Motivational arm twisting

MANNERS MATTER • PART 4 Contradiction in terms?

Motivational interviewing would seem the ideal way to defuse resentment, deflect the resistance, and improve the engagement of offenders ordered in to treatment. And it can be, if the counter-productive context and distrust of the clients can be overcome.

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by Mike Ashton *of* FINDINGS

Thanks to Maggie Rogan, Sharon Mullins, Thomas McLellan, and Jim McCambridge for their comments. Though they have enriched it, none bear any responsibility for the final text.

IN THE PREVIOUS ISSUE we explored motivational interviewing as a preparation for people voluntarily[i] entering treatment. Its mixed record seemed partly due to whether patients were in need of a motivational boost to begin with. When they were, the approach had something to 'bite on' and generally improved retention and/or substance use outcomes. Given this record, and its origins in overcoming resistance, motivational induction ought to have a special role in boosting the motivation and deflecting the anger and resentment of people coerced into treatment by the criminal justice system or other authorities.[1] Whether starting their treatment the motivational way really does help is the main question addressed in this review.

COMPATIBLE WITH CRIMINAL JUSTICE?

What hampers this endeavour most is a surprising lack of studies. Relevant research has been almost entirely limited to drink-drivers, young offenders, and mothers involved with child protection agencies. There are no controlled studies of the many thousands of adult offenders ordered in to treatment by courts because their revenue-raising offending is thought to have been motivated by addiction.

This may be the first clue to an incompatibility between motivational interviewing and the criminal justice system.[2] 'It's up to you what you do about your substance use' is arguably an inappropriate stance when your role is to control that substance use to prevent crime and/or safeguard children or the public. It may also be one the offender will find hard to credit as genuine, undermining the therapeutic relationship.

At a more practical level, there is a conflict between the requirements of the courts to know that certain things are going to be done to an offender, and motivational interviewing's insistence that it starts from where the client is at and that the client participates in the process, which cannot therefore be predetermined. Some clients may not have a serious substance use problem at all, yet this may be the focus mandated for the intervention.

Criminal justice clients are also especially likely to lack the resources – psychological, intellectual, physical, economic, and social – needed to implement change or even to get to grips with motivational interviewing's discussion-based rationality. These are some of the reasons for creating new approaches which incorporate motivational elements but are tailored for criminal justice populations *Making it more concrete*, p 16.

All these issues emerge in the studies, yet when the clients and the circumstances have been conducive, and therapists have been able to implement key elements of the motivational style, it has fulfilled its promise and made big differences to engagement with treatment.

MM4 DEPRESSED DRINK DRIVERS RESPOND (BUT NOT THE REST)

Of the three relevant studies of drink-drivers, only a study in Mississippi could assess whether motivational interviewing was a useful supplement to normal programmes. It was, but only for drinkers who also suffered from depressed mood. Promising results elsewhere are compromised by the lack of a comparison group

Each major study is numbered. Some included in the extended review behind this article have been omitted. To maintain consistency with that review, the remainder have not been renumbered.

Send comments to Findings

Background text

1 At the time Mississippi's programme for first time drink-driving offenders consisted of four weekly classes of two and a half hours each. During the first offenders completed assessment instruments, the results of which were fed back during the last session in a computer-generated report. In between were class discussions and exercises and other educational activities.

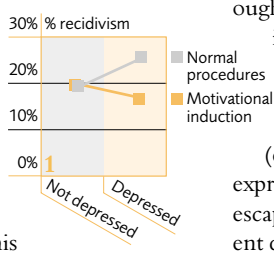
Over 4000 offenders agreed to participate in a study which for a random selection replaced class time with two 20-minute individual counselling sessions from counsellors trained in motivational interviewing.[3] The first was used to advance feedback to the second week. Since this was also the week of the first class, it occupied an induction slot in the overall programme. As well as seeking to boost motivation, where appropriate counsellors offered referral to services. The second individual session took place during time allotted to the last of the four classes. Offenders were also offered a further session four to six months later, which about half attended. Guidance for therapists stipulated neither a set objective nor a set end point to the sessions, asking only that "For those who are ready ... develop plans and alternatives for change".[4]

Over typically the next three years, drink-driving offence records revealed that the modified programme had significantly improved on the classes –

Unwilling offenders seem ideal candidates for motivational interviewing, yet at the same time the criminal justice context imposes constraints likely to undermine implementation and hamper effectiveness. Issues include the degree to which motivational interviewing can (or can credibly) stick to its person-centred, non-directive ethos, and whether it can (even whether it should) persuade offenders to open up, when the system within which it is operating is explicitly oppressive, directive, and intended to limit rather than enhance the 'client's' autonomy. These issues have recently been debated at length by motivational therapists, some uneasy at the contradictions, others convinced that despite the environment, the problems can be worked round and offenders can be helped ◤ reference 2.

Additional issues arise in respect of young offenders. Foremost is an inability to focus on the long-term pros and cons of continued drug use, partly because for many the cons have yet to be too pressing.[8] There is also a question over whether it is realistic to expect adolescents to be given, or to take, full responsibility for their lives and choices. No matter how keen to do so, youngsters lack the resources and the autonomy needed to self-initiate important changes in their lives.

but only among the quarter of offenders who had felt most depressed or sad on entering the programme; without the individual sessions, 26% were reconvicted, with them, 17%, a 35% reduction in recidivism. Among the bulk of offenders not feeling so down, results from the enhanced and standard programmes were virtually identical – about 20% were reconvicted ◤ *chart*.



The effect was to counteract (in fact, to reverse) the poor prognosis of the more depressed offenders. This result did not seem to be due to attending the follow-up sessions, and generally held regardless of which site the classes had been held in, when they had been held, and the participants' race, gender, age, education, offending history, or severity of drink problems. Of all these variables, only depressed mood predicted who would react well to the motivational sessions.

Unfortunately, this clear-cut result does not have an equally clear-cut explanation. One possibility is that offenders whose drinking was tied up with feelings of worthlessness and depression needed individual treatment and referral to services, while those whose drinking was primarily social did just as well with group education classes.

2 A study in New York state recorded good results from an approach which included motivational induction, but without a comparison group who did not have this induction, it is impossible to say whether it was the key factor.[5] The study involved 25 drink/drug offenders referred by the courts for assessment at an outpatient substance abuse clinic. All received motivational-style feedback of the severity of their substance misuse problems and the reasons for their heavy drinking.

Eight of the offenders were diagnosed as having a drink problem; before they could resume driving they were required to attend treatment, which all completed. Though not legally required to do so, 14 of the remaining 17 chose to attend risk-reduction sessions. Only among the three who refused were there any drink/drug driving re-arrests (one only) over on average the next two years. The clinicians saw these results as an encouraging indicator that motivational interviewing could improve engagement with treatment, highlighting the way clients became more willing to disclose and discuss their drink problems.

Promising treatment engagement results were also found after motivational feedback to US repeat drink-driving offenders in prison but, again, lack of a control group precludes conclusions about whether this was the active ingredient.[6]

MM4 SUBSTANCE USE MAY BE WRONG FOCUS FOR TROUBLED YOUNG OFFENDERS

Teenagers typically enter treatment having been directed by families, courts, schools or welfare services[7 8] and retention and outcomes are usually poor.[9] These unwilling, often angry and uncooperative youngsters ought to be fertile ground for motivational interviewing, but there are reasons why this approach might fail to find purchase.[8] Their lack of autonomy and resources limit the degree to which (even if it is boosted) motivation can be expressed in action and outcomes. With escape routes constricted, the non-dependent drug use or under-age drinking which typically brings them into trouble with the law may seem a valued way of coping with severe problems in the rest of their lives.

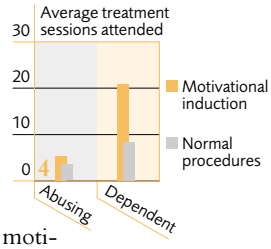
How these forces pan out in practice is largely unknown because there are very few relevant studies. The most positive findings came from a study whose subjects truly did seem to have significant substance use problems, whose therapists seemed able to practice (more or less) true-to-type motivational interviewing, and whose clients felt able to open up in response.

4 This study is available only as a dissertation from one of Bill Miller's students[10] though further information can be gleaned from reviews.[1 11 12 13 14 15] It took place at the adolescent outpatient programme of Dr Miller's New Mexico centre. The centre's clients suffer "overwhelming" problems not just with drugs but with the law, their schools, and their families. Typically they resent being told to 'say no' to drugs and half did not return after initial contact.

To find a way to stem the outflow, 77 youngsters aged 14-20 were recruited into the study. Mainly Hispanic, about a third were primarily diagnosed as dependent on alcohol and 4 in 10 as dependent on the use of several substances. There seems little doubt that most had real and multiple problems including patently excessive substance use. At intake they were randomly assigned to normal procedures (the control group) or additionally to a motivational interview lasting up to an hour.

The two motivational therapists were clinically supervised by Bill Miller and one (the study's author) seems to have been particularly well versed in the approach. Despite a commitment to motivational principles, they did not altogether avoid telling the youngsters what was good for them. There was "clear advice to reduce consumption" (reinforced by a comparison of assessment scores against national norms) and encouragement to engage with the centre's programme. Given the youngsters' problems, such advice may have seemed a warranted expression of concern rather than unwelcome arm-twisting. In a caring context, directiveness does not necessarily generate counter-productive resistance.[16]

The clearest effect was dramatically enhanced engagement with treatment. Records showed that 72% of the control group went on to meet their counsellors, itself an improvement on past performance, but the motivational interview further raised this to 95%. Moreover, these youngsters stayed for an average of 17 sessions compared to six after regular intake. Gains were most marked among those with dependence problems who stayed for 20 sessions versus eight ◤ *chart*. On discharge, unit staff rated motivational clients as having achieved significantly more of their goals.



Reductions in substance use in the three months after the motivational interview were also substantial, but confidence in these findings is eroded by the fact that only half the youngsters could be re-assessed. Among these, motivational clients were using illicit drugs or alcohol much less than at intake[ii] while the controls' substance use was relatively unchanged. Heavy use (excessive drinking or drug use three or more times in a day) was particularly clearly affected, among motivational clients falling from 81% of days at intake to 24% at follow-up, versus 65% and 73% among the controls. Motivational clients had used illicit drugs on half the days (26%

CAN BE ADAPTED FOR GROUPS

In criminal justice settings treatment is typically delivered to groups and especially in residential or prison-based programmes, therapeutic communities are often the core treatment modality. For motivational interviewing to play a role, ways must be found to adapt an individualised, one-on-one intervention to a group format. Only in New Jersey has a such a programme been evaluated with legally coerced patients.

11 There a non-residential substance misuse service found that legally coerced referrals who could see no point to their treatment (as they saw it, they didn't have a problem to work on or a goal to work towards) failed to benefit and tended to leave early.[34]

For these 'no-goal' clients, a group run on motivational lines was established as an introduction to the centre's abstinence-based treatment. It met six times led by therapists trained in motivational interviewing. The set programme included decisional balance exercises and, in the fourth session, a discussion of the written feedback each member

versus 59%) of normally admitted patients, and there was a similar gap for alcohol use.

What produced these effects? These young people were encountering an approach almost entirely at variance with their customary interactions with adult authority figures. Instead of the expected resistance, they appeared "open to exploring their substance use [with] a respectful and empathic counsellor working in a collaborative manner". In this study, too, the motivational interview was well integrated in to the surrounding treatment context yet seemingly unlinked to legal or parental authorities. It built on an extended assessment conducted by the same therapists and clients were encouraged to engage with "our" treatment programme, and to take into that what they had learned in the interview.

Apart from low follow-up, question marks over this study include the fact that only a fifth of the unit's prima facia eligible adolescent intake were included in the study, whether the motivational clients reported less substance use at follow up because they wanted to please the therapists (they did the follow-up interviews), how far therapists adhered to motivational interviewing principles, and, if they did, whether they might have had a similar impact using a non-motivational approach.[15]

5 The latter possibility is suggested by a study in Baltimore.[17 18] Instead of being pitted against normal procedures, motivational interviewing was compared with a different induction interview, equalising the degree of extra, sympathetic attention.

At issue was how best to prepare youngsters for 19 weekly group therapy sessions focused on relapse prevention skills, a programme developed for 14–18-year-olds with at worst moderate substance use problems, generally referred by the juvenile justice service after a substance-related arrest.[19]

On average the 194 youngsters in the study had used substances (mainly cannabis) on one day out of three. Apart from run-ins with the law, few reported major drug-related problems and generally they saw little need for treatment. Though their drug problems were relatively minor, the same cannot be said of the rest of the lives. Most of the clinics in the study served delinquents from poor areas whose drug use was one of a number of risky and criminal activities.

Over about an hour and a quarter, the motivational induction aimed to elicit a "formal commitment to discontinue substance use". A decisional balance (pros and cons of continued drug use versus stopping) exercise was followed by the development of a "change plan". In contrast, the comparison session focused on the treatment to come – what the youngster expected, their concerns, and what would happen and why – a form of 'role induction' seen as a "minimal" input against which to profile the benefits of motivational interviewing.

This was not the outcome. Typically the teenagers stayed in treatment for 14 out of the scheduled 20 weeks, but they left *earlier* after the motivational interview. This was the case at all five clinics in the study[20] and, across all five, was statistically significant, but how to interpret it is unclear. Stays beyond 20 weeks were permitted in case of poor progress or problems which required extra time to resolve, and this seemed to account for the findings.[20]

In any event, which induction session the youngsters had received made no difference to outcomes up to 12 months later. Drinking and criminal activity remained roughly at pre-treatment levels, though the frequency of cannabis use had fallen.

How can we account for the apparent ineffectiveness of the motivational interview in this study when in study 4 the effects were so dramatic? Possibly in both studies, extra individual attention was the active ingredient rather than a motivational approach, but there were other differences. In Baltimore, the motivational interview may have been undermined by having to promote a sole acceptable objective (abstinence), making it more like the responses the youngsters were used to rather than a novel and empowering interaction. And given their (in comparison with study 4) mild substance use, insisting that the interview focus on this rather than greater troubles elsewhere was probably a mistake. It may have been why the therapists were usually unable to elicit commitment to a change plan, perhaps the key way motivational interviews generate change.[21]

6 A study of young adult cannabis users is covered here because of the parallels with studies of younger users. Once again, it attests to the limitations of motivational (and other) substance-focused therapies for multiply problematic young cannabis users.

The subjects were 18–25-year-olds referred to an outpatient clinic by probation services in New Haven Connecticut, patients the clinic had found to be poorly motivated for treatment and poorly retained.[22] The 65 who joined the study averaged 20 years of age and were referred either to three sessions of motivational enhancement therapy or to this plus vouchers for attending these sessions and doing so promptly. In accordance with the manual, during the sessions patients were encouraged to prepare a "quit contract" for giving up cannabis at a set date, to develop a change plan to do so, and to continue outpatient treatment.

Yet just 14 patients took up the offer of further treatment. Even among those who attended all three motivational sessions, these on their own were associated with only a small reduction in cannabis use, from 10 days a month before treatment to eight the month after it had ended.

As in Baltimore (study 5), these young adults were multiply delinquent. They averaged five previous arrests and nine or ten months in prison. Most had failed to

had received after an assessment of their drinking and drink problems compared to national norms.

Four out of every ten clients admitted to the service were eligible for the group. Mainly because of limited spaces, not all joined. The study compared the progress of 75 who did against 92 who did not. Overwhelmingly they were single male problem drinkers and despite their attitudes to treatment, over 60% had problems sufficiently severe to warrant a diagnosis of dependence.

Treatment completion was the main outcome, defined as attending the final treatment session with a period of abstinence from drugs or alcohol behind one and satisfactory progress in other problem areas. On this stringent criterion, 56% of motivational patients completed against 32% not admitted to the group, and they had also attended more of their treatment sessions (83% versus 76%).

However, more of the motivational patients were employed and fewer diagnosed as dependent. When these variables were taken into account, there remained significant but now only slight retention gains after the motivational sessions, gains which could have been be due to other, unmeasured differences between the samples. They may also have been due simply to the extra group therapy time given to the motivational patients. Arguing against this are their distinctive reactions to the approach: surprise at not being confronted with "alcoholic" labels and at not being told "what was good for us"; resultant deflection of resistance and anger leading to an improved atmosphere, greater openness, and less conflict; and the salutary impact of learning how far one's drinking exceeded national norms. The relief of staff as well as patients is palpable in the research report.

One of this study's achievements is to show that motivational interviewing can be adapted for groups. Another particularly thoughtful adaptation has been used as an induction for voluntary patients, with promising initial signs of improved motivation.[35]

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MAKING IT MORE CONCRETE

Though the best known, motivational interviewing is not the only way to boost the motivation of offenders ordered in to treatment. Alternative methods have been devised tailored to criminal justice settings where group formats and set programmes are the norm and the 'clients' are often poorly educated offenders unused to the abstract, verbal explorations of motivational interviewing.

The most persistent and systematic attempt to engineer such interventions has been undertaken by the Cognitive Enhancements for the Treatment of Probationers (CETOP) project based at the Texas Christian University, now also helping England's National Treatment Agency trial similar enhancements.[37] The aim is to lead participants to construct their *own* reasons for engaging in treatment, and then to bolster the knowledge and resources needed to make the most of it.

Though informed by motivational principles, CETOP's "readiness training" interventions attempt to enhance readiness for treatment more broadly, seen as consisting of knowledge of what it takes to change, the personal and external resources needed to do so, self-confidence in the ability to change, and willingness to accept and even welcome the process and its consequences.

In terms of delivery methods, the emphasis is on engaging, hands-on, practical exercises and 'games' requiring only basic reading and verbal skills. These must be capable of being conducted in group formats and easily integrated in to existing programmes – one reason for development of detailed manuals and ready-made or easily reproduced materials, and for the creation of a set of compatible but self-contained intervention modules which services can 'plug in' without disrupting the main programme.

RESEARCH FINDS IMPROVED ENGAGEMENT

To date research on these interventions has found gains in indices of engagement with treatment and expectations of post-treatment success, but no study has yet extended far enough to evaluate whether these expectations were fulfilled. Impacts have been modest, but so too has the investment; in the major studies, the training occupied at most eight out of about 720 hours of programming. Importantly, there were indications that, as expected, it particularly helped less well educated offenders and those who find it difficult to think things through without concrete supports.

In an early study, offenders on probation who were being treated in a residential programme were required to complete a task listing the negative consequences of drug use and the positives of abstinence.[38] As long as this was done after they'd had time to come to terms with the new regime (a month rather than ten days), the result was to heighten indices of motivation.

Under the CETOP banner, the main test bed has been a substance misuse therapeutic community at a community prison in Mansfield, Texas. Under court orders, residents live at the centre in communities of 30–40 for four months of intensive therapy, training, and education, followed by non-residential support.

HELPS LESS INTELLECTUAL OFFENDERS

The first CETOP study involved 500 offenders admitted to 16 communities in 1996 and 1997.[39 40 41] Though typically with a history drug-related offending, as a whole their drug use before treatment was less severe than among people seeking treatment voluntarily.

A randomly selected eight of the communities continued with normal procedures while the other eight supplemented these with four, two-hour readiness training sessions conducted in the fourth and fifth weeks of the programme.

In the first, residents completed the *Tower of Strengths* and *Weekly Planner* exercises. In the second, they played the *Downward Spiral* board game and drew 'maps' of the personal changes they had already made or wished to make ◤ *Serious games*. During the third session they constructed a *Personal Action List* intended to foster a positive view of treatment and to identify important actions to make the most of their stay. The final session addressed skill deficits which might impede treatment, providing techniques for improving memory and performance on cognitive or physical tasks.

Eight weeks in to the programme (so two or three weeks after completing readiness training), residents in the communities which had undergone the training were more likely to see themselves and their co-residents as actively engaged in treatment, to be positive about their communities, to see their counsellors as helpful, caring and effective, and to value community meetings about substance use. As expected, the concrete exercises had been most

◤ page 7

complete a basic education. In this context, their use of cannabis one day out of three could have been an inappropriate focus for intervention.

7 The same seems true of many of the youngsters in the Cannabis Youth Treatment Study, whose basic treatment option incorporated motivational enhancement sessions as a lead-in to cognitive-behavioural treatment.[23 24] Again, the motivational sessions were meant to lead to a pre-ordained conclusion – ceasing to use cannabis.

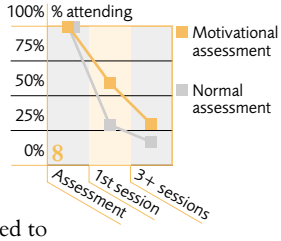
At best partly encouraging post-treatment outcomes[25 26 27 28] may be related to the fact that before treatment, 80% of the youngsters did not feel their cannabis use was a problem and, more importantly, many may have been right. The caseload was a mix of youngsters who probably did not need treatment at all, others with multiple severe problems which demanded a more holistic, intensive and persistent response than any of the treatments on offer,[29] and others who seemed the victims of how America criminalises young, black males from deprived backgrounds.

MM4 PARENTS BENEFIT WHEN MOTIVATION IS THE ISSUE

Especially in the US context, drug using parents and or parents-to-be are commonly directed in to treatment by child welfare services. As with unwilling youngsters, motivational interviewing ought to have a role in defusing defensiveness and anger, but conceivably with more success. As adults and parents, these referrals may be more inclined to look to the future, and therapists should find more leverage in their decisional balance exercises – clear potential downsides to drug use in the form of the effects on the child or on the parent's prospects of being allowed to keep them. However, results have been mixed.

8 Services in Connecticut faced the challenge of motivating substance using parents referred for outpatient treatment by child welfare services.[30 31] Often angry and resistant to treatment, most did not re-attend after assessment. At one of the provider units, the standard assessment was replaced by one which gathered the same information over the same time, but using a motivational interviewing style. The unit's own staff conducted the assessments after just a day's training in motivational interviewing, but had access to continuing problem-solving support.

Sixty parents (of the 75 asked) joined the study and were randomly allocated to normal or motivationally enhanced assessment. The enhanced version doubled the proportion who went on to attend their first treatment sessions from 29% to 59%, a statistically significant difference. But from then on about half attended no more than one further session, deterred (the researchers speculated) by encountering different therapists and a more confrontational approach ◤ *chart*.



Participants were typically white and employed and substance use was confined to occasional drinking and cannabis use and very occasional cocaine use. To them, referral to treatment may have seemed unwelcome and unwarranted. Nevertheless,

MOTIVATIONAL INTERVENTIONS TAILORED TO OFFENDERS

helpful for the least well educated offenders. Divided into those who had or had not exceeded tenth grade at school, only the latter had reacted more positively to the training than to normal procedures.[v]

Unexpectedly, measures reflecting the degree to which residents experienced each other as supportive and trustworthy and a positive influence were unaffected, and the training was no more effective for the residents who were presumably most in need of it – the ones who at the start were least committed to treatment.

WHOLE COMMUNITY TRAINING WORKS BEST

In these early studies training was applied to entire communities which retained the same residents across the four months, maximising the chances of influencing the therapeutic environment. By the time of the second study (of residents admitted in 2000–2001) each of the centre's six communities took in batches of four or five offenders a month, and it was these batches who were randomly allocated to readiness training rather than an entire community.

Perhaps as a result, and perhaps too because the sample (at most 210 residents) was smaller than before, significant overall impacts from the training were few. Towards the end of the residential phase (but not in the middle or during aftercare) they were apparent in higher ratings of how far each resident felt their motivation to get involved in treatment, resist drug use, and reduce infection risk, had increased since entering the programme.[42]

This report was restricted to the 146 participants still in aftercare at the time the last measures were taken. Another report[43] taking in all 210 residents found no overall benefits from the training, not even for the roughly half of the residents who had not graduated from their high schools, failing to duplicate the benefits for poorly educated offenders seen in the first study.

However, significant (if modest) gains did emerge when the residents were split into those who saw thinking things through and learning new ways as a chore, versus those who professed to welcome these challenges. The training had significantly helped the former, presumably because its engaging, concrete activities provided the supports they needed to get to grips with their situation and with treatment. Improvements were seen in their perceptions of how involved they were in treatment, whether they were disruptive or a bad influence, how much they cared for their fellow residents, and their expectations of success on leaving.

When the Mansfield facility converted to an outpatient programme, the study transferred to Wilmer in Texas, where a centre provides six months of residential treatment to offenders on probation. As yet unpublished findings indicate that the same interventions improved residents' ratings of their counsellors and of the programme.[44]

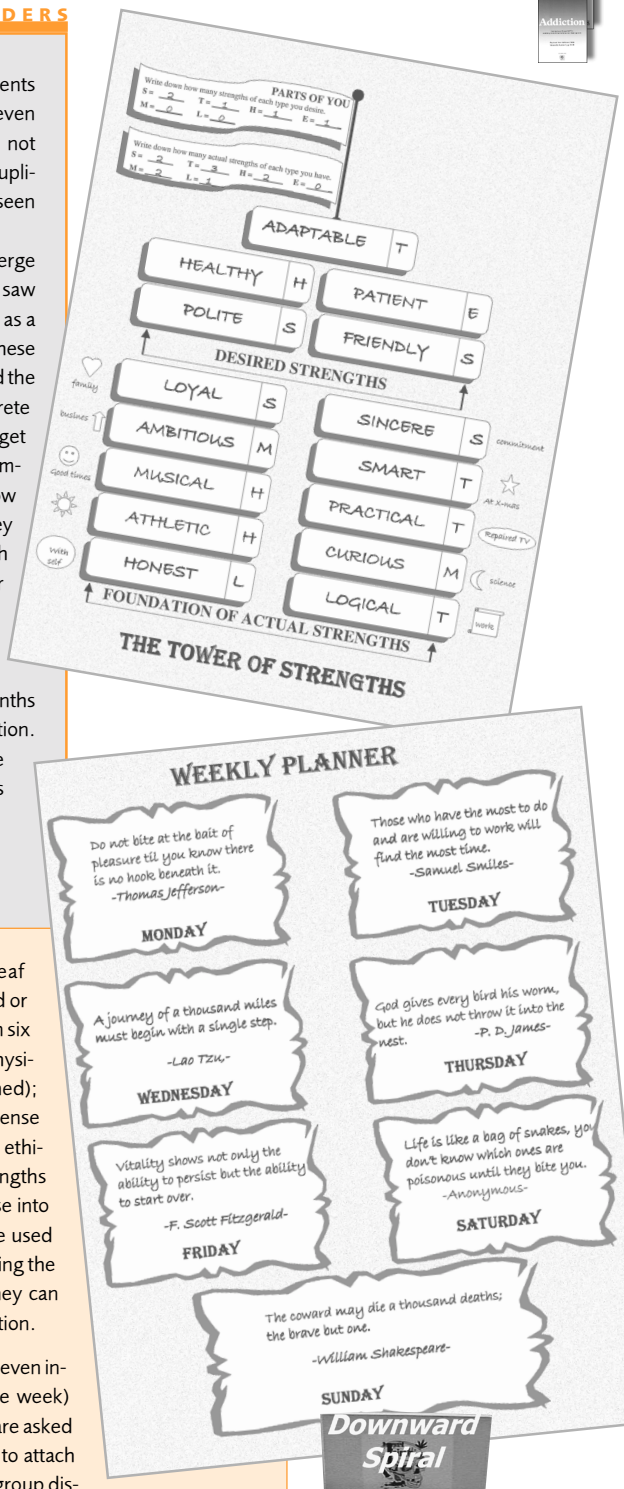
pervading the initial contact with responses which demonstrated caring and understanding, and which acknowledged their autonomy ("What you decide to do about your substance use is up to") persuaded most to at least give it a try. The impact may have been augmented by the staff's enthusiasm for a prestigious research project and for an approach which promised to resolve a major source of disappointment – 'rejection' by 7 in 10 clients.

After the study the centre expanded its commitment to motivational approaches, suggesting that patients had responded positively. As one of the clinicians put it: "[Clients] felt threatened about coming in and doing the [assessment]. I think having someone use the [motivational] approach, rather than a confrontational approach, was good for them. We were more able to engage them in treatment."

9 Positive findings in Connecticut contrast with nil effect from a motivational intervention in Oklahoma,[32] but these new mothers had every reason to clam up despite motivational probings.

The 71 in the study had attended an

SERIOUS GAMES



TOWER OF STRENGTHS Participants leaf through a pack of 60 cards each with a word or phrase designating a personal strength from six domains: social (eg, friendly); behavioral/physical (eg, musical); motivational (eg, determined); cognitive (eg, organised); emotional (eg, sense of humour); and spiritual/philosophical (eg, ethical).[45] Each chooses ten of their existing strengths and five they'd like to have and inserts these into the *Tower of Strengths* diagram. These are used to structure a small group discussion exploring the importance of these attributes and how they can used and developed to improve one's situation.

WEEKLY PLANNER Each individual selects seven inspirational quotes (one for each day of the week) from a pack of 87 quote cards. Participants are asked to select quotes relevant to their goals and to attach these to particularly relevant days before a group discussion of what the quotes mean and how they can help. Offenders enter the quotes on to their personal weekly planner to be referred to at the start of the day, providing a motivating reminder of the way forward.

DOWNWARD SPIRAL is a board game intended to motivate players by facing them with the potential consequences of continued substance abuse without being directly confrontational.[46] Five or six players take on the roles of people committed to a life of substance use. Mimicking the real-life consequences of such a decision, players throw dice to move across a board whose squares represent potential downfalls related to family, health, friendships, finances, self-esteem, and the law, each described on cards the players collect. The aim is to be the last player alive, but due to their substance use, throughout the game players lose social support, health, money, and their sense of self-value. Just staying alive becomes more challenging the longer the player stays in the game.

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intake session for a year-long programme for women who used drugs while pregnant. Over 8 in 10 had been referred by child welfare services after having their newborn child removed when a test revealed illicit drug use. The consequences of continuing to test positive could include being denied visits to their children. Despite this, over the first two months only half the scheduled therapy sessions were attended and half the urine tests were either missed or positive.

To improve retention and outcomes, a motivational interview was incorporated in the intake session and two further interviews were scheduled for a week and two months later. Women were randomly allocated to this procedure or to educational videos at times corresponding to the first two interviews, and at the two-month stage to an extra home visit. On average the trained motivational therapists faithfully adhered to motivational interviewing principles. Yet they did not significantly improve attendance either at their own follow-up sessions or at the main treatment sessions, half of which were missed. Urine test results too were unaffected; again, about half were missed or positive for drugs or alcohol.

Instead of prescriptive or manualised guidance, therapists were given complete freedom to follow the client's lead. The problem was that clients rarely gave much of a lead. At risk of perpetuating the loss of their child (the treatment service reported each client's progress to the authorities), few owned up to any substance use problems or to any ambivalence about a drug-free life, depriving therapists of essential grist to the motivational interview. That their confidence was false or misplaced was indicated by urine test results, by a history of attempts to stop using drugs with no lasting success, and by a relatively severe drug use profile.

Another possibility is that the educational videos (portraying loss of a child due to parental drug use and their subsequent return) had an impact rivalling that of the motivational interviews. Important too may have been the nature of the client group – poor, single, unemployed and under-educated mothers on welfare with a history of psychiatric symptoms, criminal convictions and domestic violence. Despite considerable attempts to bolster their resources and overcome barriers to service use,[47] perhaps what they lacked was not motivation to regain their newborn children, but the ability to put this in to effect.

10 This seems to have been the case among a similar population studied in Baltimore.[33] The caseload was pregnant women attending for their first prenatal care visit at one of three obstetric clinics. Overwhelmingly black, unmarried, unemployed, poorly educated, and with multiple unmet basic needs, 90 of the 120 women who agreed to enter the study had used heroin, cocaine or cannabis in the past month, about half each had a history of dependence on cocaine and major depression, and over a quarter were diagnosed as suffering from trauma-induced stress disorder.

They were offered four weekly motivational counselling sessions aimed at reducing drug use, plus financial incentives for drug-free urines. But by the third session, over half were skipping their appointments and drug-free urines were a rarity.

The motivational sessions had tried to mobilise the "patient's inner resources", but both these and the women's practical resources were severely depleted. Appreciating these difficulties, part way through the study the researchers began each session by identifying unmet basic needs and referring the women to relevant social and welfare services, later supplemented by providing escorted transport to appointments.

Following this enhancement, at least the first two counselling sessions were better attended, after which it seems many of the women had got the help they needed to sort out their housing (however inadequately), transport and mental health needs. Women offered this extra help also cut down their drug use to a greater degree (eg, over a third had two consecutive drug-free urines compared to just 6% of the other patients) though still over half did not produce a single drug-free urine.

MM4 BENEFITS DEPEND ON CLIENTS, APPROACH, AND CIRCUMSTANCES

As with voluntary clients,[36] with coerced samples there is no universal answer to whether motivational interviewing works. For each of the major client categories, motivational induction has had some successes, but has also failed to improve on normal or alternative procedures.

MOTIVATIONAL INTERVIEWING HELPS THERAPISTS AVOID REPLICATING THE OPPRESSIVE NATURE OF THE SURROUNDING CONTEXT

The one study of drink-driving offenders capable of addressing this issue (1) found recidivism reductions only for the minority of offenders suffering depressed mood at intake, possibly because these were the subset in need of treatment as opposed to the usual educational response.

With young people, enhanced engagement and substance use reductions were found in one study (4) but not in another (5). In the successful trial, motivational interviewing was probably true to its principles, eliciting the typical positive reactions, and the caseload seemed in need of substance-focused help. In the unsuccessful trial, the interview's aims differed little from familiar 'Don't do it' injunctions, and though the clients' problems were multiple and severe, substance use was not high among them. In other studies too (6 7), motivational interviewing may have been undermined by an insistence on one acceptable outcome (abstinence) and an inappropriate focus on substance use in the face of multiple severe problems.

Similar factors may account for mixed fortunes with parents ordered by child protection authorities for assessment or treatment. When stressed and under-resourced lives were the main features of the caseload, motivational interviewing was unable to make much of a difference (9 10). When these were less pressing and motivation more the issue, improved engagement with treatment was the result (8).

Last is the one controlled study (11) of group motivational interviewing. Among this mixed bag of offenders, the result was slight improvements in engagement with treatment for those unable to see a point to the treatment they were being forced in to.

Across these caseloads, substance-focused motivational interviewing was ineffective or only marginally effective when substance use was not the major problem in the offenders' lives (5 6 10). Even when substance use problems were relatively severe, patients would not open up to a therapist whose reports back to legal authorities might have severe consequences for themselves and their families (9).

SIX ROUNDS, FOUR HITS, NO KNOCKOUT

Among these studies, motivational interviewing was tested most adequately in the six which compared it with normal or alternative procedures. Four of these recorded positive effects for some subgroups (1 11) or for the sample as a whole (4 8). However, on their own, none was conclusive.

In two (1 4) it is impossible to say whether motivational interviewing made the difference, or the sympathetic, individualised attention which came with it.[iii] Yet even if this were true, it is not an argument *against* motivational interviewing, but *for* the quality of the relationships it fosters. One of the most important virtues of the approach may be that it clears the way for standardised, dehumanising responses to be replaced by re-humanising ones such as empathy, validation, respect and optimism.

Of the remaining two positive studies, one (8) seems a convincing demonstration that staff enthused by motivational interviewing can make a big difference to initial treatment uptake when this approach is incorporated in to assessment procedures. The second found engagement benefits from a group format adaptation (11), but these may have been due to extra group therapy time rather than the approach taken, or to differences between the non-randomly allocated offenders.

Another reason for caution is that in all the positive studies, we cannot be sure motivational interviewing really was the intervention being evaluated. In one (11) it certainly was not (because of adaptations to a group format) and the remainder neither record continuing supervision of therapists nor checks on whether they stayed true to motivational principles.[iv]

SUFFICIENT WIDTH AND DEPTH

Despite the caveats, this accretion of positive outcomes is enough to suggest that the approach *can* work – given that substance use is an appropriate focus, that the patients have the resources to make positive changes, that therapists can remain reasonably true to motivational principles, and that the patients feel safe about opening up to their therapist. Unfortunately, in legally coerced populations, elements are often missing from this virtuous constellation.

Whether the motivational approach itself accounts for these findings is harder to

QUESTIONS FOR SERVICES

? **Does the client really have a substance use problem requiring treatment or are other issues more pressing?**

? **Is lack of motivation the main thing holding clients back from engaging with treatment, or is it practical obstacles or over-stressed and under-resourced lives?**

? **Are motivational therapists insulated from reporting-back obligations to legal authorities, and are patients reassured that this is the case?**

divine – other factors almost certainly played a part. But the reactions of the clients suggest that motivational principles really were an active ingredient. When the population and circumstances have been conducive, and therapists have been able to implement key elements of the motivational style, they have been rewarded by the typical positive reactions from patients relieved of denigrating labels and injunctions about what they must do (2 4 11 and possibly 8).

For services, the implications seem to be to assess whether there really is a substance use problem requiring treatment, and whether motivation is the main issue holding their legally coerced clients back from engaging with it, or whether instead it is practical obstacles or over-stressed and under-resourced lives. If a motivational approach seems indicated, therapists should be insulated from reporting-back obligations to legal authorities, and patients should be reassured that this is the case.

Motivational interviewing is not the only way to enhance the engagement of people coerced in to treatment. In settings where dehumanisation and standardised group approaches are the norm, sympathetic, individualised attention to the offender's needs and goals may pay dividends, regardless of the particular approach taken. What motivational interviewing offers is a systematic way to do this which helps therapists avoid replicating the oppressive nature of the surrounding context and which is capable of enthusing jaundiced staff.

NOTES

i The limitations of designating patients as coerced, pressured or voluntary are acknowledged. Many legally coerced patients welcome treatment, many who appear to have chosen to enter treatment have in fact been pressured by families, employers or other third parties.

ii However, the comparison seems to have been between the full intake sample and the follow-up sample rather than confined to the youngsters who could be followed up.

iii Another study (5) which equalised this factor found motivational interviewing conferred no extra benefits.

iv The same can be said of one of the two studies (5) which found no benefits though not of the other (9). The latter was the only one to check (and find) that its therapists stayed true to motivational principles.

v Asked to compare how they felt two or three weeks after the training to how they felt on entering the centre, they saw themselves as now more motivated to engage in treatment, confident that they would do so and get something out of it, and more motivated and confident that they could resist relapse to drinking or drug use.

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