Motivational interviewing in vocational rehabilitation for people living with mental ill health

Chris Lloyd, Samson Tse, Geoff Waghorn, Nicole Hennessy

Background: People living with mental ill health are among the most socially and economically marginalized members of the community. Unemployment rates are high and suitable support to return to work may not always be available. Motivational interviewing (MI) is a focused method of communication that was originally developed to assist counsellors in the treatment of problem drinking. However, more recent applications have demonstrated success with a variety of health conditions and problem behaviours. MI helps clients identify and change behaviours that may be preventing them from achieving optimal life goals, for instance, returning to paid employment.

Content: This article gives an overview of the MI approach and highlights key research to date in the field. The vocational expectations of mental health service users and barriers to achieving them are examined. The potential for using MI in vocational rehabilitation with people living with mental ill health is then explored.

Conclusions: A successful return to work can help people regain a lost sense of purpose and identity, which is crucial to achieving optimal life goals. It is proposed that motivation for work can be clarified and enhanced by the skilled application of a MI technique. Further work and research in this area is needed.

Key words: ■ psychiatric rehabilitation ■ mental health problems ■ vocational rehabilitation ■ motivational interviewing

Submitted 20 October 2008, accepted for publication with minor revisions following double-blind peer review 10 November 2008

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Both the United Kingdom and New Zealand data show that 25–30% of people presenting to their family doctors have had concerns about their mental health (Bushnell, 2004; Ministry of Health, 2008). The common problems reported are depression, anxiety, stress, substance misuse and addictions (MaGPIe Research Group, 2003). As well as those who are currently unwell, there are others affected at home, at work, in the local neighbourhood and wider community. For example in New Zealand, it is estimated that approximately 47% of the total population will experience a mental disorder at some time in their lives and that by 2006 almost 40% had already met criteria for a disorder (Oakley et al, 2006). For those affected by mental health problems in New Zealand, about 35% report they have been discriminated against while looking for a job and when using mental health services (Peterson et al, 2006; Peterson, 2007). The global implications of the financial crisis are that labour demand is likely to decrease over the next few years, with negative implications for people with anxiety or depression wanting to return to the labour force (Waghorn et al, in press).

For the last two decades, two strategies have helped improve the employment situation for individuals recovering from mental ill health; evidence-based supported employment and supported education (Mental Health Commission, 1999; Burns et al, 2007; Nuechterlein et al, 2008). Although these programmes aim for zero exclusion, a common entry criterion is that the person wants help to return to study or employment. Here lies the problem. Many people living with severe mental ill health have experienced unfair discrimination, disempowerment, and social and economic marginalization. These experiences can impact negatively on the person, in addition to the impact of the illness and side-effects of medication which also impair motivation, self-esteem, self-efficacy and expectations for a better life (Waghorn and Lloyd, 2005; Sainsbury Centre for Mental Health, 2007). Hence the challenge remains as to how best to explore, clarify and strengthen individual motivation to obtain appropriate assistance with formal education or competitive employment. The purpose of this article is to introduce motivational interviewing, and how it might be used to assist individuals living with severe mental

ill health to develop appropriate vocational goals as early as possible in their recovery trajectory.

MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) is a therapeutic approach that was developed to help individuals with alcohol-related problems change their drinking habits (Miller and Rollnick, 2002). MI is (Miller and Rollnick, 2002: p.25) a:

'client-centred, directive method for enhancing intrinsic motivation for change by exploring and resolving ambivalence.'

The fundamental principles of MI include expressing empathy for clients' experiences, rolling with resistance rather than confronting it, avoiding argument, developing discrepancy between actual and desired behaviour, and promoting self-efficacy that change is achievable. These principles are supported through the use of:

- Reflective listening to ensure that practitioners listen to their clients
- Open-ended questions to encourage clients' elaboration
- Affirmations to support clients' self-efficacy
- Summaries to integrate and reinforce what has been discussed (Miller and Rollnick, 2002).

MI takes its theoretical basis from the Transtheoretical Model, more commonly known as the Stages of Change Model, developed by Prochaska et al (1992) (Figure 1). This model identifies a cycle of change which people move through before effecting permanent change. These stages are:

- Pre-contemplation: When the individual indicates that there is no intention to change behaviour in the foreseeable future
- Contemplation: When the individual is aware that a problem exists and is seriously thinking about overcoming it but has not made a commitment to take action
- Preparation: When the individual is intending to take action in the next month and has unsuccessfully taken action in the past year
- Action: The stage in which the individual modifies his/her behaviour experiences or environment to overcome his/her problem
- Maintenance: The stage in which the individual works to prevent relapse and consolidates gain attained during action (Prochaska et al, 1992).

Prochaska et al (1992) proposed a spiral pattern that reflects how most people actually move through the stages of change. In this spiral pattern, people can progress from contemplation to preparation to action to maintenance, but most individuals will relapse. During relapse people regress to an earlier stage.

PREVIOUS RESEARCH

As earlier stated, MI was originally developed as a brief intervention for alcohol and other substance use disorders, and it has accumulated a large number of successful empirical trials that target these problems (Kahler et al, 2004; Carey et al, 2006; Carroll et al, 2006). More recently, it has been applied to other problems, for example: dietary intake (Resnicow et al, 2001), renal diets (Karalis and Wiesen, 2007), smoking cessation (Steinberg et al, 2004), problem gambling (DiClemente, 2003; Petry, 2006) diabetes (Kenardy et al, 2002) and weight loss/physical activity (Harland et al, 1999; Pinto et al, 2001). MI has also been used with people experiencing mental ill health (Swanson et al, 1999; Barrowclough et al, 2001; Martino et al, 2006; Carey et al, 2007; Grote et al, 2007; Swartz et al, 2007).

Previous research supports the use of MI as an intervention strategy with specific sub-group populations. For example, Steinberg et al (2004) investigated the effect of MI in motivating smokers with schizophrenia to seek treatment for tobacco dependence. The researchers found that after a 1-month follow-up a greater proportion of participants (32%) who received the MI intervention contacted a tobacco dependence treatment provider and attended the first session of counselling compared to those who received a comparison intervention (11%).

Barrowclough et al (2001) investigated the effect of MI integrated with cognitive behaviour therapy and family intervention for individuals with comor-

Figure 1. Stages of Change Model. Reprinted with permission from: Prochaska JO, DiClemente JC, Norcross JC (1992) In search of how people change-applications to addictive behaviors. *American Psychologist* 47(9): 1102-14. APA

bid schizophrenia and substance use disorders. They found that integrating the MI intervention resulted in significantly greater improvement in individuals' general functioning compared to routine care. MI has also been successfully used in conjunction with other interventions. For example, compared to the non-treatment group, individuals with anxiety disorders who received MI as an adjunct to cognitive behaviour therapy had a significantly higher expectancy for anxiety control and greater homework compliance (Westra and Dozois, 2006).

Further evidence for the effectiveness of MI with people living with mental ill health was found in a meta-analysis of randomized controlled trials using MI as the intervention (Rubak et al, 2005). The analysis found that when using MI in a 15-minute brief intervention, 64% of the studies demonstrated positive treatment effects. Based on this analysis the researchers concluded that MI outperforms traditional advice giving in the treatment of a broad range of behavioural problems and diseases.

The above examples highlight the emerging evidence to support the application of MI with individuals living with mental ill health. The positive outcomes of the key research outlined above supports the use of MI to enhance the vocational and non-vocational motivation of mental health clients.

VOCATIONAL EXPECTATIONS

There are many barriers that can prevent or limit people living with mental ill health participate in community life. Some of these include a lack of support services, lack of information, community stigma, the episodic nature of mental ill health, few employer incentives, and a shortage of appropriate programme places (Waghorn and Lloyd, 2005; Mental Health Council of Australia, 2007). In addition the low expectations of people living with mental ill health can prevent many from receiving vocational rehabilitation. An examination of programmes with low rates of competitive employment among people living with mental ill health found that it was often left to the individual to bring up their interest in employment with the service provider (Waghorn and Lloyd, 2005).

Mental health clients who do not have clear vocational or non-vocational interests are likely to face additional challenges when using employment support programmes or other community participation initiatives. This is because if clients do not have vocational or non-vocational goals, they may express no interest in participating in the community. In addition, clients who do express an interest in working may be less likely to retain employment if they are in a position that they do not find personally satisfying (Lysaker and Bell, 1995; Becker et al, 1998).

A recent case study by Carlson and Rapp (2007) examined a supported employment programme at a community mental health centre. The study identified obstacles preventing staff from maintaining a focus on consumer preferences and individualized job searches. For example, the employment specialist did minimal job development with employers on behalf of a specific client. In addition there was a general focus on jobs within the community mental health centre or volunteer jobs rather than on competitive jobs in the community. Furthermore, job development or employer contracts were not being used owing to concern over employer stigma of mental illness. Overall, the study illustrates the need to improve supported employment programmes, otherwise mental health clients will continue to have limited success and low vocational expectations.

Despite the many barriers to participating in vocational activities experienced by people living with mental ill health, when asked, between 55% and 70% of people with severe mental health problems identify employment as a long-term goal (Mueser et al, 2001; McQuilken et al, 2003). A study conducted by Secker et al (2001) found that only half of the survey participants were involved in any kind of vocational activity and a similar proportion had received no vocational assistance. The main reasons given for not identifying employment as a goal were:

- Not understanding available employment assistance options and benefits
- Fear of loss of welfare benefits
- Already participating in other commitments and activities.

The first two of these reasons are potentially amenable to intervention at an individual level.

McCown and Howatt (2007: p.156) coined the term 'motivation toxicity' to refer to 'a loss of ability to be motivated about anything other than the addicting experience'. In transferring this concept to people living with mental ill health, 'motivation toxicity' implies the reluctance to step out of comfort zone in pursuing vocational goals among some clients. It is apparent that the course of mental ill health and the psychosocial consequences of living with mental ill health may have similar negative effects at various stages of returning to employment (*Figure 2*).

MOTIVATIONAL INTERVIEWING IN VOCATIONAL REHABILITATION

In the context of vocational rehabilitation for people with mental ill health, service users are those people with severe mental ill health who are accessing public mental health services, in particular the community mental health teams. The diagnoses most commonly seen in these settings include schizophrenia, bipolar affective disorder and depression.

The clinical team consisting of mental health professionals—including nurses, occupational therapists, social workers and psychologists—would be particularly interested in assisting the service user to set vocational goals, and could engage in delivering the MI to achieve this. An employment specialist (vocational counsellor or vocational specialist) may also be involved in assisting the process, although MI would be outside the scope of their practice. Employment specialists work for an employment agency whose responsibility is to find work for people with disability; they do not necessarily have a background in mental health but have experience in vocational rehabilitation or relevant business or industry experience.

A process for exploring service user motivation and vocational goals is necessary to identify all those who can participate in and benefit from an intensive and individualized employment programme. While the international evidence now rejects the concept of work readiness as obsolete (e.g. Bond, 2004), it is not possible to provide an intensive service such as supported employment to those who do not request this form of assistance. Work readiness involves assisting people to develop specific skills to allow them to reintegrate into the workplace. This typically involves a step-by-step process of completing a rehabilitation programme consisting of work assessment of the person's competencies and skills and group programmes that could include coping skills, skills training and stress management, before gaining competitive employment (Corbiere and Lecomte, 2007; Rinaldi and Perkins, 2007). Although the evidence now supports a need for zero exclusion on the basis of clinical assessments, service user assistance in obtaining employment is considered a valid entry criterion. However, many people in the early days of treatment and care following a psychotic episode can have difficulty making decisions about vocational goals, and may have difficulty exploring their own personal motivations for employment.

This means that only those who are very clear, assertive and consistent about their vocational goals are likely to find their way into suitable employment programmes, because demand for programme places often exceeds the number of places available. Use of MI allows exploration of the potential benefits of engaging service users who are not consistently expressing a desire for vocational assistance. This approach has the potential to enhance the clinical team's recovery-oriented approach, where mental health services are no longer primarily concerned with clinical recovery. This allows the team to adopt a broader perspective accommodating service user goals in terms of personal, social, and functional recovery (Lloyd et al, 2008).

To use MI effectively in vocational rehabilitation settings, it is important that practitioners have received proper training on the approach and provide clear documentation of how it is implemented. Although MI is helpful in promoting internally motivated changes, vocational rehabilitation practitioners need to support the service user in removing the external barriers (e.g. lack of transport, not knowing the benefit/ income support when returning to work on trial) to achieve the identified goals and rally social support around the service users. It remains a challenge for researchers and practitioners to understand why MI works; that is, to identify the important features of MI interventions that contribute to the success of interventions, as perceived by service users and practitioners.

Challenges encountered when using MI

Rehabilitation practitioners often carry a very heavy workload and they may have trouble finding time to use MI to support individuals explore and pursue their vocational goals. Lack of training and sense of confidence to use MI is another commonly identified challenge (Bisono et al, 2006). Effective use of MI does require specific skills and art of prompting when working with service users to identify the desire, ability, reasons, need and commitment to change. Assuming the 'expert role' is a common challenge faced by practitioners when using MI in vocational rehabilitation or any health-care settings. Health-care practitioners are very tempted to: 'offer my (medical professionals, rehabilitation therapists) solution to your (service users) problems'. Rollnick et al (1999) suggested several ways to avoid the expert role:

- Avoid arguing for change while the service user is not ready

Figure 2. Motivational toxicity- multiple factors hindering many aspects of motivation to pursue vocational goals

- Do not assume practitioners have to offer all the solutions to change

- Do not assume the service user ought to change, wants to change or that his/her health is the prime motivator for them to change.

'I fail' syndrome is another difficulty. It is very common to hear: 'if my service user does not decide to change or indeed make the change we have been discussing...I have failed'.

The authors have been unable to identify any specific set of conditions in which MI should not be used, although it is suggested that MI may perhaps not be possible to use with someone who has major cognitive difficulties or impairment owing to serious mental illness (e.g. people with limited attention span, limited abstract thinking, planning and execution or people under the influence of active psychotic symptoms). As stated above, practitioners should not assume the expert role, nor should they argue with the service user for change when he/she argues against it. Ethically speaking, practitioners should not inappropriately manipulate their service users to persuade them to make the changes the practitioner wants, i.e. there will be times when the practitioner will need to actively try to remain neutral, such as when discussing with the client the benefits of them returning to employment.

CREATING THE CONDITIONS FOR CHANGE

It is suggested by the authors that a motivational interview can be used to explore the following themes:

- The value and benefits of employment
- Reasons for including employment in recovery goals (or not)
- Sources of positive and negative motivation;
- Concerns and fears about employment
- Incentives and disincentives for having employment goals
- Short and longer term career goals
- Benefits of receiving employment assistance
- Concerns about employment assistance
- Other concerns about the future
- Personal expectations for recovery.

In addition, the person being interviewed can also receive additional printed information to assist them in accessing employment services if they choose to seek assistance. This approach is expected to improve vocational outcomes for service users. The authors would expect that because of this form of intervention, more service users will volunteer for vocational assistance earlier on in their recovery. Practitioners can consider the following principles of motivational interviewing when exploring individuals' vocational goals:

Expressing empathy

Empathy is fundamental in all therapies which involve talking and listening. Demonstrating empathy requires the ability to convey informed understanding of the service user's predicament and what maintains the ambivalence. There is the expectation that the practitioner listens actively and reflects on what the service user has said so that the practitioner can provide concise statements that address what the service user has been saying. It is important that the practitioner conveys understanding, acceptance and interest in the person. Resilience to pursuing a vocational goal is linked to a sense of self-esteem and self-confidence, ability to deal with change and adaptation; and a repertoire of social problem-solving skills. To develop resilience, an individual needs experiences of secure, stable, affectionate responses from practitioners, and an experience of success and achievement.

Avoiding argument

MI questions how much someone wants to achieve change and encourages the service user to hear themselves say why they want to change. Arguments are counterproductive and may well lead to the service user experiencing more resistance to change.

Supporting self-efficacy

Belief in one's ability to make a change and to stay with it is fundamental to that change. It is important to encourage the service user to make overt positive statements that reflect a sense of self-efficacy; these will assist in the service user reframing his/her thinking.

Rolling with resistance

This is a relatively difficult skill to acquire. Questioning, asking for clarification and elaboration can help the service user to see the incompatibility between beliefs that maintain the discrepancy between where the service user is and where he/she wants to move to. New perspectives may be offered. Humour may also be used; to lighten the mood and to give the service user a less serious perspective on the problem that is concerning them.

Developing discrepancy

It is necessary for the service user to have goals to work towards and these should be generated by the service user and not imposed. Supporting the service user to outline their goals and steps to achieving them gives the practitioner valuable insight into how realistic these goals are and what the priority for change is. Discrepancy is highlighted between where the service user is currently and where he/she wants to be.

Summarizing key steps

Towards the end of the discussion, it is always helpful to highlight and summarize the specific steps the service user and the practitioner may have to take to move to the next stage in the cycle of changes. When the timing is right, the service user may be invited to complete homework or set small goals before the next meeting, be it evaluating the pros and cons of finding part-time employment for the next 10–12 months or talking with two people who have been successful in returning to workforce.

Affirming the discussion

Given the magnitude of obstacles potentially confronting someone living with mental ill health (Figure 1), the practitioner should take time to affirm the service users' courage to contemplate returning to competitive employment. As McCown and Howatt (2007: p.86) state, practitioners should:

**'Create the sense that you are supportive.
Reinforce important statements with
reflective listening and verbal support as
well as typical nods.'**

CONCLUSIONS

People living with mental ill health may have difficulty forming vocational goals early in their recovery trajectory and may need skilled assistance. This article has explored MI as an approach that can be adopted with these service users, and highlighted key research to date in this field. The vocational expectations of mental health service users and barriers to achieving them have been examined. By applying a carefully considered MI, practitioners can help mental health service users to develop vocational goals. Although the evidence supports the use of MI for this purpose, more work is needed to explore its utility in this setting. The potential for a wider adoption of this approach depends on the mental health professionals and whether they value pursuing vocational goals with service users. MI does require some training, however, and it would be best for clinicians to undertake a course in the approach, and to have supervision in the use of MI. **UJR**

Conflict of interest: none

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KEY POINTS

- People living with mental ill health are over-represented among those not seeking employment assistance, those not actively looking for work, and are over-represented among those currently unemployed.
- Motivational interviewing can be used to clarify and enhance motivation for change and resolving ambivalence.
- Previous research supports the use of motivational interviewing for assisting people living with severe mental ill health with a variety of life problems.
- Motivational interviewing seems particularly suited to clarifying the multi-dimensional aspects of vocational goal formation.

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COMMENTARY

Practitioners in rehabilitation settings will often encounter clients who do not want to cooperate with some aspect of a programme, clients who continue to adopt behaviours that may be exacerbating their condition despite well-intentioned efforts to help them. William Miller, a clinical psychologist from the University of New Mexico, has for the past 25 years, been studying both clinical and research-based practitioner-client interactions in the treatment of addictive behaviours in an effort to understand those who are resistant to change.

Miller realized that resistance behaviour is quite common in clinical settings and should be

considered a signal to the practitioner that the methods being used may be inappropriate. He also recognized that it is normal for people to have mixed feelings about changing behaviour, which prompted him to ask the question: what can practitioners do during brief contacts with people to lower resistance and help the person resolve their ambivalence about behaviour change? This initiated numerous studies on this topic and has culminated in the publication of two landmark textbooks that describe an alternate method of communicating with clients called motivational interviewing (Miller and Rollnick, 1991; 2002).

As Lloyd and colleagues indi-

cate in their article, motivational interviewing was originally developed for use by mental health specialists in the treatment of addictions and the approach has also been used to counsel people with severe mental ill health (Arkowitz et al, 2007). However, more recent adaptations of the approach to medical settings have been effective in improving a wide range of health behaviours (Scales and Miller, 2003; McKnight et al, 2006), including the kinds of behaviours that are promoted by physiotherapists, occupational therapists and allied professionals in a rehabilitation setting. There are now over 140 published randomized controlled trials involving moti-

vational interviewing (Wagner and Connors, 2008).

The article by Lloyd and colleagues introduces the reader to the principles of motivational interviewing from an occupational therapy perspective. The specific goals of vocational counselling are clearly described and a rationale is presented to support the use of motivational interviewing to assist people with mental ill health to return to gainful employment after losing their job. This is clearly a desirable goal for both the individual and society in general. It appears that people with mental ill health may receive vocational counselling from a variety of health-care practitioners within

a rehabilitation setting, and the counsellor does not necessarily have to be a mental health specialist. Miller and Rollnick, the originators of motivational interviewing, emphasize that health-care professionals can be taught the skills that are associated with this method of communication and that these skills are not exclusive to mental health specialists. However, the authors of this article encourage practitioners to seek the correct training to conduct a motivational interview and that they use the approach appropriately within the scope of their practice.

A growing number of experienced trainers in motivational interviewing now provide training workshops that are customized to the needs of a broad range of health-care professionals and some universities now offer students training in motivational interviewing (Poirier et al, 2004; Scales, 2007). The Motivational Interviewing Network of Trainers (MINT) is an international collective of trainers who have completed a 3-4 day training workshop that was conducted by William Miller and/or Stephen Rollnick. This trainer workshop is designed to teach the training methods, techniques and spirit of the approach. It encourages good practice in the use of motiva-

tional interviewing and in the training of practitioners and trainers.

In a randomized controlled trial to investigate the effect of training methods on skill acquisition, Miller et al (2004) demonstrated that counsellors who participated in a standard 2-day training workshop showed substantial gains in motivational interviewing proficiency, at least over the short-term, and that there was no significant improvement among those who participated in self-directed learning with training manuals and videotapes. In my experience of training rehabilitation specialists in motivational interviewing, I have observed that it is not uncommon for trainees to discover that they are already using some of the skills of motivational interviewing during their more successful consultations with clients. However, participation in a training workshop helps practitioners to develop those skills and learn how to consistently practice specific motivational interviewing strategies for use in clinical settings.

In a standard 2-day training workshop in motivational interviewing, trainees are guided through a sequence of experiential learning activities to enhance their communication skills in the clinic and improve proficiency

in motivational interviewing. Workshops should be interactive, and live demonstrations and videotaped examples are used to show trainees aspects of the approach. This is combined with opportunities for trainees to practice small group exercises that are designed to simulate face-to-face conversations about behaviour change. Trainees may be asked to talk about real situations in their life (real plays) or role play client scenarios and they are then given immediate feedback from the trainer about the particular skill that is being taught. Each workshop is customized to suit the needs of the target audience, which includes addressing the unique challenges that are encountered with specific clinical populations and the associated problem behaviour(s).

The article by Lloyd and colleagues recognizes the potential to improve outcomes in vocational rehabilitation with motivational interviewing. Therefore, training opportunities should be made available and future research associated with the application of this method to this type of setting appears to be merited.

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