Motivation

David Prescott
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WELCOME!

CONTACT

David S. Prescott, LICSW
Clinical Director and
Director of Professional Development and Quality Improvement
Becket Family of Services

VTPrescott@Earthlink.net
www.davidprescott.net
www.becket.org

- *Healthy lives,*
- *Safe communities*

Don't worry!

- I won't call on you for answers
- I won't ask you to role play
- I won't put too much research into each slide

Focus

- Experience
- Relax
- Take-home skills
- Enjoy time being in a group

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The Problem

- Smith, Goggin, & Gendreau, 2002
- Meta-analysis
- 117 studies since 1958
- 442,471 criminal offenders, including juveniles

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- No form of punishment reduced the juvenile's risk to abuse

A real problem

- *Prisons and intermediate sanctions should not be used with the expectation of reducing criminal behavior.*
  - Includes intensive surveillance, electronic monitoring, DARE, Scared Straight, etc.
  - Some indication of increased risk for low-risk criminals

A brief history of treatment…

- Furby, Weinrott, & Bradshaw (1989).
  - Combined analysis of numerous studies that was unable to detect a significant treatment effect due to methodology variability.
- Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002).
  - 17% untreated
  - 10% treated

  -Equivalent to a 40% reduction
  -Youth do best with community treatment
  -See Surgeon General, 2001
- Losel, F., & Schmucker, M. (2005).
  - Recidivism reduced by nearly 40%
- SOTEP:
  - No overall differences between treated and untreated groups, but:
- Sex offenders who successfully completed the SOTEP treatment program reoffended at lower rates than those who did not demonstrate that they "got it" (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005).

Hanson, Bourgon, Helmus, & Hodgins, 2009

- Examined sexual offender treatment and RNR principles
  - *Based on a meta-analysis of 23 recidivism outcome studies meeting basic criteria for study quality, the unweighted sexual and general recidivism rates for the treated sexual offenders were lower than the rates observed for the comparison groups (10.9%, n = 3,121 vs. 19.2%, n = 3,625 for sexual recidivism; 31.8%, n = 1,979 vs. 48.3%, n = 2,822 for any recidivism). Programs that adhered to the RNR principles showed the largest reductions in sexual and general recidivism.*

Effective Programs

RISK principle

- effective programs match the level of treatment intensity to the level of risk posed by the offender
- high risk = high intensity
- mismatching can result in increased risk

Effective Programs

NEED principle

- effective programs target identified criminogenic needs
- sexual offenders require sexual offender specific treatment programming
- other programs may result in some ancillary gain, but risk for sexual recidivism likely will not be reduced

Effective Programs

RESPONSIVITY principle

- effective programs are those which are responsive to offender characteristics
  - cognitive abilities
  - maturity
  - motivation
  - mode of intervention
  - scheduling concerns

Effective Programs

PROFESSIONAL DISCRETION

- in every effective correctional intervention, there must be a coordinated plan which takes risk, need, and responsivity into consideration
- someone must be "driving the bus"
- sometimes, exceptions to the first three principles can be justified based on global perspectives

Waypoint

At each decision point, ask:

- How will this action help create a willing partner in change?

What works?

- Do we want them to get better or not?
- What can we do?
- Who should we be?

Core Message

- Healthy lives, safe communities

Best result

- A balanced, self–determined lifestyle

(Wilson, 2009)

Contexts

- Get the context right for change (Mann, 2009)
- Get ourselves *ready* to *help* other people change
  - Motivational enhancement, goal-setting, interviewing

Obstacles (Mann, 2009)

- Believing treatment is ineffective
- Competing priorities
- Concerns about side effects
- Concerns about poor program responsivity
- Distrust of key professionals
- Expectation of hostile responses
- Pressure from friends or family
- Fear of stigma

Improving the context (Mann, 2009)

- Listen
- Empathize with offenders' perspectives
  - (Empathy is not an endorsement)
- Building relationships (collaboration, trust)
- Identify and counter myths
  - (Sometimes offenders have poor information)
- Communicate strength-based treatment aims
- Make referrals quickly and respectfully
- Offer clear and transparent information about treatment and outcomes

Improving the context (Mann, 2009)

- Ensure that risk assessments take account of treatment progress
- Educate non-treatment staff
- Clear leadership to promote prosocial modeling and supportive environment
- Work with families and support networks
- Use intrinsic motivators
- Use treatment graduates
- Provide choice
- Explore and monitor Rx staff motivations

Game Theory

Anchor Points

- Risk
- Need
- Responsivity

Underneath all goals

- Competence
- Autonomy
- Relatedness

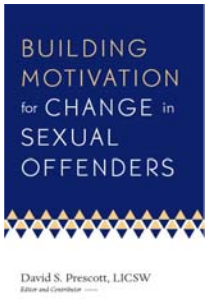
(Deci & Ryan, 2002)

Let's do it!

- Cell phones off
- Participation increases effectiveness
- Beginner's Mind

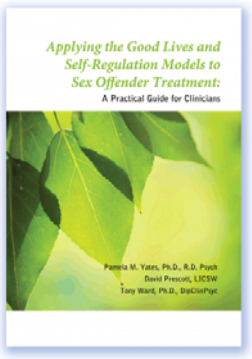
Should it interest…

- Recent release
- Very few resources on topic
- Chapters by Ward, Marshall, Marshall, Mann, Serran, Wilson, etc.



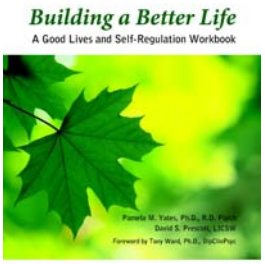
There's also this

- Yates, Prescott, & Ward, 2010
- Practical guide for clinicians on good lives and self-regulation models
- Contains case examples with motivational enhancement



And this one, too…

- Yates & Prescott, 2011
- Foreword by Tony Ward
- A good lives/self-regulation workbook
- Over 400 pages



Take-Away Message

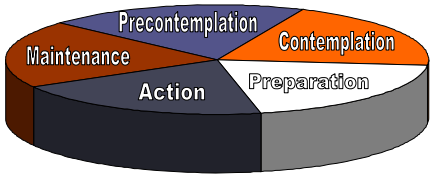
- People change
  - We have proof
- Punishment alone does not reduce recidivism
  - We have proof
- When all else fails, get back to the basics
  - Effective treatment gets young people to change the way they think and gets families to support those changes
  - **We will never change the way they think; they have to**

Take-Home Message

- Change Talk
- Acceptance
- Less Is More
- Righting Reflex
- Michelangelo Belief
- Autonomy and Choice

A man convinced against his will is of the same opinion still.

Stages of Change
Prochaska & DiClemente



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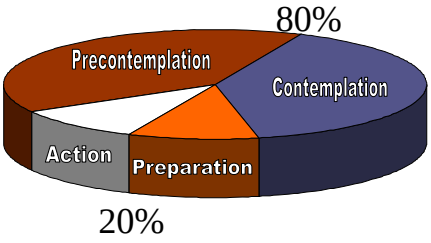

How ready are you?

0 1 2 3 4 5 6 7 8 9 10

Motivation = importance + Confidence

The Big Question

- *Do we want them to re-offend or not?*

How Dolphins Learn

Discrepancy

- The difference between where you are and where you want to be

Motivational Interviewing
Best-known Definition

Motivational interviewing is
a person-centered,
directive
method of communication
for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

Steve Rollnick, 2/28/10

- Motivational interviewing involves helping patients to say why and how they might change, and is based on the use of a guiding style

Three Essential Elements in any Definition of MI (2011)

1. MI is a particular kind of conversation about change (counseling, therapy, consultation, method of communication)
2. MI is collaborative (person-centered, partnership, honors autonomy, not expert/recipient)
3. MI is evocative, seeks to call forth the person's own motivation and commitment

The Spirit of Motivational Interviewing (2011)

- Partnership
- Acceptance
- Compassion
- Evocation

Four General Principles

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Support Self-Efficacy

Update: September 2011

- Four Fundamental Processes
  - Engaging
  - Focusing
  - Evoking
  - Planning

These processes are…

- Somewhat linear
  - E.g., engagement comes first
- And also recursive
  - Engaging happens throughout MI
  - Focusing is not a one-time event;
  - Real treatment involves re-focusing
  - "testing the water" on planning helps

Engaging

- Spirit factors
- Open questions
- Affirmations
- Reflections
- Summaries

Focusing

- Developing a clear direction and goal
- Sometimes the change goal is clear; very often it's not!
- Possibilities:
  - Clear Focus
  - Agenda Mapping (options menu)
  - Clarifying

Evoking

- Eliciting Change Talk
  - Desire, Ability, Reason, Need
  - A clear focus is a prerequisite
  - Change and sustain talk:
    - Two sides of the same coin
    - Dancing with Discord"

Amrhein et al. (2003)

- Change Talk (Miller & Rollnick, 2002)
  - Desire *"I want to…"*
  - Ability *"I can…"*
  - Reason *"There are good reasons to…"*
  - Need *"I need to"*
  - Taking Steps (e.g., *"I've been…"*)
  - Commitment talk

Change talk

- ***When you hear change talk, don't just stand there!***
- Reflect
- Reinforce
- Ask for more

Getting Moving: OARS

- Open questions
- Affirmations
- Reflections
- Summaries

Reflective listening

- Simple Reflection
  - Exact words
  - Closely related words
- Complex Reflection
  - Continuing the paragraph
  - Reflecting emotion

Discussion

- Offer
- Explore
- Offer
- Explore
- Offer
- Explore
- Offer
- Explore

- Offer
- Explore
- Offer
- Explore
- Offer
- Explore
- Offer
- Explore

Discussion includes

- How has this issue played a role in your past behavior?
- How does this issue play a role in your current behavior?
- What kinds of payoffs do you get from this?
- And on the other hand, what kinds of difficulties is it bringing you?

It might also include…

- What is happening when you decide to engage in this behavior?
- What do you want to happen and what do you get?
- How might this issue affect others?
- How might one approach situations where this issue might arise and get what you need without this issue happening?
- If you were in my (or someone else's) shoes, what might you think about this issue? (other patients often have a number of contributions to add to this question)

Potential traps

- Debate (instead of dialog)
- Unrealistic expectations (wanting too much)
- Focusing on one patient to the exclusion of others (some patients ask for more attention than others)
- Negative spotlight (it can be easier to highlight problems than successes with this population)
- Etiology (understanding the origins of a problem are not the same as resolving it)

When the client won't stop

- *Sometimes people keep repeating themselves precisely because they do not feel acknowledged. I have sometimes literally interrupted "to make sure I understand," and offered a summary reflection. I've never had anyone resent being interrupted to make sure that I understand them.*

  -- Bill Miller, 8/28/09

When the client won't stop

- OK, you're saying a lot of really interesting stuff there, so if I can just check to make sure I'm getting what you're saying... [summary of what has been said, linking this to x issue]
- So it sounds as if the main thing that's bothering you is... [If 'yes'] OK, so how does this fit in with your.. [x issue].

When the client won't stop

- What you're saying is really interesting. Let's not lose that in all the other stuff we're talking about. How about we put it in the in the parking lot, and make sure we come back to it before we finish?
- You're feeling/wondering/thinking.... and that has an impact on....[x issue]

When the client won't stop

- That sounds important but I'm not sure we have the time to do it justice today...
- You really need to talk about this (reflecting emotion/intensity)
- You have a lot of thoughts about this or it sounds like you haven't had a chance to think/talk about this with someone else
- My memory is kind of limited and to give more of the attention and help you deserve I will have to interrupt you periodically. Would that be OK with you?

When the client won't stop

- You are saying some pretty darn interesting stuff there and if we have time at the end, you can tell me more. And right now, I am wondering if it would be OK to get back to the medication problem you first talked about. What is going on with that?"
- I think I'm getting a good understanding of _____(the issue), tell me a little bit more about _____ (new topic).

When the client won't stop

- I hate to cut you off because I can tell this is something very important and something on which you are working very diligently, but would it be all right if.. (I switched gears a little and_____, took a little time to ask you about_____, summarized what we've talked about to make sure I'm understanding things, etc.).

When the client won't stop

- Above all, Remember:
- *If we act as though we have only fifteen minutes, it will take all day; however, if we act like we have all day, it only takes fifteen minutes.*

  -- Monty Roberts

Hope Theory

- Agency Thinking
  - Awareness that a goal is attainable
- Pathways Thinking
  - Awareness of how to do it
    - See works by C.R. Snyder
- "*Therapists who are burned out or otherwise fail to convey hopefulness model low agency and pathways thinking.*" (in Hubble, Duncan, & Miller, 1999)

Ensuring Clinical Success

Welcome!

Focus

- Clinical <u>triage</u> in difficult situations
- Bringing together <u>elements</u> of motivational interviewing and feedback-informed treatment (not the same as doing either individually, as each have more components)

2012

Understanding baselines

- On a scale of zero to ten, how are you doing
  - Individually?
  - In your close relationships (family, friends?)
  - Socially (work, school, acquaintances?)
  - Overall?

Focusing

- With everything you have going on in your life, how come your score wasn't lower?
- This produces client strength language and change talk
  - Desire, ability, reason, need
  - Commitment, activation, taking steps
- What would it take for you to be two points higher on this scale?
  - De facto action planning

Tracking outcome

- Same questions
- Looking at change
- *Okay, I see that you're doing a little better/worse. What kinds of things are different?*

Therapeutic Alliance

- Agreement on bond
- Agreement on goals
- Agreement on tasks
- Consumer preferences
  - (historically called "client theory of change")

Mission Critical!

- The only thing that matters is the experience of the client (or family member or stakeholder)
- Our perceptions of the alliance don't count
- Besides, documenting our unstructured opinions about the alliance is very poor clinical strategy

Translated into English

(thank you Scott Miller, Barry Duncan, etc.

- *I just want to make sure: Am I hearing, understanding, and respecting you?*
- *Are we working on the goals you hope to work on?*
- *Is the approach I'm using a good fit for you?*
- *Overall, how's this working from your perspective?*

Offer/Explore (thank you Steve Berg-Smith)

- Offer
- Explore
- Offer
- Explore
- Offer
- Explore
- Offer
- Explore

Offerings

- Reflections
- Affirmations
- Summaries
- Open-ended questions asked out of compassion and interest

- Focus is on progressive dialog. Clinicians job is to hear, honor, respect, and understand
- *Did I get it all?*

Handling difficult situations

- Ask
- Provide
- Ask

- Ask permission to share feedback =>
- Share Feedback =>
- Elicit thoughts about feedback

Case example

- Michael, 14, has made little progress in treatment. His case manager, family, and state agency representative are convening to review the case. There is question about placement and confusion about how best to understand the case. Is this young man's physical aggression more a result of trauma or of pro-aggressive attitudes and beliefs?

Whatever else is decided…

- Clinician asks the mother, in front of others:
  - *I just want to make sure… Is our clinical department understanding and respecting you? Other issues aside, are we working on goals in family treatment that are important to <u>you</u>? Has our approach been a good fit for you? Overall, what are we missing?*

The answer

- *Oh my gosh, yes. I can't imagine what we would have done without your services (others nod their heads).*

- Discussion returned to a focus on what's real at this point, and not on nebulous etiology or a sole focus on how the program was failing.

Moral

- This feedback was important and paved the way for how we could do better
- In a high-stakes meeting situation, this positive feedback could be documented

Example #2

- Angry father complains about services, apparently taking past statements far out of context. Documentation only highlights cancelations and what happened in sessions.
- Use of these questions could have provided more information to document

There is no downside to feedback

- Even if the answers from the father were all negative, the clinician could have documented attempts at improvement

Conclusion

- Return phone calls and emails
- Document everything
- Solicit routine, structured feedback and document it
- Avoid the expert trap