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Motivational Interviewing in Child, Youth and Family Residences:

Case Leaders' Experiences, Appraisal and Skill Level, and the Barriers to Implementation

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Note: It should be recognised that the statements and opinions expressed in this thesis are those of the author and do not necessarily represent the views of MSD or CYF.

ABSTRACT

Motivational Interviewing (MI) is “a collaborative conversation style for strengthening a person’s own motivation and commitment to change” (Miller & Rollnick, 2012, p.12). Utilised as a preparation tool to increase engagement in treatment, as an adjunct to another therapeutic intervention, or as a stand-alone intervention in its own right, MI promotes and strengthens an individual’s motivation to change by helping to explore and overcome ambivalence (Miller & Rollnick, 2012). This study aimed to investigate Child, Youth and Family (CYF) case leaders’ experiences of practising MI and its implementation within the context of CYF residential units throughout New Zealand. A mixed-methods exploratory sequential design was employed to address the research aims, which sought to capture CYF case leaders’ experiences and appraisal of MI, and to assess their level of skill in applying MI post-workshop training. In addition, this research aimed to identify potential barriers to MI implementation, in order to inform future training and intervention efforts. Data was collected through an online survey, focus groups and audio recordings of participant MI interactions submitted post-training. Qualitative and quantitative analyses identified that the case leaders’ perceived and externally assessed low level of MI skilfulness, as well as a lack of time and resources (e.g., quiet space), were major factors influencing the infrequent use of MI in residences post-training. Furthermore, the results highlight the complexity of implementing Evidence Based Practices (EBP)’s, such as MI, within government organisations, and the need for systematic ongoing training, feedback and organisational support for this to be successfully achieved.

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CHAPTER ONE

INTRODUCTION

While the term 'at risk' with regard to adverse outcomes is frequently applied to a subset of young people in New Zealand (NZ), it is not always clearly defined (Moore, 2006). In general, 'at risk' is given to mean the likelihood that an individual will exhibit poor outcomes and failure in their lifetime (e.g., unemployment, low educational attainment and poverty) as a result of adverse early experiences (Moore, 2006; Rak & Patterson, 1996). In conceptualising risk, an actuarial model of risk assessment is commonly employed in both research and treatment planning (Andrews & Bonta, 2010). In this model, risk is determined by reviewing historical factors that are static and unchanging to the individual, in order to make assumptions about future behaviour (Andrews & Bonta, 2010). Risk factors are then quantitatively assessed; with the presence and absence of factors used to determine an overall risk score (Andrews & Bonta, 2010). A number of biological and environmental factors are purported to predispose an individual to increased risk (Rak & Patterson, 1996). These can include disability, illness, abuse or trauma, low socio-economic status, familial discord, and exposure to violence, crime and substance abuse (Aiyer, Williams, Tolan & Wilson, 2013; Rak & Patterson, 1996).

At-risk children are a concern for policymakers and society, as they often carry these risks through youth and into early adulthood (Moore, 2006). Past research in this area suggests that at-risk individuals are more likely to lead dysfunctional lives, are more reliant on community support agencies, demonstrate economic dependency, and experience poor relationship functioning (Moore, 2006; Rak & Patterson, 1996). At the severe end of the spectrum, they also have an increased likelihood of experiencing mental health difficulties,

engaging in criminal offending, incarceration, and other risky behaviours, such as substance misuse and prostitution (Moore, 2006).

1.1 The Potential Consequences for At-Risk Children and Youth

Youth offending poses a particular challenge. While for some individuals early offending behaviour will not extend past adolescence, for some, their first conviction marks the beginning of a long-standing relationship with the justice system (Feldstein & Ginsburg, 2006). Based on data obtained from Statistics NZ (2014), it was identified that approximately 2,508 NZ children and youth aged between 10 and 16 years received a criminal conviction in 2013. Of those charged, 82% were male and 18% were female. The majority of offences were property and dishonesty offences, with a small number of violent offences also reported (Statistics NZ, 2014). Consistent with research regarding adult offending in NZ (Dannette, Fergusson & Boden, 2009; Ioane, Lambie & Percival, 2013; Tamatea & Brown, 2011), Māori were significantly over-represented in the statistics, accounting for 1,458 of those individual's charged, compared to 702 NZ European/ Pākehā (Statistics NZ, 2014). Pasifika were also heavily featured, accounting for 255 of the individuals charged (Statistics NZ, 2014). This suggests that some factors out of the individuals' control may also contribute to an 'at risk' status and the likelihood that offending will occur.

In addition to youth offending, risky behaviours such as substance misuse and prostitution are also of concern in young people identified as being 'at risk'. While there is no official data regarding the prevalence of these behaviours in NZ currently, indications from research and anecdotal evidence suggest they are more common than previously thought (Drug Foundation, 2013; Ministry of Justice, n.d.). The NZ Drug Foundation, in its 2007/2008 New Zealand Drug and Alcohol Survey, identified that 24.8% of youth between 16 and 17 years engaged in cannabis use, while 32% reported consuming alcohol on more

than three occasions per month (Drug Foundation, 2013). It was also observed that at least 25 youth had died over the last decade as a result of volatile substance use, such as huffing or the consumption of so-called 'legal highs' (Drug Foundation, 2013). Regarding child and youth prostitution, initial research is currently being conducted by 'End Child Prostitution and Trafficking NZ' (ECPAT NZ), with early indications suggesting that its prevalence is increasing in both rural and urban areas (Ministry of Justice, n.d.). This is concerning as engaging in these risky behaviours is likely to result in physical and emotional harm, and can increase an individual's likelihood of experiencing poorer life outcomes (Moore, 2006).

1.1.1 Protective Factors and Resilience

While many at risk young people do go on to engage in criminal offending and other risky behaviours, it is important to recognise that these outcomes are not inevitable (Moore, 2006). The term 'at risk' does not imply causality and should instead be regarded as a statistical probability. Thus, while a combination of risk factors is thought to elevate an individual's likelihood of engaging in offending and other risky behaviours, the presence of protective factors is considered to mitigate the likelihood that such outcomes will occur (Andrews & Bonta, 2010; Moore, 2006). This process is thought to be a matter of balancing the scales between risk and protective factors, with protective factors somewhat negating the potential influence that risk factors may have upon an individual's likelihood of going on to offend (Andrews & Bonta, 2010). In this way, protective factors could be thought of as promoting resilience and can include: intelligence, pro-social attitudes and pro-social support from friends, family or the community (Andrews & Bonta, 2010).

1.2 Child, Youth and Family Residences

In NZ, when an at risk young person lacks the familial and environmental supports that counteract risk and are in need of care and protection, or have committed an offence;

organisations such as Child, Youth and Family (CYF) may intervene on a statutory basis (Child, Youth and Family, 2011). In extreme circumstances, when a young person is assessed as having complex needs which require safe and contained support that cannot be provided by family and/ or the wider community, they may also be moved into residential care (Child, Youth and Family, 2011). Child, Youth and Family residences are designated safe and secure residential facilities where youth are supported by specialist trained staff to make positive and sustainable life changes, and to stabilise their behaviour (Child, Youth and Family, 2013). Child, Youth and Family residences function as small independent communities, in that youth are able to attend an on-site school, engage in sports and other outdoor activities, and complete interventions and programmes aimed at developing their life skills and motivation for success (Child, Youth and Family, 2014). The overall aim of residence is to prepare youth for a successful transition back into the community (Child, Youth and Family, 2014).

There are two main types of residential facilities: Care and Protection (C&P) residences and Youth Justice (YJ) residences. Care and Protection residences cater to highly vulnerable youth who have often been the victims of severe abuse and neglect, and who now exhibit extreme behavioural problems that put themselves and others at risk of harm. These individuals typically enter C&P residences via a custody order, or when all other options have been exhausted (e.g., immediate family placement, extended family placement) (Child, Youth and Family, 2011). There are four C&P residences with a total of 58 beds nationwide dedicated to supporting these young people (Child, Youth and Family, 2014). While length of stay varies depending on the complexity of assessed needs, between 132 and 149 youth have entered C&P residences per annum over the last five years (Child, Youth and Family, 2015). In 2014, there were 141 admissions overall, with 52% of those that entered male and 48% female (Child, Youth and Family, 2015). In regard to ethnicity, the vast majority of youth

who entered were Māori (65%) or NZ European/ Pākehā (28%) (Child, Youth and Family, 2015).

Youth Justice residences are designed to accommodate and support youth offenders who have appeared before the Youth Court. These individuals are placed in residence if they are awaiting hearing, are placed on remand, are sentenced by the youth court to a period of six to twelve months in residence, or are awaiting prison transfer (Child, Youth and Family, 2011). There are four YJ residences with a total of 146 beds across the country, 22 of which are allocated to female offenders (Child, Youth and Family, 2014). While length of stay is highly variable depending on the requirements of the court order received, between 716 and 960 youths have entered YJ residences per annum in the last five years (Child, Youth and Family, 2014; 2015). In 2014, there were 960 admissions overall, with 84% being male and 16% female (Child, Youth and Family, 2015). Regarding ethnicity, youth were predominantly Māori (65%), NZ European/ Pākehā (21%) or Pasifika (12%) (Child, Youth and Family, 2015).

1.2.1 Current Interventions

CYF currently employs a range of successful evidence-based interventions in its residences, provided by both internal and external providers (Child, Youth and Family, 2014). A Collaborative Systems Approach (CSA) is applied in treatment, meaning that multiple evidence-based models are drawn upon to ensure that treatment plans are tailored to the needs of each youth (Child, Youth and Family, 2014). Intervention sessions are conducted in both individual and group work contexts, with commonly used interventions including: Cognitive Behavioural Therapy (CBT), drug and alcohol counselling, education and vocational training, behavioural analysis, problem solving skills, and a Behaviour Management System (BMS) (Child, Youth and Family, 2014).

Despite the myriad of options available, the CSA approach to treatment has room to improve (Child, Youth and Family, 2014). Many of the youth are not considered to be adequately engaged in treatment modules and other facets of residential life, while others reportedly lack sufficient motivation to change their behaviour. In addition, those who are assessed as having made gains typically struggle to maintain them once back in the outside community. These challenges are not uncommon with youth populations, with a number of factors purported to influence their presentation, including treatment resistance and low motivation (Austin, Williams & Kilgour, 2011; Hohman, Barnett & Shillington, 2012a).

One of the biggest barriers practitioners can encounter with youth is treatment resistance. In a review of the adolescent literature by Hohman et al. (2012a), treatment resistance was observed to represent an interpersonal communication between clients and practitioners that is indicative of dissonance within the therapeutic relationship. Given adolescence is a period in which a number of psychological, physical and social role changes occur, youth may resist treatment as a means of asserting their autonomy. As such, they may appear highly resentful or apprehensive towards authority figures and may become argumentative if confronted (Hohman et al., 2012a; Naar-King & Suarez, 2011). These reactions may elicit hostility from practitioners, escalating confrontation and ultimately creating discord in the therapeutic relationship (Prochaska & Norcross, 2010).

Another common barrier occurs when youth have low motivation to change their behaviour (McMurran, 2009). This can occur for a number of reasons, including limited insight regarding problem behaviours and the impact they have on society, as well as a worldview that values an anti-social lifestyle over pro-social alternatives (Patel, Lambie & Glover, 2008). It is important to note that this worldview may be further enhanced as a result of the 'deviancy training effect' (Snyder et al., 2005). This suggests that peer interactions in one's environment can encourage the later development of antisocial behaviour; particularly

when peers express views in favour of crime. This is escalated in settings where association with deviant peers is high, such as CYF YJ residences. It is therefore possible that deviancy training may interfere with the successful implementation of interventions within CYF residences (Snyder et al., 2005).

In light of the barriers described, a major challenge is presented to practitioners working with youth in CYF residential settings. However, given that the transition from adolescence to emerging adulthood is widely regarded as a critical period for biological, psychological and behavioural change, it is at this time that intervention may be most positively received and have the greatest likelihood of taking effect (Naar-King, Earnshaw & Breckon, 2013). Interventions that encourage autonomy and personal agency are likely to be critical in developing the youths' intrinsic motivations and in minimising resistance, as well as potentially aiding in further therapy or treatment that is implemented (Frost, 2011; McMaster & Wells, 2011; Patel et al., 2008). The ability to foster self-efficacy in their belief that they can be successful with change is also essential (Wales & Tiller, 2011). Interest within CYF is now growing regarding ways to better incorporate these components within current rehabilitative efforts (Child, Youth and Family, 2015).

1.3 Motivational Interviewing

One possible intervention worthy of further investigation in this regard is Motivational Interviewing (MI). Motivational Interviewing is "a collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller & Rollnick, 2012, p.12). While largely developed from clinical experience and research as opposed to any specific theory or model of change, instilled in MI are elements of Carl Roger's (1961) person-centred counselling, Daryl Bem's (1967) theory of self-perception and

Albert Bandura's (1977) theory of self-efficacy (Andrews & Bonta, 2010; Britt, Blampied & Hudson, 2003; Miller & Rollnick, 2009).

Motivational Interviewing can be utilised as a preparation tool to increase engagement in treatment, as an adjunct to another therapeutic intervention, or as a stand-alone intervention in its own right (Lundahl, Kunz, Brownell, Tollefson & Burke, 2010). It is often used to address a specific pattern of behaviour that an individual is ambivalent about or reluctant to change (e.g., weight loss, smoking cessation; Lundahl et al., 2010; Miller & Rose, 2009; Prochaska & Norcross, 2010). Motivational Interviewing promotes and strengthens internal motivation to change by helping to explore and overcome ambivalence (Miller & Rollnick, 2012). Common facets of ambivalence are targeted in session to assist this process. These include increasing problem acceptance, reducing resistance, highlighting the benefits of change, and helping the client to verbally elicit and strengthen their own desires for change (Miller & Rollnick, 2012). Thus, unlike approaches that rely more on persuasive and confrontational approaches targeting change, the intention of MI is to promote engagement by creating a therapeutic space where the client feels encouraged to present the arguments for change and to make and act upon their own decisions as to whether to change (Lundahl et al., 2010; Moyers, 2014).

1.3.1 Core Processes and the Underlying Spirit

In practice, MI is not easy to apply (Miller & Rollnick, 2009). Practitioners must develop skills associated with four core processes that form the flow of MI, as well as practice within a framework which adheres to MI's underlying spirit (Miller & Rollnick, 2012). The four processes of MI comprise engaging, focusing, evoking and planning. As a necessary pre-condition for MI, 'engaging' requires the practitioner to develop a strong connection and working relationship with the client (Miller & Rollnick, 2012). Once

achieved, a ‘focus’ is established through negotiating a specific direction or area of possible change to discuss (Miller & Rollnick, 2012). The third, and most important process of MI, requires the practitioner to ‘evoke’ through eliciting the client’s own feelings and thoughts about change (Miller & Rollnick, 2012). The final process, ‘planning’, involves creating a clear plan of action to coincide with the development of the client’s personal commitment to change. It should be noted that this latter process is not necessarily required for MI, and should only be engaged in when and if a client requests it (Miller & Rollnick, 2012).

The ‘underlying spirit of MI’ encompasses partnership, acceptance, compassion and evocation (Miller & Rollnick, 2012). An equal partnership is required, which means the MI conversation is carried out in a collaborative rather than authoritarian climate (Miller & Rollnick, 2012). Within this, it is also essential that the practitioner is accepting of the client (Miller & Rollnick, 2012). This is demonstrated through honouring their absolute worth, displaying accurate empathy, affirming any strengths and efforts made toward change and through acceptance of the client’s autonomy in decision making (Miller & Rollnick, 2012). Compassion should also be conveyed in supporting the needs and welfare of the client (Miller & Rollnick, 2012). The final component of MI’s spirit, evocation, requires the practitioner to adopt a strengths-focused approach in eliciting reasons for change that are already thought to be present within the individual, as well as ideas regarding how change could occur (Miller & Rollnick, 2012). Within this, the relational hypothesis of MI proposes that when a practitioner adheres to MI’s underlying spirit, clients will feel accepted and safe, and consequently will be more open to exploring the possibility of change (Miller & Rose, 2009).

1.3.2 The Process of Change

Hubble, Duncan and Miller (1999) posit four conditions comprising change. The first is the client’s personal characteristics; including strengths, beliefs, peers, and sense of

agency. The second condition refers to the strength of the relationship shared between the client and the practitioner. The third and fourth conditions for change, in alignment with MI's spirit, regard the level of hope instilled in the client and the practitioner's belief in the client's agency and ability to succeed. It is argued that these four factors together can promote change, in assisting the client to move away from a state of risk and toward a state of resilience (Hubble et al., 1999).

Motivational Interviewing is an intervention that addresses each of these conditions for change. It encourages clients to present their own ideas and decisions regarding reasons for change, thus enlisting a sense of personal responsibility and agency in the individual. In alignment with the spirit of MI, this is received with unconditional positive regard by the practitioner (Miller & Rollnick, 2012). This approach may be particularly beneficial for youth in residential settings as it provides them with a voice, and enables them to play an active role in decision-making about their lives (Sturmfels & Manion, 2012).

While clients do most of the talking in MI, the practitioner still plays an important role; particularly through guiding the conversation to evoke and strengthen client 'change talk'. Change talk is language expressed by the client that favours the argument for change (Miller & Rollnick, 2012). There are two types of change talk: preparatory and mobilising. Preparatory change talk occurs earlier in the change process and reflects a desire (e.g. "I want"), ability (e.g. "I can"), reasons (e.g. "It would be useful") or a need (e.g. "I have to") for change (Miller & Rollnick, 2012). Mobilising change talk is regarded as the stronger form of change talk and occurs later in the process; when the client provides a commitment (e.g. "I will"), activation (e.g. "I'm ready to"), or takes steps (e.g. "I went to a support meeting this week") towards a behaviour change (Miller & Rollnick, 2012). In addition to change talk, the practitioner must also respond appropriately to client 'sustain talk', which constitutes any expression that favours the status quo (e.g. "I don't want to"; Miller & Rollnick, 2012). In

alignment with the technical hypothesis of MI, it is proposed that the practitioner's differential attention to change talk over sustain talk will serve to strengthen client change talk, and quieten sustain talk, thereby increasing the likelihood of a behaviour change (Miller & Rose, 2009). The practitioner may then choose to engage the client in decision-making and planning strategies that will help to facilitate this change (Miller & Rollnick, 2012).

1.4 The Therapeutic Relationship

A particular strength of MI is its ability to reinforce the therapeutic relationship (Hohman, Loughran & Mathiesen, 2012c; Lundahl et al., 2010; Miller & Rose, 2009; Moth & Evans, 2011). The therapeutic relationship is integral to the success of therapeutic interventions, though its importance is often overlooked (Collins & Nee, 2010; Moth & Evans, 2011; Moyers, Miller & Hendrickson, 2005; Norcross, 2001). This is concerning, given that the therapeutic relationship is thought to account for an equal amount of outcome variance as the specific treatment methods employed (Hohman, 2012; Moyers, 2014; Norcross, 2001). Positive therapeutic relationships are regarded as those in which the client feels safe and therefore able to explore the possibility of change. In these relationships, the practitioner typically demonstrates the qualities of accurate empathy, congruence and unconditional positive regard towards their clients in session (Collins & Nee, 2010; Hohman, 2012; Miller & Rose, 2009). In contrast, poor therapeutic relationships are those in which discord is present. This can have a substantially negative impact on client outcomes, resulting in resistance and in some cases, client attrition (Collins & Nee, 2010; Miller & Rose, 2009).

A poor working relationship can emerge for a number of reasons, not all of which are directly attributable to the client (McMaster & Riley, 2011). For instance, practitioner hostility can result in a confrontational style of interaction, which is likely to promote resistance and disengagement by the client (McMaster & Riley, 2011). This can occur in

many contexts and particularly in correctional settings, where the practitioner may experience an inclination or tendency to blame or judge the client and may develop a pessimistic view of their ability to change (McMaster & Riley, 2011; Oetzel & Scherer, 2003). In circumstances such as these, unsuccessful outcomes may be attributable to an inadequacy of the programme and the practitioner's ability to meet client needs, rather than to the client themselves (Collins & Nee, 2010).

In MI, the therapeutic relationship is viewed as critical (Moyers, 2014). The therapeutic relationship is also of particular importance when working with youth in residential care (Byers & Lutz, 2015). As these individuals have often experienced very few positive relationships in their lives, it can be difficult for them to form a strong alliance with their practitioner (Byers & Lutz, 2015). If a positive relationship is achieved, however, it is less likely that they will display non-compliance (Byers & Lutz, 2015). Additionally, MI's relational hypothesis predicts a significant link between a collaborative, egalitarian practitioner style and positive client outcomes (Miller & Rose, 2009). Positive change is also predicted when the practitioner demonstrates a high level of proficiency in MI, particularly in the areas of empathic understanding and reflective listening, as well as responding accurately to changes in client speech as motivation increases (Miller & Rollnick, 2009; Miller & Rose, 2009). In alignment with the technical hypothesis of MI, the practitioner is able to recognise resistance or sustain talk and adapt their approach where necessary to guide the conversation to evoke and strengthen change talk (Hohman et al., 2012a; Miller & Rollnick, 2004; Moyers, 2014). This process is likely to be particularly useful with non-treatment-seeking youth in residence that may present with resistance, and for whom arguing or pressuring for change is likely to be detrimental (Feldstein & Ginsburg, 2006; Hohman et al., 2012a; Stein, 2011). It is suggested that the successful application of the relational and technical components of MI enhances the therapeutic relationship, thus increasing the likelihood that the client will

remain engaged and that positive change will occur and be maintained over time (Miller & Rollnick, 2009; Miller & Rose, 2009).

1.5 Research Efficacy for Motivational Interviewing

Support for the efficacy of MI is considerable, with small to moderate positive effects demonstrated in over 200 published clinical trials (Hettema, Steele & Miller, 2005; Lundahl et al., 2010; Lundahl et al., 2013; McMurran, 2009). While initially developed for use with alcohol use and dependence (Brown & Miller, 1993; Lincourt, Kuettel & Bombardier, 2002), MI has since shown positive effects in treating other addictive behaviours such as illicit drug use (Berman, Forsberg, Durbeej, Källmén & Hermansson, 2010), problem gambling (Hodgins, Currie, el-Guebaly & Peden, 2004) and smoking cessation (Heckman & Egleston, 2010). It has also been found effective in assisting adaptive behaviour change, particularly in the areas of health behaviour change, such as diabetes management (Chen, Creedy, Lin & Wollin, 2012), weight loss/ dietary change (Armstrong et al., 2011), hypertension (Lundahl et al., 2013), sexual health (Schmiege, Broaddus, Levin & Bryan, 2009), and physical activity (Hardcastle, Blake & Hagger, 2012). Regarding its use with mental health disorders, MI has demonstrated efficacy as a prelude to treatment for depression (Brody, 2009), anxiety (Marcus, Westra, Angus & Kertes, 2011; Westra, 2012) and eating disorders (Weiss, Mills, Westra & Carter, 2013). Additionally, it has shown promise when applied in conjunction with other treatments; such as Cognitive Behavioural Therapy (CBT) for generalised anxiety disorder (Aviram & Westra, 2011; Kertes, Westra, Angus & Marcus, 2011), and alcohol use disorders with comorbid depression (Riper et al., 2013).

1.5.1 Motivational Interviewing with Youth

While the majority of MI research has been conducted with adult clients, studies have also evaluated the efficacy of MI with youth. For instance, research conducted by Enea and

Dafinoiu (2009) examined the effect of a combined MI/-solution-focused counselling intervention on school truancy for youth aged 16 and 17 years. Nineteen youth in the experimental condition received MI/ solution-focused counselling over eight sessions throughout the school year. Compared to matched controls that did not complete more than one counselling session and demonstrated no change over time, the MI group displayed a 61% decrease in truancy over the course of intervention. Enea and Dafinoiu (2009) concluded that the combined approach was effective in helping to reduce youth truancy.

Another school-based study, conducted by Strait et al. (2012b), evaluated the efficacy of MI in enhancing academic achievement for middle school students aged between 11 and 14 years. Students were randomly allocated to either a single session of MI or a waitlist control condition (Strait et al., 2012b). Following the intervention, it was observed that students in the MI condition demonstrated significant improvements in academic behaviour, performance and class participation overall (Strait et al., 2012b).

In addition to school-based studies, research has also been undertaken with at risk youth populations in the areas of substance misuse and risky (potentially harmful) behaviours associated with injury. A meta-analysis conducted by Jensen et al. (2011) examined the effectiveness of MI in reducing youth substance use and maintaining treatment gains over time. Twenty-one studies that evaluated the effectiveness of MI were identified for inclusion. Of these, 81% employed MI as a standalone intervention, 14.3% used MI as an adjunct to CBT and 4.8% used MI as part of a group based treatment. The majority of studies were community based (81%) and consisted of only one MI session (61.9%), while the remaining studies varied between two to nine sessions (Jensen et al., 2011). Results showed MI to have small, but significant effect sizes post-treatment and at follow-up, suggesting that MI can be efficacious in maintaining substance use reduction over time in youth (Jensen et al., 2011).

Regarding risky behaviours, a study conducted by Dunn, Droesch, Johnston and Rivara (2004) evaluated the effectiveness of a single session MI intervention in reducing risky driving behaviour associated with injury. Participants were 127 youth aged between 12 and 20 years, who were receiving medical care in a hospital emergency department (Dunn et al., 2004). The MI targeted low seat-belt compliance while driving, with counsellors rating each youth's readiness to improve seat-belt use following the intervention (Dunn et al., 2004). Of the 97 youth able to be contacted at six months follow-up, 72% of those initially rated as likely to improve had reportedly increased their seat-belt use (Dunn et al., 2004). Thus, MI was concluded to have had a notable effect on behaviour change, providing further evidence in support of its use with at risk populations engaging in risky behaviours.

1.5.2 Motivational Interviewing with Offenders

Interest has grown in recent years regarding the efficacy of MI with offenders. A systematic review by McMurran (2009) assessed the use of MI with a range of offending behaviours. Their review identified MI to be predominantly effective in the areas of substance misuse and drink driving, with results indicating improved retention and engagement in treatment and increased motivation for behaviour change (McMurran, 2009). In addition, the majority of studies reviewed also reported a reduction in offending over time (McMurran, 2009).

A recent study, conducted by Anstiss et al. (2011), evaluated the efficacy of MI in relation to general offending. Assessing the effects of a single MI session on reconviction, 58 high risk male prisoners between the ages of 22 and 64 years were recruited to participate in treatment. All participants were serving sentences greater than six months and for a wide range of offences including; violent, sexual, property and drug offences. The results revealed that offenders who received MI were significantly less likely to be reconvicted (21% lower)

or re-imprisoned (17% lower) four years post-MI, in comparison to matched controls. The authors concluded that one session of MI had a significant and positive impact on increasing change motivations and reducing recidivism in this high risk male offender group (Anstiss et al., 2011).

Providing further support for MI and offending, a process study conducted by Austin (2012) utilised the Short Motivational Programme (SMP) – an adaptation of MI, to assess whether combined MI and CBT increased motivation for change. Participants were a group of 26 male, medium risk offenders who received between one and five SMP sessions. The results revealed that offender ambivalence was highest when facilitators incorporated CBT techniques in session and when MI-inconsistent methods (e.g., direction, advice-giving) were employed. Conversely, when the facilitators engaged in MI-consistent behaviour (e.g., partnership, evocation) in session, the offenders were observed to display less ambivalence, increased motivation for change, and a stronger commitment to change (Austin, 2012). Similar findings were reported in an earlier study by Austin et al. (2011). Taking a sample of 38 high risk offenders, the SMP was employed to increase change motivations prior to community release (Austin et al., 2011). Results from the study identified motivation to change offending behaviour to have increased post-SMP, with change maintained by the participants over a 3-12 month period following their release. The authors concluded that the SMP was effective in increasing change motivations within a high-risk sample of adult male offenders (Austin et al., 2011).

With specific regard to youth offending, two key studies have been conducted in the area of substance misuse. One study, by Stein et al. (2006), evaluated the effectiveness of MI as a prelude to substance misuse education for incarcerated youth. One-hundred-and thirty youths, aged between 14 and 19 years, were randomly allocated to receive MI or relaxation training. Those that received MI were found to be more engaged during subsequent

participation in substance misuse education (Stein et al., 2006). Another study, conducted by Clair et al. (2013), evaluated the impact of MI on reducing the substance misuse of ethnic minority youth who were detained at a state juvenile correctional facility. Again, participants were randomly allocated to receive MI or relaxation therapy. While no significant differences between the two conditions were obtained for Caucasian and African American youth, MI was found to be effective over and above relaxation therapy for Hispanic youth. Hispanic youth allocated to MI displayed significant decreases in alcohol consumption in comparison to Hispanic youth allocated to relaxation therapy; indicating MI to be effective in reducing heavy alcohol consumption within this specific ethnic minority population. It was suggested by the authors that the person-centred nature of MI is likely to bode well for ethnic minority groups, many of whom have been subjected to discrimination and societal rejection by dominant populations (Clair et al., 2013).

In summary, the studies that have been discussed above indicate that MI has had a notable effect in eliciting behaviour change within a variety of settings, populations and with a number of different behaviours. Additionally, it has been shown to be effective when compared to other therapies and within ethnic minorities, which typically are under studied in regards to treatment efficacy research.

1.5.3 Motivational Interviewing with Ethnic Minority Populations

The idea of MI being particularly effective with ethnic minority populations is supported by other research (Ewing, Wray, Mead, & Adams, 2012; Hettema et al., 2005; Lundahl et al., 2010). A meta-analysis conducted by Hettema et al. (2005) found that research effect sizes were twice as large when MI recipients consisted primarily of individuals from minority groups. Likewise, in a meta-analysis conducted by Lundahl et al. (2010), significantly higher outcomes for MI were observed when studies included a large proportion

of African American or Hispanic participants. It is likely that MI's humanistic, supportive and non-confrontational approach, which emphases self-determination, is culturally congruent with the values, beliefs and traditional communication styles of many of these groups (Hettema et al., 2005; Lundahl et al., 2010). While the role of ethnicity has not yet been explicitly assessed within a New Zealand context, Anstiss et al. (2011) and Austin et al. (2011) did observe MI to be effective with predominantly Māori participant groups. Given the high proportion of Māori youth within CYF residences, it is therefore possible that MI may be particularly well suited within this setting.

1.5.4 Null Findings

Despite the evidence in support of MI's efficacy, it should be noted that null findings have also been reported in a number of areas. For instance, eating disorders, homelessness, alcohol use, illicit drug use and abuse, and smoking cessation are all areas in which some studies have found MI to be ineffective (Baer, Garrett, Beadnell, Wells & Peterson, 2007; Lundahl et al., 2010; Miller & Rose, 2009). This could be for a number of reasons. Firstly, it is possible that the practitioners who took part in these studies were not competent in MI. Research in this area does not often report on the level of training received or the integrity of the MI provided, meaning that practitioner proficiency in MI may be questionable (Miller & Rose, 2009). Secondly, the literature is often unclear as to whether studies are adhering to MI in its true form (Miller & Rollnick, 2012) or in an adaption of MI, such as the SMP (Miller & Rose, 2009). In addition, it should be noted that studies, such as the SMP, which have comprised a manual-guided version of MI, have resulted in significantly smaller effect sizes then those without manuals (Hettema et al., 2005, Lundahl et al., 2010). Finally, irrespective of whether trials are positive or negative, some clients will simply be unresponsive to MI (Miller & Rose, 2009).

1.5.5 Summary of Research Findings

Since MI was first established over three decades ago, it has been shown to be an effective, evidenced-based approach that is widely applicable across a range of behaviours and settings (Anstiss et al., 2011; Austin et al., 2011; Lundahl et al., 2010; McMurran, 2009; Miller & Rose, 2009). Initially successful in treating alcohol abuse and dependence (Brown & Miller, 1993; Lincourt et al., 2002); MI has since demonstrated positive effects with addictive behaviours, adaptive health behaviour change, mental health disorders and adult offending (McMurran, 2009; Miller & Rose, 2009). Furthermore, research suggests that MI is likely to be an effective intervention with youth engaged in offending and other risky behaviours (Clair et al., 2013; Dunn et al., 2004; Enea & Dafinoiu, 2009; Jensen et al., 2011; Stein et al., 2006; Strait et al., 2012b).

1.6 Implementing Motivational Interviewing

Despite the mass of research in support of Evidence Based Practices (EBPs), such as MI, a challenge is posed to practitioners and organisations wishing to introduce EBPs regarding the adoption of these approaches into real-world contexts (Barwick, Bennett, Johnson, McGowan & Moore, 2012; Fixsen, Blase, Naoom & Wallace, 2009; Hohman, Emlyn-Jones, James & Urquhart, 2012b). In fact, the consistent failure of EBPs to make the transition from research to practice has led to a new field of research, known as implementation science (Fixsen et al., 2009; Hohman et al., 2012b). Human service providers, such as CYF youth residences, are contracted by ministerial departments to provide quality interventions to consumers in the interest of improving wellbeing (Child, Youth and Family, 2014; Fixsen et al., 2009). It is therefore essential that practitioners employed within these services are able to apply interventions effectively. Fixsen et al. (2009) propose a set of core implementation components for achieving high fidelity

practitioner behaviour. These comprise: appropriate staff selection, ongoing training, coaching and consultation, evaluation, and administrative and system wide support. These components highlight the need for factors independent of the EBP to be considered in the implementation process (Fixsen et al., 2009). A strong emphasis is placed on the training and coaching of staff members, organisational culture, and in facilitating an environment in which practitioners are supported to achieve success in the adoption of the EBP. This is essential given that poorly implemented EBPs are likely to be ineffective and may even be harmful to client outcomes (Barwick et al., 2012).

1.6.1 Training and Practitioner Skill

Motivational Interviewing is an EBP that can be successfully taught to individuals from multiple disciplines and training backgrounds (e.g. health professionals, probation officers and community support workers) (Madson, Landry, Molaison, Schumacher & Yandrick, 2014). There are eight stages involved in learning MI (Miller & Moyers, 2006). These include learning to work in the spirit of MI, learning the skills of OARS (Open questions, Affirming, Reflecting, Summarising), recognising and responding appropriately to client change talk, eliciting change talk in favour of a behavioural change, responding appropriately to sustain talk, strengthening client commitment to change, engaging in appropriate planning strategies, and learning to employ additional treatment methods where necessary. While initial training in MI can be achieved in brief workshops, achieving full competency in MI is an ongoing process (Doran, Hohman & Koutsenok, 2011).

Research has emerged regarding what constitutes ‘best practice’ in MI training. In maintaining fidelity and furthering the development of MI skills, training in combination with ongoing coaching and feedback is recommended (Alexander, VanBenschoten & Walters, 2008; Britt & Blampied, 2014; Doran et al., 2011; Hohman et al., 2012b; Miller, Yahne,

Moyers, Martinez & Pirritano, 2004; Naar-King & Suarez, 2011; Snyder et al., 2012). For instance, research conducted by Miller et al. (2004) assessed the effects of individual feedback and coaching on proficiency in MI skills. A total of 140 substance abuse health professionals were randomly allocated to one of five training conditions. Each participant submitted practice samples of MI interactions pre- and post-training, as well as at four, eight and twelve month follow up. Compared to workshop only and waitlist control conditions, individuals who received a combination of workshop with ongoing coaching, and/or feedback displayed significant gains in post-training proficiency. The authors concluded that ongoing coaching and feedback was effective in helping to maintain and improve MI proficiency over time and regarded it as an important component of MI training (Miller et al., 2004).

Another study conducted by Doran et al. (2011) evaluated MI training for juvenile justice corrections workers. A total of 222 corrections workers completed an initial three-day MI training workshop, as well as a two-day advanced training workshop at a later date. Video samples of MI interactions were assessed following each of the training sessions. Results from the study identified a negative association between MI skills and time delays, with those individuals who completed the advanced workshop within nine months of initial training significantly more likely to demonstrate proficiency overall. The findings of both Doran et al. (2011) and Miller et al. (2004) highlight the importance of regular training, coaching and feedback in MI in order to promote and maintain the development of practitioner skill.

As is indicated in the studies above, practitioner skill is commonly evaluated by reviewing audios of MI interactions, which are coded by trainers as a means of providing feedback (Doran et al., 2011; Miller et al., 2004). The purpose of this is not solely to report on practitioner effectiveness, but also to provide feedback and coaching to trainees, and this can also be used to provide feedback to trainers and organisations regarding the progress of implementation efforts (Fixsen et al., 2009). One fidelity measure commonly employed in MI

training is the Motivational Interviewing Treatment Integrity 3.1.1 (MITI 3.1.1) coding system (Hohman et al., 2012b; Moyers, Martin, Manuel, Miller & Ernst, 2010). The MITI 3.1.1 is an objective measure that codes practitioner speech in MI interactions. It assesses the use of core MI skills (OARS), and provides a rating regarding practitioner adherence to the spirit of MI (Moyers et al., 2010). As part of MI training, it is recommended that practitioners learning MI will submit multiple audio recordings over time, in order to develop and maintain skill development (Hohman et al., 2012b; Miller & Mount, 2001). This practice should also be facilitated at a wider system level, ensuring that organisational policies and procedures are able to support practitioners, by allocating the time and resources necessary to complete this task (Hohman et al., 2012b). This is of particular importance, given that in studies which have produced null findings, factors such as poor submission rates for MI audios, low motivation to train in MI, and organisational time constraints have been reported (Barwick et al., 2012; Shafer et al., 2004).

1.7 The Current Research

In 2013, the NZ Ministry of Social Development (MSD) initiated a training project in MI, with the intention that it would be implemented in CYF youth residences nationwide. By introducing MI, it was intended that it would contribute to the current CSA approach; an initiative that aims to assist with positive re-integration into the community (Child, Youth and Family, 2014). Child, Youth and Family case leaders working within the residences were provided MI training. Case leaders work directly with CYF youth and are responsible for carrying out assessments, planning and programming of services, as well as for liaising with other support staff regarding the implementation of interventions (Child, Youth and Family, 2014).

Given there is a need for further research on MI with youth in residential settings (Clair et al., 2013; Naar-King & Suarez, 2011; Stein et al., 2006), the current study aimed to explore CYF case leaders' experiences of MI and its implementation within the context of CYF residences (both C&P and YJ). Secondly, this study aimed to evaluate the MI skill level of CYF case leaders post-training as they provided MI within their work context. It was hoped that this research would illuminate the perceived advantages and disadvantages of MI with this population and within CYF residences, as well as potential barriers to its implementation. Specifically, the current study aimed to investigate:

1) The experiences of CYF case leaders implementing MI within youth residences throughout NZ.
2) CYF case leaders' appraisal of MI within the CYF context.
3) The MI skill level demonstrated by CYF case leaders when working with youth in these residences post-MI training.

CHAPTER TWO

METHOD

2.1 Design

The current research utilised an exploratory sequential mixed-methods design, integrating both qualitative and quantitative components. The primary purpose of this research was to explore case leaders' experiences and appraisal of MI, as they utilised the intervention within the youth residential setting. Through a mixed-methods design, it was possible to examine case leaders' perspectives on the utility and value of MI within CYF services, as well as provide a measure of practitioner skill level in implementing MI.

The qualitative components (Part One) of the mixed-methods design addressed the first and second research aims. This involved administering an online survey to MI trained CYF case leaders throughout NZ, with focus groups conducted later in the year to allow for broader discussion and elaboration on survey responses. The focus groups were facilitated by the principal researcher and were conducted with CYF case leaders from four out of a possible eight CYF residential sites. The quantitative component (Part Two) of the mixed-methods design addressed the third research aim. This involved an analysis of MI audio recordings completed by CYF case leaders following MI training. In taking a mixed-methods approach, the findings of the quantitative component were then able to be compared to qualitative findings, to determine whether a fidelity measure of MI skilfulness aligned with the case leaders own perceptions of MI skilfulness in practice. By integrating qualitative and quantitative components, it was possible to gain a broader understanding of how successfully MI was being implemented within CYF services and what would be required, if anything, to improve its application at both practitioner and wider organisational/systemic levels.

2.2 Ethical Approval

Ethics and research approval were gained from the University of Canterbury Human Ethics Committee (see Appendix A) and the Research Access Coordinator at the Ministry of Social Development (MSD). Written informed consent (see Appendix E & Appendix H) was obtained from participants prior to their participation in the research tasks. Participants were informed that their participation was voluntary and that any information collected would be kept confidential. They were also informed that their consent could be withdrawn at any stage during the research process.

2.3 Motivational Interviewing Training

Prior to the commencement of this research, CYF case leaders attended an initial two-day MI training workshop, followed by an advanced one-day MI training workshop between May 2012 and July 2013. The workshops were provided by a member of the Motivational Interviewing Network of Trainers (MINT).

In alignment with the recommendations of Miller and Rollnick (2002) for MI training, the initial two-day workshop included a broad overview of MI, including MI's spirit, principles, research evidence of its efficacy, the skills of OARS and the concepts of change talk, sustain talk and ambivalence. The workshops comprised video-recorded demonstrations, didactic teaching, modelling and both real-play and role-playing with feedback. The focus of the second one-day advanced workshop was on enhancing the practice of MI skills. Case leaders received a re-cap of the initial training and were updated on the revised spirit and processes of MI according to Miller and Rollnick's (2012) revisions. Following the training, case leaders were invited to submit audio recordings of MI sessions in their workplace. The intention of the recordings was to provide feedback and coaching to further MI skill development, as well as to provide a measure of MI skill attainment. Recordings were

analysed using the Motivational Interviewing Treatment Integrity Scale 3.1.1 (MITI 3.1.1), and were coded by a MINT member (different from the MINT member who conducted the MI training), who also provided feedback and coaching to the case leaders who submitted audios.

PART ONE: QUALITATIVE COMPONENT

2.4 Online Survey

2.4.1 Participants

Participants were 15 CYF case leaders from youth residential sites throughout NZ obtained via a recruitment email (see Appendix B). This was circulated to all CYF case leaders who attended the MI training workshops between May 2012 and July 2013. A total of 46 case leaders were approached from four CYF Youth Justice (YJ) residences: Korowai Manaaki (South Auckland, *n* =14), Te Maioha o Parekarangi (Rotorua, *n* =5), Te Au rere a te Tonga (Palmerston North, *n* =5) and Te Puna Wai ō Tuhinapo (Christchurch, *n* =5); as well as four CYF Care and Protection (C&P) residences: Whakatakapokai (South Auckland, *n* =6), Epuni (Lower Hutt, *n* =6), Te Oranga (Christchurch, *n* =3) and Puketai (Dunedin, *n* =2). Participation was entirely voluntary and no incentives were offered for their involvement.

Of the 15 participant responses received, 13 were female and two were male. The age of participants ranged from 28 years to 64 years, with a mean age of 44.8 years. With regard to ethnicity, participants identified as NZ European/ Pākehā (*n* =8), NZ Māori (*n* =5), and Pacific Islander (*n* =1). Three participants indicated their ethnicity as ‘Other’ and included English, English/ Irish and New Zealander. To ensure anonymity, participants were not

requested to provide their name or indicate the particular residence in which they were employed.

The survey response rate was 32.61%, which is lower than expected given research suggesting that online surveys with follow up reminders should result in response rates of approximately 50-60% (Cook, Heath & Thompson, 2000). It should be noted that a number of case leaders were reported to have resigned from CYF in the period between the MI training and this research, which is likely to have contributed to the low number of responses received.

2.4.2 Measures

Online Survey. An online survey was developed using 'Qualtrics: Online Survey Software' (see Appendix C). It consisted of nine open-ended and four closed questions regarding case leaders' experiences of MI and MI's perceived utility in practice. The survey included questions such as; "What benefits are there to using MI in your work setting?" and "How has MI impacted on your working relationship with clients?". The survey also included four questions relating to demographic information (i.e. gender, age, ethnicity and training region attended) and an opportunity to provide additional comments. It was estimated that the measure would take between 10 and 20 minutes to complete.

2.4.3 Procedure

Case leaders who chose to participate in the study were directed to an online survey via the link provided in the original recruitment email. They were requested to read the survey information sheet which was provided as an attached document (see Appendix D). Prior to completing the survey, all participants were asked to give informed consent (see Appendix E) which required them to enter a 'Yes' or 'No' response on the Qualtrics webpage

before the survey would become available to them. If a 'No' response was entered the survey would close. Once participants had completed the survey, their responses were recorded by Qualtrics and they were thanked for their time.

In addition to the original recruitment email, case leaders received two follow up reminders requesting their participation in the online survey. These email requests were sent out to all case leaders at fortnightly intervals.

2.5 Focus Groups

2.5.1 Participants

Participants were obtained via a recruitment email (see Appendix F), sent to 32 case leaders from the Auckland and Christchurch regions as a follow up to the online survey conducted in the first stage of this research. Participation in the focus groups was entirely voluntary and no incentives were offered for their involvement.

The response rate for the focus groups was 34.38%. In total, participants included 11 CYF case leaders from four residential sites. These included two YJ residences: Korowai Manaaki (South Auckland, n =3) and Te Puna Wai ō Tuhinapo (Christchurch, n =5), as well as two C&P residences: Whakatakapokai (South Auckland, n =1) and Te Oranga (Christchurch, n =2). Of the participants, ten were female and one was male. One participant from Te Puna Wai ō Tuhinapo did not take part in the advanced MI training workshop and attended the focus group in an observer role. It should be noted that the remaining four residences (Te Maioha o Parekarangi, Te Au rere a te Tonga, Epuni and Puketai) were not invited to participate in this stage of the research due to the time constraints attributable to Master's thesis research. In light of this, Auckland and Christchurch residences were selected

for participation as both YJ and C&P residences could be accessed in these areas with relative ease.

It should be noted that some of the focus group participants did not complete the initial online survey. This was reportedly due to time constraints and/ or forgetfulness. It was determined that this would not impact on the validity of findings as these participants were still able to comment on their experiences of MI in practice. Thus, they were deemed to meet participation requirements, in alignment with the research aims.

2.5.2 Measures

Focus Group Questions. Focus group questions (see Appendix G) were developed based on the themes identified from the online survey. It consisted of 14 core discussion points, each containing between two and five sub-questions to be used when further exploration of a topic area was required. For instance, discussion point 13 – "When asked about MI's impact on the working relationship, most case leaders reported that MI had enhanced their working relationship with clients; tell me more about this" – was presented to participants followed by the sub-questions: "In what ways has your relationship with the young people changed?", "How has this been of benefit to the young people?" and "How has this been of benefit to you?". Each group was audio recorded using a Casio Digital Voice Recorder, with responses later transcribed. It was anticipated that the focus groups would take approximately one hour to complete.

2.5.3 Procedure

A total of three focus groups were conducted between September and December 2014 in the Canterbury and Auckland regions. Two focus groups were held in Christchurch at Te Puna Wai ō Tuhinapo (YJ) and Te Oranga (C&P) residences, with a third focus group held at

the Whakatakapokai (C&P) residence in South Auckland. Case leaders from the Korowai Manaaki (YJ) residence also attended this third group. Each group was held in an on-site meeting room at a time and date agreed upon by the research participants.

The same procedure was followed in all three groups. Upon arrival, participants were formally welcomed and presented with a research information sheet (see Appendix D) and informed consent form (see Appendix H) to be completed prior to the group's commencement. Participants were reminded that the interview would be audio recorded, with their responses transcribed at a later date. They were then given an opportunity to ask questions and express any concerns regarding the research. Once all participants were satisfied with the research process, the audio recorder was turned on and the focus group commenced. The 14 discussion points were presented in a semi-structured interview style to allow for discussion outside of these core areas and acted as a general framework for the focus groups as opposed to a structured interview format. Following the completion of each focus group, participants were thanked for their time.

PART TWO: QUANTITATIVE COMPONENT

2.6 Assessment of Motivational Interviewing Skill Level

2.6.1 Participants

Participants were CYF case leaders who submitted audio recordings of MI sessions following an invitation to receive further coaching and feedback following the advanced one-day MI training workshop. Case leaders (*n* =46) were invited to submit up to four recordings. Over the six month period following the workshop, a total of 12 out of a possible 184 recordings were returned. This suggests that between three and twelve case leaders completed

the task, with a response rate of between 6.52% and 26.09%. As the names of the case leaders were not revealed to the researcher it was not possible to determine: how many audios were submitted, the number of case leaders who submitted audios, or any demographic information regarding these case leaders.

2.6.2 Measures

Motivational Interviewing Treatment Integrity 3.1.1 (MITI 3.1.1; Moyers et al., 2010). The MITI 3.1.1 (see Appendix I) is a behavioural coding system that assesses MI skilfulness and can be used to provide feedback and coaching to enhance clinical skills. It is intended as a measure of treatment integrity and has been rigorously tested in both clinical trials and non-research settings (Moyers et al., 2010). The MITI 3.1.1 contains two components: Global Scores and Behaviour Counts. 'Global Scores' comprise five dimensions: evocation, collaboration, autonomy/ support, direction and empathy. Each dimension is rated on a five-point Likert scale, where 1 = 'Low' and 5 = 'High', with scores reflecting the rater's judgement of each dimension. The dimensions of evocation, collaboration and autonomy/ support can also be averaged together to yield a 'Global Therapist Rating' (Clinician Spirit). 'Behaviour Counts' require the rater to tally the occurrence of particular practitioner behaviours. These include: giving information, MI Adherent (i.e. asking permission, affirm, emphasise control, support), MI Non-Adherent (i.e. advise, confront, direct), Questions (i.e. closed or open) and Reflections (i.e. simple or complex). Behaviour counts are later converted into summary scores that can be used as outcome measures in determining MI competency. Summary scores and clinician proficiency and competency thresholds are presented in Table 1.

It should be recognised that while the current research assessed MI skill level using the MITI 3.1.1 coding system, a new version of the measure has since been released (MITI

Table 1

Summary Scores and Clinician Proficiency and Competency Thresholds

Summary Score	Formulas for Calculation	Threshold Cut-Offs	
		Beginning Proficiency	Competency
Global Spirit Rating	(Evocation + Collaboration + Autonomy/Support) /3	Average of 3.5	Average of 4
Reflection to Question Ratio (R:Q)	Total Reflections/ (CQ+OQ)	1	2
Percent Open Questions (%OQ)	OQ/ (OQ+CQ)	50%	70%
Percent Complex Reflections (%CR)	Rc/ Total Reflections	40%	50%
Percent MI-Adherent (%MIA)	MiA/ (MiA + MiNa)	90%	100%

Note. CQ = Closed Questions; OQ = Open Questions; Rc = Complex Reflections; MiA = MI-Adherent; MiNa = MI-Non-Adherent.

4.2). This is a substantial revision to the MITI 3.1.1. In the MITI 4.2 there are significant changes to the spirit scores, which now include scores for the technical components (cultivating change talk and softening sustain talk), as well as the relational components (partnership and empathy) of MI which were in the 3.1.1 version. There are also changes to the behaviour counts, which in the MITI 4.2 now include: complex reflections, the ratio of reflections to questions, MI Adherent behaviour (seeking collaboration, affirmation, and emphasising autonomy), and MI Non-Adherent behaviour (confront or persuade). The results and conclusions of the current research, however, are likely to have been similar if the more recent MITI 4.2 had been used. This is particularly so with regard to the relational spirit scores (partnership and empathy), the behaviour counts of complex reflections, the ratio of

reflections to questions, and the MI-Non Adherent behaviour, as these are unchanged from the MITI 3.1.1 version.

2.6.3 Procedure

Following the advanced one-day MI training workshop, case leaders were invited to submit up to four recordings of MI sessions with clients in their workplace. Each recording was evaluated using the MITI 3.1.1, with results, feedback and coaching then provided to case leaders individually by a member of MINT who was experienced in MITI coding (different from the MINT member who did the MI training).

CHAPTER THREE

RESULTS

PART ONE: QUALITATIVE COMPONENT

3.1 Online Survey Results

3.1.1 Data Analysis

Survey responses were analysed using Thematic Analysis (TA) as outlined by Braun and Clarke (2012). Thematic Analysis is a qualitative analytic method for identifying, categorising and reporting patterns (themes) within a data set (Braun & Clarke, 2012). Thematic Analysis was selected for the current research given its emphasis on researcher judgement to determine themes in relation to the research aims (Floersch, Longhofer, Kranke & Townsend, 2010). As TA is a method of data analysis as opposed to a methodology, it allows for flexibility in its approach, meaning it does not set rigid restrictions regarding sample size or require the use of strict statistical criteria (Braun & Clarke, 2012). Unlike other qualitative approaches, such as Grounded Theory (GT; Glaser & Strauss, 1965), TA is also able to explain the data set without the use of a specific theory (Floersch et al., 2010). Thus, given the semi-structured nature of the current research and the small number of participants, TA was considered an appropriate analytic method for use in this context.

Participant responses were collated, with initial codes generated based on their relevance to research aims one and two. The resulting codes were organised into six potential themes, which were then used to form the focus group questions to be used in the second stage of this research (see Table 2). The intention of the focus groups was to broaden responses into general themes (see section 3.2.1).

Table 2

Online Survey: Potential Themes

Themes	Illustrative Responses
Appropriateness of the MI method for CYF clients (*N*=6 quotations assigned to this theme)	"…Care and Protection residents [who are] predominantly younger, [are] developmentally and emotionally not able to manage this type of engagement" (C&P)
What case leaders like about MI (*N*=26 quotations assigned to this theme)	"Encourages young people to be involved with outcomes concerning themselves and is a non-judgemental and supportive approach to motivate my clients" (YJ)
What case leaders dislike about MI (*N*=10 quotations assigned to this theme)	"I can't get to solutions fast enough – it's difficult when the client isn't ready to make changes – having to sit with that – very resistant clients" (YJ)
Key challenges (*N*=28 quotations assigned to this theme)	"Challenges are around other work commitments, finding time frames and consistent/ regular time with clients" (YJ)
Impact on the working relationship (*N*=8 quotations assigned to this theme)	"MI enhances working relationships by showing the client that you are really listening to what they have to say and challenging their thinking. This leaves opportunities for further discussions due to leaving the client in charge to make up their own conclusions to which pathways they choose to take" (YJ)
Moving forward: Is MI worthwhile continuing in this service? (*N*=11 quotations assigned to this theme)	"Yes, I believe there is a place for this form of intervention with our clients in future. It has proven effective in my personal experiences of MI with clients" (C&P)

Inter-rater Reliability. The principal researcher and a postgraduate research assistant categorised the survey data for all 15 participants. Following this process, the researchers discussed the resulting codes to ensure agreement. Inter-rater reliability was calculated using Cohen's Kappa (k; Cohen, 1960) which produces a coefficient between zero and one. Values

above 0.70 indicate satisfactory reliability (Cohen, 1960). This analysis identified good inter-rater reliability (k=0.82), indicating general agreement in the categorisation of survey data.

As the intention of the survey was to refine and develop questions in preparation for the focus groups, no further analysis of survey responses was conducted.

3.2 Focus Group Results: Analysis

3.2.1 Data Analysis

The audio recording from each focus group was transcribed orthographically, with all spoken words and sounds reproduced; including false starts, hesitations, laughter, cut-offs in speech (indicated by three full stops; e.g., …), and strong emphasis (indicated by **bold**). Quotation marks were used to indicate reported speech and single quotation marks were used to indicate reported thoughts. Interruptions, off-topic conversations (e.g., a discussion of an actor in a local TV show), and breaks in the recording were indicated in [brackets]. To protect the confidentiality of participants, no identifying information was recorded, with participants instead assigned a number (e.g., case leader one = CL1, case leader two = CL2).

The resulting transcripts were analysed using the six-phase approach to TA (see Section 3.1.1) as outlined by Braun and Clarke (2012).

- *'Phase 1: Familiarising Yourself with the Data'* involved reading and re-reading the focus group transcripts, making notes on any items of potential interest to the research aims.
- *'Phase 2: Generating Initial Codes'* involved working through the data and assigning codes to all potentially relevant data excerpts. Codes were generated and modified when needed, to incorporate new material. A total of 23 codes were established (see Table 3).

Table 3

Initial Codes

	Sources	Extracts
1. Adjusting to a New Style of Interaction	3	16
2. Case Leaders' Sense of Competency	2	11
3. Competing Discourse and Goals within CYF	2	8
4. Contradicting Roles: Case Leaders and Floor Staff	3	8
5. Differences Between C&P and YJ Residences	3	13
6. Difficulties Using MI with 'Institutionalised' Youth	2	6
7. Difficulties Using MI within the Context of a CYF Residence	3	19
8. How Case Leaders are Currently Implementing MI	3	11
9. Impact of MI on the Working Relationship	3	7
10. Questionable Value	3	9
11. Care vs. Control	3	18
12. MI Can be Useful	3	15
13. MI is Appealing to CYF Youth	1	7
14. MI is Not Well Suited to CYF Residences	3	8
15. MI is Potentially Risky for CYF Youth	3	8
16. MI with Younger vs. Older Youth in C&P Residences	2	7
17. MI with Younger vs. Older Youth in YJ Residences	2	12
18. Need for Further Training in MI	2	18
19. Stay in Residence Not Sufficient	2	7
20. Time and Facility Constraints	3	16
21. Training Materials Not Relevant to Client Population	2	7
22. Requirements for Effective Practice	3	16
23. Working with Involuntary Clients	3	7

Note. Sources = number of transcripts from which extracts were obtained (*N*=3).

An example of a coded data extract is presented in Figure 1 below. This process was carried out using NVivo10 for Windows qualitative analysis software.

Inter-rater Reliability. The principal researcher and a postgraduate research assistant categorised the focus group data for all 11 participants, with 100 responses coded into the 23 established codes. Following this process, the researchers discussed the resulting codes to ensure agreement. Inter-rater reliability was again calculated using Cohen's Kappa (k; Cohen, 1960), which produces a coefficient between zero and one. This analysis identified good inter-rater reliability (k=0.87), indicating general agreement in the categorisation of focus group data.

- '*Phase 3: Searching for Themes'* employed both deductive and inductive approaches of TA, whereby the resulting themes were partially derived from the results of the online survey and partially derived from the raw data of the focus groups. In this phase, codes were sorted into potential themes and subthemes, with the relevant coded data collated within each theme. A total of six main themes were identified and are outlined in the thematic map presented in Figure 2.

Data Extract	**Coded For**
I was trying to use MI with one of my clients… and the kid just ended up saying, "Why do you keep repeating everything I say?" [Laughter] and I was like 'Damn It!', because I'm like "Oh you feel angry" and [he's] like "yes, I just said that thank you" (YJ)	1. Adjusting to a New Style of Interaction 2. Case Leaders' Sense of Competency 3. Care vs. Control

Figure 1. Data extract with relevant codes assigned.

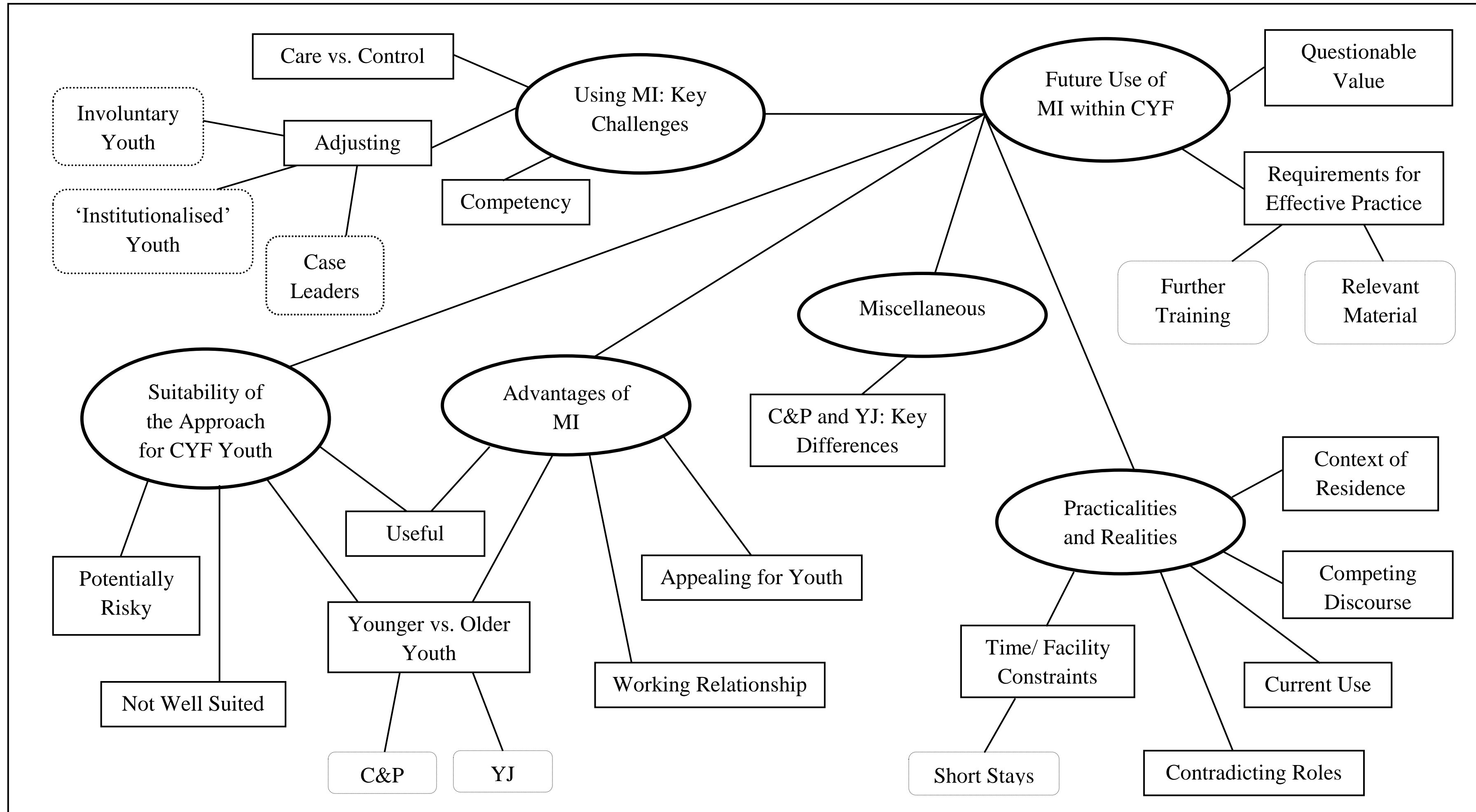

Figure 2. Initial thematic map displaying six main themes.

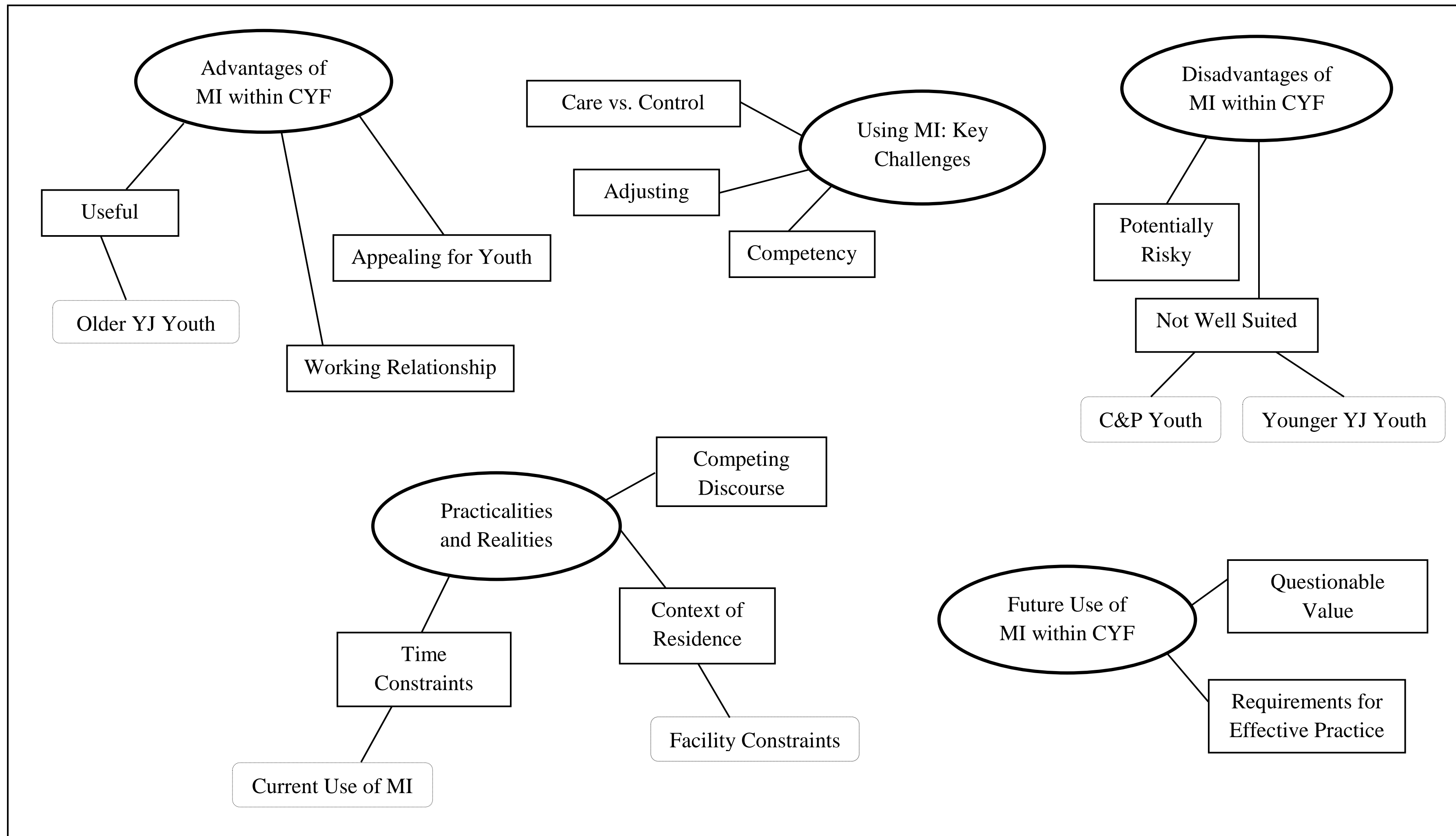

Figure 3. Final thematic map displaying five main themes.

- *'Phase 4: Reviewing Potential Themes'* required a review of initial themes in relation to the entire data set. Each theme was checked against the collated data extracts and codes, with those that did not fit renamed, moved or recoded accordingly. A final set of five themes thought to capture all aspects discussed within the focus groups was developed and is presented in Figure 3.
- *'Phase 5: Defining and Naming Themes'* involved a thorough analytic evaluation of each theme to determine the core issues they encompassed. Once defined, each theme and extract was compared within and between themes to ensure their succinctness and relevancy. Data extracts were then reviewed and selected to illustrate each theme and are presented in the final analysis.
- *'Phase 6: Producing the Report'* regards the final write up of focus group results and is presented in section 3.3.

3.3 Focus Group Results: Key Themes

3.3.1 Advantages of Motivational Interviewing within Child, Youth and Family

> *"…it's brief and you can just use those reflective words and a sentence here and a sentence there, so I guess because MI can be just the way you word something, it probably is a really good practice for a place like this, because you can just do it in that moment" (YJ)*
>
> *"We can be real with them, be honest, reflect back – yeah it definitely helps with the relationship" (YJ)*

The theme of 'Advantages of MI within CYF' exemplifies the perceived benefits of MI. While varied opinions were expressed, most participants reported MI and particularly, the skills of OARS to be a helpful addition to their practice with youth. Components such as reflection and open-ended questioning were mentioned in all three focus groups as the most frequently drawn upon and applied techniques learnt through MI training. In using MI, most

case leaders reported improvements in their working relationship with the youth, as well as perceived benefits for the youth in experiencing this new form of engagement. Motivational Interviewing was seen to be particularly useful with older youth in YJ residences.

MI is Useful. As indicated above, most case leaders spoke highly of the counselling components of MI (i.e., OARS) and reported that these were highly beneficial to their practice. For instance, one case leader reported that "you can use reflection, you can use those techniques… using open-ended questions to just improve [the youths'] ability to engage and improve their ability to use language… It's very, very useful I think" (YJ). Additionally, MI was seen to be useful with older youth in residences. It was suggested that youth of 16/17 years were "developmentally more able" to engage in MI (YJ). Given these youth are closer to transitioning out of the CYF system, they were viewed as more likely to reach a point where change would become inevitable, meaning that MI would be more relevant for these youth – "yeah, they get to the point where they know they need to start looking at themselves and what needs to change" (YJ). Motivational interviewing was also considered to be of benefit with older youth as they were reportedly more likely to come up with their own target behaviours and goals. Examples of these included: smoking cessation, staying away from anti-social peers, living arrangements and reducing offending. This is in contrast to younger clients who "might actually have **no clue** at all where to even begin" (YJ). The difficulties experienced practicing MI with younger YJ youth and C&P youth are discussed in section 3.3.2.

MI is Appealing for the Youth. As an intervention, MI was considered to be very appealing for YJ youth in particular. Motivational Interviewing's non-directive and non-confrontational approach was seen to be in stark contrast to the current methods employed in residences, meaning MI provides a rare opportunity for the youth to be heard. "They've very rarely ever had their voices heard about [what they want] because they're shut down, they're

told they're criminals, they're told they're bad… or that's wrong, so maybe some of our space is to allow it… not to be so wrong" (YJ). Many YJ case leaders considered this to be an important issue for the youth and liked the opportunity MI created for the youth to have a voice. In addition, MI was considered to be helpful in guiding the youth to clarify their thoughts, particularly when "they may be a bit all over the place" (YJ). Without instructing or providing advice, MI was reported to be an effective way to help the youth see direction for themselves.

Working Relationship. In general, MI was seen to enhance the working relationship between the case leader and the youth. Many case leaders reported that they were able to develop a better rapport with the youth simply by being "real with them" and by taking a non-judgemental stance (YJ). This was also considered to improve engagement with the youth; "like it does help because they learn to trust you quicker… you're listening and that's what they want. They want to be heard" (YJ).

It should be observed, however, that some case leaders reported that a working relationship could be better achieved through other methods, referred to as "relationship building" (C&P). This involved spending considerable one-on-one time with the youth, establishing rapport and developing trust.

3.3.2 Disadvantages of Motivational Interviewing within Child, Youth and Family

> *"…the younger kids don't get it, the one's in the middle are still trying to answer in a way that will do better for them, and it's not until they reach adult… that they suddenly think 'well maybe there's something in here that could help me'" (YJ)*
>
> *"…who helps them maintain [change] once they get out away from us? You know, so they've been through all of the steps and they've actually got to the point of 'I'm going to do this' and then what? It's almost like there needs to be some follow up somewhere" (C&P)*

The theme of 'Disadvantages of MI within CYF' encompasses the difficulties of implementing MI, both within the CYF environment and with the CYF client population. Across all three groups, it was evident that case leaders struggled to use MI with younger youth (under 16 years) who reportedly had difficulty understanding the process. There were also a number of concerns regarding the lack of support for the youth from CYF once they exited residence.

MI is Not Well Suited. Case leaders reported that they struggled to engage in MI with younger clients due to their lack of independence and autonomy. Younger clients rarely present with "an outcome or a focus or a goal for their future" as according to the case leaders, this had always been determined by others (YJ). Thus, case leaders found it difficult to elicit target behaviours with these youth and would often resort to MI non-adherent behaviour, such as direction, in these instances.

This was considered to be further complicated by the fact that many of these youth were still under the care and protection of their families outside of residence. Youth Justice case leaders, in particular, struggled with the idea of using MI to increase motivation when "whatever [client] wants to do in life, mum can [still] tell her no" (YJ). There was a general consensus among case leaders that until youth had some degree of control over their lives, MI would be difficult to implement successfully.

Care and Protection case leaders also expressed concern regarding the use of MI in their residences. Many considered MI to be developmentally inappropriate, given a significant proportion of these youth were cognitively functioning lower than their chronological age. Care and Protection youth were also regarded as less likely to have a desire to change, particularly when many of them "don't see that their behaviours are bad enough to bring them in here" in the first place (C&P). Attempts to develop motivation in

these instances were typically unsuccessful, with many case leaders reporting that directive approaches were more helpful in these situations.

Potentially Risky. A number of case leaders expressed concern that MI would set youth up for failure. Case leaders generally agreed that target behaviours needed to be small and very achievable in the immediate environment so that youth could succeed. For instance, achievable target behaviours included not fighting in residence or gaining a small number of NCEA credits. Working on more difficult target behaviours, such as staying put in their next placement or getting a job was a concern for case leaders, as the perception was that there was insufficient support for CYF youth once they left the residence.

There were also concerns regarding time constraints (outlined in section 3.3.4). As case leaders have very little one-on-one time with the youth, many felt hesitant about addressing the bigger issues; "…like if you have managed to get a 20-minute window with a kid and you do slowly start getting somewhere, all of a sudden you're interrupted by staff and they're going to have to go to P.E. [Physical Education]… and that's really scary. Do you go there? …do you really open that can of worms now? And can you do that safely?" (YJ). This highlights the pressures of time within CYF residences and how these constraints can impact on whether sensitive issues are able to be discussed.

3.3.3 Using Motivational Interviewing: Key Challenges

> *"[The youth] get quite frustrated if you're using open ended questions or exploratory questions. They actually can get quite angry because again, their experience is that any of the adults around them don't have that sort of discussion with them, they tell them" (YJ)*
>
> *"I was trying to use MI with one of my clients… and the kid just ended up saying, "Why do you keep repeating everything I say?" [All laugh] and I was like 'Damn it!' because I'm like "oh, you feel angry" and he's like "Yes. I just said that thank you" (YJ)*

The theme of ‘Using MI: Key Challenges’ regards the transition from MI training to practice and the difficulties case leaders encountered. Implementing MI required case leaders to adopt a facilitative, as opposed to directive interaction style with the youth which they reported to be novel and challenging for both parties. While many liked what MI could offer, the anxiety that ensued in practice often made them question their competency in engaging in MI and created concern about the consequences of using it incompetently. In addition, many case leaders struggled with working with ambivalence and resistance, and reported feeling overwhelmed by what the practice of MI involved.

Adjusting to a New Style of Interaction. Case leaders who were comfortable with their current methods of interaction reported MI to be a particularly challenging adjustment. These case leaders found that the facilitative guiding style of MI did not come naturally and reported feeling as though they were “trying to be something that [they] hadn’t been before” (C&P). Motivational Interviewing’s non-directive style was also reported to be a difficult adjustment for the youth. Case leaders’ reported that the youth would sometimes become frustrated or suspicious by the use of open questions and lack of instruction (the youth being told what to do). Some case leaders also considered it inappropriate to just “dive in with MI”, as most CYF youth are not used to this type of interaction, either within CYF or within their family of origin. It was suggested that the youth needed to be taught “how to have that language skill and how to have that ability to answer questions” first, in order to even attempt MI (YJ).

Competency. Case leaders frequently reported not feeling confident in their ability to practice MI following the training workshops. One case leader said that they “liked the training and liked the idea of having the tools, but [they] still went away feeling like [they] didn’t have it… something didn’t click” (C&P). While most case leaders acknowledged that confidence would come with practice, some were deterred by their early experiences, where

youth had interrupted sessions with such comments as “Why do you keep repeating everything I say?” and “What **are** you doing?” (YJ; C&P). In addition, a number of case leaders reported feeling overwhelmed in trying a new approach and struggled to give their full attention to the youth in session. “I’m thinking in my head ‘I want to do MI’ and that stops me from actually listening to what [the client is] saying and I just, I remember [the trainer] was saying “You’ve still got to listen” and then you listen and then you’re like ‘Crap! How do I MI that back?’” (YJ). All case leaders agreed that further training and refreshers would be required in order for them to feel more confident and competent in using MI (discussed in section 3.3.5). It should be noted that ongoing coaching and feedback post-workshop training was offered to case leaders, however, many were reluctant to submit audio recordings. For instance, one case leader reported that “[they wanted] to do more training, just not the recordings and sending them away… that was nerve-wracking” (YJ).

Care vs. Control. There were a number of scenarios reported in which case leaders struggled to employ a ‘caring’ guiding style, when situations were considered to require a more directive ‘control’ approach. Working with ambivalence was reported to have been challenging, particularly when there was strong sustain talk and when the youth provided compelling counter-arguments. For instance, one case leader reported a situation regarding underage prostitution. “You get a 13- or 14-year-old girl whose prostituting and… they will openly say to us, “Oh come on, I’m not going to go and work at McDonalds for ten dollars an hour when I can make so many hundred bucks in one night”. And that’s where the thought is” (C&P). Other case leaders agreed – “You know, how do you motivate a young person to realise that actually, you don’t have to be in that environment?” (YJ). Motivational Interviewing was also seen to be difficult when youth presented with no clear target behaviour. “You could just sit here and listen to the kid forever, and you’re just constantly reflecting and asking open questions and you could be there all day” (YJ). In these situations,

case leaders reported feeling as though they had hit a roadblock with MI and would often transition to other approaches which they considered to be more effective. This may in part be linked to case leaders' competency or level of experience, as the skill of collaboratively negotiating a focus and target behaviour is a core practice in MI.

3.3.4 Practicalities and Realities

> *"The noise is huge in there, especially when you've got ten young people and doors banging and buzzers going and you know, staff yelling across the room. So it's a very hectic, distractive environment and for some young people that is really overwhelming…" (YJ)*
>
> *"Yeah, I mean if we are talking about empowerment, we all know how powerful and how important that is to have that autonomy. But in an involuntary residence or situation in here with all the regulations and everything else and the time frames… I mean realistically, empowerment may be very much just that little moment where they have a choice to go left or right" (YJ)*

The theme of 'Practicalities and Realities' encompasses the many frustrations and restrictions of residences, both in regard to the physical environment and the over-arching structure and rules of the CYF system. Case leaders reported feeling overwhelmed by their caseloads, which consequently impacted on the time they had available to learn and practice MI. Regarding the over-arching structure of CYF, there was also a general consensus among case leaders' that MI did not align well with a system that they considered to demand answers and solutions in a timely manner. Many case leaders reported that they did not have enough time in their schedules to complete MI on top of required tasks, such as structured assessments and care plans. Again, while most case leaders could see the value of MI, they did not believe it could be truly supported by the residential system, at least in its current format.

Context of Residence. The physical environment of the residences was frequently reported as hectic and distracting. In addition, a lack of interview rooms meant that even if MI conversations were conducted, these occurred in less than ideal circumstances, such as at the end of a corridor. As such, case leaders were rarely able to schedule private sessions with the youth. This was of particular concern for the larger YJ residences, as case leaders reported finding it difficult to keep the youth focused in MI sessions due to noise and a lack of privacy. In addition, a number of case leaders were concerned that any behaviour changes that may occur following MI sessions might ultimately be demoralising for the youth once they transitioned back into the community. As "[residence] is very supportive; they're not on drugs and alcohol, they're fed regularly, they're in school, they're structured… and to gain that motivation… like the fear I've got is that it just, it does feed into the disappointment when things go terribly wrong when they get out (YJ)". This view may also represent the case leader's experiences of youth cycling in and out of residence with similar problems. Again, the perceived lack of follow-up and support for youth once they leave residence was presented as an ongoing concern.

Time Constraints. With a caseload of between five to ten youth each, case leaders felt pressed for time. The national office requires a number of tasks to be completed for each youth that enters and this takes precedence over intervention sessions. One case leader reported that they "would love to do an MI session – that would be amazing. But I have to talk about this task, so whilst I can weave some sort of MI in there, my goal is to complete my task" (YJ). In addition, having multiple high risk clients on a case load makes it more likely that interventions like MI will slip further down the priority list as responding to crisis situations takes precedence. Another issue reported was the short time frame in which many youth are in residence. Both C&P and YJ case leaders reported that they could not engage in MI with youth on very short stays (sometimes as little as one week) due to a lack of rapport

and trust. One YJ case leader estimated that this would affect as many as 90% of the youth that entered their residence. As a result of the time constraints mentioned, case leaders reported that their current use of MI in residence was typically unplanned and conducted in an ad hoc fashion. Most case leaders reported that they "took bits and pieces of MI", such as open questioning and reflection and felt they were able to use these frequently with the youth, "just by the way in which [they] worded their comments" (YJ). However, as addressed in section 3.3.5 below, this suggests that while case leaders found the MI training useful for improving their counselling skills, they were not actually practicing MI. None of the case leaders considered it realistic to schedule regular sit down one-on-one MI sessions with the youth. It was suggested that this would not become a possibility until residences underwent a "culture shift" (YJ), where the time and space was provided for MI.

Competing Discourse. As CYF operates as a system, many case leaders reported feeling significant pressure to "fix the problem" and that the priority was for the case leaders to develop plans and solutions (YJ). This conflicts with the spirit of MI, and in particular, the components of partnership and acceptance, in that "it takes all of [the youths'] power away because… they're pressured to do something right away" (YJ). Despite MI training being provided by the organisation, most case leaders did not consider there to be any less emphasis placed on finding immediate solutions. Some YJ case leaders also found irony in the fact that MI encourages empowerment and autonomy, when the restrictions of residence actually prevent the youth from having any independence or control. This begs the question of whether such an approach fits within these kinds of residences due to these contrasting elements. In addition, YJ case leaders reported concerns regarding the conflicting messages youth received from different types of staff members. While case leaders will typically take a therapeutic approach to change, floor staff are trained to use authority-based direction. One case leader reported their experience of this: "When I'm sitting with a kid that's really angry,

I'm actually ok to sit with that. But in the unit, if they're really angry they'll get marked down on the BMS [Behaviour Management System], they'll have to go to time out, which is a punishment let's face it, you know they get told off for being angry…" (YJ). It was generally agreed that all staff needed to be on board with interventions, for the youth to experience a clear and consistent message regarding their behaviour.

3.3.5 Future Use of Motivational Interviewing within Child, Youth and Family

> *"There is absolutely a place for it every day in every setting, constantly on the floor… it works really well, particularly with these kids who never get their voices heard" (YJ)*
>
> *"…it's not that the training hasn't been beneficial because there have been parts of it that we've all used, it's whether it's applicable in our environment and it's not. That's the hardest thing we have to admit" (YJ)*

The theme of 'Future Use of MI within CYF' articulates the concluding opinions of CYF case leaders regarding the continued use of MI in the residences. Mixed views were expressed by both YJ and C&P case leaders. It was generally agreed that the systems and structure of residence would need to change first, before MI could be implemented successfully. A number of ideas were presented as to what would be required in future, including changes to the residential context and to the content of MI training workshops.

Questionable Value. Most case leaders reported that they found some of the skills learnt in MI training to be worthwhile, such as open questioning and reflection. In this regard, the training was viewed as valuable because it could be used as "a way of interacting and engaging" (YJ) with the youth on a daily basis and in every situation. However, some case leaders did not believe it was worthwhile continuing MI within CYF residences. For example, one case leader stated, "…I don't think residences are ready for it and I don't think

the young people are ready for it" (YJ). Most C&P case leaders also strongly considered MI to be inappropriate for their youth and did not think they were likely to continue using MI.

Requirements for Effective Practice. If MI was to continue in CYF, it was considered that a number of changes would need to occur. It was suggested that case leaders should "have [their] practice prioritised, with dedicated case work time" (YJ). This would mean that all of the youth on their caseloads could receive the support and attention they required, and have time for MI conversations with the case leader. The building of new facilities with enough office space was recommended by the case leaders as one way to facilitate this. In addition, there were suggestions that residences needed to operate more as therapeutic communities with the entire CYF team trained in MI, including both case leaders and floor staff. This would help to provide consistency and assist MI to have greater effect.

Regarding MI training, most case leaders reported that booster sessions would be helpful "once every six months" (YJ; C&P). There was also a common suggestion that training materials needed to be tailored to a CYF client population to allow for case leaders to gain an understanding of how to use MI more appropriately with that group. A number of case leaders' reported that "there was nothing that we could see [about how MI would work] with our youth… it would help if we saw those 'aha' moments [with] our youth and those non-voluntary ones too…" (YJ). While video examples of MI with youth populations were not provided in the training sessions, it should be noted that case leaders were given the opportunity to practice real-work situations in practice exercises and role-plays.

3.3.6 Summary of Findings

In summary, the focus group results shed light on the context of CYF residential settings and the challenges faced when implementing MI within their service. Motivational Interviewing was widely seen to be a positive and valuable approach. However, it was

viewed as unsuitable for younger clients (less than 16 years), short term clients, and C&P clients. In addition, the demand of the case leader role, in combination with a perceived pressure to find immediate solutions were considered to be barriers to engaging in MI. However, case leaders were able to incorporate some of the components of MI (e.g. OARS) within their work. It was generally agreed that until there were organisational and systemic changes, MI was likely to have limited success in CYF residences. Should MI be continued, changes at a system level and further training to increase case leader competency were recommended.

PART TWO: QUANTITATIVE COMPONENT

3.4 Motivational Interviewing Treatment Integrity 3.1.1 Results

3.4.1 Data Analysis

Descriptive statistics (means, standard deviations and ranges) were derived for both Global Therapist Ratings and Behaviour Counts. This data was analysed using the STATISTICA 12 statistical software package. Comments made by the coder during the coding process were analysed using TA (Braun & Clarke, 2012) to provide supporting information (see section 3.1.1). These results were collated and discussed in relation to the third research aim.

3.4.2 Clinician Spirit

Global Therapist Rating (Clinician Spirit) scores were found to be an average of *M* =3.11 (*SD* =0.30), which is less than beginning proficiency (Table 4). None of the case leaders reached threshold for beginning proficiency, with the exception of one, who met the threshold for competency.

Table 4

Descriptive Statistics for Clinician Spirit Scores (*n* =*12)*

Dimension	Mean	Standard Deviation	Range
Evocation	3.08	0.29	3.00-4.00
Collaboration	3.08	0.29	3.00-4.00
Autonomy/ Support	3.17	0.39	3.00-4.00
Clinician Spirit Score	3.11[a]	0.30	3.00-4.00

Note. Each dimension is rated on a five-point likert scale where 1 = 'Low' and 5 = 'high'. Clinician Spirit Score = average of the three dimensions.
[a] Threshold cut-off for clinician spirit (Beginning Proficiency = 3.5, Competency = 4).

This indicates that case leaders had difficulty adopting the Spirit of MI. More specifically, the ratings suggested that they had difficulty showing interest in or awareness of the client's own reasons for change; attended to client goals in a lukewarm fashion, and/ or displayed a neutral stance regarding client autonomy and choice (Moyers et al., 2010).

3.4.3 Behaviour Counts

The mean R:Q ratio was M =0.60 (SD =0.32), which is less than the threshold for beginning proficiency (Table 5). Only two case leader's audios met criteria for beginning proficiency on the R:Q ratio. This indicates that the case leaders mostly asked more questions than they made reflections.

The %OQ questions (M =39.92; SD =16.60) did not meet threshold for beginning proficiency, suggesting that most case leaders asked more closed questions than open ones. Only one case leader met criteria for beginning proficiency, and actually exceeded this, with a rating at competency. With the exception of this one case leader, it appears that case leaders demonstrated an overuse of questions which were likely to elicit a simple yes/no or shorter fact response, as opposed to questions which allowed for more elaborative answers.

Table 5

Descriptive Statistics for Behaviour Counts (n =12)

Behaviour Count	Mean	Standard Deviation	Range	% Does Not Meet Threshold	% Beginning Proficiency	% Competency
Reflection to Question Ratio (R:Q)	0.60	0.32	0.17-1.27	83.33	16.67	0.00
Percent Open Questions (%OQ)	39.92	16.60	21.00-87.00	91.67	0.00	8.33
Percent Complex Reflections (%CR)	40.75	15.12	15.00-63.00	50.00	16.67	33.33
Percent MI-Adherent (%MIA)	97.92	3.99	89.00-100.00	16.67	8.33	75.00

Note. Threshold Cut-offs: R:Q (Beginning Proficiency = 1, Competency = 2); %OQ (Beginning Proficiency = 50%, Competency = 70%); %CR (Beginning Proficiency = 40%, Competency = 50%); %MIA (Beginning Proficiency = 90%, Competency = 100%).

The mean score for the %CR was M =40.75 (SD =15.12), which meets criteria for beginning proficiency. While one third (n=4) of the audios met competency for the %CR, 50% still did not meet beginning proficiency. This suggests an over-reliance on simple reflections on some audios. On the audios which met criteria for competency, the majority of reflections made were complex, meaning they were able to express deeper meaning and understanding of client speech.

Finally, the mean score for %MIA was M =97.92 (SD =3.99), which is above beginning proficiency. Furthermore, the majority of audios met threshold for competency suggesting that these case leaders were able to resist from engaging in MI-non adherent behaviour. Two audios, however, had a %MIA below beginning proficiency. The MI non-adherent behaviours exhibited on these audios were: providing advice (n =1), directing (telling) the client (n =1), and an MI non-adherent behaviour not indicated (n =1).

In summary, the MITI 3.1.1 ratings of the audios suggested that the case leaders who submitted audios were mostly able to avoid MI non-adherent behaviour. However, with the exception of one audio which reached competency, none of the audios met threshold for at least beginning proficiency across all of the behaviour counts and clinician spirit.

3.4.4 Coder's Comments: Additional Themes

The coder's comments for each audio were collated and coded in relation to the third research aim. The resulting codes were organised into five themes (Table 6).

Table 6

Coder's Comments: Additional Themes

Themes	Illustrative Responses
Practitioner Style (*N*=7 quotations assigned to this theme)	"The practitioner was naturally affirming and supportive of her client and you could feel the warmth in the interaction"
Focus Unclear (*N*=6 quotations assigned to this theme)	"I was not 100% sure what the focus of this interview was. It would have been useful to have a more explicit focus for the interview"
Behaviour Counts: Inflection Errors (*N*=6 quotations assigned to this theme)	"On several occasions a good reflection was turned into a closed question due to a noticeable upwards inflection at the end of the reflection"
Challenging/ Disengaged Clients (*N*=5 quotations assigned to this theme)	"…questions elicited some good responses but the client seemed disengaged and unwilling to answer the practitioner's questions fully. Some questions were met with humour or dismissed as 'dumb'"
Client-Centred Interviews vs. MI Interviews (*N*=4 quotations assigned to this theme)	"I think this interview could be described as a client-centred session and not a true MI session because it lacked a guiding style and a clear focus for guiding by the practitioner"

Practitioner Style. The coder noted and commended the case leaders for their warm and empathetic style as demonstrated on seven audios. However, on two audios it was noted by the coder that the case leader appeared to have become frustrated and challenged the client (MI non-adherent).

Focus Unclear. For half of the audios, the theme of 'focus (target behaviour) unclear' was made. This was largely in response to when target behaviours were not identified or when multiple target behaviours had been addressed. As noted by the coder a clear target behaviour is required in order for a session to be evaluated as MI. While most target behaviours appeared to address 'life post-release', this often had to be assumed by the coder with no degree of certainty.

There were only three audios which were coded as being able to identify and maintain a clear focus in-session, with target behaviours including plans after release (n =2) and living at home with parents (n =1). The remaining audios (n =9) focused on one or more possible target behaviours in the areas of anger management, court appearances, living arrangements and/ or preparing for release.

Behaviour Counts: Inflection Errors. In regard to the behaviour counts outlined in section 3.4.3, the coder noted six instances of good reflections being spoiled as a result of an upwards inflection (a rise in pitch at the end of a statement). In alignment with the MITI 3.1.1, when used at the end of a reflection, these statements are coded as closed questions. It is possible that this may have contributed to the poor %OQ rates demonstrated, with each of the case leaders who received this comment failing to meet threshold for beginning proficiency on this count. However, upon closer examination of the data, this is only likely to have impacted two out of the six audios.

Challenging/ Disengaged Clients. In five audios, the coder noted that clients seemed to be disengaged in the interview process. This highlights the challenges of working with non-treatment seeking populations. The coder acknowledged the difficulties experienced by the case leaders and commended them for continuing with the session through to its conclusion. None of these audios met beginning proficiency for %OQ and/ or %CR, suggesting that in these situations, the case leaders resorted to the use of closed questions and simple reflections, which in turn are unlikely to have facilitated client engagement and encouraged the client to speak more.

Client-Centred Interviews vs. MI Interviews. The theme of client-centred interviews vs. MI interviews was mentioned by the coder four times. It is similar to the theme of 'focus unclear' above, as sessions without a clear target behaviour cannot be evaluated as MI sessions and are often more consistent with client-centred counselling. While eight of the audios were deemed to have at least been attempting an MI session, only four successfully achieved this through identifying and maintaining a clear target behaviour and focus throughout.

CHAPTER FOUR

DISCUSSION

The study presented here investigated CYF case leaders' experiences of MI and its implementation within the context of CYF youth residences throughout NZ. A mixed-methods exploratory sequential design was employed to address the research aims, which sought to capture case leaders' experiences and appraisal of MI, and to assess their level of MI skill. Data were collected through an online survey, focus groups and MI audios submitted post-training. The intention of this research was to illuminate the perceived advantages and disadvantages of MI, both with a youth population and within an involuntary residential context. In addition, this research aimed to identify potential barriers to MI implementation, in order to inform future training and implementation efforts.

4.1 Overall Findings

This study identified a number of interesting findings regarding the perceived benefits of MI, as well as the challenges associated with practicing MI in the CYF residential context. Both the case leaders' perceived and externally assessed low levels of MI skilfulness, as well as organisational/systemic factors which did not support the implementation of MI, were identified as major factors influencing the infrequent use of MI in residences post-training. Furthermore, the results highlight the complexity of implementing EBPs within government organisations, and the need for an implementation plan which comprises systematic ongoing training, feedback and organisational support (Doran et al., 2011; Fixsen et al, 2009; Miller et al., 2004). These components are crucial to the success of EBPs, in ensuring that practitioners

provide effective interventions, in the interest of improving client wellbeing (Fixsen et al., 2009).

4.1.1 Advantages of Motivational Interviewing within Child, Youth and Family

While few case leaders reported engaging in full MI sessions, most considered the micro-counselling skills of OARS that they were introduced to as part of the MI training to be a useful addition to their practice with youth. These skills were considered helpful because they could be freely integrated into conversations with the youth, as a means to increase engagement and encourage client openness and reciprocity. A number of case leaders reported that these were the only skills they had learnt from the MI training that they were using post-training. This suggests that the MI training may have facilitated the development of the case leaders' counselling skills and that they were able to use these skills post-training to facilitate engagement with the youth. However, it appears that more training, feedback and coaching is required to develop the case leaders' ability to move beyond the process of engagement, in order to establish a focus and then evoke and strengthen change talk as required in MI. Similar findings were described by Wood, Ager and Wood (2011), who observed that clinicians often incorporated the techniques of MI into existing strategies (such as direction or advice-giving), despite the incongruence of these strategies with MI's underlying spirit.

In addition to the skills of OARS, the spirit of MI was seen by most case leaders as advantageous in improving their working relationship with the youth. Given that the over-arching structure of CYF residences (and particularly YJ residences) is largely authority-based, the youth are often wary of CYF staff due to the distinct power differential. Thus, it was reported that MI offered a rare opportunity for the youth to be heard, which was considered appealing for both parties. This aligns well with research regarding the youth developmental age (Naar-King & Suarez, 2011), which purports adolescence to be a period in

which youth strive for autonomy in decision making and in the self-governance of their behaviour. Interventions like MI, which promote client autonomy are well matched to the youths' developmental needs and are likely to be effective in developing motivations and reducing resistance (Naar-King & Suarez, 2011). In addition, research suggests that when an individual experiences their ideas as being valued, respected and accepted, they are encouraged to explore and develop these ideas further (Day, 1979; Magrinelli, Lafortune & Brochu, 2010; Sturmfels & Manion, 2012). This was observed in interactions with older YJ youth, who were viewed as more likely to offer up ideas and identify target goals in attempted MI sessions.

From the case leaders' perspective, the MI spirit broke down hierarchy barriers in their relationship with the youth, meaning they could 'be real' and supportive, as opposed to directive in their interactions. Such factors are among key predictors of successful change in psychotherapeutic practice (Collins & Nee, 2010; Naar-King & Suarez, 2011). In alignment with the relational hypothesis of MI, case leaders also reported MI to have improved the working relationship through promoting engagement and increasing change motivations (Miller & Rose, 2009). It should be acknowledged, however, that most case leaders in C&P residences did not view MI as useful in this regard, with these case leaders reporting conventional relationship-building techniques to be more conducive to their practice with the youth. These involved spending significant one-on-time with the youth, establishing rapport and developing trust over a considerable period of time prior to engaging in any formal intervention. Conversely, the MI engagement process, a core skill of MI, proposes that these same techniques can be achieved within an MI session, with the practitioner working to develop a strong connection and working relationship with the client at the outset (Miller & Rollnick, 2012). This requires the practitioner to work in a collaborative manner with the client, ensuring they feel accepted and heard throughout (Miller & Rollnick, 2012).

4.1.2 Disadvantages of Motivational Interviewing within Child, Youth and Family

One of the major disadvantages reported by case leaders was that they considered MI inappropriate for C&P youth and younger YJ youth (those under 16 years). Care & Protection case leaders considered MI to be developmentally inappropriate, particularly given a significant proportion of C&P youth present with low cognitive functioning. To date, there have been very few studies conducted regarding the efficacy of MI with younger and/ or low cognitive functioning children and youth. One review conducted by Strait, McQuillin, Smith & Englund (2012a) regarding the use of MI with child and adolescent populations observed that of the studies conducted, most have targeted adolescents over 12 years of age, with the average age of participants being in the mid- to late-teens. Additionally, in other studies that identify children to be the primary focus of MI interventions, the techniques employed are in fact often focused on the parents, rather than the children (Cryer & Atkinson, 2015). Despite recent publications promoting MI with younger clients, there is currently minimal theoretical and empirical guidance regarding its application with these populations (Strait et al., 2012a). Thus, it is not yet clear whether younger children (under 12 years) will experience the same benefits from MI, as has been evidenced in studies with adolescents and adults (Erickson, Gerstle & Feldstein, 2005; Strait et al., 2012a). With regard to CYF residences, it is possible that MI may not be developmentally appropriate for youth under 12 years of age or for youth who are functioning cognitively lower than this level. However, as identified in the findings of Strait et al. (2012a), there is still reasonable evidence to support its use with older youth, including those between 12 and 15 years. As an intervention, MI is also theoretically well suited to this developmental period, particularly as youth begin to develop an identity and assert their independence (Erickson et al., 2005).

Another disadvantage presented was the lack of follow-up able to be provided by case leaders once youth left residence. While CYF does have follow-up procedures in place, these

tend to be carried out by other staff members who do not work within the residences, and who may consequently be unaware of the changes and goals the youth have made during their stay. Therefore, due to this potential lack of support in maintaining change motivations during this transitional phase, a number of case leaders were concerned that MI would set the youth up to fail once they returned to their family of origin and encountered familiar antisocial influences within the community. This opinion was based on their experiences of youth cycling in and out of the system. However, there is research evidence to suggest that MI can have a significant and positive impact on increasing change motivations post-release in adult offender populations, irrespective of whether ongoing supports are available (e.g., Anstiss et al., 2011). Whereas, there is an additional challenge for CYF youth in that they typically return to the care and protection of guardians and family members that may disrupt their ability to maintain changes. This raises an organisational issue as to whether there are appropriate supports in place to keep the youth engaged and motivated to maintain therapeutic gains following discharge, and what supports could be added to facilitate this.

4.1.3 Using Motivational Interviewing: The Key Challenges

A number of challenges were reported by case leaders regarding their readiness to implement MI. Adjusting to this style of interaction was considered particularly difficult for some case leaders. Traditionally, case leaders take a dominant role in their conversations with youth, providing advice, direction and taking control of their individual care plans while in residence. In transitioning to MI, some case leaders reported instances in which they had become frustrated by MI's guiding style, particularly when the youth demonstrated challenging behaviours. This was also evident in the quantitative results, whereby some audios were observed to have involved clients who appeared disengaged and unwilling to participate in session. In these instances, case leaders struggled to refrain from reverting to a control approach. Treatment resistance is a common process issue which can occur with

involuntary youth populations and may indicate that a discord is present in the therapeutic relationship (Hohman et al., 2012a; Naar-King & Suarez, 2011). The frustration experienced also suggests a lack of experience and skilfulness in MI, and provides further support for the importance of ongoing feedback and coaching to facilitate implementation post-training (Doran et al., 2011; Miller et al., 2004).

In addition to the case leaders' experiences in practicing MI, CYF youth were also reported to have become suspicious of MI's facilitative guiding style at times. This could indicate a lack of engagement with the youth, in that they may have felt misunderstood or distrustful of case leaders. The case leaders' perception of this, however, was that this was likely due to the novelty of the approach and a lack of language skill. This raises the question as to whether some case leaders may take a deficit approach as a result of their previous experiences, whereby the youth are not seen as having the skills necessary to benefit from MI. Such an approach is incongruent with the strengths-based philosophy of MI, which supports personal empowerment and holds the belief that clients enter MI sessions already equipped with the skills needed to achieve their goals (Manthey, Knowles, Asher & Wahab, 2011). Having low expectations is concerning in settings such as CYF residences, given that expectations of failure, whether conscious or subconscious, can impact the working relationship and the ability of interventions to be implemented successfully (Magrinelli et al., 2010).

Another challenge reported was the tension inherent in the notion of 'Care versus Control'. Many case leaders struggled to use MI with youth who they perceived as unmotivated and resistant to change behaviours the case leaders considered unhelpful and potentially harmful (e.g., prostitution, drug-dealing). In these instances, case leaders found it difficult to stay within the spirit of MI, and to guide the conversation in such a way as to facilitate the youth to explore and consider these behaviours in an alternative light.

Additionally, given the nature of these behaviours, case leaders faced a dilemma. In one regard, the nature of 'caring' interventions and MI, suggest that their role is to respect their client's freedom of choice. Conversely, case leaders also perceived there to be organisational and societal pressures to 'control' these behaviours for the perceived welfare of the individual and of the community (Day, 1979). In these situations, case leaders struggled to avoid MI non-adherent behaviours, such as directing and advice giving, with one quarter of the audios submitted including MI non-adherent behaviours.

A final challenge reported by case leaders was the difficulty experienced when trying to develop a clear focus in MI sessions. Case leaders reported that they struggled to establish a focus and control the direction of sessions, particularly when the youth did not present with predetermined goals or target behaviours. This was supported by the quantitative findings, with half of the audios submitted lacking a clear focus. This may indicate low levels of MI skilfulness, given that developing a 'focus' is a core process in MI (Miller & Rollnick, 2012).

4.1.4 Competency, Ongoing Training and Motivational Interviewing Skilfulness

Case leaders' sense of competency, or lack thereof, was a significant issue discussed in the focus groups. Many case leaders reported that they were not confident in their ability to practice MI following the training workshops. This is not unexpected given the findings of previous research, which suggest that in addition to initial training, ongoing practice in combination with post-training coaching and supervision is required for practitioner's to develop confidence and skilfulness in MI and to integrate MI into the demands of their workplace (Doran et al., 2011; Miller et al., 2004; Naar-King & Suarez, 2011). For instance, a study by Snyder, Lawrence, Weatherholt and Nagy (2012) evaluated the efficacy of MI implementation in combination with long-term coaching in child welfare services. Following initial MI training, a MINT member continued to provide coaching and feedback to child

welfare case workers in monthly group supervision sessions over a one year period. Results from the study found that all caseworkers reported improvements in their practice of MI as a result of the ongoing training and skill building sessions. However, the authors also emphasised that the maintenance of MI skill was highly dependent on the case workers' continued uptake of training and coaching supports over the one year period (Snyder et al., 2012).

In contributing to the case leaders' lack of confidence, it was also reported in the focus groups that challenging reactions by the youth (e.g., interrupting sessions) in early MI attempts would often deter case leaders from practicing MI altogether. This also suggests that case leaders needed more support in the form of regular and ongoing coaching and supervision to facilitate the transfer of skills learnt in MI training to the work situation, as well as to facilitate ongoing MI skill development over time. It should be acknowledged that CYF management in their MI implementation plan did actually include the opportunity for six months of post-training coaching and supervision through the submission of audios to the MINT member. However, this opportunity was not typically sought out by CYF staff. This is also likely to have added to the case leaders' reported lack of confidence and competency in practicing MI post-training, given research shows that when practitioners partake in workshop training alone, without ongoing coaching and supervision, MI skill level typically regresses to baseline (pre-training) levels (Miller et al., 2004).

While almost all of the case leaders in the focus groups reported that they would like more training and support in their practice of MI, most case leaders were not willing to take up further coaching and feedback in the form of submitted audio recordings. Case leaders reported that this was due to time and resource constraints, a lack of confidence, and feelings of discomfort and nervousness at the prospect of being recorded and having the audios evaluated. Similar challenges were reported in research by Shafer, Rhode and Chong (2004),

which evaluated the effectiveness of MI training via distance education methods for a group of behavioural health professionals. Of the 23 participants who originally agreed to submit audio recordings of MI interactions, only nine participants had provided these by the time of the study's completion (Shafer et al., 2004). The poor rates of audio submissions obtained in both Shafer et al. (2004) and the current study are problematic, as research regarding MI training has identified that ongoing feedback and coaching through reviewing in-work audio examples of MI sessions is essential to the development of practitioner skill and the transition of skills learnt from training to the workplace (Doran et al., 2011; Miller et al., 2004). Furthermore, at an organisational level, this type of feedback also provides valuable information regarding the progress of the implementation (Fixsen et al., 2009). Further research needs to be undertaken to determine what additional measures can be taken to facilitate an increase in MI audio submission, in both research and real-work settings.

Regarding practitioner skill, the MITI 3.1.1 results revealed that 11 out of the 12 submitted audios did not meet criteria for at least beginning proficiency in clinician spirit, indicating that attempts to engage in MI sessions were largely at a relatively low level of MI skilfulness. This is not necessarily surprising given the findings of previous research (Miller & Mount, 2001; Miller et al., 2004), which have identified only modest improvements in MI skilfulness when initial training is not followed by ongoing coaching and feedback. Only one audio met the criteria for clinician spirit and did so to a level of competency. Practicing within the framework of MI's underlying spirit is important as it assists clients to feel accepted, safe and open to exploring the possibility of change (Miller & Rose, 2009). As most of the participant audios did not achieve clinician spirit, consistent with beginning proficiency in MI, this suggests that case leaders may have struggled to form an equal partnership with the youth, demonstrate acceptance and compassion and effectively evoke the youths' ideas and values in session (Miller & Rollnick, 2012). This also highlights the

challenges of 'care vs. control' and suggests that case leaders found it difficult to employ MI's caring guiding style, in lieu of more directive control approaches that have long been employed.

Similar findings were observed on the MITI 3.1.1 behaviour counts, with the majority of audios failing to meet beginning proficiency on the reflection to question ratio and percent open questions. Promisingly, half of the participant audios did met criteria for at least beginning proficiency on complex reflections, while the majority of participant audios were also successful in achieving at least beginning proficiency on the percent MI-adherent behaviours. Overall, however, with the exception of one audio which reached competency, none of the audios achieved at least beginning proficiency on all four behaviour counts and clinician spirit and therefore, cannot be considered to be representative of MI. Thus, consistent with the case leaders' perceptions of their lack of MI skilfulness, these results indicate that the majority of case leaders who submitted audios were not competent in their practice of MI and required further training, coaching and feedback. However, given the small proportion of audios submitted for evaluation and the fact that some participants may have submitted more than one audio, it is not possible to draw any significant conclusions regarding practitioner skill level overall.

Given that one case leader was able to demonstrate competency in MI, however, this suggests that it is possible to engage in MI within the CYF context. If it were possible to identify this case leader, it would be interesting to establish if s/he experienced any of the barriers described by other case leaders and if so, how s/he overcame these. Additionally, this person could potentially provide useful support to other case leaders who wish to develop their MI skills. Furthermore, should there be a commitment within CYF at an organisational level to support the implementation of MI within the residences, it may be useful to identify and support case leaders who demonstrate competency to further develop their skills (e.g.,

through MINT), so that they could become champions of MI within the organisation, providing training and supervision for other staff.

4.1.5 Practicalities and Realities: Context and Process

Irrespective of case leader willingness to use MI and MI skilfulness, there were several factors within the CYF environment that were not considered conducive for practicing MI. A lack of private interview space was reported as a significant problem in all four locations, with a number of case leaders reporting that MI conversations occurred in less than ideal circumstances (e.g., noisy corridors). Additionally, time constraints were identified as one of the major issues preventing case leaders from engaging in MI. High caseloads and administrative requirements were cited as significant factors that restricted case leaders' availability, and therefore time to engage in MI conversations with the youth. In addition, case leaders reported that the need to prioritise higher risk youth prevented a number of lower risk youth from receiving any individual intervention at all. Thus, the frequency with which case leaders were able to attempt MI sessions was variable. It is possible that a lack of suitable facilities and time constraints may have also contributed to the low number of case leaders who submitted audio recordings of their MI sessions. These issues are not uncommon within busy government organisations. However, for MI to be implemented effectively, as with any other new intervention, practitioners need to be supported to carry out the intervention, with provisions made for the time and resources required to complete them (Fixsen et al., 2009; Hohman et al., 2012b).

The high administrative workload and time constraints experienced by case leaders and the impact this had on their ability to utilise MI, may also be more generally impacting on the youth. This is evidenced in a study by Henriksen, Degner and Oscarsson (2008) who examined the way in which youth perceived their counsellors in residential settings. Youth

involuntary placed in Swedish youth protection centres were asked to comment on their relationship with their counsellor one year into treatment. Results identified a common perception that counsellors spent too much time on institutional administrative tasks and not enough time on activities with the youth during working hours. The youth in their study reported that this made them feel disconnected from their counsellors and consequently impacted on their ability to feel comfortable opening up during intervention sessions (Henriksen et al., 2008).

While the youth in Henriksen et al. (2008)'s study were in residence for at least one year, an even bigger challenge is faced by CYF residential staff and the youth, as some youth only enter the residences for as little as one to two weeks. This was an issue presented by CYF case leaders, who strongly believed that they needed more time with the youth in order to build a therapeutic relationship and make any real progress. This may, in part, be a reflection of the case leaders' current MI skilfulness, given that the competent use of MI can involve rapid engagement and does not necessarily require the therapeutic relationship to be established prior to the session (Anstiss et al., 2011; Strait et al., 2012b; Wahab, 2005). This idea is supported by research which has found that MI can have positive effects following just one session (Anstiss et al., 2011; Dunn et al., 2004). However, it should also be acknowledged that 'engagement' is an important therapeutic factor and there are additional challenges for CYF case leaders; given that youth in residential care settings have often experienced significant inconsistency and insecurity in their lives, which may make it difficult to establish a therapeutic alliance quickly (Byers & Lutz, 2015). It is therefore possible that more than one MI session would be required for some youth in residence, in allowing additional time for the engagement process to occur.

Another barrier to the implementation of MI presented by case leaders was the idea of a 'competing discourse' within CYF. While case leaders are trained in a number of

supportive therapeutic techniques like MI, they still reported experiencing significant pressure to come up with solutions in a 'timely manner'. Consequently, many case leaders did not feel that MI was the best approach for meeting this demand. This suggests that case leaders might have a misconception about MI and the length of time required to complete the intervention. It also suggests that case leaders experience conflicting expectations regarding their role with the youth. If case leaders are in fact expected by CYF to determine solutions rather than work with the youth in a collaborative way to motivate and assist them to develop their own goals for change, then this is a significant conflict with MI. It also raises questions regarding why CYF as an organisation would invest in MI if this were the case. Whether these expectations are real or perceived requires further evaluation. Regardless, if practitioners do not believe the culture of their organisation is open to supporting MI, gains in MI skill are unlikely to be obtained (Hohman et al., 2012b).

A final issue reported by case leaders was the conflicting messages youth receive from different types of staff members in residence. While case leaders will typically take a therapeutic approach, their perception was that floor staff members (youth support workers) were trained to employ control approaches (e.g., impose time out, contain disruptive behaviours). Floor staff are involved in the everyday care of the youth and assist with their routines, safety and security, the modelling of pro-social behaviours and implementing the behaviour management system (Child, Youth and Family, 2014). A lack of a consistent approach can be problematic as the youth may feel confused and frustrated when their behaviours are responded to differently in different environments (Byers & Lutz, 2015). Consistency is therefore essential in every therapeutic context and should be of particular importance with those individuals who have experienced significant instability in their lifetimes (Byers & Lutz, 2015). This also raises the question as to whether there is ambiguity and a lack of clarity in the residences' institutional mission.

It is important to acknowledge here that a small number of floor staff were provided with the opportunity to attend the introductory MI workshop. This suggests that there was some awareness by management that MI could be a useful skill for all staff working with the youth. In taking this further, turning residences into therapeutic communities, where MI is a core skill used by all staff, is one possible way in which any inconsistencies among staff members may be minimised and this is discussed in section 4.4 below.

4.1.6 Future Use of Motivational Interviewing within Child, Youth and Family

A final theme captures case leaders' opinions regarding the future use of MI within CYF. Whilst they could see the potential benefits of MI, case leaders were generally tentative in their responses, with many questioning the organisation's commitment and readiness to facilitate and maintain the intervention. A lack of confidence in the system's ability to support therapeutic 'care' approaches was once again presented as a barrier, and this opinion, whether real or perceived, is likely to interfere with continued MI skill development (Hohman et al., 2012b). Regarding their own practice, most case leaders reported that they would continue to use the micro-counselling skills (e.g. OARS) they learnt in MI training, though they were unlikely to conduct full MI sessions. Most case leaders reported this to be due to the time and facility constraints of the residences. In addition, most C&P case leaders reported that they were unlikely to continue using MI as they considered it developmentally inappropriate for the younger or low cognitive functioning youth in C&P residences.

If MI was to be continued within CYF, case leaders reported that regular six-month training sessions would be helpful. However, they were not interested in submitting more MI audios irrespective of the feedback and coaching they would receive. Case leaders also reported that a culture shift was necessary at an organisational level to ensure that their practice was prioritised, with sufficient resources and time allocated to implementing MI.

These opinions suggest that the core implementation components required for achieving high fidelity practitioner behaviour were not being managed successfully within CYF and would require an organisational shift (Fixsen et al., 2009). Similar findings were observed in a study by Wood et al. (2011) who qualitatively assessed the adoption of MI within substance abuse treatment settings. Twenty practitioners at various stages of MI training were asked to report on their experiences and attitudes toward MI, as well as the factors influencing implementation within their agencies. A number of barriers to implementation were reported, including time constraints, inadequate staffing, a preference for the individual's current therapeutic approach, and a view that agencies were inflexible to supporting new interventions. Facilitators to implementing MI were also presented and included agency support, openness to change, permission from the agency to practice MI and further training opportunities. The authors considered their findings to represent common themes in the EBP and implementation science literature, particularly in regards to practitioner willingness, organisational readiness and the need for ongoing training and supervision in order for interventions to be implemented successfully (Wood et al., 2011). Given these findings have also been highlighted within the current study, practical implications for the continued use of MI within CYF are discussed further in section 4.2 below.

4.2 Practical Implications

The findings from the current study have important implications for the future implementation of MI and other EBPs within CYF residences and wider government services in NZ or even throughout the world. In particular, this research draws attention to the challenges of introducing new interventions into established services, both in regard to staff willingness and organisational readiness to cope with training and implementation requirements. As described earlier, Fixsen et al. (2009) proposed a set of core implementation components for achieving high fidelity practitioner behaviour. These included: appropriate

staff selection, ongoing training, coaching and consultation, evaluation, and administrative and system wide support (Fixsen et al., 2009). As is evident in the results of the current study, a number of these components were not implemented within CYF residences with the introduction of MI.

The Multifactorial Model of Treatment Readiness (MORM) proposed by Ward, Day, Howells and Birgden (2004) suggests that low treatment readiness can reside in both the client population and within the setting in which treatment is delivered. Regardless of where this lies, it is the responsibility of practitioners and the wider organisation to build readiness by ensuring that interventions are effectively adopted and delivered in a format that caters to the needs of the client population (Ward et al., 2004). An organisational culture that is perceived as supportive and open to change is likely to encourage practitioners to use MI and will see improvements in MI skill development over time, which ultimately will benefit the clients they work with (Hohman et al., 2012b). However, when practitioners are mandated to attend MI training without consultation and prior knowledge of the intervention, they may view it as time consuming and unhelpful (Hohman et al., 2012b). In addition, if staff members do not view the organisation as being ready to commit to the intervention through the provision of additional resources and practice opportunities, they will consequently be less invested in using MI (Taxman, Henderson, Young & Farrell, 2014). Conversely, integrating MI into social services requires that staff members who receive training are open to learning and practicing the intervention (Hohman et al., 2012b). Following through with completing assessment measures (e.g. MI audios) is an essential part of this and provides valuable information for both individual practitioners and the organisation regarding MI's progress within the service (Hohman et al., 2012b; Taxman et al., 2014).

It is important to emphasise that the successful implementation of EBPs, such as MI, within established government services is no easy feat. While these services will often

provide staff with initial training, commitment from both parties can falter over time, particularly when services are under significant pressure to perform and achieve results quickly. In these situations, it is often easy for practitioners and organisations to revert to their former comfortable ways (Fixsen et al., 2009; Wood et al., 2011). In ensuring that quality EBP interventions, such as MI, continue to be delivered, it is therefore crucial that services, such as CYF, work collaboratively with their staff to provide the time and resources needed for ongoing skill development, training, coaching and feedback to improve practice and to maintain the fidelity of the treatment (Fixsen et al., 2009).

4.3 Methodological Considerations

There were a number of methodological inadequacies in the current study and the results should be considered in light of these. First, the online survey employed in this research was constrained in that questions did not allow for a great deal of flexibility in participant responses. In this regard, while it was intended that the research would employ both inductive and deductive approaches to TA data coding, the former was restricted by the specificity of the questions asked. Thus, a deductive top-down approach to data coding was predominantly utilised, whereby the emergent themes were largely resultant from the researcher's ideas and were only later refined by those of the participants. As the results of the online survey were then used to inform focus group questions, the resulting themes from this second qualitative phase of the research were also constrained. In hindsight, the online survey could have been broader, with fewer questions asked of participants. This would have allowed for inductive codes to be generated, with themes derived primarily from the content of participant responses.

In addition, the quantitative measure utilised as part of the mixed-methods exploratory sequential approach had some limitations as well. As the data recorded from the

MI audios was anonymous, there was no way of telling whether these were submitted by the same case leaders who completed the online survey and/ or the subsequent focus groups. As case leaders were able to submit up to four audios for evaluation, it is also possible that as few as three case leaders were responsible for the quantitative data reported on. Furthermore, given pre-testing measures of practitioner skill in MI were not assessed, there is no way to determine whether practitioners demonstrated an increase in MI skill level over the six month period following the MI training. These limitations mean that the MITI 3.1.1 results can only be regarded as a loose indicator of practitioner skill level and should consequently be interpreted with caution.

Another significant limitation in this study was sample size. Despite relatively frequent reminders, the online survey had response rates lower than what would be expected based on previous research findings (Cook et al., 2000). Similarly, small participant numbers were also obtained for the focus groups and MITI 3.1.1 audio submissions. There are a number of possible reasons as to why this might have occurred. These include; time and resource constraints, forgetfulness, staff turnover, and/ or a dislike for the MI approach, or lack of engagement with the research. With specific regard to the focus groups, it should be acknowledged that it was challenging to find times in which all case leaders within a residence could meet. This was particularly difficult for the Auckland focus group which required case leaders from both C&P and YJ residences to come together. As a result of this, data collection took a number of months to complete and consequently, initial plans to conduct focus groups in other centres throughout the country were not able to be followed through.

A final limitation regards the original intention of this research. In the early stages of this project, research access was granted by the Ministry of Social Development to conduct an evaluation with Te Puna Wai ō Tuhinapo youth regarding their experiences of MI and

their working relationship with case leaders during MI. While case leaders initially expressed a willingness to engage in the research and with research requirements, they later decided to withdraw from this component of the study due to time constraints. If it were completed, it would have involved conducting MI sessions with the youth, followed by the completion of a brief rating scale to gauge their experiences of MI and its utility. As such, these results are limited to the case leaders' experiences of MI and do not contain the experiences of the youth, which would have provided a more thorough picture of the effectiveness of MI within this setting.

Despite these limitations, it is important to acknowledge the study's strengths. Irrespective of the small sample sizes in this research, the findings still provide important information regarding the perceived advantages and disadvantages of MI within CYF residences, as well as the difficulties experienced in its implementation. It identifies some of the current challenges with regard to organisational and practitioner readiness to implement new EBPs within CYF and also outlines potential strategies to improve MI's use within these services. Thus, these findings provide useful insights which can inform CYF organisational practice, and more generally contribute to the MI research literature and future research in this growing field.

4.4 Future Research

Further research is required to determine the overall efficacy and utility of MI within CYF residences. It would be important to include measures of youth experiences and/ or satisfaction with the MI approach. One possible measure for consideration is the 'MI Measure of Staff Interaction'. Research conducted by Hohman and Matulich (2010) validated the 'MI Measure of Staff Interaction' for the purpose of gathering client feedback regarding staff member adherence to the MI spirit. A total of 227 clients across two facilities completed

the measure, along with an additional measure of working alliance. Ten items were identified as providing a measure of MI spirit and were included in the final scale, with correlational analysis then conducted to provide support for concurrent validity. The authors concluded the 'MI Measure of Staff Interaction' to be useful as an additional form of MI programme evaluation, particularly given that it allows for client feedback in evaluating interactions with staff, as well as the agency atmosphere (Hohman & Matulich, 2010). The use of such a measure within the current study or future research could provide another measure of fidelity for MI interventions, as well as lead to further advances in the MI research field.

In addition to introducing measures of youth satisfaction within CYF, it would be useful to conduct individual interviews and/ or focus groups with CYF youth regarding their experiences of MI and the influence it has on their behaviour while in residence. Follow up research could also be used to determine the youths' success in implementing behaviour changes once they have returned to the community. Additionally, future research would need to reassess practitioner skill in MI. Possible ways to increase case leader engagement in submitting audios could include: allocating time for practice, and encouragement and ongoing support from management, as well as the inclusion of MI skill development and supports within staff performance plans and appraisals.

As suggested by CYF case leaders, another idea for consideration is to turn CYF residences into therapeutic communities. A therapeutic community is a treatment modality which uses a community of peers to teach and model life skills such as open communication, role modelling, peer feedback and personal responsibility; with the intention of creating healthy and trusting relationships which clients' can later replicate in the real world (Klag, O'Callaghan, Creed & Zimmer-Gembeck, 2009; Lemieux, Barthelemy, Schroeder & Thomas, 2012). The therapeutic community consists of both staff members and clients, and resembles a mini society (Klag et al., 2009; Lemieux et al., 2012). Recent research has

identified the effectiveness of MI when integrated into this type of residential setting. For instance, Klag et al. (2009) looked at the effectiveness of MI for individuals with chronic substance use and comorbid mental health difficulties within a therapeutic community context. All participants were over 18 years of age and had voluntarily entered the residential facility for treatment. Thirty-two participants in the research group received MI integrated drug and alcohol counselling, while 29 participants in the comparison condition received drug and alcohol counselling alone. All staff members assigned to the research group had attended a two day MI training workshop followed by ongoing supervision. Key findings from the study identified that the MI integrated group had higher client retention, higher motivation to participate in treatment and more positive treatment outcomes compared to the comparison group participants overall. Thus, the authors concluded that the MI-integrated approach appeared highly effective in producing positive effects within a therapeutic community context, as compared to standard drug and alcohol counselling methods (Klag et al., 2009).

While turning CYF residences into therapeutic communities would be no small undertaking, a therapeutic environment may be highly beneficial for CYF youth, particularly as it would enable them the opportunity to demonstrate behaviour change across different contexts within the CYF environment. To achieve this, case leaders recommended that floor staff might also benefit from training in MI, particularly given these staff members have the most frequent contact with the youth. This would allow floor staff and case leaders to work collaboratively with one another to provide CYF youth with a consistent treatment approach and environment.

Finally, given the small proportion of MI research studies conducted with youth populations, further research regarding the efficacy of MI with this group is recommended. In light of the current findings, it would also be particularly useful to explore the use of MI with

those under 12 years of age, and those who present with low cognitive functioning/ intellectual impairment.

4.5 Conclusions and Recommendations

The current study aimed to investigate the experiences, appraisal and post-training skill level of CYF case leaders as they implemented MI within CYF youth residences. The results of this research highlight a number of advantages and disadvantages regarding MI within this context, as well as the challenges associated with MI in a residential context. Practitioner willingness, competency and organisational readiness were implicated as major factors impeding the implementation process and this is likely to have contributed to the infrequent use of MI in residences post-training. A number of suggestions were presented by case leaders regarding how MI, and other EBPs, might be better facilitated within their service that if followed, could lead to large improvements in the organisation and the benefits CYF youth could gain. Methodological limitations, such as small sample sizes, limit the conclusions that can be drawn and the generalisability of findings of the current research. This research provides important information regarding the use of MI with youth in a residential service and in particular, the barriers and facilitators to successful implementation.

In light of the current findings, and given MI has shown to be an effective, evidenced-based approach that is widely applicable across a range of problem areas and populations (Anstiss et al., 2011; Clair et al., 2013; Enea & Dafinoiu, 2009; Jensen et al., 2011; Lundahl et al., 2010; McMurran, 2009), the following recommendations are made to facilitate the successful implementation and practice of MI in CYF residential services. At an organisational level, it is recommended that CYF work with case leaders to support the implementation of MI. In doing so, case leaders need to be allocated the necessary time and resources in which to practice MI. It is also important that the case leader role is clarified and

in particular, when a care (collaborative, facilitative) or control (directive, authoritative) approach is expected of case leaders. If the latter is required, then MI is not recommended for future use within CYF. However, if the former is true, then this needs to be exemplified within the case leader role, with staff selected for these qualities and provided with the support and training required to act consistently within this approach.

Regarding case leader responsibilities, it is recommended that practitioner willingness and readiness be assessed prior to training in MI, with any concerns case leaders may have subsequently addressed by the organisation. It is also recommended that case leaders follow through with completing fidelity measures, including the submission of audio recordings so that they can receive ongoing feedback and coaching to build/maintain their MI skills, and as a means of the organisation monitoring MI implementation. Additionally, case leaders should continue to seek and receive training and supervision for ongoing skill development in MI. Finally, case leaders might wish to further enhance their practice of MI by: considering the use of MI within client intake sessions, considering the use of MI when developing care plans in collaboration with the youth, introducing an MI style in supervision interactions, and introducing a group supervision format with other case leaders to discuss and provide feedback on MI interactions.

Regarding CYF youth, it became clear during the focus groups that C&P and YJ youth were two very different populations. It is recommended that consideration be given as to whether MI is suited to each context, and that this is accounted for in future training or research. It is also recommended that CYF consider the possibility of operating residences as therapeutic communities, with MI as a core skill for all staff. This would require all staff members to be trained in MI, so that the youth may be treated in a similar manner across all contexts of the residential environment. Finally, it is recommended that CYF review the follow-up youth receive once they leave the residences, as to whether this needs to be

strengthened to support the youth to maintain gains once they have returned to the community.

Some final words regarding the value of MI within CYF residences: “There is absolutely a place for it, everyday, in every setting, constantly on the floor. Motivational Interviewing is a great tool if we know how to do it properly and it works really well, particularly with these kids who never get their voices heard” (YJ). However, “as a formal clinical intervention at this stage… I don’t think residences are ready for it. I think the mission then going forward; it’s about a culture shift” (YJ).

He aha te mea nui o te ao?

He tangata, he tangata, he tangata

What is the most important thing in the world?

It is the people, it is the people, it is the people

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APPENDIX A: Ethical and Research Approval

HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2013/141

13 November 2013

Victoria Wilkinson
Department of Psychology
UNIVERSITY OF CANTERBURY

Dear Tori

The Human Ethics Committee advises that your research proposal "Motivational interviewing with youth offenders: the therapeutic experience and the process of change" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 11 November 2013.

Best wishes for your project.

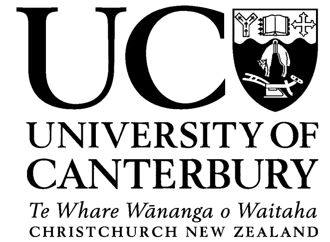
Yours sincerely

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee

University of Canterbury Private Bag 4800, Christchurch 8140, New Zealand. www.canterbury.ac.nz

APPENDIX B: Email Advertisement – Online Survey

Department of Psychology
Telephone: (+64 3) 364 2987 (Ext. 7885)
Email: victoria.wilkinson@pg.canterbury.ac.nz
12th May 2014



Email Advertisement – Online Survey

Hi _____,

My name is Victoria Wilkinson and I am an MSc Thesis student at the University of Canterbury undertaking research on Motivational Interviewing within Child, Youth and Family Services. This research has just recently been approved by the Ministry of Social Development.

The first stage of this research seeks the participation of CYF staff members who attended the advanced one day Motivational Interviewing workshop with Eileen Britt in 2013. Staff are asked to complete a brief online survey investigating the value of MI based on their perspectives and experiences of MI in practice.

The survey can be found at the following link:
http://canterbury.qualtrics.com/SE/?SID=SV_6yVeVfzDa3j6DVr
Please Note: This survey will close at Midnight on Friday March 21st, 2014.

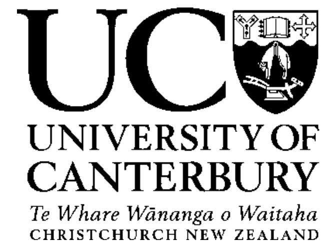
It would be much appreciated if you could forward this email on to those staff members from _____ and _____who attended the advanced one day Motivational Interviewing workshop in _____ last year. If possible, it would also be appreciated if I could be Cc'd into this email as both a means of confirmation and also for research purposes, to establish the number of case leaders in the _____ regions likely to be involved.

I am aware that CYF staff members are very busy people, so would be grateful for any assistance you can provide in helping to distribute this survey. Please feel free to contact me should you have any questions or require any further information.

Kind Regards,

Victoria Wilkinson

APPENDIX C: Online Survey



Department of Psychology
Telephone: (+64 3) 364 2987 (Ext. 3658)
Email: victoria.wilkinson@pg.canterbury.ac.nz
30th January 2014

Online Survey

(1) What is your gender?
   a. Male
   b. Female
   c. Other (please specify):

(2) What is your age?

(3) What is your ethnicity (select all applicable)

   a. NZ European/ Pākehā
   b. NZ Māori
   c. Pacific Islander
   d. Asian
   e. Other (please specify):

(4) In which region did you attend the advanced one day MI workshop last year?

The following questions relate to your experiences of Motivational Interviewing (MI) in practice. Please respond to each question as best you can.

(5) How long have you been practicing Motivational Interviewing (MI)?

(6) How often do you conduct MI sessions?
Please Indicate:

Daily | Weekly | Monthly | Infrequently

(7) What do you like about MI?

(8) What do you dislike about MI?

(9) What benefits are there to using MI in your work setting?

(10) What challenges (if any) have emerged when using MI within your work setting?

(11) If there have been challenges, how have you overcome them?

(12) How has MI impacted on your working relationship with clients?

(13) Overall, how would you rate the experience of MI for **your clients**?

a. Positive Experience
b. Neutral
c. Negative experience

Please explain:

(14) Overall, how would you rate **your own** experiences of MI?

a. Positive Experience
b. Neutral
c. Negative experience

Please explain:

Please think about your most recent client.

(15) Prior to commencing MI, how much did you believe your client would change their behaviour?

Please indicate:

Highly Likely	Likely	Somewhat	Unlikely	Very Unlikely

(16) Upon completion of MI, how much did you believe your client would change their behaviour?

Please indicate:

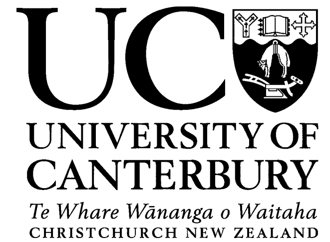
Highly Likely	Likely	Somewhat	Unlikely	Very Unlikely

(17) Is MI something you would like to continue with in future? Why/ Why not?

(18) Additional Comments:

APPENDIX D: Information Sheet for CYF Case Leaders

Department of Psychology
Telephone: (+64 3) 364 2987 (Ext. 3658)
Email: victoria.wilkinson@pg.canterbury.ac.nz
26th August 2013



Information Sheet for CYF Case Leaders

My name is Victoria Wilkinson and I am an MSc thesis student at the University of Canterbury, beginning my research looking at Motivational Interviewing (MI) within Child, Youth and Family residences. The purpose of this research is to investigate the value of MI (a brief form of psychotherapy) in relation to the therapeutic experiences had by CYF case leaders and their skill level in practice. It is intended that the resulting information may be used to inform the future use of MI in CYF residences.

Your involvement in this project will be completing an online survey relating to your experiences of MI. This survey contains 18 open-ended and multi-choice questions and should take approximately 10-20 minutes to complete. Steps will be undertaken to ensure your anonymity and your responses will not be directly identifiable to others at any point in this research.

As a follow up to this investigation, you will be invited to participate in a focus group with other CYF case leaders at a later date. These groups will take place in Christchurch and Auckland. Your participation in this group is entirely voluntary. The purpose of this focus group is to provide an opportunity for CYF staff to elaborate on survey responses, so that wider group discussion regarding perceptions and experiences of MI may be had. The focus group will be recorded by audiotape to assist with research collection and this tape will be kept in a locked and secure facility. You may review a transcription of this session by contacting the researcher, Victoria Wilkinson at victoria.wilkinson@pg.canterbury.ac.nz .

It is not expected that there are any risks involved in the tasks in this research; both the online survey and focus groups are designed to be brief and non-distressing. However, your participation is voluntary and if at any stage you do feel distress then you may cease participation immediately. You can take as much time as you need to decide whether to take part. If you decide to participate you have the right to withdraw from the study at any time without penalty. If you withdraw then any information relating to you will be removed and destroyed.

You may receive a copy of the project results by contacting the researcher at the conclusion of the project.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation and your identity will not be made public. To ensure anonymity and confidentiality, data will be gathered using the procedure stated above and will only be accessible by the researcher (Victoria Wilkinson) and research supervisors (Eileen Britt and Andrew Frost). All data will be securely stored in a locked filing cabinet in the University of Canterbury's Psychology building, with only the above named being able to access this. All information collected will be securely stored for five years, and will then be destroyed. A thesis is a public document and will be available through the UC library; however, no material that could potentially identify you will be used in any reports on this study.

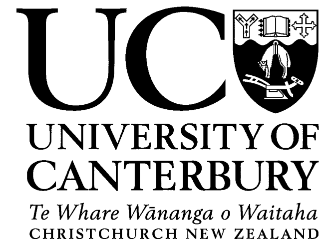
The project is being carried out as a requirement of the Master of Science in Psychology by Victoria Wilkinson (principal researcher) under the supervision of Eileen Britt, who can be contacted at eileen.britt@canterbury.ac.nz and Andrew Frost, who can be contacted at andrew.frost@canterbury.ac.nz. They will be pleased to discuss any concerns you may have about participation in the project.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should direct any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

Victoria Wilkinson

APPENDIX E: Informed Consent – Online Survey

Department of Psychology
Telephone: (+64 3) 364 2987 (Ext. 7885)
Email: victoria.wilkinson@pg.canterbury.ac.nz
12th May 2014



Informed Consent

I have read and understood the information sheet provided to me and I understand what is required of me if I agree to take part in this research. I have also been given a full explanation of this project and have had the opportunity to ask questions.

I understand that taking part in this study is completely voluntary and that I may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided.

I understand that any information or opinions I provide will be kept confidential to the researcher (Victoria Wilkinson) and research supervisors (Eileen Britt; Andrew Frost) and that any published or reported results will not identify the participants.

I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years.

I understand that I am able to receive a report on the findings of the study by contacting the researcher at the conclusion of the project. I understand that a thesis is a public document and will be available through the UC library.

I understand that I can contact the researcher (Victoria Wilkinson) or supervisor (Eileen Britt, eileen.britt@canterbury.ac.nz) for further information. If I have any complaints I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

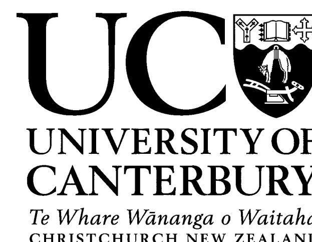
Regards,
Victoria Wilkinson

I have read and understood the above information and am aware that I am under no obligation to accept this invitation. I understand that completion of this survey implies my consent to participate in this research.

- Yes
- No

APPENDIX F: Email Advertisement – Focus Groups

Department of Psychology
Telephone: (+64 3) 364 2987 (Ext. 7885)
Email: victoria.wilkinson@pg.canterbury.ac.nz
1st September 2014



Email Advertisement – Focus Groups

Hi _____,

You may recall being sent a link to an online survey a few months ago regarding Motivational Interviewing research. As a follow up to this survey, I would like to conduct a focus group with ______ case leaders to encourage further discussion regarding their experiences of MI in practice. The group will take approximately one hour and will consist of questions based on key themes derived from the online survey.

If possible, I would like to conduct this group in November, at a time that suits you and your staff. It would be appreciated if you could let me know when a good time might be, as well as how many case leaders are likely to be in attendance.

There is also a consent form which case leaders will need to complete in order to take part, and of course, participation is voluntary.

I look forward to meeting with you and your team. Please let me know if you have any further questions or queries about this process.

Kind Regards,

Victoria Wilkinson

APPENDIX G: Focus Group Questions

Department of Psychology
Telephone: (+64 3) 364 2987 (Ext. 3658)
Email: victoria.wilkinson@pg.canterbury.ac.nz
15th September 2014

Focus Group Questions

In analysing the responses to the online survey, particular themes regarding case leader perceptions and experiences of MI became apparent. I would now like to find out more about these.

Appropriateness of the MI method with CYF clients

1) **One response was that 'MI is potentially inappropriate with younger clients as opposed to older youth'. Tell me more about this.**
   Sub-questions
   - How young is too young?
   - Why is it inappropriate?
   - Are there any circumstances in which it would be appropriate with younger clients?

2) **Conversely, another response was that 'MI is a potentially effective intervention with this group'. Tell me more about this.**
   Sub-questions
   - What specific things are there about MI that makes it appealing for adolescents?
   - How capable are your young people at identifying behaviours to change and outlining the reasons for why?
   - What success stories have you had?

What case leaders like about MI

3) **When asked what case leaders liked about MI, a common response was that 'clients are empowered'. What is your understanding of empowerment?**
   Sub-questions
   - Do you have any examples of how this has happened?
   - In what ways are they empowered?
   - Why is 'empowerment' important for this group?

4) **Another response was that 'MI provides a platform for youth to be supported in their own motivations for change, as opposed to being told what to do by the system'. Please comment.**
   Sub-questions

- Why is feeling supported as opposed to being told what to do important for this population?
- When practising MI, how do you believe your young people see you?
- There may be times when you are required to tell the young person what to do. How do you manage this dual role?

5) **Another common survey response regarded MI's 'efficiency and ease of application'. Tell me more about this.**
   Sub-questions
   - What has been easy about its application?
   - What has been difficult?

6) **A final survey response in this area was that 'MI promotes engagement'. Please comment.**
   Sub-questions
   - In what ways does it promote engagement?
   - Is engagement an issue for some of the young people you work with? Why?

What case leaders dislike about MI

7) **When asked what case leaders didn't like about MI, some case leaders reported a dislike for MI's 'complexity'. Tell me more about this.**
   Sub-questions
   - What aspects of MI did you find complex?
   - Were there any components that were particularly difficult to get your head around?
   - What, if anything, have you done to overcome this?

8) **Case leaders also reported experiencing difficulty 'adjusting to this new method of engagement with the young people'. Help me understand what this has been like for you.**
   Sub-questions
   - In what way is MI different to your usual method(s) of engagement?
   - How have you overcome this challenge?

The key challenges

9) **When asked about the key challenges case leaders had experienced with MI, one difficulty that emerged was that 'some clients are just not ready to change'. Tell me more about this.**
   Sub-questions
   - What is your response to this?
   - Can you give me an example of when this occurred? How did you manage it?

10) **Another difficulty regarded 'case leader competency in MI'.**

   Sub-questions
   - How confident do you feel in your ability to practice MI?
   - What would enhance your feeling of competency?
   - What is your experience of the training received in MI?
   - Would you like more training in MI? What, in particular, would be of benefit?

11) **Another key challenge regards time constraints and a general feeling that there are not many 'opportunities to practice MI with the young person'. Please comment.**

   Sub-questions
   - What constraints are there?
   - Do you have any ideas/ suggestions as to how this could be improved?
   - What resources/ facilities would help you to practice MI? Do you have access to these at present?

12) **Another key challenge regarded the formal vs. informal application of MI, with MI more likely to be integrated into other work as opposed to being used in a formal session. Please explain.**

   Sub-questions
   - How often do you use MI?
   - In what context are you using MI?
   - Is there another way you would like to practice MI if you had the opportunity?

Impact on the working relationship

13) **When asked about MI's impact on the working relationship, most case leaders reported that MI had enhanced their working relationship with clients. Tell me more about this.**

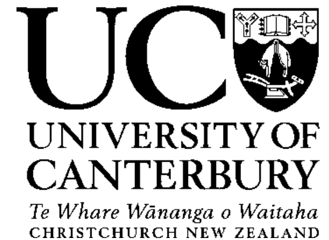
   Sub-questions
   - In what ways has your relationship with the young people changed?
   - How has this been of benefit to the young people?
   - How has this been of benefit to you?

Moving forward: Is MI worthwhile continuing in this service?

14) **When asked whether MI was worthwhile continuing with the young people in CYF services, mixed views were reported. What is your perspective on this and why?**

   Sub-questions
   - What are the benefits?
   - What are the challenges?
   - Do the benefits outweigh the challenges?
   - Is it feasible to use MI in your current work situation? If not, why not?
   - What would help you to overcome these challenges?

APPENDIX H: Consent Form for CYF Case Leaders – Focus Groups



Department of Psychology
Telephone: (+64 3) 364 2987 (Ext. 7885)
Email: victoria.wilkinson@pg.canterbury.ac.nz
12th May 2014

Consent Form for CYF Case Leaders (Focus Group)

I have read and understood the information sheet provided to me and I understand what is required of me if I agree to take part in this research. I have also been given a full explanation of this project and have had the opportunity to ask questions.

I understand that taking part in this study is completely voluntary and that I may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided. I understand that any information or opinions I provide will be kept confidential to the researcher and research supervisors (Eileen Britt; Andrew Frost) and that any published or reported results will not identify the participants.

I understand that it is not the researcher's intention to intervene in people's lives, except in two exceptional circumstances where an individual is deemed to be; an immediate threat to himself; or an immediate threat to the safety of others.

I understand that this session will be recorded by audiotape and that this will be kept in a locked and secure facility. I also understand that I can contact the researcher (Victoria Wilkinson) should I wish to review the transcription of this session. I understand that all other data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years. I understand that I am able to receive a report on the findings of the study by contacting the researcher at the conclusion of the project. I understand that a thesis is a public document and will be available through the UC library.

I understand that I can contact the researcher (Victoria Wilkinson) or supervisor (Eileen Britt, eileen.britt@canterbury.ac.nz) for further information. If I have any complaints I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

By signing below, I agree to participate in this research project.

Name______________________________________

Date_______________________________________

Signature___________________________________

Please return this form to the researcher.

APPENDIX I: Motivational Interviewing Treatment Integrity 3.1.1 (MITI 3.1.1)

Motivational Interviewing Treatment Integrity Code (MITI)
Coding Sheet Revised June, 2007

Interviewer ____________________. **Tape #** _________ **Coder:**____________________. **Date:**__________.

Global Ratings

	Your Rating	*Thres-hold*	*Compe-tency*	*Rationale for Rating*
Evocation	1 2 3 4 5 Low High	Overall Mean 3.5	Overall Mean 4.0	
Collabora-tion	1 2 3 4 5 Low High			
Autonomy/ Support	1 2 3 4 5 Low High	Your overall mean was…		
Direction	1 2 3 4 5 Low High			
Empathy	1 2 3 4 5 Low High			

Behavior Counts

	Definitions/Classes	*Count*		*Your Percents & Ratios*	*Thres-hold*	*Compe-tency*
Giving Information				You…		
MI Adherent	**Asking permission, affirm, emphasize control, support.**			**MIA is what percent of total adherence measures?**		
MI Non-adherent	**Advise, confront, direct.**				90%	100%
Question (subclassify)	**Closed Question** **Open Question**			**Open questions are what percent of total questions?**	50%	70%
Reflect (subclassify)	**Simple** **Complex**			**Complex reflections are what percent of total reflections?**	40%	50%
	TOTAL REFLECTIONS:TOTAL QUESTIONS RATIO:		_:_		1:1	2:1

First sentence: ____.

Last sentence:____.

Comments: