MOTIVATING CHANGE

At Northern Road clinic in Portsmouth, methadone pulls in the clients and 'motivational interviewing' helps nudge them to move away from drugs.

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DURING OUR TIME in the caring profession we have shared a concern that clients assessed as being 'poorly motivated' or 'unmotivated' have often been rejected from treatment possibilities. Such rejection deserves even greater scrutiny today, when a client may return to behaviour risking not only an overdose and loss of limbs, but also HIV infection. As a result, our work at Northern Road Clinic over the past two years has been aimed at developing a service for a wider range of drug users, regardless of their reason for attending.

Motivated clients often have little or no need of treatment clinics or rehabilitation centres. The challenge is to meet the needs of the 'unmotivated' client. To meet these needs we have employed the motivational interviewing method developed by Miller[1] and by Van Bilson[2], a method used mainly in America and Holland, initially with problem drinkers and latterly with heroin users. Motivational interviewing has been incorporated into our assessment procedure as well as into individual and group therapy settings with a variety of drug users.

There is a close relationship between our use of motivational interviewing and the low threshold methadone programme described previously in ***Druglink***.[3] One point of the programme is to attract clients who would not otherwise attend and who do not come with ready-made motivations for change. Motivational interviewing gives us a constructive way to work with these clients, avoiding the confrontations or demands that would merely drive them back out the door.

Conversely, the methadone programme enables us to require almost daily attendance at the clinic to take the drug. This gives us the chance to identify the emergence of opportunities to intervene as they happen, rather than having to seek to create those opportunities at weekly or fortnightly appointments.

Attitudes and morals

There is little point in employing motivational interviewing if one starts with the idea that drug use must stop before treatment can begin and that clients have no power over their addiction. Van Bilson has described the key principles of the approach as:

- Accepting the client in a complete and unconditional way;
- The client is a responsible person;
- The client must be ready for change and not forced into it by the counsellor;
- The goals and the forms treatment must be negotiated.

Figure 1 shows how Van Bilson has contrasted these and other tenets of his approach with traditional approaches.[4] Non-adherence to principles such as those behind motivational interviewing often leads to a breakdown of relationships with clients who may not return to treatment centres for fear of disapproval from staff.

There are many pitfalls drug counsellors need

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Figure 1. The characteristics of motivational interviewing

Motivational interviewing	Traditional approach
Individual responsibility	
Emphasis on personal choice regarding future use of heroin.	Emphasis on the disease of addiction which reduces personal choice.
Goal of treatment is negotiated based on data and preferences.	The treatment goal is always total and life-long abstinence.
Controlled heroin use is a possible goal though not optimal for all.	Controlled heroin use is dismissed as impossible.
Internal attribution	
The individual is seen as able to control and choose.	The individual is seen as helpless towards heroin and unable to control his/her own heroin use.
The interviewer focuses on eliciting the client's own statement of concern regarding the heroin use.	The interviewer presents perceived evidence to convince the client of his or her problem.
Denial/telling lies	
Denial and telling lies are seen as an interpersonal behaviour pattern (communication) influenced by the interviewer's behaviour.	Denial and telling lies are seen as a personal trait of the heroin addict/junkie, requiring heavy confrontation by the interviewer.
Lies and denial are met with reflections.	Lies and denial are met with argument/ correction.
Labelling	
There is a general de-emphasis on labels. Confessions of being a junkie or being an irresponsible heroin addict are seen as irrelevant.	There is a heavy emphasis on acceptance of the person as a junkie or an addict.
Objective data of impairment are presented in a low-key fashion, not imposing any conclusion on the client.	Objective data of impairment are presented in a confrontational fashion; as proof of a progressive disease and the necessity of complete abstinence.

See reference 4 for source.

to guard against. Motivational interviewing demands that we do not reinforce labels, whether self-attributed or given to the drug user. Information on the client's situation can be fed back to them in a neutral way, not to force change.

Another pitfall may be the perception of drug users as telling lies and untrustworthy in reporting their own drug use. Confrontational approaches can make this a self-fulfilling prophecy. Denial and lies are often a product of the treatment programme or drug service. For example, if the methadone programme requires abstinence from other drug use, will the client be honest if the consequence is the loss of a prescription?

Assessing motivation

To assess a client's motivation to change we use the model documented by Prochaska and DiClemente.[5] Six stages of change have been identified (see figure 2).

Precontemplation is a stage where clients do not perceive they have a problem but others around them may be disapproving. Often at this stage clients arrive at a drug unit having been sent by the courts, probation office or family, etc. A typical interview may start with, "I've been told to come here by ...".

Contemplation is the stage where the client is weighing up the pros and cons of their drug use. They may be suffering financial hardship and deteriorating physical health, but on the other hand may see their drug use as helping to cope with life's stresses.

Decision is the point where the client decides what to do about their drug use based on the previous stage of contemplation. Clients rarely stay in this stage for long and soon choose either to return to precontemplation, preferring to continue with their previous level of drug use, or, alternatively, to move to 'change'.

Active change is the process of the client taking steps to put their decision into effect. To do this they use methods and goals negotiated with programme staff, for example, obtaining clean needles and syringes from our exchange scheme rather than sharing with friends.

Maintenance involves the drug worker introducing and encouraging conscious coping strategies to maintain the change already made, using relapse prevention techniques such as those described by Marlatt and Gordon.[6]

These include problem solving skills, strategies to avoid or escape situations where relapse might occur, and cue exposure tactics which deliberately expose the client to these situations and to drug-related stimuli. Cue exposure in a controlled and supportive environment can enhance the client's confidence in their ability to cope with 'temptation' without losing control.

Once again there are two routes out of this stage. One is to move out of the process of change to optimal recovery. Here change can be maintained with less effort and less need for conscious preoccupation with avoiding relapse. (This model differs from the philosophy 'once an addict always an addict', which assumes people must remain at the maintenance stage for life.) Another way out of this stage is to move to relapse then back to precontemplation.

Relapse is the return to the drug use patterns of the pre-change period. The odd drink or drug use episode does not, however, amount to a relapse. Many such setbacks can be dealt with in maintenance and learned from, rather than interpreted as a relapse.

Even if relapse does occur, it should not be seen as a failure. Each revolution through the process of change should be used as a positive learning experience, leading to a greater chance of success the next time around.

Counselling techniques

Motivation for change arises when the client sees their drugtaking behaviour as incompatible with their view of themselves or their feelings about what they should be like or should be doing. To reduce the resultant discomfort, either the drugtaking behaviour must change, or the client must revise their thinking about themselves. Counselling interventions based on this conflict (or 'cognitive dissonance') are more likely to succeed in moving the client through the stages in the process of change.

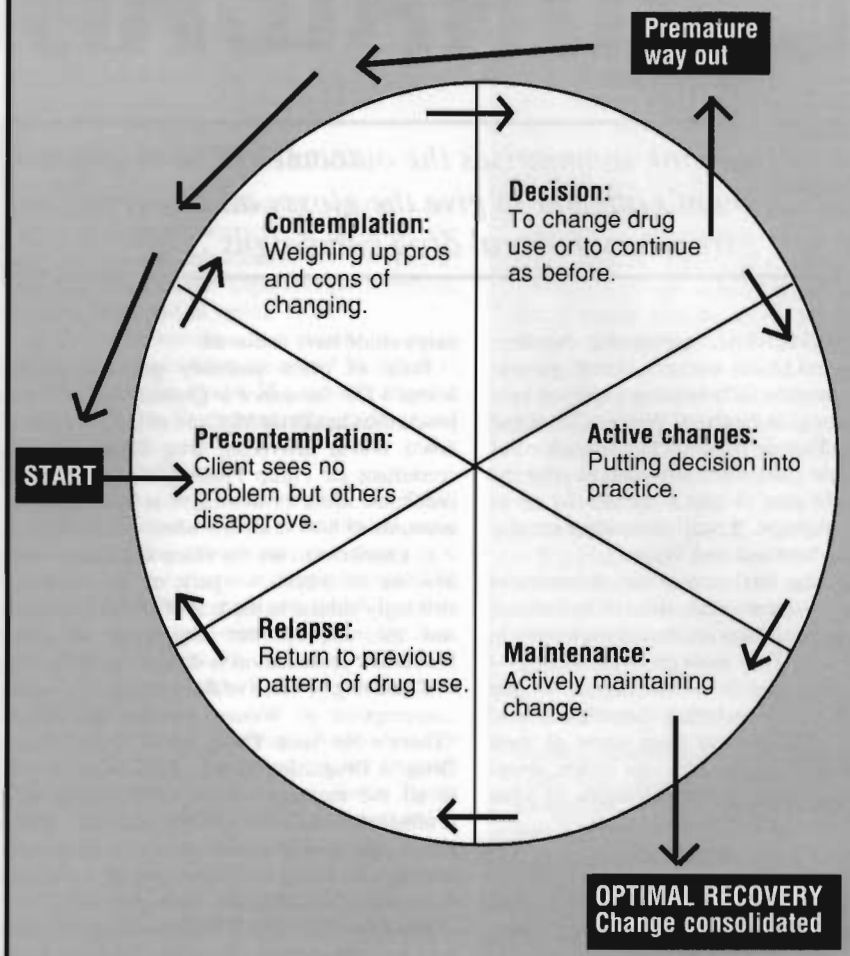
In the precontemplation phase, thinking changes (through mechanisms such as rationalisation and denial) to fit in with the drugtaking. At this stage the first task is to create conflict between the two, for without this there is little chance of lasting change. This may take one session or it may take many months. To create conflict we mainly summarise the client's behaviour and reflect it back to them, to first elicit and then reinforce expressions of self-concern.

Once conflict is created (the contemplation stage) we use positive feedback to raise the client's self-esteem and feeling of being able to control their own life. This may take the form of praise, or of finding and playing back to them the positive achievements in what they may see as negative experiences — a version of finding the 'silver lining'.

'Positive restructuring' of, for instance, a return to drug use for a couple of days in the previous week might highlight the achievement of abstinence on the other days. Such positive feedback encourages the client to end the decision stage with a change in drugtaking behaviour rather than a return to rationalising and denial to reduce conflict.

These counselling techniques are not new to the helping professions,[8] but in the context of the motivational approach they do provide us with a fresh approach to working with those experiencing difficulties with their drug use. ■

Figure 2. Phases in the process of change



Adapted from the work of Prochaska and DiClemente.

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6. Marlatt G.A. and Gordon J.R. *Relapse prevention*. London: Guilford Press, 1985, p.128-200.
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8. Nelson Jones R. *Human relationship skills*. Cassell Education Ltd, p.163-193.