Motivational Interviewing

1. What is MI?

Motivational interviewing is a counseling approach developed in part by clinical psychologists William R. Miller and Stephen Rollnick. It is described by them as follows:

‘Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.’ Rollnick and Miller (1995, p. 326).

Compared with non-directive counselling, it is more focused and goal-directed, and departs from traditional Rogerian client-centered therapy through this use of direction, in which therapists attempt to influence clients to consider making changes, rather than engaging in non-directive therapeutic exploration. The examination and resolution of ambivalence is a central purpose, and the counsellor is intentionally directive in pursuing this goal. MI is most centrally defined not by technique, but by its spirit as a facilitative style for interpersonal relationships.

MI treats ambivalence as a normal and understandable component of the change process. Any decision to change can involve competing motivations, each of which has costs and benefits associated with it. Motivational interviewing is a strategy that is used to help individuals examine, understand, and resolve their ambivalence to change; it is a strategy used to enhance a person's motivation to change.

Individuals will not change if they are not motivated to change, and how motivated or ready a person is to change fluctuates as a function of time and situation. A person's motivation to change can actually be influenced by others in their life, including their worker. The challenge for the worker is to appropriately assess where the person is in the process of change and to respond accordingly. Directing a parent to make changes in their life when they haven't even considered the need to make changes or are ambivalent about changing is likely to backfire and result in resistance.

As practitioners, we cannot control a parent's behaviour and make parents change. Only they can take charge of their own lives. In motivational interviewing, the role of the worker is to help parents explore the possibility of change. Providing parents with information and advice has been found to be effective in changing behaviour in only 5% to 20% of patients (Glynn & Manley, 1989; Law & Tang, 1995; The Smoking Cessation Clinical Practice Guideline Panel and Staff, 1996). This type of approach is only effective with people who are ready and motivated to change. A social worker/therapist must build a parent's commitment to change before he/she can teach the parent how to change. In other words, the worker should respond in a way to help motivate the parent to move in the direction of positive change; this does not mean confronting and directly persuading the parent. It means empathetically encouraging the parent to explore their risky behaviour.

Motivational interviewing is a brief intervention that has been found to be particularly effective in the treatment of alcohol-related problems; it has been modified for the Options/Opciones Project to deal specifically with HIV risk reduction. Rather than taking on an authoritarian role and acting as expert and prescribing change, the worker leaves the responsibility for change with the parent. This does not mean, however, that the worker is not directive. To the contrary, the worker has a clear goal, which is to reduce HIV risk behaviour, and she/he uses various strategies to achieve that goal. The worker does a brief assessment of where the parent is, provides feedback based on that assessment, discusses various strategies for changing behaviour, and negotiates a goal with the parent. The parent is intimately involved in every step of the process, especially in the selection of the goals. The relationship between the parent and the worker is thus a collaboration - one in which they work together to negotiate an individualised plan for positive change.

'The strategies of Motivational Interviewing are more persuasive than coercive, more supportive than argumentative. The clinician seeks to create a positive atmosphere that is conducive to change. The overall goal is to increase the patient's intrinsic motivation, so that change arises from within rather than being imposed from without. When this approach is done properly, it is the patient who presents the arguments for change, rather than the clinician. Miller and Rollnick (1991, p. 52)

2. Key Components of Motivational Interviewing:

- It is the individual's personal responsibility and choice whether or not to change their behaviour.
- Whereas a practitioner may be an expert on how people in general can change their behaviour, the patient/parent is the expert on how they themselves can change. Each person is unique in what motivates them to change, and it is assumed that the parent has important insight and ideas for how to solve their own problems.
- The worker should ask simple open-ended questions (as opposed to close-ended, or yes-no questions) to encourage exploration and decision-making.
- The worker should use skilful reflective listening. Reflective listening involves briefly summarizing what the parent is saying in order to show that they understand the meaning of what parents are saying. It also provides the opportunity to verify understanding of the parent's perspective. It is only by carefully listening to the parent that workers can learn what it will take for them to change.
- The worker should create and amplify, in the parent's mind, any discrepancies between present behaviors (where they're at now) and broader goals (where they want to be).
- The worker should embrace ambivalence. Many parents are ambivalent about change, and they have very good reasons for not changing their high-risk behaviour. It is important for the clinician to understand those reasons. Allowing the parent to discuss what they like about their high-risk behaviour can paradoxically serve as a catalyst for positive behaviour change.

- The worker should avoid arguing, confronting, and pressuring the parent into action. Arguing, confronting, and pressuring can lead to the parent to take a defensive and rigid posture, and thus not be amenable to making any changes.
- Approaches that support the parent's autonomy are more effective in helping a parent to change than are coercive measures. A parent is more likely to adopt healthy behaviours if they 'want to' than if they 'ought to' or 'have to'. Adopting a controlling and paternalistic approach is antithetical to supporting the parent's autonomy. Parents are more likely to make healthy choices if the worker acknowledges and supports their right to choose than if the worker behaves as if she/he can make the parent change. (Botelho, 2000)
- The worker should work at a pace that is sensitive to parent's needs and their readiness to change. If the worker pushes the parent ahead of where they are ready to be, the worker is likely to engender resistance on the part of the parent.
- The worker should 'roll with resistance'; any statement made by the parent can be rephrased or re-framed to create momentum toward change. Resistance (e.g., denial, arguing, objecting, refusing to engage in conversation) is influenced by the way in which the worker interacts with the parent. It is a function of the interpersonal interaction between the parent and the worker, and it can either be exacerbated or diminished depending on the worker's response to it. Resistance is a signal that the worker and parent are not at the same place. Further exploration or shifting focus may help to 'melt' the resistance. (Rollnick, Mason, & Butler, 1999)
- The worker should provide non-judgmental feedback and information. The role of the worker is to understand the parent's feelings and perspectives without judging, criticising, or blaming.
- Acceptance facilitates change. By adopting an attitude of acceptance and respect, the parent's self-esteem is supported, which frees them to change. (Acceptance refers to 'understanding' the parent's perspective. It does not mean approving of their behaviour.)
- The worker should support and increase the parent's self-efficacy and her/his ability to cope with obstacles and succeed at change. Self-efficacy refers to a person's confidence in her/his ability to make a specific change in behaviour (Rollnick, Mason, & Butler, 1999, p.92). The worker should help the parent to believe that healthy outcomes are possible.
- Negotiate goals that are realistic and attainable. It is critical that the parent be successful in their efforts to reach their goals so that their self-efficacy and their motivation to make changes increases. Therefore, it is important that realistic goals be chosen, and that may mean choosing smaller goals at which they can succeed rather than large behaviour change goals at which they will fail.

3. What are the implications of this way of working in Surrey?

The DfE has recognised the positive outcomes for children that have resulted in a change to this way of working in the 5 local authorities who have adopted MI and multi-disciplinary working as a result of Innovation Funding over the last 3 years. In the November 2018 budget, the Chancellor announced a further £84m for a national roll out of this way of working. It is proposed that as a partnership we should make a bid for some of this funding, but we can only do so if we agree to do it together and agree to sustain the approach through adjustments to how services are delivered on a longer term basis-specifically, that a small proportion of the investment partners make to

provision of adult mental health, substance misuse and probation/domestic abuse resources are redirected via secondment and co-location into children's services teams to support the families of Surrey children most at risk of significant impairment to their health/development and/or significant harm.

It would mean a different way of working together to embed an understanding of the principles of what we are aiming to do and the principles behind it across our organisations and especially with our front line staff. It would mean we would work together on an assertive outreach basis to meet parent's needs in relation to their mental health, substance misuse and to change abusive behaviours, in family homes where necessary, as these are not services that Children's Social Workers have any training or expertise in and their difficulties are too complex for any one agency to address alone. We must also acknowledge that there is substantial evidence that setting up appointments for avoidant families at traditional 'hubs' when they have a lot to lose by admitting to their needs, is an ineffective strategy for achieving change.

We would also need to renew how we, as senior leaders, work together going forward and establish relationships of trust and collaboration, putting aside some of the difficult relationships of the past.

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