RESEARCH ARTICLE

▲ Health Care Practitioners' Perceptions of Motivational Interviewing Training for Facilitating Behaviour Change among Patients

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OBJECTIVES: To investigate, qualitatively, practitioners' perceptions of a 1-day interactive and applied workshop in motivational interviewing (MI). Specifically, participants explored the training's usefulness in supporting perceptions of competence, confidence, and attitudes towards facilitating behaviour change among patients. **METHODS**: Ten health practitioners including dieticians, pharmacists, nurses, and social workers participated in this qualitative pilot study. Participants received a 1-day (7.5 hour) workshop focused on MI. In-depth one-on-one interviews were conducted prior to the workshop and at 1 and 4 weeks post-training. Methods were employed throughout to ensure data trustworthiness. **RESULTS**: Pre-workshop themes about facilitating patient behaviour change included: persistence; advice-giving; behaviour change as hard work for practitioner; low perceived confidence and competence to help; barriers; and feelings of frustration. Post-workshop themes included a renewed inspiration and motivation to facilitate behaviour change; partnering with patients and giving less advice; experiencing a positive perceived impact on the patients; feeling that behaviour change is easier and less stressful; enjoying higher levels of competence and confidence; and being mindful of practitioner impact. **CONCLUSION**: Participation in the structured, interactive, and applied MI training was deemed effective by practitioners dealing with patient behaviour change. Allied health care practitioners are in a key position to facilitate health behaviour changes that contribute to behaviour-related illness. The integration of similar MI trainings for health practitioners should be further explored with a larger group. J Allied Health 2012; 41(3):131–139.

CHRONIC NONINFECTIOUS ILLNESSES and conditions such as cardiovascular disease, type two diabetes, cancer, and obesity are the leading causes of death, disability and health care spending in Canada and worldwide.[1,2] Healthcare providers are encouraged to counsel their patients about preventive health behaviours as part of routine visits.[3] While utilization of primary healthcare by the Canadian population is high,[4] a patient typically spends only about 10 minutes with a physician during an office visit, and most additional time is spent with other health professionals.[5] By engaging in the time needed for behaviour change counselling, health professionals such as nurses, dieticians, social workers, and pharmacists can play a vital role to facilitate patient behaviour change.[6,7]

Chronic health conditions including, but not limited to, type two diabetes and hypertension are often related to behavioural patterns[8] and may require patients to be seen on a regular schedule. Researchers have found that patients tend to respond more positively to health care practitioners with whom they have continuing clinician-patient relationships and who utilize a patient-centred approach.[9] The traditional approach to behaviour change counselling often relies on advice and direct persuasion;[10] however, research indicates that providing advice promotes healthy behaviour change in only 10 to 20% of patients.[11,12] Furthermore, giving advice often increases patient resistance to change.[13] By contrast, motivational interviewing (MI), as both a treatment philosophy and a set of principles, is intended to help people increase intrinsic motivation.[14] MI was first described in 1983 for treating alcoholism.[15] Today, MI is considered theoretically grounded with clinical recommendations for behaviour change in a wide variety of problem behaviours including, but not limited to, alcohol or drug abuse, risky sexual behaviours, smoking, medication adherence, and diet and exercise.[16–18]

Despite the popularity of MI, formal training evaluations suggest variable skill improvements and insufficient competence in using the approach.[19–20] A set of motivating behaviour change competencies that serve to bridge the principles of MI with readily applied and efficacious skills is needed. Co-Active Life Coaching (CALC)[21] may fill this need.

CALC is an approach grounded in at least three theories of behaviour change[22] and is considered effective for bringing the tenets of MI to practical use.[23] The purpose of this study was to qualitatively explore non-physician health care practitioners' perceptions of a 1-day training in MI

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TABLE 1. Measures to Ensure Data Trustworthiness*

Measure	Description
Credibility	Member checking was done between questions and at the end of each interview to ensure the researcher correctly understood the responses from each participant. The interviewing researcher provided her perception and a summary of the participant's responses before moving to another question.
Dependability	Following each interview, the interviewing researcher debriefed and summarized the content with one or both other researchers, and details were recorded. Any potential biases were voiced, recorded, and considered to ensure that analyses were not influenced by researcher bias. Detailed information was continually documented for the purpose of an audit trail.
Confirmability	Inductive content analysis was performed independently and simultaneously by two researchers, who met later to compare analyses. Data was examined for similarities and differences across the interviews. From here, emerging themes were identified. A summary of this was then discussed and final themes agreed upon.
Transferability	The research process was documented in detail, which allows interested groups to evaluate if the results may be transferable to other settings.

*Adapted from Irwin et al., 2005.[27]

applied using CALC tools on their experience of behaviour change counselling in clinical practice. The current study was part of a larger mixed-methods pilot investigation on the utility of a 1-day workshop on practitioners' experiences of behaviour change (the quantitative aspects of this study are presented elsewhere).[24]

Methods

Ten health care practitioners were recruited through a local health team. Participants were eligible if they were English-speaking health care practitioners who worked full time and had an interest in behaviour change among patients. Ethical approval was granted from the University of Western Ontario's Office of Research Ethics. Pre- and post-workshop in-depth interviews were used to explore practitioners' experiences with facilitating patient behaviour change, and their perception of the training's impact on their competence, confidence, and attitudes towards facilitating behaviour change among patients.

All interviews were conducted over the telephone, were audio recorded, and transcribed verbatim. Inductive content analysis, as described by Patton,[25] was performed independently by two researchers. Data trustworthiness was maintained using strategies described by Guba and Lincoln,[26] and the specific application of these strategies for this study was adapted from Irwin et al., and is summarized in Table 1.[27] Data saturation was reached by the sixth interview, and the additional four interviews were conducted because the current study is part of a larger study and utilizing all 10 participants enabled the collection of additional rich and salient information.

DESCRIPTION OF THE MI VIA CALC WORKSHOP

A no-cost 7.5-hour workshop in MI applied via CALC tools was provided for the health care practitioners who were invited to use the tools, if and when they wished, during routine communication with patients. Two MI-trained PhDs in the health sciences, who are also Certified Professional Co-active Coaches (JDI and DM) with extensive workshop-delivery experience for health providers, facilitated the workshop.

The workshop began with an introduction to MI (descriptions extracted from the work of Miller and Rollnick).[14,28] The utility of CALC as a model for health promotion and health behaviour change was then described.[23] The workshop was highly interactive with a focus on practical tools for working with patients/clients for preventing a health-related problem or promoting a health-related goal. Facilitators demonstrated the tools/skills, and participants used breakout sessions to practice tools while receiving feedback from facilitators. Some of the specific tools/skills used included: attaching behaviour change goals to patients' personal values; dropping assumptions; rolling with client resistance; adopting a competency view of patients; open-ended questions; and using 'tangible' agreements with patients. Each participant received a workshop folder, which included additional resources and facilitators' contact information if any post-workshop questions arose.

Results

Ten health care practitioners volunteered to take part in the study and completed all aspects. All were female; five were registered nurses, two pharmacists, two social workers, and one dietician. Participants ranged in age from 26 to 65 years with 60% between ages 38 and 55, and 95% had 10 or more years of fulltime experience in their current specialty (one participant had 2 years' experience). Two participants had previous MI training, which consisted of 1 hour or less.

PRE-WORKSHOP INTERVIEWS

Five prominent themes, one with four subthemes, about practitioners' experiences and perceptions of facilitating

TABLE 2. Pre- Workshop Themes about Behaviour Change Facilitation

Theme	Quotation
Persistence in Facilitating Change	*"What motivates me is when patients are coming in, and their disease process isn't improving, their lab tests aren't improving, their pain isn't improving but they don't seem—they don't seem to be motivated to make themselves do what is necessary."*
	"You feel like you're making a difference in someone's life."
	"It's [facilitating behaviour change] very difficult. It feels like you are banging your head against the wall and you don't just want to give up on them because you know they have to make the change."
Giving Advice and Suggestions	*"And not that I want to say that I'm threatening. But I mean that sometimes . . . you need to tell them what can happen if they don't change. . . . '. . . your diabetes would get worse. . . . You'd have to go from oral meds to insulin. . . .' I guess showing them . . . stages they could end up. So I guess it's a bit of a scare tactic."*
	" 'If you behave like this, these are going to be the consequences'. . . so I would give them something sort of specific that they could do . . . suggestions . . . or I would always say 'have you thought of. . .'."
	"I have actually said, 'look . . . here's what I'm hoping that you might want to do', cause let's say they complain about this issue all the time, but when you make a suggestion they will not follow through with anything, so I will say 'when you do this make a follow-up appointment', and you know what sometimes they will not come back because they had no intention of doing it."
Behaviour Change is Hard Work for Practitioner	*"It's frustrating that you're putting so much effort into it and they [patients] don't seem to."*
	"I think I think I've come to the conclusion that people just won't change no matter how hard you [the practitioner] try."
	"I think eventually I feel like I can break them [patients] down."
Low Perceived Competence and Confidence to Facilitate Change	*"It's defeating [patient non-compliance]. . . . It doesn't make you feel like you're a great practitioner."*
	"I know I'm trying but I don't think that I'm doing a very good job."
	"If they [patients] absolutely have no motivation . . . whether it's smoking cessation or whether it's lifestyle change with diabetes or whatever, that's where I run into roadblocks and then I think 'oh gee I, I'm not competent to do this.'"
	"It's [when a patient does not make a change] a feeling of hopelessness . . . failure and . . . you know basically I guess I feel that they . . . either something is wrong with me . . . or they don't want to change, or both. . . ."
	"I think since I'm not as competent as I think I could be then my confidence isn't as high as it could be."
	"I know what the [behaviour change and motivation] concepts are, but whether I'm doing it effectively I don't know."
	"On a scale of 10, I would say my competency is 4 or 5 whereas on a practical level I can't even grade myself. It's much lower than that."
	"Especially when they [patients] come back and they haven't done what you've agreed upon so . . . competence is low as well."

patient behaviour change emanated from the pre-workshop interviews. Although quotations may fit in more than one theme, they are presented in the section in which the quote best fits.

Persistence to Facilitate Change

Despite many participants expressing feelings of frustration, their persistence with patient behaviour change counselling was a prominent theme. Their persistence was fueled by caring about their patients and knowing patients needed to change to improve their health; this knowing was as motivating factor to counsel about behaviour change regardless of success. Specific quotations illustrative of participant responses are provided in Table 2.

Giving Advice and Suggestions

Giving advice and suggestions was a commonly described approach for encouraging behaviour change. Participants stressed the importance of making the patient aware of the long-term health consequences of not changing certain behaviours, providing relevant guidance/information, and explaining which behaviour changes need to happen (illustrative comments are in Table 2).

TABLE 3. Barriers and Facilitators to Facilitating Behaviour Change

Theme	Quotation
Patient Receptivity and Interest	*"Some of them [patients] they just—you know—they don't accept that they're sick, or that they have a health issue."*
	"I'll say 'so what brings you?'. . . .[if patient responds with something like] 'oh my mom made me come' . . . and I know we're not going anywhere with that."
	"If someone [patient] is absolutely not interested [in change] that creates quite the barrier. So patient buy-in is pretty important."
	"If I can go back into the chart and see that they [patients] have had really poor diabetes control and they're not doing anything about it for two years and then the doctor has finally sent them to me. I would say that makes it harder for me because of the thing in my head that says, 'well they've been slacking off for two years, what exactly is it that the doctor expects me to be able to do?. . . So I'm . . . throwing in the towel before I've even started."
	"If I have a sense that they [patient] at least want to try . . . sometimes just the fact that they keep coming back you know and making the appointment, then that gives me more patience."
	"Once the crisis situation becomes stable then sometimes they will lose the motivation to do some of the other behaviour pieces because they are no longer in crisis. They're motivation is actually the highest and sometimes that's the only reason they come is because of the crisis."
Frustration with Unmotivated Patients	*"The patients that don't comply or don't try to do anything—you get frustrated with. . . . I try not to get angry. Ahh, Sometimes I do. I think—I just think why . . . can't you just get the point that if you don't take care of things you're going to be sicker down the road? I never say that to them."*
	"And my own personal frustration I guess [is] that . . . the way that I'm doing it [behaviour change facilitation] isn't very effective…that we're not making progress towards goals. . . ."
	"Frustrating. I feel like it's [behaviour change facilitation] sometimes a waste of my time."
Need More Tools	*". . . I understand that the behavioural change is complex, especially in the context of smoking. I've heard numerous talks where they've alluded to that. So I think I can regurgitate it, but as for my practical hands-on knowledge, what I'm lacking is that nobody's ever really sat down . . . and adjudicated how I'm doing that in day-to-day practice."*
	"I need to learn different techniques and to . . . motivate people without being threatening"
	"Sometimes I think with smoking cessation it's . . . how exactly . . . how do you motivate people. . . . So I think . . . what stops you [practitioner] sometimes from getting into these conversations is actually how to get into it . . . from a conversation standpoint."
Patient-Practitioner Rapport	*"Patients that I know better that I've seen a few times, I feel as though . . . it flows a little more easily rather than a person that I've only met for the first time."*
	"The patients—if they are familiar with you it's nice. A previous relationship to begin with makes it a lot easier for sure."

Behaviour Change Facilitation was Hard Work for Practitioner

Some practitioners felt that behaviour change conversations were hard work, and at times it seemed that the practitioner is the one doing most of the work. This contributed to feelings of frustration and reduced motivation to address behaviour change, especially when dealing with chronic non-compliant patients (illustrative quotes are in Table 2).

Low Perceived Confidence and Competence to Facilitate Change

Practitioners described patients' lack of scheduling follow-up appointments and low success with behaviour change outcomes as contributors to feelings of low confidence and competence for effectively facilitating behaviour change. Some also described feeling hopeless and defeated when a patient was unsuccessful in lifestyle change (see quotations in Table 2).

Barriers and Facilitators to Aiding Behaviour Change

Participants reported four sub-themes related to barriers and facilitators to effective behaviour change, as outlined below (illustrative quotations are in Table 3):

Patient receptivity and interest. Practitioners stressed that patient receptivity and interest to make a change was critical and could be a major barrier if low, and a facilitator if high. Some participants did not know where to start the behaviour change conversation or felt "stuck" when dealing with unreceptive patients.

TABLE 4. Impact of the MI/CALC Workshop on Health Care Practitioners 1-Week Post-Workshop

Theme	Quotation
Renewed Inspiration and Motivation to Facilitate Behaviour Change	*"If you get stumped [facilitating behaviour change]…I think before [the workshop] I would just quit, and now if I get stumped I have two or three different possibilities to move into."*
	"Honestly, I would really just have to say I just feel so much more inspired [since the workshop]."
	"I would say it's [behaviour change facilitation] still frustrating, but I would say I have so much more hope that I can make a difference."
	"I would say that in the past when I would look at my appointment schedule and would say 'oh, look there's patient A, B, C . . . what a waste of time.' Now, I think, ok, let's try out this motivational piece, behaviour change piece and see not if we can make the difference that I'm looking for, but really elicit what it is that he or she [patient] is looking to change."
	"[I feel] More optimistic for sure [since the training], more motivated to work at it [behaviour change]."
	". . . he's [referring to an unreceptive patient] one in the past that I would have thought I don't think we are going to make a lot of headway here, there doesn't seem to be a lot of interest or motivation on his part . . . but [now that I have the training] he'll be a good client to kind of play around with some of the things I've been learning, there's an opportunity there."
Partnering with Patients and Giving Less Advice	*"Before, . . . I thought it was up to me to figure out what their [patients'] issues were, and through the motivational [workshop] day it's not, it's listening to them [patients] and making them into more self-managers of their own issues."*
	"Normally, in those [behaviour change discussion] appointments—now that I'm reflecting back on it—it was a lot of me bombarding information at them [patients] and them just kind of sitting there. I was trying to be—like I would just talk endlessly . . . now I'm just more having an open conversation. The biggest thing I'm trying to remember is trying to use those 'what questions'."
	"Before [the workshop] I used to tell patients what to do without asking what they'd like to work on. Now it's either their decision, or a joint decision."
	"I'm definitely trying to do more listening and asking questions rather than being the one that's providing all of the information."
Perceived Positive Impact of Tools on the Patient	*"I think they [patients] are far more self-motivated to do that [specific behaviour change actions] and they feel more connected somehow to it [behaviour change goal]."*
	"[Unlike previous to the training] [T]he patients enjoyed it here I mean it was all I could do to get them to leave [when using MI approach]."
	"I think [since using new tools] they [patients] were actually motivated to come back. . . . Well first of all they didn't want to leave and second of all they wanted to book next appointments."
	"It [when I use new tools] gives them [patients] more confidence or autonomy . . . they feel valued like their opinion, they're not just here for me to tell them what to do. They're responsive . . . they're taking the responsibility. . . ."
Behaviour Change Facilitation is Easier and Less Stressful	*"They [patients] come out with a new realization that isn't from me—it's from them. . . . I think, wow, we [health professionals] didn't do anything."*
	"It's [MI approach] refreshing. And it seems like less . . . not like I'm trying to get out of work . . . it just seems less stressful on me . . . pushing them, making them more responsible."
	"I feel like I'm sitting back and letting them [patients] do the thinking."
	"It feels easier for me . . . knowing that . . . you're putting the questions out there and they're [patients] coming up with the decision on what to do, and once they decide then I just kind of wrap it up for them."
	"I think it's easier for me, like they were saying at the workshop, you know if you feel like you're doing all the work then you're not doing it right. So it's really that client feeding it and just kind of going with the flow . . . it just feels easier."
Competence and Confidence Improved	*"If you [practitioner] get stumped . . . I think before I would just quit and now if I get stumped I have two or three different possibilities to move into."*
	"I'd say my competence is increased, I'd say my confidence is greatly increased. . . . My competence I'd say I think I know what I'm supposed to do and I think I have the tools to do it . . . but if you're not confident then it makes it harder to even try, and I think that whole day [workshop] was very confidence building."

TABLE 4. (continued)

Theme	Quotation
	"This [workshop] has given me some strategies on where to start. Even that pictogram of the wheel [tool provided at workshop]—that is a terrific way to start. . . . if you've got a block of time set aside, you can use that strategy. If you don't have that block of time, then some of those short questions . . . that you [workshop facilitators] provided are strategies that can be implemented."
Mindful of Impact in Conversation	*"I'm actually very cognizant of the process [MI] when I'm speaking to my patients. So it's [MI approach] just more at the forefront of my mind."*
	"Open-ended questions is something I was doing before anyway, but I think just being more conscious of it, aware of that."
	"Certainly . . . I feel I'm probably more effective now. It's still awkward. Doing something that you're, I mean, you have to be thinking all the time and it's very very difficult not to give that advice."

Frustration. All practitioners expressed varying levels of frustration when dealing with non-compliant patients. The majority described some level of frustration toward the patient who was not ready to make a health behaviour change and/or felt they were wasting their time. Others felt frustrated with themselves.

Need more tools. All participants expressed a desire to learn new techniques with some expressing that they knew their current approach was not effective but did not know what else to do. Practitioners felt stuck during conversations with unreceptive or continually non-compliant patients. Participants wanted practical tools that coupled behaviour change principles.

Practitioner–patient rapport. Practitioners perceived that behaviour change conversations were easier if it was not the first time meeting the patient and if there was a good practitioner–patient rapport.

ONE WEEK POST-WORKSHOP

Themes that emerged from the 1 week post-workshop interviews included: a renewed inspiration and motivation to facilitate behaviour change; partnering with patients and giving less advice; experiencing a positive perceived impact on the patients; feeling that behaviour change is easier and less stressful; enjoying higher levels of competence and confidence; and being mindful of practitioner impact. See Table 4 for illustrative quotations for each theme described below.

Renewed Inspiration and Motivation to Facilitate Behaviour Change

Practitioners reported an eagerness to work with all, including non-compliant patients, and a feeling of renewed motivation to engage in behaviour change conversations. They also reported greater optimism at their effectiveness due to their access to new tools, positive perceived impact on patients and an increase in follow-up appointments scheduled by patients.

Partnering with Patients and Giving Less Advice

All participants described a shift in their approach to behaviour change counselling after the workshop. Practitioners felt less responsible to *solve* problems for the patient and reported engaging in a working relationship with the patient being much more involved in choosing changes. Practitioners also expressed feelings of greater awareness of the patient's own health-related agenda and motivation and having fewer preconceived assumptions about patients prior to appointments.

Perceived Positive Impact on Patient

Practitioners reported that when using the MI/CALC tools, they perceived a very positive impact on the patients. Some practitioners described patients' increased enthusiasm to engage in behaviour change conversation and make concrete changes. Others described perceiving patients as feeling more valued as an individual and empowered to make health decisions for themselves.

Behaviour Change Facilitation is Easier and Less Stressful

Practitioners emphasized repeatedly that when using MI, behaviour change conversations were less stressful and felt easier compared to pre-workshop. Participants reported reduced feelings of stress while facilitating health behaviour change, even with unmotivated patients, because the new approach engaged the patients to problem-solve.

Competence and Confidence Improved

All participants felt they were more effective at behaviour change using the workshop tools, and they were more confident to engage in behaviour change conversations. For example, practitioners described the value of having new techniques for patients presenting with low motivation. However, some participants also noted that learning a new skill had challenges, and that the tools needed to be a focus of concentration and/or felt awkward during initial use.

Mindful of Impact in Conversation

Participants noted that they were very conscious of the MI approach during their conversations with patients and that

TABLE 5. Impact of MI/CALC Training on Health Care Practitioners 4 Weeks Post-Workshop

Theme	Quotation
Behaviour Change Facilitation is Easier and Less Stressful	*"It doesn't seem like it's [facilitating behaviour change] work, it seems like it's having a conversation with somebody, it's not like you're probing and . . . it's not as exhausting I guess."*
	"I don't I don't feel the burden of having to decide what they want to do."
	"It's [using MI approach] a lot easier on staff because definitely there . . . doesn't seem to be as much pressure on us to try to find a way for them [patients] as opposed to themselves finding a way [to make the change]. So . . . it [using the MI approach] takes a little bit of pressure off us [practitioners] as well."
	"You get sick of pulling teeth after a period of time so it's nice to know that you actually don't have to in most cases."
	"It doesn't need . . . to be rocket science it can be a very simple question that . . . either you . . . help the patient realize they want to change or what it is they want to change. So, you know, I don't need to go and read 10 textbooks and take courses forever and ever I should be able to incorporate this [MI approach] into my day-to-day practice."
	"I think it [MI approach] really does open up the lines of communication and having the individual say what you want them to say without you saying it, without you prompting is really cool."
Mindful of Impact in Conversation	*"Even having the awareness . . . when you go through training like that, it sort of becomes forefront that you're even thinking about that sort of thing, rather than just going through the standard agenda. So, that awareness piece is huge that you're approaching it [behaviour change conversations] and even thinking about those questions."*
Renewed Inspiration and Motivation to Facilitate Behaviour Change	*"In the past I would've been like, 'that was a totally useless waste of time [trying to help a resistant patient change],' but now those people are the biggest challenge and they're the people that I'm trying to rope-in."*
	"I think I just do it [approach behaviour change with patients] more often, way more often than I was ever doing it before." "It's [since the workshop] like a renewed motivation to tackle . . . this [behaviour change with patients]."
	"In general, it [the workshop] just got me more inspired. . . , more enthused and I've mentioned it, I've given some of these things to other people just to say, 'hey look, do you ever think of something like that?'"
Partnering with Patients and Giving Less Advice	*"I used to . . . not by a script, but I knew . . . what to do if they [patients] had hypertension this is what they needed to . . . they needed to take their medication regularly, they needed to change their diet, they needed to do this. . . . And now it's more, I'm finding out why maybe they're not taking their medication . . . or why they're overeating."*
	"I would have to say, in hindsight, I think that often when I have a patient come in I would look at their chart and have a preconceived notion of what the problem is or what the answer is, whereas now as I am asking these opened-ended questions. I get to hear it from them [patients] which I think which is useful because we are pursuing their goals or identifying their problems and issues, rather than what I think are the problems and issues."
	"Before [the workshop] I would have been very quick to say, 'this is what you need to do' as opposed to now, I'll be a little more patient and say, 'well what is it you need to do?'"
	"I'm not sure that I would've approached it [behaviour change conversations] in that manner at all. We might have bombarded them [patients] with all the information . . . rather than make it doable . . . before it probably would've been so overwhelming that it may be not as effective."
Perceived Impact of Tools on the Patient	*"They're [patients] more willing to make the change if they have come up with the change basically, and I'm not sitting here with a ruler telling them to do it kind of thing."*
	"You know, it [MI approach] makes them [patients] more involved in their care—not being dictated too."
	"I got the information that I needed [from the patient] and . . . it was a very relaxed atmosphere and it didn't feel like a medical appointment [when using MI/CALC techniques] which I think he [patient] quite enjoyed."
	"I actually can feel their [patients] excitement. . . . It's [MI approach] more of a collaborative kind of effort—as opposed to paternalistic information-providing kind of thing."
Competence/Confidence Increased	*"Well I definitely feel more competent [since workshop] in doing the behaviour change appointments because, you, know the questions [I'm] asking are appropriate and I am seeing more progress."*

TABLE 5. (continued)

Theme	Quotation
	"I feel confident to engage in the [behaviour change] conversations—more confident. I would say that I'm probably able to get more behaviour change because of the workshop, just because I know the steps to go about having people make the change or encouraging the change."
	"I do feel much better, more confident with using it [MI tools] and I've seen it work, so you know . . . I still lapse back into the other but then I think, 'oh I shouldn't be doing that.'"
	"When you see something that—when you see the client respond positively [to MI approach], it obviously makes you feel more confident and competent as well so it's a good thing all around."
Have a Practical Tool	*"The 'what questions' really resonated with me and I've really latched onto them because I understand what motivational interviewing is but now [after the workshop], I have the 'what questions' that have really resonated with me the most and I found them really easy to use [in behaviour change conversations with patients]."*
	"What's different now [since taking the workshop] is that I feel like I have something that I can use for behavioural change rather than thinking, 'ahh, I'm stuck, I can't go any further.' So it's given me a tool to explore with individuals when there seems to be something in the way of behavioural change—be it motivation or whatever the situation is."
View Success Through the Lens of the Patient	*"It could be the smallest little thing like, 'I'm gonna drop my cream for my coffee from three to two.' It can be just the smallest little thing, it doesn't have to be huge, you know, even [just a small change] that is encouraging . . . that they're willing to do something."*
	"I'm just celebrating smaller successes, so not that I expect them [patients] to take 100% of their pills 100% of the time. But I'm happier with bargaining with them to get them to take one pill and see what happens—that kind of thing."

they were more aware of their impact on the patient after the training. They described being aware of the patients' receptivity to their approach and noticing if they were giving advice or being curious with the patient.

THEMES FOUR WEEKS AFTER TRAINING

Four weeks after the workshop, participants continued to report similar themes to the ones described 1 week post-workshop. The themes were: behaviour change facilitation is easier and less stressful; mindful of impact in conversation; renewed inspiration and motivation to facilitate behaviour change, partnering with patients and giving less advice, perceived positive impact on patient, and competence and confidence improved. In addition to the themes presented in Table 5, three participants reported that in addition to the list of resources they were provided, they would have liked more reference materials to help them feel confident in keep using the skills.

A theme that was present 1 week post-workshop but emphasized more strongly 4 weeks post was that practitioners reported changing their perception from viewing small changes as a failure or not good enough to viewing behaviour changes as successful through the lens of the patient. Another theme that emerged more strongly 4 weeks after participation in the workshop was that participants felt they had practical tools to effectively facilitate behaviour changes; they noted that with time and use, they felt more comfortable and capable using the tools. Illustrative quotations are in Table 5.

Discussion

Health care practitioners in this study cared deeply for their patients, understood that patients need to make behaviour changes to improve their health, and were motivated to counsel behaviour change in spite of frustration or low success with patients who were not willing to make changes. Frustration when working with unreceptive patients was identified along with a desire for a wider range of behaviour change tools and low perceived competency as barriers to behaviour change in their clinical setting. Themes that emerged from this study were common across all specialties of health care providers who participated. This thematic consistency is encouraging in that it suggests that a structured, interactive, and applied MI training using skills from CALC can impact a variety of health care practitioners and, therefore, could be broadly applied.

Prior to taking the workshop, participants described their common method of facilitating behaviour change as giving advice and suggestions. After the workshop, practitioners reported less advice giving and instead adopting a more partnered, patient-centred approach, which is consistent with the spirit and intent of MI.[14] Participants described their new approach as more effective at actually facilitating patients' behaviour changes, while at the same time being a more positive and less stressful experience for both practitioner and patient. Previous research has found that unsolicited advice-giving is associated with increased patient resistance,[13] and a patient-centred approach is asso-

ciated with higher patient satisfaction and motivation.[9] Furthermore, the shift in practitioners' approaches in the current study is important given that there is a growing number of randomized controlled trials that have shown that MI-based approaches outperform traditional advice and education in the treatment of multiple conditions.[18]

After the training workshop, practitioners reported a renewed motivation to address behaviour change in clinical practice, even with patients not ready to make health behaviour changes. This suggests that practitioners may engage in behaviour change conversations more often after receiving training perceived to be useful.

The qualitative nature, small sample size (n=10), and self-selected participants in the current pilot study means these findings cannot be assumed to be representative of health care practitioners in clinical practice; nonetheless, the reported results are consistent with previous research. For instance, in addition to being prominent themes in the current study, perceptions of patient receptivity/motivation, feelings of low competency, and lack of tools have been reported as barriers to behaviour change counselling by other health care providers in primary care.[29,30] It must also be noted that although two follow-ups were conducted after the workshop, a longer follow-up may have provided more information regarding the long-term impact of the intervention.

In conclusion, the impact of MI using CALC tools training was positive for all participants, and a larger study with objective measures of practitioner and patient behaviour is warranted. As behaviour-related illnesses increasingly plague our society, it is crucial that researchers continue to evaluate approaches to prepare health care practitioners to effectively and confidently counsel patients toward behaviour change in daily clinical practice.

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