Substance Misuse Skills Consortium

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Briefing Paper 1: Motivational interviewing May 2013

1. What is the purpose of these briefing papers?

This briefing paper is the first in a series. Each paper will focus on an individual topic - usually either a type of intervention or a specific target group for those working in drug and alcohol treatment. The briefing papers will provide a short overview of the topic, with expert input from Skills Consortium staff, Executive members or Drug and Alcohol Findings and link to the five most relevant and popular resources on the Skills Hub and the Drug and Alcohol Research Matrixes.

2. What is motivational interviewing?

Almost certainly the most influential approach in substance use counselling in Britain, motivational interviewing was first formally documented in 1983 when Bill Miller noted that many clients resist treatment because they reject stigmatisation as an 'addict' or 'alcoholic' and the loss of control implied by being a patient. Dr Miller developed an approach which explicitly avoided these and other deterrent interactions. Instead he relied on amplifying aspects of the client's ambivalence towards their substance use to nudge them in a seemingly non-directive manner towards finding their own reasons to change in a positive direction. In a seminal trial published in 1993, he found that among problem drinkers, when counsellors adopted motivational interviewing's non-confrontational style they reduced both resistance and drinking compared to the more typical confrontational approach.

Motivational interviewing's great advantage is its applicability across the board, from risky but as yet non-problematic drinkers or drug-takers, to those with established problems who welcome being afforded the dignity of self-definition and self-control. It is, however, important to separate out these applications. The motivational state of people who decide they have a problem and seek treatment is likely to be very different from that of people intercepted by screening programmes while routinely visiting their GPs. Appropriate comparators also differ. For people seeking intervention, the key issue is whether motivational interventions are preferable to other treatments. When all relevant studies are amalgamated, the answer seems to be, not much, but they do usually take less time. A similar message emerged from the most definitive trials in the USA and in Britain, which also generally failed to find the expected synergies between different types of patients and different types of therapies.

For people identified through screening, the key issue is whether having a motivational intervention 'seek them' is better than doing nothing. Here across relevant studies, the answer is yes, usually it is better. But that depends to a surprising degree on who is doing the motivating, a finding which emerged from studies as different as one in London involving cannabis using students and one in Switzerland involving heavy drinking adult emergency department patients. In both cases, how far counsellors embodied the spirit of motivational interviewing in their comments and tone, and in particular the skill of 'reflective listening', were among the factors which made a difference. Another Swiss study offered corroboration; our commentary explored the

implications of these and other studies of how motivational interviewing works. One implication was confirmed by a US study; that recruiting clinicians who have not been trained in motivational interviewing but take to it naturally would be better than trying to turn round less promising recruits through training. In this study too, not only were the promising recruits better to begin with, they also gained most from training.

How motivational interviewing works was also explored in our own reviews of the approach as a preparation for addiction treatment and of findings in respect of matching counselling style to the client. We discovered that motivational interviewing has worked best when therapists have not been tightly constrained to work to a manual, and that it can be counterproductive among patients who welcome explicit direction or who are already committed to a way out of their substance use problems. One explanation is that the quality of seeming genuine, long recognised as one of the keys to effective therapy, can suffer from drilling in techniques and in withholding normal caring responses in order to adhere 100% to motivational principles.

[This explanation is taken from the Findings Hot Topic 'Motivational interviewing - the Swiss army knife of substance use counselling']

3. How can the Skills Hub help me?

The most popular motivational interviewing resources on the Skills Hub are:

1. **A brief cognitive behavioural intervention for regular amphetamine users**
   [Baker A, Kay-Lambkin F, Lee NK, Claire M & Jenner L, 2003]

   A treatment guide for a brief, four session, intervention for amphetamine users. The approach uses motivational interviewing and relapse prevention based approaches combined with some specific information about amphetamine use. There are detailed guides and resources for the four sessions, covering; Motivational Interviewing, cravings and lapses, managing thoughts about amphetamine use and relapse prevention skills. The guide may also have some use for service users with problems with other stimulants.

2. **Enhancing Motivation for Change in Substance Abuse Treatment (TIP 35)**
   [CSAT, 1999]

   A clinical resource that highlights a variety of psychosocial strategies for enhancing motivation to change. The interventions are organised around the trans-theoretical stages of change model, incorporating the theory and practice of motivational interviewing.

3. **Drug misuse and dependence: UK guidelines on clinical management**
   [DH & devolved administrations, 2007]

   A guideline on the treatment of drug misuse in the UK. This document updates and replaces *Drug Misuse and Dependence – Guidelines on Clinical Management* (UK health departments 1999) – hereafter referred to as the 1999 Clinical Guidelines. It has the same status across the UK as the 1999 Clinical Guidelines.

   The 2007 Clinical Guidelines provide guidance on the treatment of drug misuse in the UK. They are based on current evidence and professional consensus on how to provide drug treatment for the majority of patients, in most instances. The 2007 Clinical Guidelines do not provide rigid protocols on

how clinicians must provide drug treatment for all drug misusers. Neither does this guidance override the individual responsibility of clinicians to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient (and guardians and carers if appropriate)."

4. **Motivational interviewing assessment: supervisory tools for enhancing proficiency** (MIA:STEP) [NIDA/SAMHSA, 2009]

   A manual to support the implementation of motivational interviewing in clinical services. Developed as part of the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) Bending Initiative, the manual includes a variety of resources including teaching and supervisory tools This work programme set out to encourage the use of current, evidence-based treatment interventions by professionals in the treatment field.

5. **A brief guide to motivational interviewing** [Latchford, 2010]

   A brief document to give an overview of the theory and practice of motivational interviewing. It is written for use across health care settings and not solely substance misuse. There are useful summaries of the main points of MI skills and theory, with a few helpful resources and references for other material.

4. How can the Drug and Alcohol Research Matrixes help me?

Click here for everything relevant to Motivational Intervening on the Drug and Alcohol Findings site.

The selection below represents some of the most informative and important research on Motivational Interviewing, as highlighted by the partnership work between the Skills Consortium and Drug and Alcohol Findings. You can see the matrixes in full online:

The Drug Research Matrix - The Alcohol Research Matrix

1. **Still hard to find reasons for matching patients to therapies**

   The results of the largest UK alcohol treatment trial confounded expectations that a motivational approach would best suit unmotivated or hostile clients and that clients lacking social support would do best when this was explicitly addressed. Overall the therapies were equally effective.

2. **How does motivational interviewing work? Therapist skill predicts client involvement within motivational interviewing sessions.** [Moyers T.B., Miller W.R., Hendrickson S.M.L., 2005]

   The featured report derives from a US study which randomly allocated an unusually diverse (in terms of initial proficiency) set of addiction counsellors and clinicians who applied for training in motivational interviewing to different training regimens. An earlier report from the study had established that client

responses to trainees changed in the desired direction only when workshops had been reinforced by continued expert coaching and feedback on performance.

3. **Motivational interviewing for substance abuse**
   [Smedslund G., Berg R.C., Hammerstrøm K.T. et al., 2009]

   This Cochrane review of motivational interviewing finds it equivalent to other therapies. It concludes that its "results are consistent with motivational interviewing and other approaches sharing common therapeutic factors such as empathic attention from and a therapeutic relationship with a helper.

   Clinicians and researchers may have overemphasised treatment method as opposed to the individual who delivers the treatment and the client who receives it. Some studies may have failed to pay sufficient attention to whether the patient and/or therapist feel positive towards the treatment and whether they like and respect each other. Such factors may have a much greater influence on outcome than the contribution made by a specific approach or technique."

4. **An evaluation of workshop training in motivational interviewing for addiction and mental health clinicians**
   [Baer J.S., Rosengren D.B., Dunn C.W. et al., 2004]

   A US study of a workshop on motivational interviewing, whose participants were mainly addiction treatment specialists, confirmed the rapid erosion of improvements in practice and added an intriguing insight into the importance of choosing the right raw material. Trainees demonstrated their motivational interviewing skills with actor-clients before the workshop, at the end, and two months later, when most indicators of how far they had absorbed the approach's principles and techniques were no longer significantly elevated. However, this was not the case for all the trainees.

   Based on their last audiotapes, eight of the 19 had retained their proficiency in motivational interviewing. The interesting thing was that even before the training, these clinicians had been more proficient than the other trainees – in fact, they were already more proficient than the rest would be two months after training. Not only did they start from a higher level, they went on to absorb and retain more of what they had learnt.

5. **The Motivational Hallo** (pdf)
   [Ashton M., 2005]

   “With its emphatic style, motivational interviewing seems the ideal way to engage new clients in treatment, a psychological handshake which avoids gripping too tightly yet subtly steers the patient in the intended direction. And often as it is, as long as we avoid deploying a mechanical arm”.

   This review found that inflexible manualisation of motivational approaches is associated with worse outcomes.