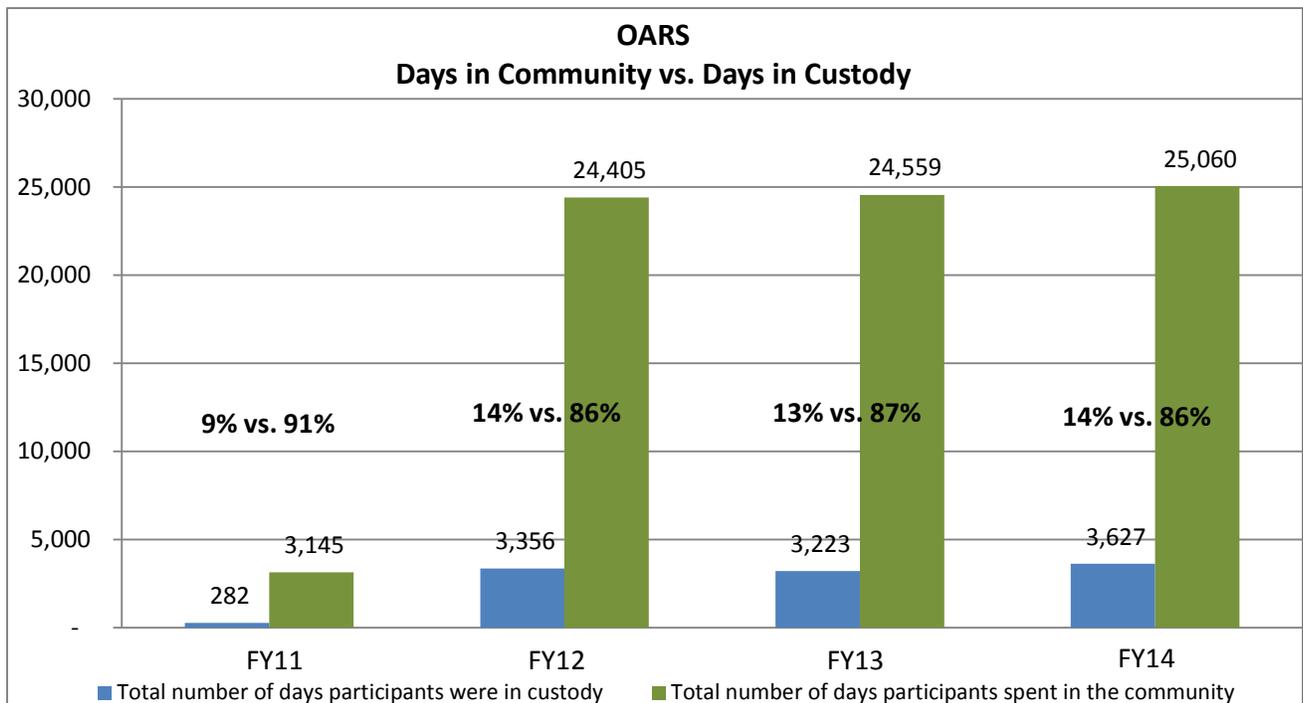
The following are notable OARS data points for FY14.

- The program provided services to 162 participants, 128 participants were served in the post-release phase.
- 48% of participants were referred to the program with a high risk rating, based on Department of Corrections assessment tools.
- 98% of participants had a primary major mental health diagnosis.
- 72% of participants suffered from a diagnosed co-occurring substance use disorder.
- 54% of participants were diagnosed with a co-occurring Axis I major mental illness and an Axis II personality disorder.
- 18% of participants were subject to sex offender supervision rules.
- 1.2% were convicted of a new crime during their enrollment in the program. (two participants, both crimes were misdemeanors)
- 52% of post-release participants were receiving SSI and/or SSDI benefits.
- 96% of post-release participants were receiving FoodShare.
- 2% of post-release participants were receiving benefits through Family Care.

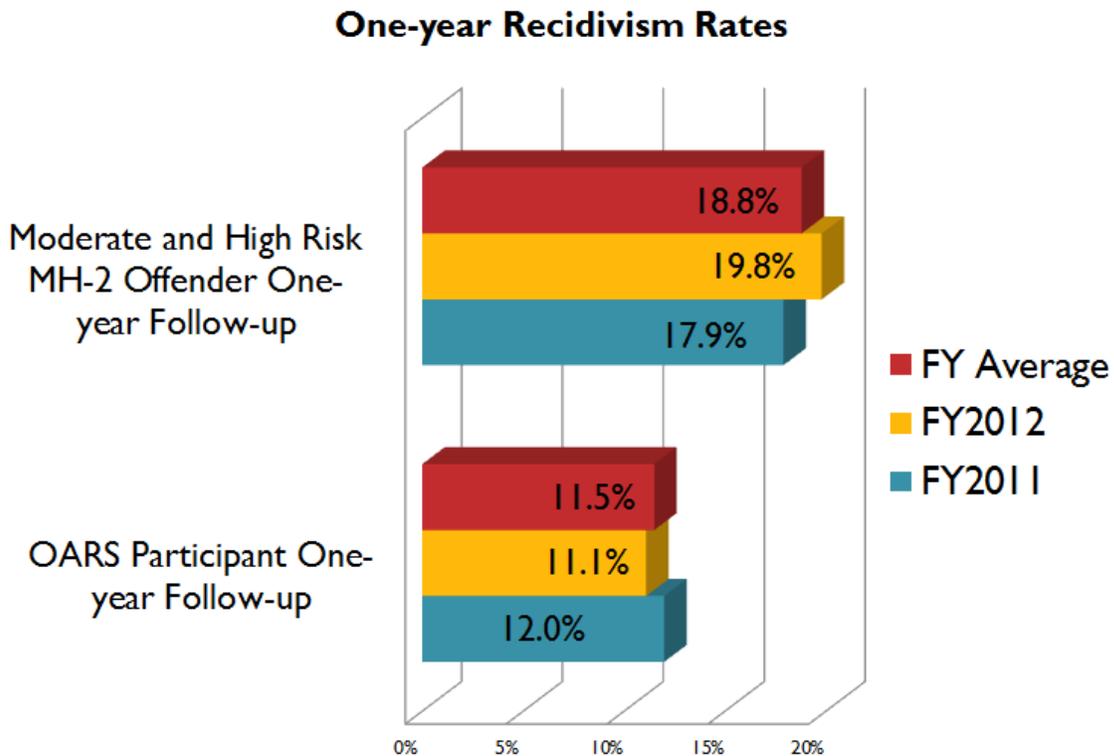
- 83% of participants resided in independent living during the majority of the post-release phase.
- 5% of participants resided in a CBRF or Adult Family Home throughout the majority of the post-release phase.



- During the post-release phase, OARS participants spent 86% of their time in the community versus 14% of their time in custody.



Recidivism: One-Year Follow-Up

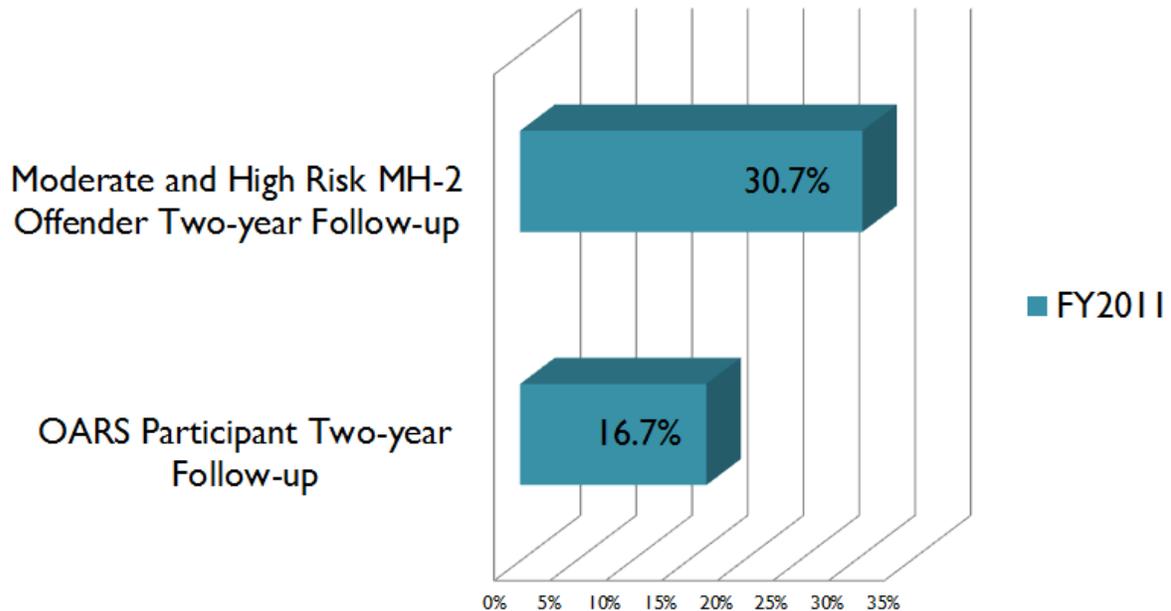


Compiled by the WI Department of Corrections (DOC) for the “Becky Young Community Corrections Recidivism Reduction Fiscal Year 2014 Report”

Based on a one-year follow-up period with 104 participants, the combined recidivism rate calculated for all OARS Participants for FY11 and FY 2012 is 11.5%. As a comparison, all medium and high risk offenders not enrolled in the OARS program releasing with a serious mental illness in FY11 and FY12 have a one-year recidivism rate of 18.8%. Recidivism measures for participants in the first two fiscal years of the program indicate a 38.8% reduction in recidivism rates compared to non-participants with similar characteristics, a reduction of about 7%.

Recidivism: Two-Year Follow-Up

Two-year Recidivism Rates



Compiled by the WI Department of Corrections (DOC) for the “Becky Young Community Corrections Recidivism Reduction Fiscal Year 2014 Report”

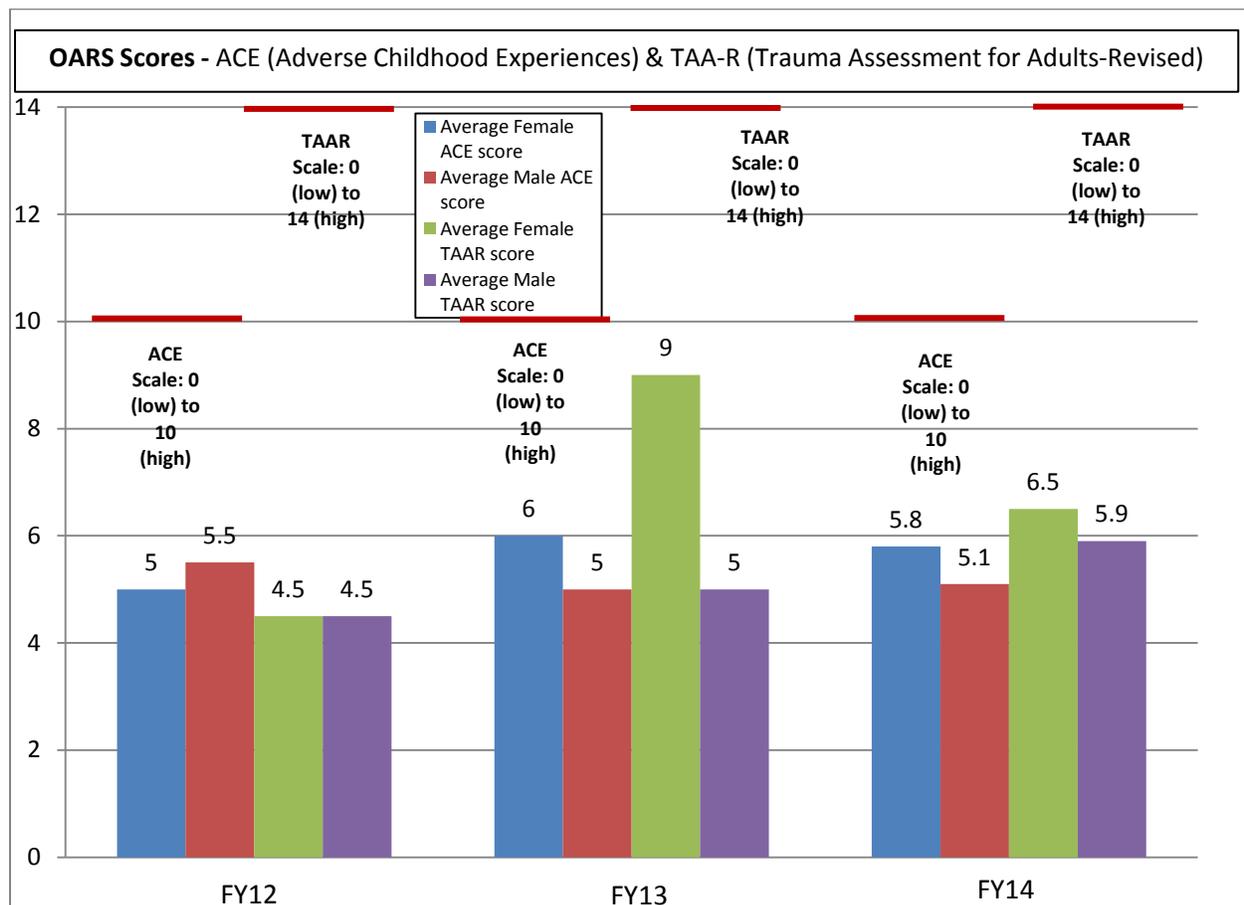
The two-year follow up rate is available for FY11, the first fiscal year of the program. There were eight recidivists in a sample size of 48 participants, yielding a recidivism rate of 16.7 percent. By comparison, all medium and high risk mentally ill inmates not in the OARS program releasing in FY10 had a two-year recidivism rate of 30.7%. This indicates a recidivism rate reduction of 45.6% for program participants.

While the sample size is fairly low for the first year of the program, these results are very encouraging. The program has a significant impact on participants and re-incarceration rates. A continued drop in the recidivism rates for all follow-up years is anticipated since the program focuses on the population most likely to respond to treatment, case management, and supervision. The next sets of annual recidivism data will also show higher participant numbers as the program now maintains an average daily population of 100 participants.

OARS AND TRAUMA-INFORMED CARE

As part of larger Trauma Informed Care initiatives at the Departments of Health Services and Corrections, the OARS Program utilizes two trauma screening tools: The Adverse Childhood Experiences (ACE) and Trauma Assessment for Adults-Revised (TAA-R).

These screening tools are administered by the OARS case manager in the pre-release and post-release phases. Screening provides an opportunity to enhance the professional working relationship with the participant, reduce the stigma, and silence surrounding traumatic experiences, and to recognize many “problem” behaviors as coping strategies. Results from these tools indicate a significant degree of trauma history in both the male and female populations served. All participants were offered these screens.



A study by the Centers for Disease Control and Prevention (CDC) found that persons who scored a four or more on the ACE screen, compared to those who had experienced none, had:

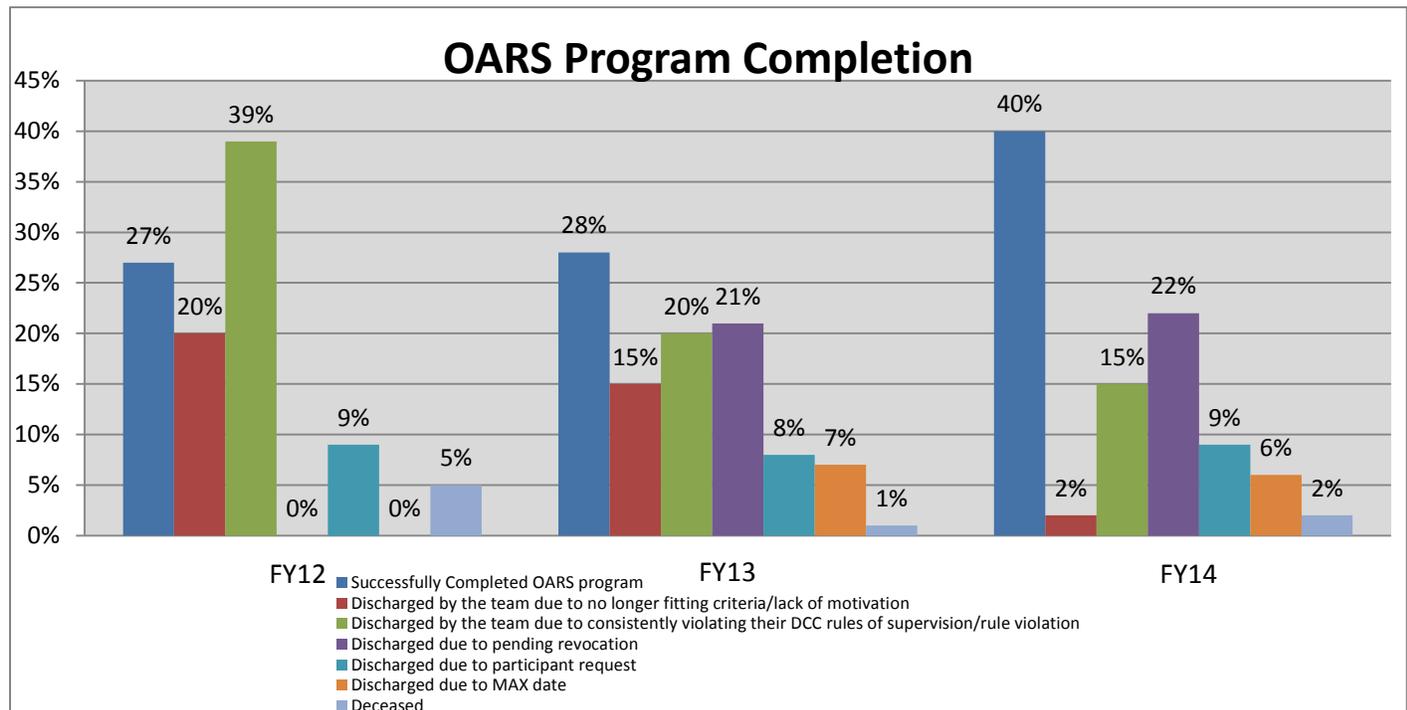
- A 4- to 12-fold increase in health risks for alcoholism, drug abuse, depression, and suicide attempt.
- A 2- to 4-fold increase in smoking, poor self-rated health, greater than 50 sexual intercourse partners, and sexually transmitted disease.
- A 1.4- to 1.6-fold increase in physical inactivity and severe obesity.

The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

The conclusion of the CDC study is there is a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

OARS PROGRAM PARTICIPANT DISCHARGES

- 40% of participants successfully discharged from the OARS Program
- 2% discharged due to team decision, primarily due to lack of motivation and meaningful follow through on program goals
- 15% discharged due to consistent violations of their rules
- 22% discharged due to pending revocation
- 9% discharged due to participant request
- 6% due because their criminal sentence expired
- 2% passed away from natural causes while in the program (1 while in prison, 2 in the community)



SUMMARY OF OPENING AVENUES TO REENTRY SUCCESS PROGRAM DATA

	FY11 Total	FY12 Total	FY13 Total	FY14 Total
Total Served, eliminating transfer duplication, pre & post	88	142	174	162
ADP	48	79	101	97
Admissions to OARS Program				
Pre-release as of 6/30	29	23	40	30
Post-release as of 6/30	72	76	69	92
New Admissions Release Origin				
WRC	52	34	42	44
	59%	45%	61%	44%
WWRC	n/a	3	2	4
	n/a	4%	3%	3
TCI	36	23	24	23
	41%	30%	35%	33%
Living Situation				
Independent	35	83	115	110
CBRF/Adult Family Home	16	21	16	6
Transitional Living Placement (TLP - DOC funded)	0	1	0	2
Halfway House (HH - DCC funded)	5	2	1	1
Supported Apt./Living	2	4	4	5
Dependent w/family, Nursing Home/Health Care Facility	0	0	1	4
WRC/WWRC/TCI/OSCI/REECC awaiting placement on 6/30	29	23	40	31
Employment				
Competitive	5	12	17	19
Sheltered/Supportive	2	2	1	2
Pre-employment training/DVR	2	6	12	1
Unemployed - seeking employment/Laid off	18	20	37	49
Unemployed - currently unable to work	8	6	10	20
Unemployed - disabled or unwilling to work	24	59	52	31
School/Other educational, Retired, Unknown	0	6	8	12
Diagnostic Categories				
Schizophrenia	17%	18%	35%	17%
Other Psychotic Disorders	29%	28%	16%	15%
Mood Disorders	42%	39%	43%	52%
Anxiety Disorders	8%	13%	13%	9%
% of total population with co-occurring diagnosis	85%	74%	67%	72%
% of total population with co-occurring axis II diagnosis	75%	72%	58%	54%
DOC Mental Health Code 2A	85%	90%	89%	98%
DOC Mental Health Code 2B	15%	10%	11%	2%
Crime at Sentencing				
Total served - violent felony committing offense	42%	46%	49%	48%
Total served - nonviolent felony committing offense	56%	38%	36%	58%
DOC Risk Assessment Rating – Medium	45%	50%	52%	48%
DOC Risk Assessment Rating – High	55%	78%	48%	48%
Total served revoked	3%	4%	1%	2%
Total participants placed in short-term hospitalization (WRC/TCI, community)	9	20	24	20
Percentage of total	29%	18%	17%	15%
Population approved for SS benefits as of 6/30	63%	66%	66%	52%

FY15 GOALS

In FY15, the OARS Program will continue to use measurable outcome performance expectations in its contracting process.

FY15 Contract Deliverables	Performance Expectation	Performance Standards	Data Source
Goal 1	To the extent possible, OARS participants will be financially self-sustained.	At 6 months post release, 75% of OARS participants will have a reduction in the cost of their care, which may assist in clients becoming more financially self-sustained.	Contract deliverable spreadsheet
Goal 2	OARS participants engage in meaningful daily activities.	90% of participants in the OARS Program will be involved in meaningful daily activities. Meaningful activities will be discussed and implemented as a goal on client Individual Case Plans.	Contract deliverable spreadsheet Review of Individual Care Plans
Goal 3	Justifications for all OARS participants placed in CBRFs are completed at three months, and every month thereafter, unless otherwise exempt, until a lesser restrictive environment is appropriate for the participant and community.	Prior to discharge from the OARS Program, 90% of participants who were residing in a CBRF or Adult Family Home when they were placed in the community are moved to a less structured living situation.	CBRF tracking spreadsheet Review of CBRF justifications Monthly bills <i>OARS case management agencies will track all clients in CBRFs.</i>
Goal 4	Case managers will use Motivational Interviewing with clients to address their treatment and behavioral issues.	Continue with monthly tracked measures: <ul style="list-style-type: none"> • Staff attendance • Staff presentation of recorded audio • Peer review results • Individual Learning Plan on file • Staff participation in learning activity • Staff submit one consumer evaluation monthly 	Motivational Interviewing training attendance Motivational Interviewing tracking sheets

Appendix A: Motivational Interviewing and Implementation Project

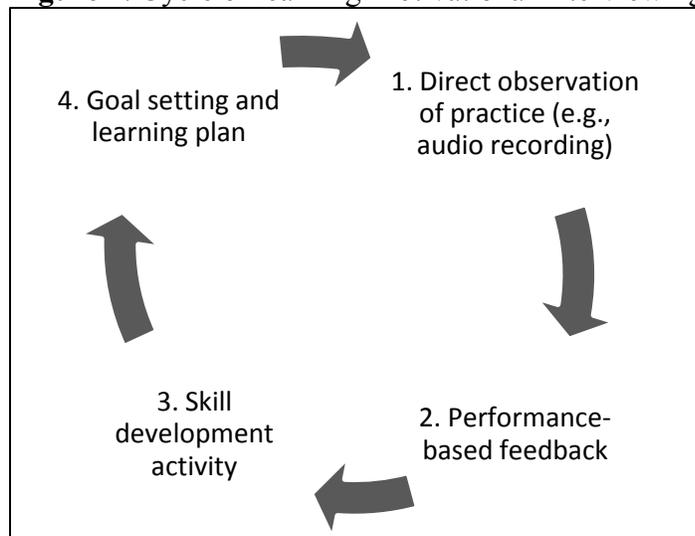
The following is a report from Scott Caldwell, Motivational Interviewing Trainer.

This report summarizes the results of the Motivational Interviewing Training and Implementation Project (MI-TIP) for Conditional Release Program (CR) and Opening Avenues to Reentry Success Program (OARS) case management staff during contract year 2013-2014.

Background

MI-TIP involves an innovative training process with the goal of helping staff to learn MI as an evidence-based practice, that is, to fidelity standards. Training research in MI increasingly shows that “one shot” trainings are insufficient to promote even a basic level of competency in MI.¹⁻³ Moreover, the training research shows that MI is not easy to learn⁴ and, like learning any complex skill, requires ongoing learning.^{5,6} As depicted in Figure 1, training research shows that the following elements comprises an effective learning cycle: 1) direct observation of practice is critical, because, there is “no reliable and valid way to measure MI fidelity other than through the direct coding of practice samples.”⁷ 2) performance-based feedback, 3) continued opportunities for skill building, and 4) goal setting. MI-TIP used this process to promote learning among CR/OARS case management staff.

Figure 1. Cycle of learning Motivational Interviewing.



As a contract deliverable, staff were required to attend a monthly 1-hour MI peer learning group. During the group, staff presented (on a rotating basis) an audio recorded sample of MI practice, then received structured feedback from peers. With time remaining, staff participated in a skill building exercise from a workbook.⁸ Following the presentation and feedback, each staff completed an individualized learning plan which addressed the following questions: What area of MI do you wish to continue focusing on? What 1-2 specific goals you will work toward? Barriers to achieving these goals? How will these barriers be overcome (strategies)?

MI-TIP with CR/OARS

Staff were required to present two audio taped practice samples each during the contract year. The first sample was presented during 2013 (the first 6 months of the contract year) and the second sample was presented during 2014 (the last 6 months of the contract year). With feedback on two practice samples, each case manager was able to compare their results and revise their learning plan accordingly. Each provider agency was given a spreadsheet to track their peer learning group data. Spreadsheets were submitted by the director on a quarterly basis. As shown in Table 1, case managers were highly engaged in the learning process. Each peer learning group, on average, comprised about 7 staff and this reflected about 90% of the contracted employees. Furthermore, almost all staff (98.5%) developed and revised their individualized learning plans.

Table 1. Peer learning group descriptives.

Measure	First 6 months (2013)	Second 6 months (2014)	Total
Number of staff presenting an audio recorded practice sample	32	24	56
Average number of staff attending peer groups	7.2	7.4	7.3
Average percentage of CR/OARS staff in attendance (of total)	85.5%	95.0%	90.25%
Average percentage of staff who completed a learning plan	97%	100%	98.5%

The peer review of audio recorded practice samples was based on the skill behavior count component of the Motivational Interviewing Treatment Integrity (MITI) instrument.⁹ During review, peers coded (mutually exclusive) the presenting case manager's utterances into the following categories: Open Question, Closed Question, Simple Reflection, Complex Reflection, MI Adherent behavior, and MI Non-Adherent behavior. Staff received an overview and initial practice on how to conduct MITI coding during on-site training. Based on the skill behavior counts, five measures of MI could be calculated then compared to the corresponding fidelity standards (see Table 2).

Table 2. Calculation of MI skills and fidelity standards.

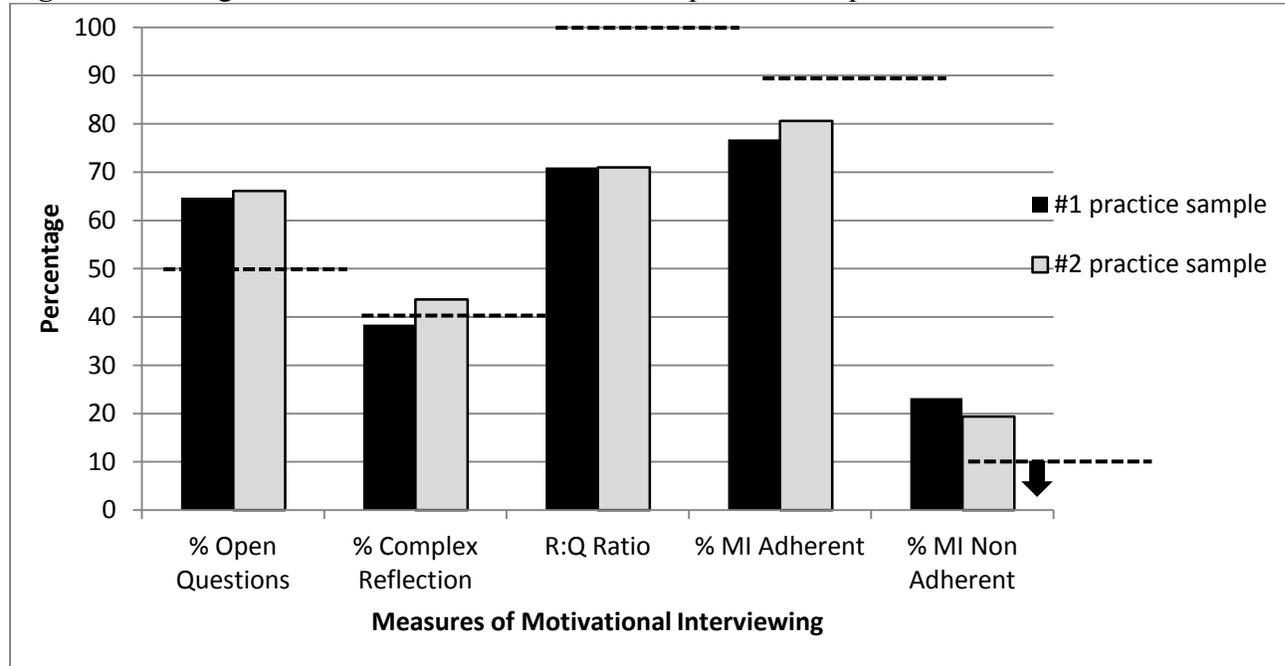
MI Measure	Calculation	Fidelity Standards ¹⁰	
		Basic Competency	Proficiency
% Open Questions	# of Open Questions /total Questions x 100	≥ 50%	≥ 70%
% Complex Reflection	# of Complex Reflections /total Reflections x 100	≥ 40%	≥ 50%
Reflection to Question Ratio	Total # of Reflections / Total # of Questions	≥ 1.0	≥ 2.0
% MI Adherent behaviors	# of MI Adherent behaviors/ # of total other behaviors x 100	≥ 90%	≥ 98%
% MI Non-Adherent behaviors	100% - % MI Adherent	≤ 10%	≤ 2%

Results

Spreadsheets containing the skill behavior counts were submitted throughout the contract year based on the peer review results. This data was imported into a statistical software program (SPSS) to examine overall progress in staff demonstration of MI skills. As depicted in Figure 2, staff skill behavior counts were averaged and compared to the fidelity standard of basic competency. Results showed that two skill measures exceeded basic competency (i.e., percentage of Open Questions both practice samples; percentage of Complex Reflection in practice sample #2). However, the other measures (Ratio of Reflection to Question, percentage of MI Adherent and Non-Adherent behaviors) did not reach fidelity. Additionally, pair-wise comparisons showed no difference between average practice sample #1 results and practice sample #2 results on measures of Open Questions (65% vs. 66%, $p = 0.64$), Complex Reflection

(38% vs. 44%, $p = 0.27$), Reflection to Question ratio (0.7 vs. 0.7, $p = 0.98$), MI Adherent (77% vs. 81%, $p = 0.46$) and MI Non-Adherent behaviors (23% vs. 19%, $p = 0.46$). In sum, staff showed fidelity in two skill areas, however, skills showed no change from the first to the second practice sample which were about 6 months apart. Note: statistically significant difference is when the probability (p) of results due to chance is less than 5 in 100, that is, $p < .05$.

Figure 2. Average results for staff's first and second practice samples.



Note: The fidelity standard of basic competency is indicated by hash mark.

Beyond average results, to what extent did individual staff achieve MI fidelity on practice sample #2? To address this question, each MI measure for staff who completed practice sample #2 ($N = 24$) was converted into a dichotomous score of either 0 (did not achieve fidelity) or 1 (achieved fidelity), thus creating a 0 (no fidelity measures achieved) to 5 (all fidelity measures achieved) scale. This group of staff demonstrated, on average, 2.3 fidelity measures. Table 3 shows the percentage of staff by number of measures.

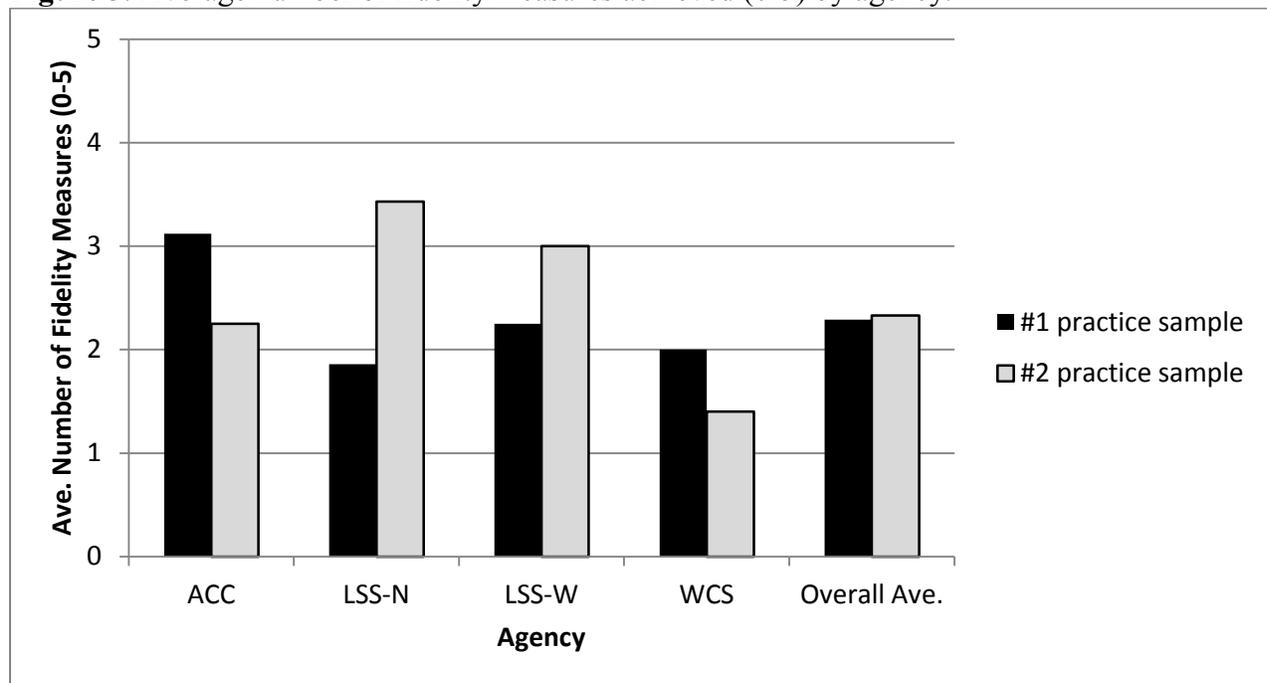
Table 3. Percentage of staff who achieved fidelity measures (basic competency) on practice sample #2.

No. Fidelity Measures	Percentage of Staff
0	0%
1	25%
2	29%
3	12%
4	21%
5	12%

The number of MI fidelity measures achieved (0-5) offers a useful glimpse into the extent to which participants advanced their skillful practice of MI during the contract year. Results showed that the majority (64%) achieved two or fewer fidelity measures. Only one-third of staff (33%) achieved four or more measures. Although some staff attrition was noted between practice samples #1 and #2, there was no difference in number of fidelity measures achieved at practice sample #1 (baseline), suggesting that no selection bias existed for the staff who completed practice sample #2.

Regarding the number of fidelity measures achieved by staff, there was no significant practice improvement, overall, from practice sample #1 to #2. However, several within and between provider agency differences existed. As depicted in Figure 3, there was a range of differences. ACC showed a non-significant trend toward a decrease in fidelity ($p = 0.08$), however, LSS-N ($p < 0.01$) and LSS-W ($p < 0.05$) both showed significant gains in practice toward fidelity. On the other hand, WCS ($p < 0.01$) started with a relatively lower level of fidelity and lost ground between practice sample #1 and #2.

Figure 3. Average number of fidelity measures achieved (0-5) by agency.



Summary

How to make sense of these results? CR/OARS case managers showed a high level of engagement in the monthly peer learning group process. Provider agencies demonstrated that staff involvement in peer learning that utilized best practices (e.g., direct observation + feedback) is feasible. Yet, although staff engagement in ongoing learning following training is necessary, it does not appear to be at all sufficient to promote gains in MI skills toward fidelity across time. Results showed that staff on average were able to demonstrate a basic level of competency for 2 of 5 fidelity measures (Open Questions, Complex Reflections). However, staff overall did not show practice gains from the practice sample #1 to #2. This finding is consistent with the training outcome literature that shows MI is not easy to learn.⁴ Nonetheless, it is of concern because, presumably, staff are showing their best MI practice in the audio recorded practice

samples. If staff are struggling to show even a basic level of competency in this context, it is likely that the majority of CR/OARS case management staff are not utilizing MI in routine practice. The high percentage of MI Non-Adherent behaviors (e.g., telling clients what to do, advising, warning, confronting) is revealing because such behaviors would be considered practice-as-usual in CR/OARS case management services. Unfortunately, research shows these behaviors to be ineffective in promoting positive behavior change with confrontation being discredited.¹¹ As MI training researchers have noted, “it may be at least as important in teaching MI to diminish old habits of MI-incompatible responding.”⁵ The data also showed that about one-third of staff is able to demonstrate basic MI fidelity. Interestingly, some provider agencies appear to be promoting good practice compared to others. So although the overall average results show no improvement in skills over time, analysis on the individual staff and agency level show a range of ability. That the implementation of MI varies by provider agency is consistent with research that shows “site matters.”¹²

Moving Forward

Based on the results of this study, there are several implications and questions for the 2014-2015 contract year:

1. The study provides a reminder that for staff to advance from practice-as-usual to delivering MI as an evidence-based practice, *staff's own behavior change is required*. It is a “use it or lose it” proposition. For staff who are not integrating MI into practice, it shows in the practice sample results. Staff are not going to benefit from a monthly dose of learning if there is not an effort to integrate MI. What incentives can be offered to help motivate staff to learn and integrate MI into practice?¹³ What learning resources can be made available to increase staff's efficacy as learners? For staff who struggle to demonstrate even 1 or 2 fidelity measures, how can these staff be identified and worked with in a collaborative, effective manner?
2. The site differences are interesting. What is occurring at the provider agencies in which staff are starting at a baseline of MI skills comparable to the other provider agencies, yet show greater gains in skills over time? What are the implementation factors within the agencies that seem to be promoting skillful MI practice? How can these factors be identified and replicated in other provider agencies? How can technical assistance be developed and tailored to meet the needs of staff within the agencies that seem to be struggling?
3. Support, resources, and assistance is one component in a successful implementation project. Monitoring the accountability is another component. How can the contracting process be used to focus on deliverables and provide ongoing monitoring and accountability?

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