Motivational Interviewing
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Motivational Interviewing in a Residential Treatment Programme

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Abstract

An Irish entrepreneur and motivational interviewing specialist created a residential treatment programme for addictions in Ireland with motivational interviewing not only as the model for therapy but also as the guiding spirit for the treatment environment and repertoire of activities. This article describes the treatment programme, characterises those served by it, and presents results of a preliminary assessment of treatment outcomes. The article concludes with consideration of the challenges and successes of this unique residential programme.

Keywords

motivational interviewing, residential treatment, evidence based practice

The present article reviews the creation of Forest Treatment Centre, a motivational interviewing (MI) treatment programme in a residential context. The article details its birth through specific interactions and encounters, its establishment through programme design, and its development through treatment integrity.

THE BEGINNING

An Irish entrepreneur was lucky enough to come across Tom Barth, Norwegian psychologist, whilst researching addiction treatment options and approaches. He was excited by both the man he encountered and the approach that he was learning about. He was determined to bring MI to Ireland, and for the approach to be available in a residential context. He saw this as a positive addition to the more common traditional treatment centres, which tended to be either hospital-based or faith-based and to share the Minnesota Model as their approach.

The vision was to embrace the MI approach from top to bottom and start to finish. He therefore wanted every aspect of the service to reflect the ethos of the model itself. Forest was to be an evidence-based residential treatment centre exclusively utilising the model of motivational interviewing, with its robust empirical support, in four forums:

- One-to-one therapy with psychologists (trained in MI)
- Group therapy with psychologists (trained in MI and the transtheoretical model)
- Holistic activities (e.g., yoga, mindfulness, Aikido therapy, massage)
- Environmental therapy (all aspects of the environment intended to reflect the ethos of MI, through staff MI training)

They started by picking a location, and building and recruiting a team, that would help to realise his vision. The actual centre chosen was a guest house in the Wicklow mountains, the garden of Ireland. Befitting this location, those who come to Forest are referred to not as patients, or even as clients, but as guests. The environment is completely open (no locked doors or gates), and guests are free leave the programme at any point in time. Guests are not searched upon arrival; they are trusted to make good decisions and the responsibility to do so is not taken from them. Guests are permitted to use mobile phones, reading materials, computers, etc. In fact, the only real rule that may be imposed is that they abstain from alcohol or non-prescribed drugs throughout their stay—a limitation that is more about protection of the environment (respect for others and safety of staff) than about any judgment of guests' decisions.

The environment of the centre was to reflect the spirit of MI. The goal is for the guest to always be made to feel welcome. All staff (from domestic to treatment) were to be trained in the basic skills of MI. Emphasis was placed on warmth and empathy and treating those who came to Forest for help in changing processes of addiction as autonomous adults, in an atmosphere of absolute dignity and respect.

THE TREATMENT PROCESS

Enquiry and Assessment

Guests who enquire about Forest are greeted warmly and respectfully. They are informed of their options. No commitments are imposed. The decision to take an assessment is made available.

During the assessment, a psychologist enquires by way of a standard clinical interview as to what the individual would like help with, engaging the guest in an MI style conversation, with the aspiration of increasing readiness for change. This is also an opportunity for the psychologist to explain about the programme and answer any questions that the guest may have. At the conclusion of this conversation, if both are agreed about the necessity and appropriateness of treatment, a place on the programme is offered.

Assessment begins at this interview but is considered continuous during guests' stays. Assessment tools used include the URICA (University of Rhode Island Change Assessment), Socrates (Stages of Change Readiness and Treatment Eagerness Scale), DRINC (Drinker Inventory of Consequences), BDI (Beck Depression Inventory), and HAS (Hamilton Anxiety Scale).

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	Mon, Wed & Fri	Tues & Thurs	Sat & Sun
09:30	Group Review	Group Review	Group Review
10:30-13:00	1 hour 1:1 therapy	2 hour Yoga	Aikido (Sat) Hiking (Sun)
13:00-14:00	Lunch	Lunch	Lunch
14:00-17:00	1 ½ hour group therapy	Mindfulness (Tues) Art Therapy (Thurs)	Visiting
17:00	Group Review	Group Review	Group Review
19:00	Evening Meal	Evening Meal	Evening Meal
20:30	Meditation	Meditation	Meditation
	Scheduled Massage		

Figure 1

Typical guest schedule

Admission

Guests arriving at Forest are greeted by both care workers (staff with basic training in healthcare who are employed to organise the.environment for guests and provide support where necessary) and the administration team. They are shown around the house, offered tea, introduced to the team and their fellow guests and shown to their room, where they can settle and orientate before meeting the nurse and doctor for formal admission.

The Programme

The following morning the guest has breakfast and then meets with the project worker, who outlines the programme for that day (which will include a one-to-one therapy session, group therapy session and meditation). On non-therapy days (in between therapy days) guests engage in a range of holistic activities. A typical schedule is outlined in Figure 1.

Having awoken, shared breakfast and attended a morning review, on therapy days guests attend their one-to-one therapy session. They are met with a respectful and non-judgemental therapist who will present as a collaborator in the shared role of supporting a change. The therapeutic goal initially is about developing a strong alliance. As phase 1 of their treatment (the "whys" of change) progresses, exploration of ambivalence and level of change is the primary objective.

By session 6 at the end of their 2nd week, guests are invited to write a summary of their therapeutic experience. In this session they share their summary and a "milestone summary" prepared by the therapist is then read and presented to them. This report centres on strengthening commitment (summarising guests' concerns, summarising ambivalence, providing evidence of change talk, and subjective and objective assessments of guests' situation). This report is written to the guest (in "you" language), and is followed up with MI key questions, again geared towards strengthening commitment. Guests are then presented with a change plan to fill in. From session 7 on guests are in phase 2 (the "how's" of change).

The group therapy component of the programme follows the same phased structure as the individual therapy; in phase 1 the emphasis is on developing alliance and working with ambivalence about change, and in phase 2 the focus shifts to the "hows" of change. The transtheoretical model (TTM) understanding of the processes of change informs the content of the group sessions, including the teaching of standard relapse management strategies arising out of the relapse piece in the stages of change.

The repertoire of holistic activities is supplied by individually registered and qualified individuals in their respective fields. The specific activities were selected on three terms. Firstly, activities that embrace general health and well being were regarded as essential. Secondly, activities that are likely to develop self-efficacy were prioritised. Thirdly, activities that demonstrate an independent evidence base in this treatment area were considered to be optimal, for example, hiking (adventure therapy), mindfulness, and art therapy.

As previously stated, all staff are trained in basic skills of MI. Therefore, in addition to structured MI individual and group therapy sessions, all conversations in the environment are expected to be conducted in a generally MI adherent manner, and policies and procedures for staff reflect this.

Throughout their stay, each guest's care plan is continually monitored, and the tailoring of the programme to their specific needs is always prioritised. Continuation with the programme occurs only on the basis of guests' fully collaborative involvement; engagement in the programme is for them to choose on an on-going basis.

The performance of treatment programme staff is also monitored on an ongoing basis. Fidelity to MI in both individual and group therapy sessions is monitored using the Motivational Interviewing Treatment Integrity (MITI) coding tool in addition to dedicated MI supervision.

GUEST PROFILE AND PATHWAYS TO ADMISSION

The most common guest presents with problems relating to alcohol dependence and abuse. The female population is marginally greater than 50%. The second most common guest presents with problems associated with substance misuse and dependence (most commonly prescription, or over the counter, followed by illicit). The remaining guests (about one quarter of the total) present with process addictions (e.g., gambling, internet, sex) and various presentations of stress and depression.

Guests who come to Forest do so through a variety of pathways. Private health insurance is the norm for Forest, and indeed the norm for Ireland (65% of population). Some guests pay privately, although this is very much the minority and mainly overseas guests from the USA or Europe. There are some public treatment options, meaning that some of

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the guests are referred through inner-city (Dublin) drug task forces for either respite care or intensive therapeutic week stays (intensive MI in the context of coming off the last dose of methadone).

It is worth noting that although the exclusion criteria include severe and acute mental health problems (e.g. acute psychosis) and requirement for extended detoxification, more than 95% of all who present for assessment are deemed to be appropriate. The most common reason for a place not being offered by the assessing professional is judgment that an extensive detoxification process (e.g. from benzodiazepines) is required.

MEASUREMENT OF TREATMENT EFFECTS

Programme retention and completion is tracked by Forest staff. Baselines are established at the beginning of treatment in a number of outcome areas, and guest outcomes are assessed at discharge and 3 month, 6 month, and 12 month follow-up. In addition, an independent psychologist conducted an outcome analysis which involved a mixed-method design using a specifically designed survey to interview by telephone all past guests of Forest between three months and three years post discharge. Thirty seven percent of the target sample (n = 69) took part in the survey interview; 60% of the sample could not be contacted and 3% refused to participate.

Treatment Outcomes

As both the theory of MI and research on its effects on treatment engagement and adherence would lead us to predict, guests at Forest tend to come in, make good decisions for themselves, stay in treatment, and engage fully. Retention among all who begin the programme and consequently complete the programme is above 95%.

Analysis of change between baseline and follow-up points is not currently available. Results of the survey interview analysis showed that:

- Over 4 out of 5 rated their progress between 75-100%;
- 61% changed exactly in accordance with the change plan they left the programme with;
- 70% of those with a goal of abstinence felt that they had achieved (or are achieving) that goal;
- <8% felt that they had not achieved that goal;
- 93% would recommend Forest as a treatment option to others;
- 86% reported that their quality of life had improved since treatment at Forest;
- 97% reported that they would, if they could go back in time, choose again to seek treatment at Forest.

Research Limitations

The 37% response rate is relatively low and a higher response rate and/or sample target size may have yielded more complete and reliable data. It is reasonable to assume that a higher portion of poor outcomes would be found among the 63% who refused participation. Analysis of data from the 3, 6 and 12 month follow-up assessments would provide a fuller picture of the Centre's outcomes.

CHALLENGES AND SUCCESSES

Forest as a residential treatment centre does not fit into the standard frameworks for addressing these diagnostic groups (for instance alcohol dependence, substance misuse). It is neither a hospital, nor a public health outreach centre. It is not psychiatrically led and therefore the public health system has no concretely defined basis for engaging with Forest. As a result, despite 6 years of demonstration of promising outcomes, Forest still has little or no engagement with the public sector and has therefore had to be entirely self-sustaining and self-sufficient.

This is also true of involvement with any agencies that are used to engaging with a more traditional/institutional setting. Forest provides an open environment which promotes autonomy. Often referring professionals are looking for a more structured and, they believe, secure environment in which to place their "patient" and they may not believe that an environment such as that at Forest is sufficient to maintain them in care.

A focused effort to obtain quality accreditation (healthcare specific ISO9001:2008) was viewed as crucial because of this sense of existing somewhere between all other therapeutic entities and not falling straight into any one pre-defined box. Attainment of international quality standards, which requires comprehensive and on-going review of standards across all areas of the organisation. resulted in achievement of that accreditation.

Monitoring treatment integrity on an on-going basis is time consuming and challenging to staff. Provision of coaching and feedback is a wonderful thing, when staff look for it; the sense of imposing it however creates a very different dynamic. Furthermore, it is virtually impossible, and possibly ineffective, to ensure that only MI takes place, especially when the primary therapists are well trained and experienced psychologists with more tools in the box. Therefore, although the programme was planned as a pure MI treatment process, in practice aspects of other models are incorporated by staff members. Therefore, it is most accurate to say that the primary governing approach of the Centre is MI, and all therapy is MI adherent, but other models may be utilised on a case-by-case basis.

Finally, as with any structured treatment programme, there needs to be flexibility to meet the needs of individual guests. As detailed above, the programme includes a 6th session milestone process that has proved to be powerful and beneficial in terms of strengthening commitment. However, not every guests is ready to go into phase 2 at session 6, and indeed some are in phase 2 before they even contact Forest. Therefore, Forest has developed a broad interpretation of this process; whilst most milestones do take place on session 6, some do not, and in some cases they may not take place at all.

CONCLUSION

Forest Treatment Centre uses an evidence based, MI dominant approach, investing trust in its guests and facilitating guests' articulation of their reasons for being there and their reasons for wanting to make treatment work. Forest guests are retained at remarkably high rate and appear to do very well; the likelihood of successful change (as reflected in the independent outcomes analysis) appears to be superior to the norms in these treatment areas. Our understanding of why this is so can be summarised thus:

- When people are treated as responsible and dignified adults they tend to act as such.
- When people are trusted they tend to make better decisions.
- When agents of treatment promote autonomous involvement with change, the likelihood of perceiving it as a safe prospect is higher.
- Thus people are more likely to openly discuss their concerns, reflected not only in the clinical conversations, but indeed in the whole environment (exploring ambivalence).
- When there is no pressure exerted externally to abide by a programme structure, people are more likely to choose to engage and thus benefit more from it.
- The sense that they have come through a process of change because they have decided to do so safeguards against a

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catapulting effect of leaving a safe, cocooned treatment environment to being back in their old environment free to decide for themselves (this freedom was never removed).

- Skilled therapeutic response to developed articulation around reasons, need and ability to change (change talk and commitment language) is key to strategically helping people dramatically increase in their sense of drive and strength to implement change and simply find a way (with full practical and emotional support).

The Forest experience blends motivational Interviewing (its spirit, principles, and in therapy its techniques) inside the therapy context and also outside of it, and a holistic environment that pays specific attention to general well-being and the development of self efficacy. The result is a pleasant environment, where guests can take the opportunity to attend to developing a sense of inner peace whilst availing themselves of a highly focused therapeutic programme with only one simple goal: increasing the likelihood of successful change.

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