Using Motivational Interviewing to treat adolescents and young adults with substance use disorders

A case study of Hazelden Betty Ford Plymouth

Audrey A. Klein, PhD, MBA, Executive Director, Butler Center for Research

Young people receiving treatment for substance use disorders (SUDs) present a unique clinical challenge. Though premature dropout from treatment happens with adults, as many as 50% of teens and young adults with SUDs do not complete treatment. In addition, many who do complete treatment do not fully engage with the treatment process (Gogel et al., 2011). Treatment engagement involves more than just being physically present; it involves actively taking part in all aspects of the treatment process and becoming emotionally invested in those processes as well as in peers attending the same services (Szapocznik et al., 2003; Wise et al., 2001). Another factor that may complicate treatment engagement is the fact that many adolescents enter treatment because of external pressures (such as parental insistence) and, as a result, may have low motivation to engage (Battjes et al., 2003). Because both retention and active engagement in treatment are associated with positive outcomes and recovery from SUDs (Williams and Chang, 2000; Moos & Moos, 2003; McWhirter, 2008), organizations offering treatment services to youth should focus on approaches that promote engagement and enhance the patient's intrinsic motivation and commitment to change.

Hazelden Betty Ford has a facility in Plymouth, Minnesota, that focuses on providing SUD treatment to adolescents and young adults. In a recent interview with me, Dr. Joseph Lee, medical director of the Youth Continuum, stressed the importance of empathy in working with adolescent and young adult patients. A key piece of that work involves recognizing that empathy differs from identification. Empathy is the ability to imagine and accurately understand the feelings of another person and respond in a helpful way, and people with strong empathy can do this while maintaining a sense of being separate from that person (Buckman et al., 2011; Amsel, 2015). Identification, on the other hand, can be expressed as either relating to someone else so much that you lose a sense of yourself, or as identifying someone as so similar to yourself that you feel they must do and experience their situation as you do or did.

"We needed to take an honest look at how we were viewing and working with our patients," said Dr. Lee.

Figure 1

FIVE PRINCIPLES OF

MOTIVATIONAL INTERVIEWING

Express empathy for the client

Develop discrepancy between the client's goals and values and their current behavior, particularly regarding substance use

Avoid argumentation and direct confrontation

Roll with client resistance, instead of fighting it

Support the client's self-efficacy, or their belief that they can change

"This clinical introspection was especially critical as we began to treat more patients awash in the opioid epidemic. These kids are even more likely to drop out than other kids, and for them, the risk of going back out and using drugs can be fatal." The realization that empathic rapport is critical to helping the patient get better, combined with too many patients leaving treatment prematurely, particularly those with a high degree of clinical severity, prompted Lee and other clinical leaders to improve clinical practice at the therapist level.

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—Dr. Joseph Lee, medical director of the Youth Continuum

Hazelden Betty Ford had therefore identified an opportunity to strengthen their empathy in working with patients, along with addressing the urgent needs to keep young patients in treatment, increase their engagement in the treatment process and increase their motivation to change. The next step in the process was to decide on a therapeutic approach to meet these objectives. As applied to patients with substance use disorders, motivational interviewing (MI) is a brief psychotherapy aimed at increasing the patient's motivation and ability to change his/her addictive behaviors (Miller, Zweben, DiClemente, & Rychtarik, 1992). It focuses heavily on therapists bringing empathy to the therapeutic process with clients. Figure 1 lists the five elements of the approach, as outlined by Miller et al. (1992). The first element is expressing empathy for the client, which can be done in a number of ways. Empathic communication signals dignity and respect for the client and helps prevent the development of a superior/inferior relationship where the therapist is telling the client what he or she should be feeling. Empathic communication involves reflective listening, communicating an acceptance of where the client is and supporting them in the process of change (Miller & Rollnick, 1991). In addition to its strong focus on empathy, MI was chosen by Plymouth staff because it is an evidence-based practice in treating SUDs, with several studies indicating its effectiveness for adolescent and young adult populations (Barnett et al., 2012; Brown et al., 2015).

"Once we identified that we needed to start doing MI in a more formalized, consistent way across our clinicians, we needed to map out and implement a plan for doing it," Dr. Lee observed.

As one might imagine, this plan was fairly complex. Though all staff in patient-facing roles received training, the implementation of MI was heavily concentrated on two roles: alcohol/drug addiction counselors and addiction technicians. Addiction counselors are a core part of the residential program. They administer assessments, participate in treatment planning and engage in therapy with the patient around his or her unique needs and challenges. The addiction technicians help support the patient, including

easing their transition between the medical services unit and the residential treatment unit, helping them get to appointments on time and filling in for other non-clinical aspects of treatment, such as conducting meditation exercises.

Systematic training of staff in these two roles was a vital first step in implementing MI with patients. Several tactics were used as part of training, including the use of an MI text, required attendance at several two-day workshops and in-person training by both external MINT-certified specialists and several Plymouth staff well-versed in MI methods, including Dr. Lee; Travis Vanderbilt, an LADC counselor; and David Wells, a PhD-level psychologist in the mental health clinic. Once counselors and technicians were trained, Lee and other Plymouth MI experts set up a process to measure how counselors conducted therapy sessions with patients. The process involves periodically taping therapy sessions and auditing them for elements of MI. The conclusions of these audits are then shared with each counselor in regular supervision meetings with his/her manager. "The results of the audits and feedback on the clinician's use of MI are a vital part of the process and happens on an ongoing basis," says Dr. Lee. "But we focus on making these conversations collegial and constructive as opposed to punitive…the idea is to model MI even in the practitioner/supervisor discussions."

Successful implementation of MI with Plymouth staff took several months, as is typically the case with clinical programs addressing behavioral health issues. By the middle of 2016, MI was fully implemented and used consistently with all residential patients. Figure 2 shows atypical discharge rates for patients as a function of when they were discharged from the Plymouth residential program. These rates represent the percentage of patients who left treatment prematurely for various reasons (against staff advice, against medical advice, or occasionally at staff request). Over the last several quarters, the percentage of atypical discharges has been trending downward in a pattern consistent with the timeframe of motivational interviewing implementation. Only 9.9% of patients discharged in Q1 of 2017 left treatment prematurely, as opposed to 13.28% of patients in Q3 of 2015 (a 25% decrease). Though several other factors may have impacted these rates—for example, an increase over time in the use of Suboxone for patients with opioid use issues—the results are encouraging.

Qualitative feedback from staff members at Plymouth also suggests a positive impact of MI on both staff and patients. Staff members described it as a "very person-centered" approach, in part because it allows the clinician to effectively build rapport through empowerment rather than directives. Young patients are very receptive to the approach because they feel they are being worked with in a collaborative way, not talked down to or ordered to do certain things. Several staff members reported being able to help emotionally distressed patients change their mind about leaving treatment. In a couple of cases, the patient

had left the facility, but the counselor was able to convince them to come back. Plymouth staff members directly attributed these outcomes to their use of MI. "MI is helping our patients because it reduces many of the impulsive decisions and encourages them to think through their actions before doing them," said one staff member. "It also helps them process through emotions they are not used to experiencing before making important decisions." Several counselors also reported that the therapeutic alliance formed with their patients has been strengthened through the use of MI, which is quite important given the role of the alliance in predicting positive outcomes after treatment (Connors et al., 1997; Cook et al., 2015).

Behavioral health provider organizations wanting to implement evidence-based clinical practices in a highly accurate, reliable way can do so through an implementation science approach. At its core, implementation science involves the use of research and measurement to ensure that practices are implemented correctly within clinical settings (Proctor et al., 2009). The first step of the approach is to identify a practice that has a strong evidence base, meaning that it has been studied in a scientific manner and found to

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—Hazelden Betty Ford Plymouth staff member

though critical, is often overlooked by organizations implementing new clinical practices. It is one thing to implement something and occasionally measure how things are going. It is another thing to use what is learned and apply it back to care delivery on a continuous, long-term basis. As more behavioral health service providers use this model to bring evidence-based practices to patients, we can expect patient engagement and outcomes to improve.

Figure 2

Atypical Discharge Rates
for Hazelden Betty Ford Foundation Residential Treatment

2015–2017

Quarter	Rate
3Q 2015	13.28%
4Q 2015	13.95%
1Q 2016	9.91%
2Q 2016	8.17%
3Q 2016	9.70%
4Q 2016	10.80%
1Q 2017	9.90%
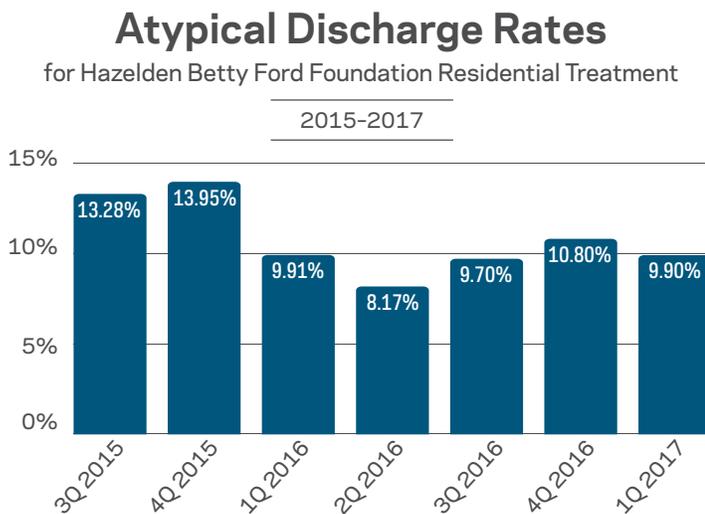
produce positive outcomes across studies. The second step involves mapping out how to deliver the clinical practice based on the organization's current structure, staffing models, clinical workflows and other processes related to care delivery. A key part of the second step is the training of staff directly administering the program or practice. Hazelden Betty Ford at Plymouth has completed these steps with regard to implementing motivational interviewing with residential patients. Clinical leaders and other staff will focus on subsequent steps over the coming months. This work will focus on evolving and standardizing the processes for measuring how effective each counselor is at implementing MI with patients. Most importantly, counselors and supervisors will make sure that these assessments are used to continuously improve MI practice. This final step,

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