

The effectiveness of motivational interviewing social work essay



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INTRODUCTION

What is the Effectiveness of Motivational Interviewing on Mandated Clients with Substance Abuse Problems?

Purpose

Mandated client's motivation to change is a major challenge to health professionals working in the treatment of clients with substance abuse problem in the community treatment program as well as in prisons and the Criminal Justice System. Treatments for substance use disorders can benefit the individual in the short term, by managing withdrawal symptoms during detoxification and the use of replacement drug therapy however, the longer term prevention of relapse into substance use can only be achieved through change in behavior which are geared towards positive changes that relates to substance misuse. Motivational interviewing (MI) is commonly used to motivate resistant client to change substance abuse behaviors. There have been several comprehensive systematic reviews of substance abuse treatment interventions in substance abuse populations in general. These reviews focus generally on substance abuse population and not specifically to mandated clients in substance abuse treatment programs. In this review I have highlighted gaps in the treatment of mandated substance abuse client's research and practice. The recent review by McMurrin 2009 focuses on the efficacy of MI in offenders in general with multiple index offenses including substance abuse while that of Smedslund et al.,(2011) was focused generally on substance abuse clients. Although these recent reviews show a general positive effect on the effectiveness of Motivational Interviewing (MI) on client with substance abuse (Macgowan and Engle 2010, Barnnet et. al <https://assignbuster.com/the-effectiveness-of-motivational-interviewing-social-work-essay/>

2012 Smedslud et al 2011; McMurrin 2009), a review on the effectiveness of MI specifically with mandated clients is required. This review aim to examine the efficacy of MI on the treatment of substance abuse offenders that are undergoing mandated treatment. This is an area which has shown high interest in research and practice by researchers and health practitioners globally. Recent policy and guidance has also indicated interest in the recent research finding relating in this field. The NICE guidelines published in July 2007. Section 1 report contains a summary of the most recent policy for the treatment of drug and alcohol misuse and dependence in the criminal justice system. Whilst there is a large body of evidence on the treatment of voluntary or informal substance abuse clients, there has been far less research in the treatment of mandated client in the criminal justice settings in England. 1. 2. Background

1. 2. 1. Substance use problem:

There are about 76. 3 million people in the world with alcohol use problems and another 15. 3 million who also suffer from drug abuse as reported by the World Health Organization (WHO 2009). McManus et al.,(2009) reported that twenty-four per cent of England adult population consumes alcohol in a way that is hazardous to their health and wellbeing this includes 33% of men and 16% of women. Of this 24%, four per cent are alcohol dependent (6% men; 2% women), which involves a high level of addiction to alcohol (Drummond et al., 2005). Substance abuse refers to the excessive use of alcohol and drugs and the dependence on drugs and alcohol which results to detrimental effects on the person's mental and physical health and the welfare of their close relations. This is usually evidence by a lifestyle of continued use of

drug or alcohol or both that have a negative impact on social life relating to work, family, school obligations and legal issues. In most cases substance abuse and substance dependence are always used interchanging however, the American Psychiatric Association (APA 2000) distinguishes substance abuse from dependence by defining substance abuse as the maladaptive pattern of substance use which result to continues and significant adverse consequences which are linked to repeated substance use. APA (2000) also stated that for a person to be classified as having substance abuse problem, the substance related problem must have occurred repeatedly for a period of 12-months. Substance dependence as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) is a cluster of physiological, behavioral and cognitive symptoms which indicates that the person has lost control over the use of the substance despite realizing significant negative effect relating to the substance use. There is usually a repeated pattern of self-administration that can result in tolerance, withdrawal, and compulsive substance use behavior (APA 2000). In most cases substance abuse may lead to substance addiction or dependence. For an individual to be physiological and medically substance dependent, they require developing tolerance which will lead to withdrawal symptoms when they abruptly stop using.

1. 2. 2. Consequence of substance abuse

Substance abuse increases the likelihood of violence injury and involvement with the law, and the link between substance abuse and criminal behavior is well-documented (Sinha and Easton 1999). In recent years, the rise in substances abuse has led to a growing number of substance abuse related

injuries, hospital admissions and arrests resulting to convictions, with greater retributive consequences for substance abuse related charges. The rise in the number of hospital admissions resulting from substance abuse related injuries and mental health related problems has resulted in restraint on the health care resources and pressure to the health care professionals which result to a need for more hospital beds, longer stay in hospitals and a higher costs of maintaining patients (.....). There has been an increased in the number of mandated clients who have been referred into substance abuse treatment by various sources. The criminal justice system view referral to substance abuse treatment as a viable and lower cost alternative to prison terms because of the possibility of the clients accessing treatment and rehabilitation, especially for those with high offending rates relating to substance abuse (Straussner 2004). Other substance abuse clients are also referred from children welfare agencies and other by their employers for poor work performances.

1. 2. 3. Treatment of Mandated clients

Mandated clients often view the treatment as " passing time." They are more focused on their release dates and are much more concerned with meeting the requirements set out by the judge, probation officer, child welfare, school authorities or their employer than with the successful completion of clinical goals set out in the treatment program. These clients are often referred to as difficult, resistant, oppositional or defiant by health professional. With this frustration, nurses often wonder how they can help make these clients admit that they are in denial or helping them to see that following a schedule and maintaining abstinence will help them keep their job or stay out of prison.

Most health professional know that no one can change another person, when faced with " clients who are in denial of the effect of their substance abuse and are literally killing themselves with alcohol or other drugs, or harming their children or other people, it is extremely difficult to admit that one is helpless to change others. However, it is worth noting that only the clients can change themselves; the role of the health professional is to attempt to help clients identify and move toward change that is congruent to their own idea of what is " better" for them.

1. 2. 4. Health professional's views of mandated clients

Most current substance abuse treatment models have been developed and delivered based on health professional work with voluntary clients. There is limited literature available on the models or theories in general which provide guidelines on how to work with mandated or involuntary clients (Ivanoff, Bluthe, & Tripodi, 1994). What is indicated in the literature is the need to engage clients through active listening and empathy; once trust and cooperation are established, only then are health professionals encouraged to move on to problem solving. While this approach may be appropriate for many clients, it does not necessarily work for those who are mandated into treatment. Such clients often feel that they have been unjustly and unfairly treated by the system, and may not stay around long enough to develop a trusting relationship with a health professional. They are often not convinced that suggested changes are helpful or useful to them and at times they view them as even harmful. Therefore, there is a need for a practice model that not only elicits the cooperation of clients, but also empowers them to take responsibility for their own solutions. Recently there has been growing

literature evidence on the need for better relationship between health professional and client motivation (Procheska, DiClemente 2008). Miller and Rollnick (2002) suggested that health professional pay attention in fostering client participation throughout the treatment program by using autonomy and using non- confrontational measures for motivating them for behavior change. They highlighted that this will give them a sense of responsibility for the success or failure in achieving the treatment goals that they have established. However, most mandated clients usually do not want to stay in treatment long enough to see the results, nor do they see the benefit of following suggested remedies that they typically see as useless, inconvenient or even harmful. Thus, there is a fundamental disconnect between what the expert health professional believes is helpful to the client, and what the client wishes or believes is helpful to them. When this occurs, it is usually the client who is labeled " non-compliant," " resistive," or " oppositional and defiant." In contrast, Motivational Interviewing (MI) counseling begins with making the client think on the pros and cons of their substance abuse behavior. It asks clients what is their view of their own future; how do they want their lives to be different? How confident are they that they can make these changes happen? These questions set the direction and tone for the treatment endeavor. The general believe is that substance abuse is a chronic illness and that with withdrawal or detoxification is generally followed by relapse. Studies have also shown that other substance abuse treatments such as the Methadone maintenance treatment often relapse (Nyamathi et. al. 2010). It is suggested that the most effective treatment method of substance abuse is that which is central towards behavioral change. Substance abuse treatment program such as the <https://assignbuster.com/the-effectiveness-of-motivational-interviewing-social-work-essay/>

use of Motivational Interviewing remains the cornerstone of change of addiction behavior because MI is associated with positive behavioral change which results to a reduction in criminal activity, mortality and reduction in hospitalization secondary to substance abuse.

MOTIVATIONAL INTERVIEWING

1. 3. 1. Definitions and general characteristic of MI

MI was developed from the dissatisfaction of patients and practitioners on the prescriptive nature of many substance abuse treatment programs. At that time treatment was typically involved aggressive and confrontational approach often in groups and in family settings especially in the United State where the 12-step approaches were often used (Sellman, MacEwan, Deering, & Adamson, 2007). The use of confrontational therapies requires the therapists to challenge clients by outlining strong negative effects of their current behaviours to emphasize the threat. It was assume that the result of fear will act as an energizer of change. Another approach that was used then was the rational-emotive therapy which involves confronting clients with their irrational cognitions, as defined by the therapist, and pressuring the client to change (Miller, 1983). Based on these approaches, Miller believed that inducing fear or using communication means that persuade the clients can immobilize them making it more difficult for them to change (Miller, Benefield, & Tonigan 1993). Miller and Rollnick(1995) first provided an explicit definition of MI as a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence (Rollnick & Miller, 1995). This definition was revised slightly in 2002, defining MI as " a client-centred, directive method for enhancing

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intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25). This definition was further revised in 2008 as " a collaborative person-centred form of guiding to elicit and strengthen motivation for change" (Miller & Rollnick, 2009). Based on the definition Miller and Rollnick (2008) believes that most people hold conflicting motivations for change and often fluctuate between their degree of motivation and ambivalence (Arkowitz & Miller, 2008). Their allows clients to openly express their ambivalence in order to guide them to a satisfactory resolution of their conflicting motivations, with the aim of facilitating desired behavioral changes (Rollnick & Miller, 1995). MI is a directive counselling approach with patient focus and it is a highly individualised therapy intervention which aims to help the client explore and resolve ambivalence behaviour. It places particular emphasis on perception of risk, problem recognition, the patient concerns and the possibility of change (Miller and Rollnick, 2002). MI involves between one to four counselling sessions between the counsellor and the client for about one hour on each session. During the session, the counsellor expresses empathy with the client and supports the client in making their own decisions. The counsellor does not try to convince the client to change their behaviour but discusses with them possible consequences of changing their behaviour. They will finally discuss the patient goals and evaluate how far they have gone to achieve the goals (Smedslund et al., 2011). MI is believed to be a useful tool in the treatment of clients with substance misuse problems who are still in the early stage of committing themselves to treatment or to changing their behaviour (Gossop 2006). Rohsenow et al (2004) reported that it is beneficial for patients with lower initial motivation to behavioural change than those with higher initial

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motivation which is typical of mandated clients with substance abuse problems. The most important part of the technique is that the patient's motivation to change their behaviour is enhanced when there is gradual process of negotiation in which the patient and not the counsellor articulate the benefits and cost involved in their changing behaviour and for the intervention to be successful there need to be a collaborative relationship between the patient and the counsellor on how they tackle the problem together (Bosack et al 2007).

1.3.2. The spirit of MI

Rollnick et al (2008) defined MI spirit in terms of three key characteristics: collaborative, evocative and honoring client autonomy. The MI spirit is the style or intention of the counselor's relates with the patients. The spirit provides the fundamental skills or techniques of delivering MI. The spirit of MI involves the ability and willingness of the counselor to be with a patient enough to sight their inner world (Wahab, 2005). Collaborative involves the partnership between the client and the counselor which involves a joint decision-making process between the two parties (Rollnick et al., 2008). Rollnick et al. (2008) also highlighted that MI counselors should seek to activate clients' own motivation and resources for change instead of just giving them what they might lack, for example, medication or information. This involves connecting behavior change with a client's values and concerns. Usually during the first sessions of MI the counsellor tries to establish a therapeutic relationship with the client, set agenda and also to assess the patient readiness for change. To accomplish this, the counsellor needed to express empathy and avoid arguments as recommended by (Mille

and Rollnick 2002). The counsellor acknowledges that patient has substance abuse problems for a long period and that he has little interest in stopping. Rolling with resistance as stated by Karzenowski et al (2011) helped patients to have confidence that he could not be judged and being lectured on their behaviour but could talk about them openly and honestly. The first phase as identified by Mill (2010) is for the counsellor to encourage the patient to express his opinions using open-ended questions, reflective listening, affirmation, and summarization. Initially, the patient will be very passive when talking about their substance abuse and the link to their criminal offense and will responding to open-ended questions with short, blunt answers. It is usually helpful to use reflection when the counsellor noticed the patient is losing interest and shutting down. During the opening phase the counsellor will also verified what the client might want to change. The second phase is to focus on strengthening the commitment to change once the client is motivated and at this phase they will be able to focus on their substance abuse. Karzenowski et al (2011) recommended that counsellors should encourage and listen for " change talk" where the patient is motivated by hearing what they say themselves rather than by what someone else says. The patient will be encouraged to use self-motivation to recognize their accomplishments. Karzenowski et al 2011 also highlighted that a useful strategy in motivational change is to allow the patient to choose one issue they want to work on and to talk about the benefits and consequences of change and spending time where it is most required and making priority in listening. Based on this strategy health care professionals can use reflection to review the benefit and consequence of substance abuse with their patients. In most cases the client will be able to identify that the <https://assignbuster.com/the-effectiveness-of-motivational-interviewing-social-work-essay/>

consequence of substance abuse are more than the benefits especially when they are involved with the criminal justices system. Realizing that the patient is comfortable, the counsellor can begin to gently challenge their thinking by revisiting the barriers to them abstaining from substance abuse. The counsellor will then supported the client's self-efficacy by telling them they are in counselling now and willing to accept help because they want to change their substance abuse behaviours. The final sessions of the intervention are to evaluate the client's motivation to abstain from substance abuse. Some clients may continue using substances however, at this stage the counsellor will be able to support them through the change process. This is usually in line with the outcome expected in MI in relation to the five stages of the Transtheoretical Model (TTM) of Change introduced by (Levesky et al 2007).

1. 3. 3. The Transtheoretical Model (TTM) of Change

The TTM is a theoretical model of behaviour change which was developed by (Prochaska and Diclemante 1983). This model consists of five stages of change and was used in the development of MI by (Miller and Rollnick 1983). The TTM assumed that individuals will usually progress through the five stages of change while undergoing a behavioural change. These stages consist of the first stage which is the pre-contemplation where the individual has no intention to change their behaviour in the nearest future. IM proved to be a valuable therapy especially for mandated offenders with substance abuse problems who are usually in the pre-contemplation stage of change (Rollnick et al 2008). The second stage is the contemplation stage where the patient is considering making a change in the nearest future. In the

contemplation stage of change, a person acknowledges that he or she has a problem and begins to think seriously about solving it. Miller and Rollnick (2002) explained that usually contemplators struggle to understand their problem, to see its causes, and also to think about possible solutions. The third stage is the preparation stage where the individual is preparing to make a change. Individuals in this stage may have tried and failed to change and they have often learned valuable skills from past change attempts. Diclemente and Valasquez (2002) suggested that people at this stage of change need to develop a plan that will work and also need to make firm commitments to follow the action plan they have chosen. The fourth is the action stage, the individual is actively engaged in making a change and the final stage is the maintenance stage where the change has been maintained for 6 months. Armitage & Conner (2000) highlighted that individuals will move through these stages of change but the rate at which each person will progress through the stages will differ greatly from one individual to the next. Raistrick (2007) stated that the model will only act as a guide for the understanding the tasks that need to be accomplished for motivating individuals to change behaviours. Miller described the relationship between MI and the Stages of Change concepts as "kissing cousins" (Rollnick et al 2008). The two concepts have shared characteristics which include the approach to motivating individuals as a process of change and the view of ambivalence as an integral part of the change process. However, MI is mainly based on the early stages of change, by eliciting and resolving ambivalence for enhanced motivation in the direction of action (Arkowitz & Miller, 2008). Rollnick et al (2008) also report that in the relationship between MI and the TTM that people will sometimes relapse and move

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through the stages multiple times (as shown in figure 1) in different orders before reaching the maintenance stage. They also specify that it will be necessary for the counsellor to work with the patient at whatever stage they find themselves to promote collaboration and reduced resistance. Figure 1. Transtheoretical Model (TTM) of Change: The change cycle.

1. 3. 4. Ambivalence and MI

The concept of ambivalence has been integral to the development of MI and an understanding of its mechanisms of action. Unlike cognitive dissonance, however, the elicitation and resolution of ambivalence towards changing target behaviour continues to be seen as central to the process of MI. Miller and Rollnick (2002) regard the elicitation and resolution of ambivalence as the central process of MI in helping clients move towards changing target behaviour. The concept of ambivalence was integrated in the development of MI. Rollnick et al (2008) proposed that problems can persist and become overwhelming when individuals are stuck in an ambivalence state and that it is normal human nature and it is also a phase in the change process. They also highlighted that the aim of MI is to help clients move from the ambivalence state and enable them move towards making decisions which support behaviour change. Ambivalence is referred to as a confusing and frustrating state. This is when a client express a change and a sustain talk at the same time such as I really enjoy using drugs but I have to give it up for my family. Miller et al (2008) developed the MISE 2. 1 code used to indicates or measure ambivalence. This code patients language to indicate if they are moving towards or a way from change and this has been able to capture client's language which represent ambivalence. This can be an effective

assessment tool to determine the effect of an intervention which is focus on eliciting and resolving ambivalence such as MI. However there are other methods of assessment client level of ambivalence relating to the change process. Armitage et al (2003) evaluated the relationship between ambivalence and the stages of change defined in the transtheoretical model (TTM) (Prochaska & DiClemente, 1983). They found out that there is a strong relationship between potential ambivalence and the stages of change process. Individuals in the beginning of the change process (pre-contemplation) or end (maintenance) stages showed least attitudinal ambivalence while those at in the middle stages (contemplation, preparation and action) were significantly more ambivalent. This is consistence with the evidence found by the McMurrin (2009) systematic review which indicated that offenders with substance abuse problems have less ambivalence because they are still in the denial stage and have not yet weigh on the pros and cons of their behaviour to even think about behaviour change. To use ambivalence to measure the outcome of an intervention in mandated offenders will not give a realistic picture of the effect of the intervention. However, Armitage et al (2006) supported the use of ambivalence in evaluating the client's progress through the stages of change. They suggested that ambivalence can be an outcome evaluation index to measure patient's progress from pre-contemplation to the contemplation stage. The present of ambivalence will definitely indicate a progress from stage one of the change process to stage two. Since offenders with substance abuse problems undergoing mandated treatment are identified to be in the pre-contemplation stage of the change process and the main aim of MI is to elicitation and resolve ambivalence that is to make the client start thinking

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on changing behaviour and also to support them through the change process. The difference between MI and cognitive behaviour therapy (CBT) or other cognitive behavioural therapies is that while MI focuses on elucidating and resolving ambivalence . CBT addresses specific topics relating to substance abuse for patients that are already on the later stage of the change process where there are no signs of ambivalence. These specific areas may be relating to identifying and challenging thought patterns regarding drug and alcohol, assessing and enhancing social support networks, identifying and increasing activities that provide feelings of joy and accomplishment, and developing a relapse prevention plan (Cooper 2012).