UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Report for Child Youth and Family
Ministry of Social Development

Motivational Interviewing in Child, Youth and Family Residences:

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

Victoria Wilkinson

Dr Eileen Britt

Dr Andrew Frost

Department of Psychology

University of Canterbury

December, 2015

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). The present report details an investigation of Child, Youth and Family (CYF) case leaders' experiences and appraisal of MI, as well as their level of skill in applying MI post-workshop training. In addition, it explores barriers to MI implementation within the context of CYF residential units, which may inform future training and intervention efforts. A mixed-methods exploratory sequential design was employed in this research, with data collected through an online survey, focus groups and audio recordings of participant MI interactions submitted post-training. Both 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 implementation planning, which includes systematic ongoing training, feedback and organisational support, for interventions to be successful.

Ethical Approval

Ethical approval for the research was obtained from the:

- Human Ethics Committee, University of Canterbury
- Research Access Co-ordinator, Ministry of Social Development

Introduction

Motivational Interviewing (MI) is "a collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller & Rollnick, 2012, p.12). It promotes and strengthens internal motivation to change by helping to explore and overcome ambivalence (Miller & Rollnick, 2012). 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; McMurran, 2009). Initially successful in treating alcohol abuse and dependence (Brown & Miller, 1993); 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 (Enea & Dafinoiu, 2009; Stein et al., 2006).

Despite research in support of Evidence Based Practices (EBPs), such as MI, a challenge is posed to organisations wishing to implement EBPs within real-world contexts to ensure that practitioners employed within these services are able to apply the intervention effectively (Fixsen, Blase, Naoom & Wallace, 2009; Hohman, Emlyn-Jones, James & Urquhart, 2012). Implementation research suggests that a strong emphasis should be placed on the training and coaching of staff, organisational culture supportive of the EBP, and in facilitating an environment in which practitioners are supported to develop their practice of the EBP (Fixsen et al., 2009). Consideration of these factors is essential, given that poorly implemented EBPs are likely to be ineffective and may even be harmful to client outcomes (Barwick, Bennett, Johnson, McGowan & Moore, 2012).

In 2013, the NZ Ministry of Social Development (MSD) initiated a training project in MI, with the intention that MI would be implemented in CYF youth residences nationwide.

The present report details an exploration of CYF case leaders' experiences of MI and its implementation within the context of CYF residences (both Care and Protection (C&P) and Youth Justice (YJ)). Secondly, this report details the MI skill level of CYF case leaders post-training as they applied MI within the CYF context.

Method

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, basic counselling skills (open questions, affirmation, reflections, and summaries – abbreviated to the acronym OARS), and the concepts of change talk, sustain talk, resistance 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 MI skills, with a focus on evoking and strengthening change talk. 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.

Design

This research utilised an exploratory sequential mixed-methods design, integrating both qualitative and quantitative components. Qualitative components 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. Quantitative components involved an analysis of MI audio recordings completed by CYF case leaders following MI training. 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.

Measures

Online Survey. An online survey was developed using 'Qualtrics: Online Survey Software'. 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?"

Focus Group Questions. The focus group questions 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?".

Motivational Interviewing Treatment Integrity 3.1.1 (MITI 3.1.1; Moyers, Martin, Manuel, Miller & Ernst, 2010). The MITI 3.1.1 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 proficiency.

Procedure

Online Survey. The online survey was circulated via email 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, with 15 participant responses received. Once participants had completed the survey, their responses were recorded. These were later coded into themes which formed the basis of focus group questions utilised in the second stage of this research.

Focus Groups. A total of three focus groups were conducted between September and December 2014 in the Canterbury and Auckland regions. Of the 32 case leaders approached in these two regions, 11 consented to participate. 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 focus group was audio recorded, with responses later transcribed.

Motivational Interviewing Treatment Integrity 3.1.1. Following the advanced one-day MI training workshop, the 46 case leaders in attendance were invited to submit up to four recordings of MI sessions with clients 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. Over the six-month period following the workshop, a total of 12 out of a possible 184 recordings were returned. 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).

Data Analysis

Survey and focus group 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 can also explain the data set without the use of a specific theory (Floersch et al., 2010).

Online Survey. Participant responses were collated, with initial codes generated based on their relevance to the research aims. Inter-rater reliability was calculated by the principal researcher and a postgraduate assistant for all 15 responses using Cohen's Kappa (k; Cohen, 1960), which produces a coefficient between zero and one. Values above 0.70 indicate satisfactory reliability. This analysis identified good inter-rater reliability (k=0.82), indicating general agreement in the categorisation of survey data. The resulting codes were organised into six potential themes, which were then used to form the focus group questions used in the second stage of this research.

Focus Groups. The audio recording from each focus group (N=3) was transcribed orthographically, with the resulting transcripts analysed using the six-phase approach to TA. This involved reading and re-reading the focus group transcripts, making notes on any items of potential interest, working through the data and assigning codes to all potentially relevant data excerpts, sorting codes into potential themes and subthemes, reviewing the potential themes, conducting a through analytic evaluation of each theme to determine the core issues they encompassed, and producing the final report. The principal researcher and the postgraduate assistant calculated inter-rater reliability by categorising the focus group data for all 11 participants, with 100 responses coded into the 23 established codes to ensure agreement. This analysis identified good inter-rater reliability (k=0.87), indicating general agreement in the categorisation of the focus group data. In total, five key themes were identified and are presented in Figure 1.

MITI 3.1.1 Descriptive statistics (means, standard deviations and ranges) were derived for both Global Therapist Ratings and Behaviour Counts. Comments made by the coder during the coding process were analysed using TA to provide supporting information.

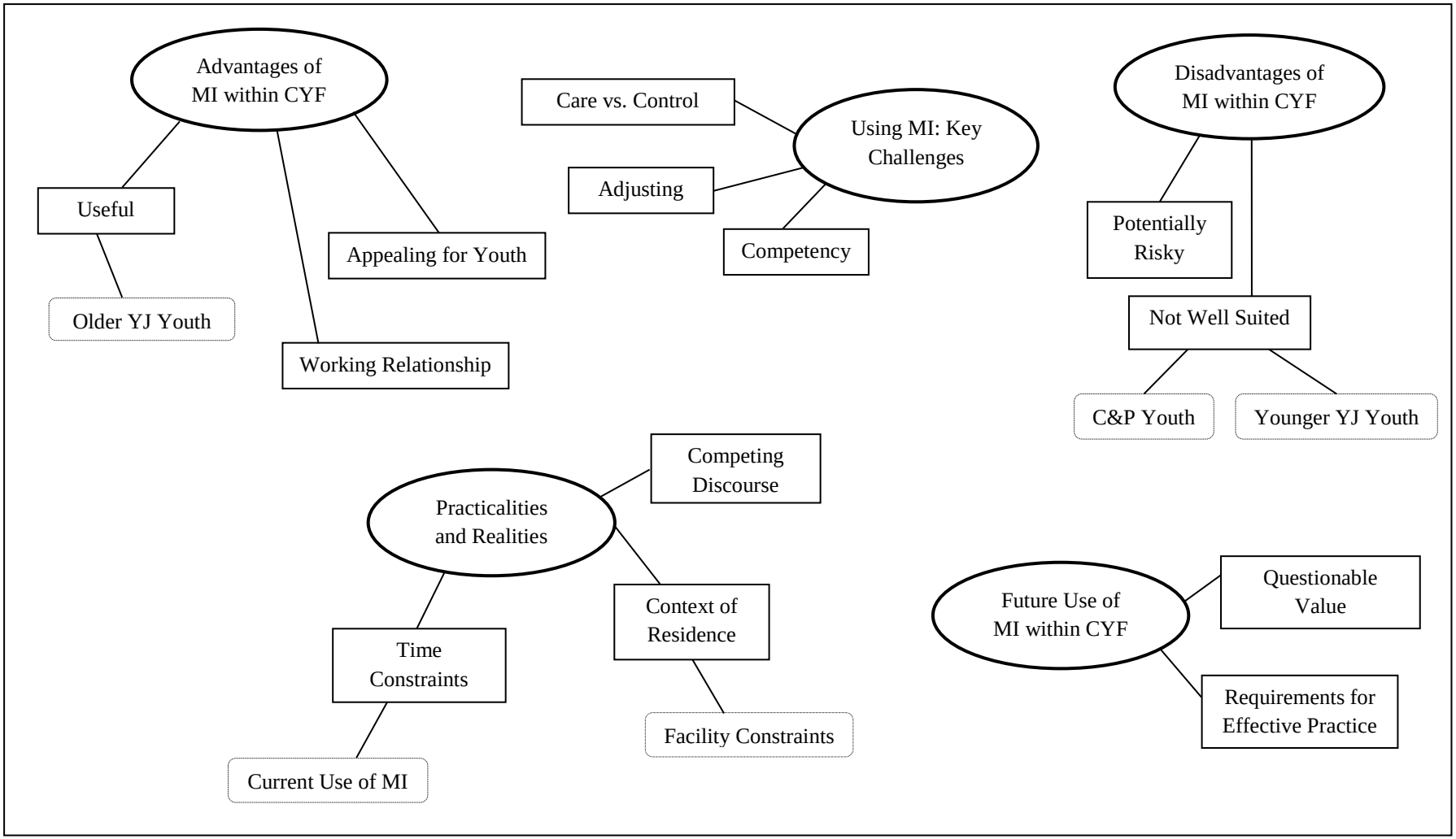

Figure 1. Final thematic map displaying five main themes.

Results

Online Survey

Six potential themes were derived from the online survey. These included; the appropriateness of MI for CYF clients, advantages of MI, disadvantages of MI, the key challenges associated with implementing MI, the impact of MI on the working relationship and opinions regarding the future use of MI within CYF services. 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.

Focus Groups

Advantages of MI within CYF. Most participants reported MI and particularly, the basic counselling skills of OARS learnt as part of the MI training to be a helpful addition to their practice with youth. Reflections and open-ended questioning were mentioned in all three focus groups as the most frequently drawn upon skills learnt through the 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.

"We can be real with them, be honest, reflect back – yeah it definitely helps with the relationship" (YJ)

Disadvantages of MI within CYF. This theme encompasses the difficulties of implementing MI, both within the CYF environment and with the CYF client population. Across all three groups, case leaders struggled to use MI with younger youth (under 16 years) who

"…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)

reportedly had difficulty understanding the process. There were also a number of concerns regarding the lack of support for youth from CYF once they exited residence.

Using MI: Key Challenges. This theme regards the difficulties experienced with adopting MI in daily practice. Motivational Interviewing requires adopting a facilitative, as opposed to directive, interaction style with the youth, which case leaders 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.

"[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)

Practicalities and Realities. This theme encompasses the restrictions of residences, which created barriers to the implementation of MI. Case leaders reported feeling overwhelmed by their caseloads, which consequently impacted on the time they had available to learn and practice MI. 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 also reported that they did not have enough time in their schedules to complete MI

"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)

on top of required tasks. Again, while most case leaders could see the value of MI, they did not believe it could be truly supported by the CYF residential system in its current format.

Future Use of MI within CYF. Mixed views were expressed by both YJ and C&P case leaders regarding the continued use of MI within CYF residences. It was generally agreed that the systems and structure of residences would need to change first, before MI could be implemented successfully. A number of ideas were presented as to what would be required, including changes to the residential context, such as a quiet and private space and the time to conduct MI sessions.

"…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)

Summary of Findings. 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, case leaders considered MI 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 basic counselling skills (i.e., OARS) learnt in the MI training within their work, with positive effect. 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 in MI to increase MI skilfulness were recommended.

MITI 3.1.1

Clinician Spirit. Global Therapist Rating (GTR) scores (M=3.11, SD=0.30) were less than beginning proficiency (GTR=3.5). None of the case leaders reached threshold for

beginning proficiency, with the exception of one, who met competency (GTR=4). This indicated that case leaders had difficulty adopting the Spirit of MI.

Behaviour Counts. The mean R:Q ratio (*M*=0.60, *SD*=0.32) was less than the threshold for beginning proficiency (R:Q=1:1). This indicated that case leaders tended to ask more questions than they made reflections. The %OQ questions (*M*=39.92, *SD*=16.60) did not meet threshold for beginning proficiency (%OQ=50%), suggesting that most case leaders asked more closed questions than open ones. Thus, it appears that case leaders demonstrated an overuse of questions, and questions which were likely to elicit a simple yes/no or shorter fact response, as opposed to questions which allowed for more elaborative answers. On the other hand, the mean score for the %CR (*M*=40.75, *SD*=15.12), met criteria for beginning proficiency for the use of complex reflections (%CR=40%). While one third (n=4) of the audios met competency for the %CR (i.e., %CR=50%), more than half did not meet beginning proficiency. This suggests an over-reliance on simple reflections on some audios in which the case leaders merely repeated what the youth had said. In contrast, on audios which met criteria for competency the case leaders were able to express, through a reflective statement, deeper meaning and understanding of what the youth had said. Finally, the mean score for %MIA (*M*=97.92, *SD*=3.99) was above beginning proficiency (%MIA=90%). Furthermore, the majority of audios met threshold for competency (%MIA=100%) suggesting that the case leaders in these sessions were able to resist from engaging in MI-non adherent behaviour (such as, confronting, directing and advising) in these sessions.

In summary, the MITI 3.1.1 ratings of the audios suggest that in these sessions, the case leaders 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.

Discussion

The results of this research highlight a number of advantages and disadvantages regarding the implementation of MI within the CYF 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 (e.g., dedicated case work time, additional training and support).

In light of these findings, the following recommendations are made to facilitate the successful implementation 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, as this is in conflict with the practice of MI. 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 to learn and implement MI 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, based on the findings of the MITI 3.1.1, case leaders should continue to seek and receive training and supervision for ongoing skill development in MI, in order to promote MI skilfulness to a level that is likely to produce positive outcomes for youth they work with. 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. 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.

*"**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).***

References

Barwick, M.A., Bennett, L.M., Johnson, S.N., McGowan, J., & Moore, J.E. (2012). Training health and mental health professionals in motivational interviewing: A systematic review. *Children and Youth Services Review, 34,* 1786-1795. doi: 10.1016/j.childyouth.2012.05.012

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper (Ed.), *APA handbook of research methods in psychology: Vol. 2. Research designs* (p. 57-71). United States of America: American Psychological Association. doi: 10.1037/13620-004

Brown, J.M., & Miller, W.R. (1993). Impact of motivational interviewing on participation and outcome in residential alcoholism treatment. *Psychology of Addictive Behaviours, 7*(4), 211-218. doi: 10.1037/0893-164X.7.4.211

Child, Youth and Family. (2014). *Request for information for DHS (Victoria, Australia) project.* Received August 1, 2014, from Residential and High Needs Services: Child, Youth and Family.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and* 87 *Psychological Measurement, 20*(1), 37-46. doi:10.1177/001316446002000104

Enea, V., & Dafinoiu, I. (2009). Motivational/ solution-focused intervention for reducing school truancy among adolescents. *Journal of Cognitive and Behavioural Psychotherapies, 9*(2), 185-198.

Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531-540. doi: 10.1177/1049731509335549

Hettema, J., Steele, J., & Miller, W.R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1,* 91-111. doi: 10.1146/annurev.clinpsy.1.102803.143833

Hohman, M., Emlyn-Jones, R., James, B., & Urquhart, C. (2012b). Integrating motivational interviewing into social work practice. In Hohman, M. (Ed.), *Motivational interviewing in social work practice* (p. 127-147). United States of America: The Guilford Press.

McMurran, M. (2009). Motivational interviewing with offenders: A systematic review. *Legal and Criminological Psychology, 14*, 83-100. doi: 10.1348/135532508X278326

Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change (2nd Ed.).* United States of America: The Guilford Press.

Miller, W.R., & Rollnick, S. (2012). *Motivational interviewing: helping people change (3rd Ed.).* United States of America: The Guilford Press.

Miller, W.R., & Rose, G.S. (2009). Toward a theory of motivational interviewing. *American Psychologist, 64*(6), 527-537. doi: 10.1037/a0016830

Moyers, T.B., Martin, T., Manuel, J.K., Miller, W.R., & Ernst, D. (2010). Revised global scales: Motivational Interviewing Treatment Integrity 3.1.1 (MITI 3.1.1). Unpublished Manuscript. Centre on Alcoholism, Substance Abuse and Addictions (CASAA), University of New Mexico.

Stein, L.A.R., Colby, S.M., Barnett, N.P., Monti, P.M., Golembeske, C., Lebeau-Craven, R., & Miranda, R. (2006). Enhancing substance abuse treatment engagement in incarcerated adolescents. *Psychological Services, 3*(1), 25-34. doi: 10.1037/1541-1559.3.1.0