Motivational Interviewing as an AOD Intervention

When combined with more active cognitive–behavioural methods tailored to the client's stage of change, motivational interviewing (MI) is a powerful approach for achieving long-term results. As described by Burke et al. (2003), it is a client-centred but directed approach for increasing intrinsic desire to change via the exploration and resolution of the client's ambivalence. Originally developed as an approach to behaviour change, motivational interviewing has increasingly been used in public health to promote health. It is a promising approach to AOD intervention in determining a client's willingness to change and acknowledging the client's feelings of connection to the drug or behaviour under consideration (Lundahl & Burke, 2009). The need for AOD clients to change their behaviour is what makes MI applicable for use with AOD clients. This paper provides a rationale on why when applying MI as an AOD intervention, it is important to acknowledge the clients' experience of AOD use and why both clients and workers should recognise the function of the drug use.

Since no amount of information compounded by zero motivation can result in any change, the change process must include an element of motivation as a component. A client's motivation to change is found to be strongly impacted by the therapist's relationship style, to the point where the therapist's conduct may even be the determining factor in the client's noncompliance with change recommendations, according to research. The therapist is cautious not to openly advocate for change, even if motivational interviewing is purposefully prescriptive; the client offers the grounds for change (Lundahl & Burke, 2009). Therefore, when a client displays opposition to change, it serves as a signal for the practitioner to respond in a different manner. Motivational interviewing considers resistance an emotional variable. The third fundamental principle is not to aggressively challenge the client's reluctance but rather to embrace and flow with it, again employing reflective active listening.

According to MI, a positive working relationship in which individuals are seen as experts in their own lives helps to reduce resistance to change and, as a result, increases motivation. With MI, the professionals must work toward specific goals such as decreasing client ambivalence and increasing motivation to actively modify a target behaviour, which is a directional component of the intended intervention. It accomplishes this by drawing upon theories such as self-perception Theory (Bem, 1967) and cognitive dissonance theory (Festinger, 1957), which define processes associated with behavioural changes. MI aims to create a discord between the client's detrimental status quo habits, such as drinking, and the healthy objectives, options such as responsible living, with the expectation that concentrating on the disharmony will drive the client to modify his or her behaviour.

The first step in creating a positive working relationship on the road towards creating discord in the status quo is to acknowledge the clients' experience with AOD. To achieve this, it is vital to recognise both the perceived costs and benefits of use. Research has shown that there are several reasons why individuals take drugs. According to the Australian Health Department (2004), for the majority of individuals, taking drugs is yet another means of changing consciousness, and it is not that dissimilar from a variety of other leisure activities. Nonetheless, for some individuals who acquire more obsessive drug-using behaviours, drug use is not only about having fun, calming, or socialising; rather, it is about achieving a sense of control over one's life. It generally serves a more profound goal, such as assisting in enhancing identity and acceptability, as well as reducing psychological discomfort or a feeling of isolation, among other things.

To the AOD user, the reason for use is a perceived benefit in that it is what directs or prompts the use. Acknowledging the clients' experience will thus have to look at this perceived benefit based on the understanding of the client. If, for example, a client is depressed and uses alcohol to elicit sleep, then this perceived benefit of alcohol use has to be acknowledged in the

context of the wider experience. However, since the intention is to create a behaviour change by creating discord between the benefits and costs, the perceived costs have to also be acknowledged. The goal here is to better understand the perceived benefits and risks and then work on making the client understand how the costs outweigh the benefits to create intrinsic motivation to change the behaviour. Acknowledging the experience in terms of benefits and costs will also pave the way for inviting the client to examine both the benefits and problems of changing behaviour (Miller & Rollnick, 2002).

As argued by Morton et al. (2015), there are several guiding concepts that guide MI in its various forms. Some examples include expressing compassion and understanding by listening carefully and the professional's attitude of affirmation; developing disparity by exacerbating the discrepancy between the present behaviour and the important goals through the provision of feedback on the behaviour; avoiding counterarguments and potential conflict by ensuring the patient is responsible for making informed decisions. The capacity to deal with resistance by actively engaging the patient in the problem-solving process and fostering self-efficacy and positivity through supportive comments, verbal persuasion regarding competence, and urging the patient to reflect on prior accomplishments is vital to the success of MI. Acknowledging the role the use of substances may have had in the life of the client affirms it plays a role in the client's life and enables the practitioner to be empathetic towards the client to initiate a collaborative relationship.

It is also important for both the AOD worker and the client to recognise the function of the substance use. Recognising the purpose of the substance use identifies the root cause of the prevailing behaviour. The client can identify the cause of the problem and starts to contemplate the behaviour change. Most of the individuals who use substances may be aware of their behaviour's function but are in self-denial or have never thought about what they do it. According to the addiction universal health care system, "denial" is a harmful personality trait

that is characteristic of alcoholics nearly universally. It is often regarded as the most significant impediment to successful therapy and the most significant reason for therapeutic failure (Miller, 1983). As previously said, it also serves as a handy excuse for why so many individuals fail to better their situation. By affirming the function of substance use, the client can then accept the problem exist and start the journey to recovery. On the other hand, the AOD worker can identify what motivates the client towards substance use and use this information to create strategies to create a discrepancy to motivate the client.

With the help of the MI spirit, the AOD professional will thoroughly avoid the context of authoritarian posture and extensively preserve the context of the autonomy of the patient via the notion of embracing the client's responsibility to alter their drinking behaviour, whether they choose to or not. Instead of counselling patients on why they should systematically stop their drug use, motivational interviewing substantially emphasises essential concerns of eliciting answers for the progressive transformation for the patient (Miller & Rose, 2009). It is so frequent among patients who are classified as having unresolved ambivalence in the persuasive communication framework that the overall context of missing motivation is built for the majority of them. In this setting, the ultimate goal of the AOD professional is to have a thorough understanding of the patient's indecisiveness about the treatment. This is accomplished by a detailed examination of the advantages and disadvantages of continuing to use illegal drugs. The practitioner and the client will next collaborate on the resolution of ambivalence, using the notion of linking important items that the patient really values within a methodical context of change to achieve success.

Motivational interviewing works to increase the desire to change the prevailing behaviour of substance use and adopt a more healthy behaviour. It acknowledges the client's feelings of connection to the drug or behaviour under consideration and determines the client's willingness to change. However, the relationship style adopted by the AOD worker in dealing and relating

with the client is significant in the success of MI. the AOD worker has to be highly responsive to the behaviours and responses of the client and ensure the client makes informed decisions with full autonomy. Since MI does not address the root cause of substance use, critics have argued that it can be an avenue for AOD workers to make clients aware of their insufficiencies. However, MI is not used alone but can be combined with other intervention strategies for the full recovery of the client.

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