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Deflection Encounters:

Motivational Interviewing and Maximal Minutes

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EN | Abstract:

This article is a practice review for the application of Motivational Interviewing (MI) to be applied to First Responder Deflection programming. Deflection relies on law enforcement and a host of community responders to be the referral source to community-based drug treatment and mental health services prior to any potential crises or arrest. Deflection differs from the common term of diversion as it deflects those needing substance use or mental health services without an arrest and legal system processing. There is a short review of the innovative structure that Deflection has constructed and a brief examination of the delivery framework of this new approach. With over 1,000 sites of Deflection currently in operation, this practice review calls for the field to place more focus on what treatment mechanics are to be used. Specifically, the implementation and deployment of Motivational Interviewing is discussed by reviewing seven benefits. A question is asked of the field: Could MI be endowed as a best practice for deflection? A listing of several of these benefits include; Mi employs nonadversarial methods which syncs with the voluntary nature of Deflection along with the research that if MI is added to an existing evidence-based practice, MI increases the outcomes for both practices. Other benefits include MI doubles its effect size when used with minority populations; has effective resistance-lowering techniques; and MI is helpful when used with person's challenged by post-traumatic stress disorder (PTSD) and co-occurring conditions. Readers are asked to consider that the leading service that deflection programs link to is substance use disorder (SUD) treatment and medication assisted treatment (MAT). With that leading service connection, it is explained that MI can increase a client's sense of importance to choose, comply, and continue with the use of MAT. This review moved further to report MI has been called an "effective tool" for use within short time frames and is notable for creating "potent opportunities" within first contacts. The term "maximal minutes" is coined in this review to speak to how the use of MI can help first meetings with clients that occur within compressed time frames.

Key Words: *criminal justice deflection, motivational interviewing, opioid crisis, deflection, prearrest deflection, law enforcement, racial equity, criminal justice, SDG 1, SDG 3, SDG 5, SDG 10, SDG 16, SDG.*

ES | Abstract:

Este artículo es una revisión de la práctica para la aplicación de la Entrevista Motivacional (MI) que se aplicará a la programación de la Deflexión de Primera Respuesta. La deflexión se basa en la aplicación de la ley y una serie de respondedores de la comunidad para ser la fuente de referencia para el tratamiento de drogas basado en la comunidad y los servicios de salud mental antes de cualquier crisis potencial o arresto. La deflexión difiere del término común de deflexión, ya que desvía a quienes necesitan servicios para el consumo de sustancias o de salud mental sin que se produzca una detención ni se tramite en el sistema judicial. A continuación se presenta una breve reseña de la estructura innovadora que ha construido Deflection y un breve examen del marco de prestación de este nuevo

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enfoque. Con más de 1.000 centros de Deflexión actualmente en funcionamiento, esta revisión de la práctica hace un llamamiento para que se preste más atención a los mecanismos de tratamiento que deben utilizarse. En concreto, se analiza la aplicación y el despliegue de la Entrevista Motivacional mediante la revisión de siete beneficios. Se plantea una pregunta al campo: ¿Podría MI ser dotado como una mejor práctica para la deflexión? Una lista de varios de estos beneficios incluyen; Mi emplea métodos no adversariales que se sincroniza con la naturaleza voluntaria de Deflexión junto con la investigación que si MI se añade a una práctica basada en la evidencia existente, MI aumenta los resultados para ambas prácticas. Otros beneficios incluyen que la IM duplica su tamaño de efecto cuando se utiliza con poblaciones minoritarias; tiene técnicas eficaces para reducir la resistencia; y la IM es útil cuando se utiliza con personas que padecen trastorno de estrés postraumático (TEPT) y afecciones concurrentes. Se pide a los lectores que tengan en cuenta que el principal servicio al que se vinculan los programas de deflexión es el tratamiento de los trastornos por consumo de sustancias (TUS) y el tratamiento asistido con medicación (TMA). Con esa conexión de servicio principal, se explica que la IM puede aumentar el sentido de importancia de un cliente para elegir, cumplir y continuar con el uso de MAT. Esta revisión fue más allá para informar de que la IM se ha calificado de "herramienta eficaz" para su uso en plazos cortos y destaca por crear "oportunidades potentes" en los primeros contactos. El término "minutos máximos" se acuña en esta revisión para hablar de cómo el uso del IM puede ayudar a los primeros encuentros con los clientes que se producen dentro de marcos temporales comprimidos.

Palabras clave: *Deflexión, deflexión de la justicia penal, entrevista motivacional, crisis de opioides, deflexión previa a la detención, aplicación de la ley, equidad racial, justicia penal, ODS 1, ODS 3, ODS 5, ODS 10, ODS 16, ODS.*

INTRODUCTION

Over the last several decades, traditional methods were used when a community response was needed for someone believed to have a substance use disorder, mental health disorder, or co-occurring disorder. These methods assigned these calls to police and other first responders. Law enforcement with fire and emergency medical services were called upon through long-established protocols to intervene (Consalo, 2024). The Legislative Analysis and Public Policy Association (LAPPA) summarizes these typical responses, responses that proved not to be remedies:

"For law enforcement, these options involved arrest, issuing a warning, or doing nothing, that is leaving the individual in question in the same condition and circumstances that precipitated the encounter. For other first responders, the options involved administering naloxone, when appropriate, taking the individual to an emergency department, or, again, doing nothing" (LAPPA, 2022).

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A Deflection expert (Charlier, 2021) notes that these types of services were inadequate, primarily hindered by locating this response within the legal system. Law enforcement and the legal system were never designed to mediate these problems. Not for the lack of trying as in the field's enactment of "diversion," yet diversion programs still involved an arrest and processing through the legal system. Treatment of these health problems suffered from a lack of access to a larger range of community resources—as well as pathways to better health available before arrest and deeper involvement with the legal system.

Through recent decades, the ageless phrase "necessity is the mother of invention" was demonstrated by police departments, emergency medical services (EMS) and fire departments becoming inundated with calls respond to mental health and substance use troubles. When opioid and fentanyl use gained momentum, a quantum increase in overdose incidents brought a crisis to many countries. The necessity to bring more community resources to bear by creating pathways, often non-traditional, to a larger array of community resources seemed as obvious as it was crucial (Ekelund, 2019). Fortunately, a consortium of programs, jurisdictions, governmental organizations and like-minded initiatives have pooled resources, working together to offer more options. A very short list of a large group offers some idea of the many who have joined this effort:

- The International Association of Chiefs of Police,
- Treatment Alternatives for Safe Communities (TASC)
    - Center for Health and Justice (CHJ) at TASC
    - Police, Treatment and Community Collaborative (PTACC) at TASC
- The Bureau of Justice Assistance, Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP),
- The Office of National Drug Control Policy (ONDCP)

The key option that has taken form from the collaboration between these entities is Deflection. PTACC defines Deflection as an early "upstream" preventative approach to substance use and mental health concerns. One that offers pathways for a community-based response to occur before an event such as an overdose, arrest, or mental health crisis. Centered in the community and guided by the goals of stabilization and treatment, Deflection, by its nature, is truly a shared public safety and public health approach. One that reduces crime while promoting well-being for the marginalized and underserved. For police, Deflection creates a new, third option for addressing substance use disorder, homelessness, and mental health conditions. While in the past, officers can only arrest or take no action, Deflection programs give them the opportunity to serve as conduits to treatment and services. (PTACC, 2024).

It is important to understand the extensive involvement of community resources. Law enforcement, as well as other traditional first responders remain involved, but not in the primary role as they were placed before. The range of Deflection programs now involves an

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estimate of well over a 1,000 separate sites across the country operating Deflection initiatives (LAPPA, 2022).

There are several significant principles that seem to guide this movement (Charlier, 2021):

- Participation is voluntary.
- Pathways to community services for SUD or mental health issues are available before arrest and deeper involvement with the legal system.
- More recently, Deflection initiatives more commonly involve first responders rather than law enforcement, such as fire and EMS, or behavioral health providers teamed with others, (termed "community responders").
- Police and traditional first responders encounters—not leading to arrest—are turned into "warm handoffs" or other types of referrals to community providers.

Operational Structure

For the creation and implementation of any large initiative, developing the operational structure must come first. It is easy for communities to be overwhelmed regarding the varieties and differences that may be involved in any Deflection program's framework. The presence or absence of resources and the strength or weaknesses of their connection points, differs from one community to the next. Yet regardless of the multiplicities of makeup, the development and dissemination of operational structure is making this possible. This emerging operational structure is evident in the BJA publication title, "The Six Pathways: Frameworks for Implementing Deflection to Treatment, Services, and Recovery" (BJA, 2023).

Even with such regional differences in available resources, confidence grows as research tells us over 1,000 communities have found a way to bring a Deflection program into existence. We are mindful of the maxim that "Motivated people solve their own barriers" (Stinson & Clark, 2017) and this is surely the case for so many communities finding novel ways to develop new resources, as well as connect and share existing recovery assets.

Treatment Mechanics.

Many call Deflection a new field, and depending on what publication you choose, the identified starting point for Deflection may differ. Compared to traditional contact and treatment of SUD and mental illness, most agree that Deflection is new, yet has become an emerging force over the last decade (J. Chevalier, personal communication, November 10, 2024). This practice review article asks a critical question: Is it too early for this field to consider the next step of formulating treatment mechanics? Past development of new initiatives would tell us it's not. Most benefits from Deflection programming are rooted in the person accepting help and starting down treatment pathways. Deflection looks beyond

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compliance and yielding, focusing instead on the goal of healthy behavior change send wooden.

Participant Motivation.

Our technical assistance group has been part of the birth of many new initiatives to lessen the societal impact of crime, alcohol and other drugs as well as mental illness. We find it truly incongruous that the issue of participant motivation is seldom considered and tackled until the framework is developed, and the service is underway. In many instances the program is buffeted by problems of client participation. The progress stalls or early outcome research proves to be less than hoped for. Client's are negatively affected—but so are staff. Consider the dictum, "It is exhausting to try and convince a person to do something that they don't want to do." (Stinson & Clark, 2017). Woefully, many who work in the helping professions feel this sense of exhaustion (Murphy and Kruis, 2023).

Client participation may be overlooked because of the saying, "Build it and they will come," a phrase that came from Hollywood movie and may well need to stay there. Yes, there is the idea that if you create something of value or interest, people will naturally be drawn to it, essentially suggesting that the quality of what you build will be enough to attract an audience without needing extensive promotion. Yet in so many cases, it is "not enough" in human services programming because we are assisting truly difficult problems—the types that can often reach acute severity or become chronic over time. Regardless of the program offerings, where are we if we have not inspired willing acceptance and active participation within our participants? (Clark, 2022).

Consider these short phrases gleaned from several publications speaking to Deflection programming:

- … linking these individuals to…
- … each consenting individual will then…
- … steer people…
- … connect people…
- … if the person accepts help, there is a need to…

Consider that we often find staff who lack adequate training in two critical topics. The first topic involves the process of behavior change. Yes, some behavior change can occur as a "point-in-time" event, such as spontaneous remission or due to decisions stemming from critical life events; births, deaths; marriage, divorce; hiring into a new job or getting fired are some significant events that come to mind. Yet most staff have never been taught that most change occurs as a process—and a process that occurs over time.

Beyond this process, a second critical topic is whether staff have received a thorough review regarding human motivation. What is motivation? What staff behavior can raise it?

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And alternatively (and possibly more importantly) what staff behavior can lower it? To find a lack of understanding of what impels human motivation is a concern, especially when staff work for programs where participation is voluntary in nature.

We recommend the evidence-based practice of Motivational Interviewing as a treatment foundation, one that can be used across the service timeline from engagement to completion. All to assist healthy behavior change and teaching staff the skills of a compassionate guiding style to help move voluntary clients along a continuum of change.

Motivational Interviewing (MI)

MI was developed 40 years ago in the substance use dependency field. It is listed on the evidence-based practice registry for substance use dependency (SUD) treatment and is an "accepted treatment" for opioid use disorders (OUD). This is an approach designed to help resolve ambivalence and influence decisional balance. The authors of this approach describe it as, "A helpful way of assisting people in finding their own reasons for change" (Miller & Rollnick, 2023). MI is extensively researched (2,300+ clinical trials), and is taught in 75 languages across 6 continents (Miller, 2024).

We offer seven benefits for the adoption of motivational interviewing across the Deflection field. A listing of these benefits is offered:

Benefit #1: MI trains staff to gain the most from the "maximal minutes" within compressed time frames.

The cultural adage, "You never get a second chance to make a first impression" seems applicable to Deflection programming. We use the term "maximal minutes" to speak to those first contacts that occur in compressed time frames. Without adequate training, staff may offer their own ideas and reasons for change, moving then to pressure or persuade the new contact to make healthy choices. We can do so much more than give a shrug of shoulders and lament that our healthy options were refused. Research warns us to advice giving and "telling" is not often effective, even when approaching with a warm demeanor (Stinson & Clark, 2017).

With MI as a fundamental service approach for Deflection, a first contact can create "potent opportunities" (Forman & Moyers, 2019). This issue of client engagement is a priority in the Deflection field. Engagement in the context of deflection programs involves measuring both the initial rate of engagement with treatment or recovery support services and how long-lasting this engagement is (BJA, 2021). These skills can extend to participants during both initial contact as well as across the service spectrum. MI has been designated as an evidence- based practice for increasing both engagement and retention in treatment (NREPP, 2013). This type of engagement is as rapid as it is durable. MI has been called an "effective

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tool" for use within compressed time frames (Forman & Moyers, 2019). For durability, a meta-analysis of 25 years of Motivational Interviewing studies found improvements were still present at one and two year follow up (Lundahal et. al., 2019)

Multiple randomized clinical trials have shown reliable outcomes when it is used in just a single session (McCambridge & Strang, 2004; Diskin & Hodgins, 2009). An investigation conducted among adult patients in an emergency department found a single 30-minute session of motivational enhancement reduced prescription opioid misuse—including opioid overdose risk behaviors—for those who had histories of non-fatal overdoses and/or misuse of prescription opioids (Bohnert et al., 2016).

In training sessions, we are often asked, "We have so much to do and so little time to do it, can you raise motivation in five minutes?" Certainly, you can. The contrasted response is that you can also ruin motivation in three minutes (Clark, 2020). Little time to intervene means little room for error. MI helps staff to gain the most productivity in their "maximal minutes."

Benefit #2: MI is designed to influence positive behavior change through nonadversarial methods.

Deflection programming is voluntary. With that principle, the field of Deflection would be well served by an approach that starts with engagement yet has directional capabilities. Maximal minutes and ongoing work with MI has a directional aspect, whereby clients are intentionally guided toward receiving services (Stinson & Clark, 2017; Miller & Rollnick, 2023). The directional aspect of MI is not immediately apparent. Those who give MI only a superficial review may see it as not being "tough enough" on crime or lacks the intensity to meet mental health challenges. Yet MI fits with the depiction offered by Charlier, "Deflection is an evolution from 'tough on crime' to 'smart on crime'" (Charlier, 2021).

MI agrees with this "smart" depiction as progress and change do not have sides. Direct confrontation, persuasion, and advice-giving have sides (staff vs. client) yet holds little relationship with actual behavior change. In most instances, the more direct the advice becomes, the more it can damage engagement where staff is less able to influence change. Your advice and directions may be "right" yet even here, it evokes the adage, "Do you want to be right, or do you want to be successful?" The MI alternative of negotiating ambivalence, evoking change talk, and increasing the readiness to change—the directional aspect of MI—is one important reason that MI has been described as a "natural fit" for short time frames (Iarussi & Powers, 2018). This is MI's strong suit—building an all-important working alliance through a directional, nonadversarial approach.

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Benefit #3: MI empowers other evidence-based practices that any responder group or treatment agency may already be using.

It's not difficult to surmise that with a thousand Deflection programs in operation, each program would be collaborating with multiple teams, agencies and departments across their region. Many of these entities may already have an evidence-based practice they've been trained in. Here MI can be characterized as having the utility of a multi-tasking tool. Research has found that when MI is added to another evidence-based practice (EBP), both become more effective—and the effect size is sustained over a longer period of time (Miller, 2018). Research finds that combining MI with another EBP appears to cause both approaches to be more effective for two reasons: first, with MI in place, people are also more responsive to participate; and second, participants are more likely to complete what is intended by implementing the EBP treatments in tandem (Miller & Rollnick, 2013).

Yet, for many more services that have not trained or implemented EBP, there are over 200 clinical trials and several meta-analyses showing MI's effectiveness as a stand-alone treatment (Miller, 2019). Any person being helped could interact with multiple personalities across a community's spectrum of services. Having MI as a common base of service ensures that while some are rowing the boat (e.g., Using MI to increase engagement and help to tilt decisional balance) you don't have others who are drilling holes in the bottom of the boat (i.e., coercion, overly directive, lacking engagement skills). Many states are passing laws that agencies must use an evidence-based practice (Pew-MacArthur, 2015). A practice alliance between several groups using motivational interviewing across the same region, could be helpful for both implementation and sustainability (Clark, 2021-2024).

Benefit #4: The use of MI doubles the effect size when used with minority populations.

The efficacy of many evidence-based treatments do not cross cultures well as evidence by a lower effect sizes (Miller, 2018). Here is where MI separates itself from so much other evidence-based practices. When MI is used with people of color the effect size of MI is doubled. The efficacy of most treatment EBP models lose efficacy when used with minority clients. These authors hope for at least similar outcomes and are often disappointed (Miller, 2017). This increase in effect size was determined by 11 controlled clinical trials examining the cross-cultural applications of MI (Miller, 2020). Finding from one meta-analysis is significant. Hettema et al. (2005) published a meta-analysis of 72 studies, 37 of which looked at racial and ethnic composition. These researchers found that the effects of MI were significantly larger for people of color.

Why does MI work better cross-culturally— especially when one hopes for no difference between differing ethnic or cultural groups? William Miller, co-originator of this approach, offered a thought-provoking explanation: "MI seems to be particularly useful with people who are least respected. It is for people who are the most marginalized and who are

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the most despised and rejected members of our society. If you're a minority member, you may not be familiar with being treated respectfully" (Miller, 2018).

Benefit #5. MI can stand the heat. It has effective resistance-lowering techniques for those considered more reluctant and resistant, as well as those challenged by post-traumatic stress disorder (PTSD) and co-occurring disorders.

Motivational Interviewing was originally developed for those who are more resistant, angry, or reluctant to change (Miller & Rollnick, 1991). MI has been found to be a particularly effective approach for working with people who are angry and defensive at first contact (Miller & Rollnick, 2013). MI offers Deflection staff multiple resistance-lowering techniques that can keep reluctant or resisting participants moving forward without using threats or punishment. Considering the voluntary nature of Deflection, it would be easy to predict that MI will be considered a "best practice" for this work.

Posttraumatic stress disorder (PTSD) can add heat to any Deflection staff's interactions. Studies have shown that people with a higher reactance level have a better response to MI than to more directive styles (Miller & Rollnick, 2013). A person with elevated reactance can be oversensitive, touchy, or even volatile. Consider that individuals entering Deflection assistance might suffer from PTSD and the elevated reactance levels so prevalent in this condition. Research from the field of trauma-informed work states, "MI enables service providers to carry out the intentions and goals of trauma-informed practice" (Motivational Interviewing and Intimate Partner Violence Workgroup, 2010, p. 101).

Another common hurdle for Deflection programming is the complexity of co-occurring disorders where a person may be challenged by both a mental health disorder and a substance use disorder. The Center for Behavioral Health Statistics (SAMHSA) cautions that between 40 to 50 percent of those who abuse drugs have a comorbid mental health disorder (SAMSHA, 2011). Results from a 2018 study indicated that MI was associated with increased self-efficacy and treatment completion of dually diagnosed clients (Moore, Flamez, & Szirony, 2018). MI can "stand the heat" that can be experienced across the broad range of Deflection programming.

Benefit #6: Even when actively offering Medication Assisted Treatment (MAT), there are no guarantees. MAT needs MI.

MAT availability and it's offer may not be enough. We need participant's buy-in. For any OUD client, the "how" these medications are used often dominates any discussion at the expense of "why" or "if" MAT is to be used. The 2021 National Report on First Responder Programs cites that "…substance use disorder treatment, including medication -assisted treatment (MAT), is the leading service to which deflection programs link." (BJA, 2021, May 13). With that recent finding, consider that MI can increase the person's sense of importance to

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choose, comply with, and continue MAT (Lewis-Fernandez et al., 2018). A 2019 study applied motivational interviewing to help patients resolve ambivalence and problem-solve treatment barriers. This research found that "managing expectations" of patients for MAT is an important theme and has much to do with "psychological readiness for treatment," a view shared by both providers and patients (Muthulingam et al., 2019).

MI can help those involved with opioids to forego the status quo (in this case, continuing with street opioids) by tipping the balance to create an appetite for change. In another 2018 study, receiving one session of brief behavioral treatment that included Motivational Interviewing was associated with higher odds of receiving MAT (Allison et al., 2018). Accessing MAT is helped when we use MI.

Benefit #7: MI aligns with two important aspects of human behavior change research; ambivalence, and discrepancy.

The first of these two is ambivalence—which MI views to be a normal experience in the process of behavior change. It is not inherently pathological, and one only needs to consider the MI adage, "Change is difficult. You first!" to know that ambivalence is visited upon all of us. Is every Deflection contact ambivalent about the problem(s) they face? No, but know that research tells us the far largest majority are ambivalent That is, part of them wants to stop and, with equal force, part of them does not. Here is a seesaw, a teeter totter, where the person thinks a little bit about changing, then a little bit about not changing, then they move on.

MI teaches that how any staff person negotiates a client ambivalence is critical; if you champion the healthy change side it will cause a psychological reactance for the client to defend the "keep it the same" side. Here, the unknowing behavior of staff, can literally cause the client to argue with you to defend the problem behavior. MI cautions helpers that people generally do not overcome the "stuckness" of ambivalence from a staff person's advice or warnings. In contrast, MI teaches staff to negotiate a client ambivalence, enlisting the "want to change" side of any client to become an "assistant" to positive behavior change. The second aspect is discrepancy. MI places a strong focus on amplifying the person's discrepancy that arises between wants, aspirations, and values of the—and the gap between those values and their actual behavior. Considering that these first contacts usually involve distress on the part of the Deflection client, it's easy to believe most people have a large gap between "what is real—and what is their ideal." This forms the MI basis of eliciting a person's own reasons for change (person-centered evoking) rather than dispensing the staff's ideas or "good advice" (staff-centered installing). All change is self-change, so having the client articulate thier own reasons for change is paramount.

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Points of Interest: Blending of Deflection and Motivational Interviewing.

The tasks of Deflection are many. It is important to note that sharing advice and information can occur through the lens of Motivational Interviewing. We summarize this strategy as, "How to give someone advice without telling them what to do." Staff seek to gain permission to give advice. Permission can occur in three ways. First a client can ask for advice (What should I do?), and that's a clear overture of permission. Second, we can ask for permission from the client to offer it, or, third, often when the person is upset or distressed, we can share our advice and tell them they can ignore it or disregard. Personal choice and control (autonomy) and creating an atmosphere of safety is important (Stinson & Clark, 2017).

MI suggests offering choices. To only offer one choice can brew resistance. Offering two or more options helps the client feel in control via choice-making.

We are quick to tell staff that they are not responsible for the person starting point but they have much to do to influence the client from there. MI asks staff to stay mindful that client motivation is not a fixed-trait (like having brown eyes) but rather is a changeable state—one we can influence.

We also toss any contingent relationship where staff will change a warm and friendly approach contingent on the client's response to them. Regardless of how the client treats us, we start warm and accepting and stay that way. Anything else and we become passive, moving ourselves out of any guiding role.

There are three issues that make motivational interviewing quite *unique* from other evidence-based practices.

First, MI evokes from the client reasons for change. We don't install change we elicit it. Although there are several EBP's that are client-centered, yet no other practice does this. We evoke motivation from the client rather than try to install it.

Second is change talk. Change talk (CT) refers to client language that indicates movement toward a particular change goal. It is the opposite of sustain talk, which supports the status quo and moves away from change. MI is unique in identifying and researching change talk (Miller & Rollnick, 2023).

Research has found that when staff use MI-consistent skills, people are more likely to respond with CT. (Moyers & Martin, 2006; Moyers et al., 2007, Moyers et al., 2009). CT statements can either favor change ("I need to do something") or disfavors their status quo ("I can't stand this anymore"). When maximizing minutes, MI can help Deflection staff to both recognize and elicit change talk from those they work with.

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Understanding this type of talk is important because research finds that voicing change talk has been found to increase the probability of change (Amrhein et al., 2003; Moyers et al., 2007, Moyers et al., 2009). A person who talks about the benefits of change is more likely to make that change, whereas a person who argues and defends the status quo is more likely to continue his or her problematic beliefs and behavior (Miller & Rollnick, 2013).

Third, interventions must fit the compressed times frames. Considering most EBPs, this might seem an impossible order to fill. However, consider Moyers' (2015) description of Motivational Interviewing as the only EBP that values the relational aspects of treatment (engagement, collaboration) at the same level it values the technical aspects (evidence-based practice). The "what" you do (technical) and the "how" you do it (relational) are both equally prized and would become a dual skill focus by any Deflection staff person. Here lies the needed skills connection and engagement skills for "maximal minutes."

Next, consider that MI is learnable. A helpful research finding is that one's ability to learn MI is not contingent on experience, education, or professional field. You do not have to have years of seniority or advanced degrees (Stinson & Clark, 2017). MI has been taught to EMT's, Judges, clinical practitioners, behavioral health staff and peer support / recovery coaches and more. All with the same learning uptake (Clark & Chandler, 2022).

Practice recommendation.

A research article reports, "…the low numbers that have developed and provide formal training suggest another area in which adoption of certain best practices is critical to advancing the field." (Ross & Taylor, 2022). Finally, an info sheet published by the Center for Health and Justice (CHJ) at TASC notes that relatively few Deflection programs offer training in motivational interviewing (BJA, 2023). With a good deal of structure and framework in place, Deflection programs would be well served to consider treatment mechanics and place more emphasis on increasing training in 2025/2026 and beyond.

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