Motivational Interviewing and Child Welfare: What Have We Learned?

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Introduction

It has been a decade since motivational interviewing (MI) has been proposed as a promising approach that could be used in child welfare practice (Hohman, 1998). MI was originally developed as an alternative counseling style for use in the substance abuse treatment field, using a collaborative and nonjudgmental approach to clients. The goal of MI in any field of social work is to enable clients to resolve their ambivalence about change and to begin to take steps in a positive direction.

MI is directive in that the social worker strategically chooses what to reflect, clarify, and summarize in a nonjudgmental, empathic manner. Key questions are posed to elicit what is known as "change talk" in an attempt to have clients verbalize how they will solve their problems, instead of the social worker directing them (Miller & Rollnick, 2002). The MI approach may be well-suited for child welfare work as clients are involuntary and are often very resistant to working with social workers (Forrester, McCambridge, Waissbein, Emlyn-Jones, & Rollnick, 2007). Use of MI skills reduces resistance and enables the social worker to work as a partner with clients (Shaffer & Simoneau, 2001).

Motivational interviewing has received a great deal of attention as an evidence-based practice, particularly in the substance abuse field. The California Evidence-Based Clearinghouse for Child Welfare (2006–2007) has evaluated MI to be a "1" or a "well-supported effective practice" for parental substance abuse. MI has also been expanded, applied, and studied in areas other than substance abuse treatment, including co-occurring disorders (Martino, Carroll, O'Malley, & Rounsaville, 2000), smoking cessation (Soria, Legido, Escolano, Yeste, & Montoya, 2006), cardiac care (Brodie & Inoue, 2005), weight management (Resnicow, Jackson, Wang, De, McCarty, Dudley, et al., 2001), HIV prevention (Carey, Braaten, Maisto, Gleason, Forsyth, Durant, et al., 2000), criminal justice (Harper & Hardy, 2000), and homeless adolescents (Peterson, Baer, Wells, Ginzler, & Garrett, 2006). A systematic review of MI found that MI was an efficacious intervention to engage and retain noncoerced clients in drug treatment (Dunn, Deroo, & Rivara, 2001).

Trainers who have gone through the MI Training for Trainers represent 24 countries plus most states in the United States (Rollnick, Miller, & Butler, 2008), indicating the wide interest in MI. With the explosion of knowledge and interest in MI as an evidence-based practice, many agencies and public service systems have had social workers and other helping professionals participate in one- to two-day workshops or more of training. Thus, the purpose of this article is as follows: (1) define and describe concepts of motivational interviewing, (2) review research studies where MI has been applied to child welfare populations, including cases where there is substance abuse and domestic violence, (3) describe what is known about training professionals to become competent in MI, and (4) discuss how child welfare systems and social service agencies can move forward regarding integration of the MI approach.

What Is Motivational Interviewing (MI)?

Motivational interviewing, a client-centered but directive counseling style, was developed in the 1980s as an alternative approach to the confrontational methods typically used in alcoholism-drug dependence treatment. Dr. William Miller, one of the developers of MI, indicated,

> Knowing nothing about alcoholism, I did what came naturally to me—Carl Rogers—and in essence asked patients to teach me about alcoholism and tell me about themselves: how they got to where they were, what they planned to do, etc. I mostly listened with accurate empathy. There was an immediate chemistry—I loved talking to them and they seemed to enjoy talking to me. Then I began reading about the alleged nature of alcoholics as lying, conniving, defensive, denying, slippery, and incapable of seeing reality. "Gee, these aren't the same patients I have been talking to," I thought. The experience of listening empathically to alcoholics stayed with me and became the basis for motivational interviewing. (Miller in Ashton, 2005, p. 26)

In MI, the counselor or social worker works to understand and activate the clients' own internal motivators for change. It is directive in that the social worker, while working toward specific goals, uses communication skills to evoke from clients their own goals, desires, and ways of solving problems. Also important to the "spirit" of MI is to honor the clients' autonomy because clients are ultimately the ones who have to make their own decisions (Miller & Rollnick, 2002; Rollnick et al., 2008).

MI involves a strategic use of specific skills and pays particular attention to how clients engage in "change talk" or discussions around their desire, ability, reasons, or need to change. Using an empathic style, the practitioner works to develop discrepancy between the clients' goals or motivators (such as being a good parent) and the clients' current behavior (leaving children alone to go drinking) and to explore and resolve ambivalence that emerges from the discrepancy. MI builds on the strengths perspective to a "competence" perspective, which assumes that most clients know what they need to do and that they have the skills, strengths, and capabilities to achieve their goals (G. Corbett, personal communication, October 2007). The social worker functions more as a collaborator in the process than as a director (Rollnick et al., 2008). Her job is to support the self-efficacy of the client to make changes and, if she is met with resistance from the client, to "roll" with the resistance and use it as a signal that the social worker needs to change the way she is communicating with the client.

Resistance is not uncommon in child welfare work. Clients are often angry, disagreeable, noncooperative, or threatening. MI is particularly well-suited to engaging reluctant clients. Through reflective listening and empathy, the social worker can connect with clients; however, he is not condoning or agreeing with their

behavior. Of course, it is important to also maintain the focus on the needs of the child and to address the reasons why the social worker is involved with the family (Forrester et al., 2007).

Research of the Use of MI in Child Welfare

MI has been studied in about 180 clinical trials to date (Rollnick et al., 2008). In the area of child welfare, specifically, there have been relatively few studies of the application of MI. A few conceptual articles have indicated that MI fits well with engaging child welfare clients (Hohman, 1998; Hohman, Kleinpeter, & Loughran, 2005; Wahab, 2005a). Rullo-Cooney (1995) provided a detailed description of the goals and services made possible through an Intensive Family Preservation Program (IFPP) that integrated the use of MI. The following section reviews studies regarding the use of MI in the child welfare system and in domestic violence work, since these areas interface greatly with child welfare (Edleson, 1999).

Child Welfare, Substance Abuse, and MI

We found only two studies that have investigated the effect of using MI with parents involved with child welfare, and these were in regard to their initiation and continuation of substance abuse treatment. No studies to date have examined if MI is effective in increasing child safety, well-being, or permanency.

Carroll and colleagues (2001) conducted a randomized control trial to investigate if a single session of MI would increase participants' seeking of substance abuse treatment. The participants of this study were referred from Project SAFE (Substance Abuse Family Evaluation), a partner of Connecticut's Department of Children and Families. A total of 60 participants were randomly assigned to either a control group that received a standard intake assessment of Project SAFE, or to an intervention group that received a standard intake assessment plus a 20-minute MI session. The results of this study indicated that the single, short MI session significantly increased substance abuse treatment initiation at a rate of 59.3% compared with only 29.2% in the control group. Participants of the intervention group also continued to attend treatment at a higher rate, although both groups decreased in treatment attendance over time (Carroll, Libby, Sheehan, & Hyland, 2001).

Mullins, Suarez, Ondersma, and Page (2004) studied the impact of MI interviews on engagement and retention in substance abuse treatment of women who identified having used illicit substances during pregnancy. Participants in this study were under the supervision of Child Protective Services; they had self-reported use of cocaine (40%), marijuana (28%), and methamphetamine (25%). Sixty participants were randomly assigned to three 1-hour sessions of MI (intervention group) or to a control group, which received educational information through videotapes. Both groups also received a 1-hour home visit. Results of this study indicated that all participants followed through with the first session, and more participants of the control group complied with attending the second session at a rate of 64% versus only 49% of the MI intervention group. Participation at the third session decreased in both groups at 42% (control) and 46% (MI group). Thus, this study did not find that MI increased substance abuse treatment engagement or retention of coerced clients. The authors speculated that this may be due to the fact that clients were mandated to treatment and appeared to be hesitant to discuss ambivalence regarding drug use with the therapists. They may have believed that this could be used against them for child removal.

Child Abuse, Domestic Violence, and MI

Wahab (2005a; 2005b) has written conceptual analyses of how MI can be applied to work with domestic violence survivors, indicating that it fits well with the domestic violence field's emphasis on client empowerment. At this time, there have been few studies of MI as an intervention in domestic violence. Kistenmacher (2000) studied 33 male batterers, half of whom were randomly assigned to receive two sessions of MI in addition to court mandated treatment. Results indicated that while there was no change in their self-reported motivation to alter abusive behavior, those who received the MI sessions were less likely to blame external factors for their behavior compared with the control group.

Ogle and Baer (2003) studied the impact of using MI techniques to increase substance abuse treatment participation with survivors of domestic violence (DV). Participants (n=147) of a residential DV shelter were randomly assigned either to a control group, whose members received a substance abuse assessment with written feedback, or to the intervention group, whose members received the same assessment feedback provided in a 45-minute face-to-face interview using MI. The feedback contained information about participants' own substance use compared with that of an average American female, the negative consequences due to their use, their motivation to change substance use, and their psychological symptoms related to substance use. Results showed that applications of MI feedback significantly increased participants' attendance at one substance abuse treatment session, at a rate of 60% for the feedback group versus 0% for the control group.

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Studies of Training in MI

Motivational interviewing is a complex counseling style to learn (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). Based on research and training experience, Miller and Moyers (2006) propose eight stages that practitioners experience while learning MI. They are as follows: (1) developing a collaborative relationship, with openness to the clients' own expertise or grasping the "spirit" of MI, (2) developing proficiency in client-centered counseling skills, (3) recognition of "change talk" or clients' expressions of their desires, reasons, ability, and need to change, (4) developing the ability to elicit "change talk" or clients' discussions of their desires, abilities, reasons, and need for change, (5) recognizing and "rolling" with client resistance, (6) helping clients develop plans regarding change, (7) consolidating clients' commitment to change, and (8) being able to use MI with other intervention therapies. So, the question arises, what is the best way to learn all of this?

Early studies of training in motivational interviewing focused on evaluating knowledge and skill acquisition after 2 days of training. Rubel, Sobell, and Miller (2000) found that substance abuse counselors were able to make knowledge and skill gains, based on written measures, one of which included the *Helpful Responses Questionnaire* (*HRQ*). This is a series of client statements to which the trainee writes a response, which is scored for adherence to MI (Miller, Hedrick, & Orlofsky, 1991).

Another study of probation officers who had received a 2-day training found that the trainees self-rated their skills in using MI quite high at the end of the workshop. Coded audiotapes of pretraining interviews with clients, posttraining interviews with simulated clients, and a 4-month follow-up of taped interviews with clients indicated that the trainees did make skill gains and maintained them, but that they were not as proficient as their own self-rating suggested. Further, they still continued to utilize non-MI-adherent interviewing methods as well, such as persuading or directing. Qualitative interviews of the probation officers at the 4-month interview found that they felt that they were competent in MI and did not need any more training. The coded tapes also indicated that there were no differences in client responses from pre- to posttesting. Overall, it was found that using the one-shot training was insufficient to make significant enough gains to change client response, although the trainees saw themselves as proficient (Miller & Mount, 2001).

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Baer, Rosengren, Dunn, Wells, Ogle, & Hartzler (2004) conducted a similar study of a 2-day training for substance abuse and mental health clinicians, utilizing a pen-and-paper skills measure, including the *HRQ*, and audiotapes with clients' (real and simulated) pre-, post-, and 2-month follow-up reports. Results indicated that the trainees became proficient in MI skills at posttesting, and 8 of the 19 trainees were able to maintain their proficiency in most areas at follow-up.

Miller, Yahne, Moyers, Martinez, and Pirritano (2004) conducted a clinical trial of training conditions for learning MI. In the EMMEE Trial (Evaluating Methods for Motivational Enhancement Education), 140 social workers, psychologists, addiction counselors, and nurses who had volunteered for a 2-day training were randomly assigned to one of five conditions: (1) workshop only, (2) workshop with coaching, (3) workshop with feedback, (4) workshop with feedback and coaching, and (5) a waiting list, where the trainees received a therapist manual and videotapes. Personal feedback using a standard reporting form was E-mailed or mailed to trainees. It contained scores from coded tapes provided by the participants. Coaching involved six individual 30-minute sessions that were conducted over the telephone.

Participants were asked to provide sample tapes of interviews with clients at pretraining as well as at 4, 8, and 12 months posttraining. All participants were taped interviewing a simulated client posttraining. Tapes were coded using the *Motivational Interviewing Skills Code* (*MISC*) (Moyers, Martin, Catley, Harris, & Ahluwalia, 2003). This measure requires three passes by coders, who first rate global scores of the interaction, follow this with behavior counts of both client and counselor speech, and finally, measure "talk time" by both the counselor and client. Trainees were also asked to provide self-assessment of MI skill, complete the *HRQ*, and undergo several measures of personality characteristics.

Results indicated that all participants were able to make a substantial gain in MI skill proficiency by the end of the workshop. Miller et al. (2004) suggested that this was due to the voluntary nature of the training (versus being required by the probation service as in the Miller and Mount (2001) study). They also speculated that the gains may be more related to the increased emphasis on the "spirit" of MI and decreased emphasis on techniques. Non-MI methods, such as confrontation, declined after training. The MI skill proficiency, however, declined at follow-up measures for the workshop-only group, whose members returned to baseline levels at the 4-month measure. Self-assessment of skills had no correlation with skill level as coded by the *MISC*. No personality characteristics were related to acquisition of MI-skill level. Those who received either feedback or coaching or both were able to sustain proficiency levels at the follow-up measures; those who received both the feedback and coaching showed the most improvement on client responses (decreased resistance, more talk about change) as measured by the *MISC*. Those in the control wait-list group that received a manual and videotapes showed no improvement in their skills. The researchers had difficulty with compliance of the sample in submitting tapes of clients at the follow-up time points (Miller et al., 2004).

Training of Child Welfare Social Workers in MI

Forrester and colleagues (2007) in the United Kingdom investigated the communication skills of child protection social workers and explored whether their being trained in MI and receiving coaching resulted in increased MI-adherent skills. The study recruited 42 social workers who attended 4 days of training on alcohol misuse, with 2 of those days emphasizing MI training. The study consisted of a pretraining interview and 3-month posttraining follow-up. The pretraining assessment included audiotapes of interviews with a standardized client, completing the *HRQ* adapted for social work, clinical vignettes to assess child risk, and responses to a resistant parent scenario that measured empathy and whether the social worker set the agenda or allowed the parent to set the agenda, the latter being consistent with MI.

Trainees were randomly assigned to one of two workshops. The control group received the workshop only, and the intervention group received the workshop plus additional telephone coaching over 3 months. Tapes were also collected with standardized clients at 3 months posttraining and were coded using the *MISC*.

Initial preworkshop results indicated that the social workers used aggressive and confrontational communication styles, had low levels of listening and empathy, and typically set their own agenda instead of allowing the client to do so (Forrester, McCambridge, Waissbein, & Rollnick, 2008). Results at follow-up showed that according to the *HRQ* and the parental resistance scenario, the social workers used more empathy and less confrontation and were less likely to impose their own agenda; however, only 10 out of 35 in the final sample achieved minimal competence in MI. Those who were competent in MI were still able to accurately assess child risk, meaning that they could engage the parent while remaining focused on the child.

In this study, there was low participation in telephone coaching due to time constraints, thus there were no differences among the groups in their level of MI skills. Qualitatively, the social workers reported that they felt better able to handle resistant clients and increase parental engagement; they also felt little support from their agency for MI skill development.

In a somewhat similar study, Owen and Hohman (2007) trained seven domestic violence counselors over 2 days. These counselors also received 2 half-day booster sessions at 4 and 8 weeks posttraining. Three months later they were interviewed regarding their use of MI. Qualitative analysis indicated that the counselors had grasped the "spirit" of MI, felt more confident in their work, and felt better equipped to handle resistant clients. Clients appeared to respond and engage more quickly when they used MI skills. Limitations of this study include lack of taped interviews to determine how proficient the counselors actually were in MI.

Implications for Child Welfare Agencies

MI has been demonstrated to be an effective practice to engage resistant clients in behavioral and medical treatments, particularly in the area of substance misuse treatment. This review found that the initial studies of MI with child welfare clients in the context of drug treatment provided mixed results. MI may be useful for working with the kinds of resistance often seen in parents who are involved with the child welfare system (Forrester et al., 2007; Hohman, 1998); however, more research in the use of MI in child welfare work needs to be conducted. No studies have been conducted at this point to determine if MI, as utilized by child welfare social workers, affects client outcomes, such as client engagement, child safety, or permanency. Client engagement needs to be studied to determine if it, in turn, could influence children being maintained in their own homes, leading to fewer child removals and lower costs.

The review of training studies of MI has indicated that participating in a one-shot training session is not enough to sustain skills, and some social workers may have a difficult time even learning these skills, particularly if they have entrenched non-MI-adherent skills, or they work for a system that does not support learning and practicing MI, or both. The best way to learn MI appears to be through training and ongoing coaching and supervision. Unfortunately, audio- or videotaping client interviews and coding them is an expensive and labor-intensive process. As an alternative, peer-support groups that meet regularly to practice and provide feedback regarding MI skills may be one helpful way to increase and sustain skill development. Busy schedules and large caseloads can make learning MI difficult, as was seen in the training studies; however, if administration at an agency makes learning and incorporating MI skills a priority, individuals may be more likely to take the time and invest energy in learning.

Agencies are sending their social workers to learn MI despite lack of research on how the use of MI may impact child welfare clients. For instance, the State of Washington, in an effort to make its child welfare system more effective, client-focused, and evidence-based, has a new policy initiative focused on strength-based case-management that includes a focus on client engagement and working with clients in a more collaborative manner. Currently, all Child Protective Service and contracted child welfare program professionals (e.g., family preservation services, family reconciliation services, and visiting nurses) are now required to attend a one-day introduction to MI. They are also offered an opportunity to return for a second day of MI training, but this is not required (D. Rosengren, personal communication, December 2008).

Summary

Research has supported the benefits of using MI in contexts other than child welfare. Despite mixed findings in initial studies, MI intuitively appears to be a promising approach for social workers in child welfare practice because many of its tenets are similar to social work values, such as self-determination, client empowerment, and respect for the client. Social workers have reported less resistance from clients when they use MI; the time and commitment to learning MI may be beneficial for clients, social workers, and the agencies in which they work. Although there is little evidence at this time to support this, what we do know is that to truly learn and utilize MI takes more than attending a one-day workshop. Support from agency administration and in supervision and small, peer skill-development groups may help maintain initial skills gained from workshops.

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