Enhancing Motivation for Change in Substance Use Disorder Treatment

UPDATED 2019

TREATMENT IMPROVEMENT PROTOCOL

TIP 35

SAMHSA
Substance Abuse and Mental Health Services Administration

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Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the U.S. Department of Health and Human Services agency that leads public health efforts to reduce the impact of substance abuse and mental illness on America's communities. An important component of SAMHSA's work is focused on dissemination of evidence-based practices and providing training and technical assistance to healthcare practitioners on implementation of these best practices.

The Treatment Improvement Protocol (TIP) series contributes to SAMHSA's mission by providing science-based, best-practice guidance to the behavioral health field. TIPs reflect careful consideration of all relevant clinical and health service research, demonstrated experience, and implementation requirements. Select nonfederal clinical researchers, service providers, program administrators, and patient advocates comprising each TIP's consensus panel discuss these factors, offering input on the TIP's specific topics in their areas of expertise to reach consensus on best practices. Field reviewers then assess draft content and the TIP is finalized.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of care and treatment of mental and substance use disorders. My sincere thanks to all who have contributed their time and expertise to the development of this TIP. It is my hope that clinicians will find it useful and informative to their work.

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Executive Summary

Motivation for change is a key component in addressing substance misuse. This Treatment Improvement Protocol (TIP) reflects a fundamental rethinking of the concept of motivation as a dynamic process, not a static client trait. Motivation relates to the probability that a person will enter into, continue, and adhere to a specific change strategy.

Although much progress has been made in identifying people who misuse substances and who have substance use disorders (SUDs) as well as in using science-informed interventions such as motivational counseling approaches to treat them, the United States still faces many SUD challenges. For example, the National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2018) reports that, in 2017, approximately:

- 140.6 million Americans ages 12 and older currently consumed alcohol, 66.6 million reported at least 1 episode of past-month binge drinking (defined as 5 or more drinks on the same occasion on at least 1 day in the past 30 days for men and 4 or more drinks on the same occasion on at least 1 day in the past 30 days for women), and 16.7 million drank heavily in the previous month (defined as binge drinking on 5 or more days in the past 30 days).
- 30.5 million people ages 12 and older had used illicit drugs in the past month.
- 11.4 million people ages 12 and older misused opioids (defined as prescription pain reliever misuse or heroin use) in the past year.
- 8.5 million adults ages 18 and older (3.4 percent of all adults) had both a mental disorder and at least 1 past-year SUD.
- 18.2 million people who needed SUD treatment did not receive specialty treatment.
- One in three people who perceived a need for substance use treatment did not receive it because they lacked healthcare coverage and could not afford treatment.
- Two in five people who perceived a need for addiction treatment did not receive it because they were not ready to stop using substances.

Millions of people in the United States with SUDs are not receiving treatment. Many are not seeking treatment because their motivation to change their substance use behaviors is low.

The motivation-enhancing approaches and strategies this TIP describes can increase participation and retention in SUD treatment and positive treatment outcomes, including:

- Reductions in alcohol and drug use.
- Higher abstinence rates.
- Successful referrals to treatment.

This TIP shows how SUD treatment counselors can influence positive behavior change by developing a therapeutic relationship that respects and builds on the client's autonomy. Through motivational enhancement, counselors become partners in the client's change process.

The TIP also describes different motivational interventions counselors can apply to all the stages in the Stages of Change (SOC) model related to substance misuse and recovery from addiction.

A consensus panel developed this TIP's content based on a review of the literature and on panel members' extensive experience in the field of addiction treatment. Other professionals also generously contributed their time and commitment to this project.

Intended Audience

The primary audiences for this TIP are:

- Drug and alcohol treatment service providers.
- Mental health service providers, such as psychologists, licensed clinical social workers, and psychiatric/mental health nurses.
- Peer recovery support specialists.
- Behavioral health program managers, directors, and administrators.
- Clinical supervisors.
- Healthcare providers, such as primary care physicians, nurse practitioners, general/family medicine practitioners, registered nurses, internal medicine specialists, and others who may need to enhance motivation to address substance misuse in their patients.

Secondary audiences include prevention specialists, educators, and policymakers for SUD treatment and related services.

Overall Key Messages

Motivation is key to substance use behavior change. Counselors can support clients' movement toward positive changes in their substance use by identifying and enhancing motivation that already exists.

Motivational approaches are based on the principles of person-centered counseling. Counselors' use of empathy, not authority and power, is key to enhancing clients' motivation to change. Clients are experts in their own recovery from SUDs. Counselors should engage them in collaborative partnerships.

Ambivalence about change is normal. Resistance to change is an expression of ambivalence about change, not a client trait or characteristic. Confrontational approaches increase client resistance and discord in the counseling relationship. Motivational approaches explore ambivalence in a nonjudgmental and compassionate way.

The Transtheoretical Model (TTM) of the SOC approach is an overarching framework that helps counselors tailor specific counseling strategies to different stages. Motivational counseling strategies should be tailored to clients' level of motivation to change their substance use behaviors at each of the five stages of the SOC:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Effective motivational counseling approaches can be brief. A growing body of evidence indicates that early and brief interventions demonstrate positive treatment outcomes in a wide variety of settings including specialty SUD treatment programs, primary care offices, and emergency departments. Brief interventions emphasize reducing the health-related risk of a person's substance use and decreasing consumption as an important treatment outcome.

Motivational interviewing (MI) and other motivational counseling approaches like motivational enhancement therapy are effective ways to enhance motivation throughout the SOC. Motivational counseling approaches are based on person-centered counseling principles that focus on helping clients resolve ambivalence about changing their substance use and other health-risk behaviors.

MI is the most widely researched and disseminated motivational counseling approach in SUD treatment. The spirit of MI (i.e., partnership, acceptance, compassion, and evocation) is the foundation of the core counseling skills required for enhancing clients' motivation to change. The core counseling skills of MI are described in the acronym OARS (Open questions, Affirmations, Reflective listening, and Summarization).

Counselor empathy, as expressed through reflective listening, is fundamental to MI. Use of empathy, rather than power and authoritative approaches, is critical for helping clients achieve and maintain lasting behavior change.

Adaptations of MI enhance the implementation and integration of motivational interventions into standard treatment methods. Training, ongoing supervision, and coaching of counselors are essential for workforce development and integration of motivational counseling approaches into SUD treatment.

Content Overview

Chapter 1—A New Look at Motivation

This chapter lays the groundwork for understanding treatment concepts discussed later in the TIP. It is an overview of the nature of motivation and its link to changing substance use behaviors. The chapter describes changing perspectives on addiction and addiction treatment in the United States and uses the TTM of the SOC approach as an overarching framework to understand how people change their substance use behaviors.

In Chapter 1, readers will learn that:

- Motivation is essential to substance use behavior change. It is multidimensional, dynamic, and fluctuating; can be enhanced; and is influenced by the counselor's style.
- Benefits of using motivational counseling approaches include clients' enhancing motivation to change, preparing them to enter treatment, engaging and retaining clients in treatment, increasing their participation and involvement in treatment, improving their treatment outcomes, and encouraging a rapid return to treatment if they start misusing substances again.
- New perspectives on addiction treatment include focusing on clients' strengths instead of deficits, offering person-centered treatment, shifting away from labeling clients, using empathy, focusing on early and brief interventions, recognizing that there is a range of severity of substance misuse, accepting risk reduction as a legitimate treatment goal, and providing access to integrated care.
- People go through stages in the SOC approach; this concept is known as the TTM of change.
- The stages in the SOC model are:
  - Precontemplation, in which people are not considering change.
  - Contemplation, in which people are considering change but are unsure how to change.
  - Preparation, in which people have identified a change goal and are forming a plan to change.
  - Action, in which people are taking steps to change.
  - Maintenance, in which people have met their change goal and the behavior change is stable.

Chapter 2—Motivational Counseling and Brief Intervention

This chapter is an overview of motivational counseling approaches, including screening, brief intervention, and referral to treatment (SBIRT). It describes elements of effective motivational counseling approaches, including FRAMES (**F**eedback, **R**esponsibility, **A**dvice, **M**enu of options, **E**mpathy, and **S**elf-efficacy), decisional balancing, discrepancy development, flexible pacing, and maintenance of contact with clients. The chapter describes counselors' focus in each stage of the SOC model. It addresses special applications of motivational counseling with clients from diverse cultures and with clients who have co-occurring substance use and mental disorders (CODs).

In Chapter 2, readers will learn that:

- Each stage in the SOC approach has predominant experiential and behavioral catalysts for client change on which counselors should focus.
- Counselors should adopt the principles of cultural responsiveness and adapt motivational interventions to those principles when treating clients from diverse backgrounds.
- Even mild substance misuse can impede functioning in people with CODs, including co-occurring severe mental illness. Counselors can adapt motivational interventions for these clients.

- Brief motivational interventions, including SBIRT, are effective in specialty SUD treatment facilities and opportunistic settings (e.g., primary care offices, emergency departments).
- Brief interventions emphasize risk reduction and referral to specialty addiction treatment if needed.

Chapter 3—Motivational Interviewing as a Counseling Style

This chapter provides an overview of the spirit of MI, the principles of person-centered counseling, the core counseling skills of MI (i.e. asking open questions, affirming, reflective listening, and summarizing), and the four processes of MI (i.e., engaging, focusing, evoking, and planning). It describes what's new in MI and dispels many misconceptions about MI. The chapter discusses the components that counselors use to help clients resolve ambivalence and move toward positive substance use behavior change.

In Chapter 3, readers will learn that:

- Ambivalence about substance use and change is normal and a motivational barrier to substance use behavior change, if not explored.
- The spirit of MI embodies the principles of person-centered counseling and is the basis of an empathetic, supportive counseling style.
- Sustain talk is essentially statements the client makes for not changing (i.e., maintaining the status quo), and change talk is statements the client makes in favor of change. The key to helping the client move in the direction toward changing substance use behaviors is to evoke change talk and soften or lessen the impact of sustain talk on the client's decision-making process.
- The acronym OARS describes the core skills of MI:
  - Asking Open questions
  - Affirming the client's strengths
  - Using Reflective listening
  - Summarizing client statements
- Reflective listening is fundamental to person-centered counseling in general and MI in particular and is essential for expressing empathy.
- The four processes in MI (i.e., engaging, focusing, evoking, and planning) provide an overarching framework for employing the core skills in conversations with a client.
- The benefits of MI include its broad applicability to diverse medical and behavioral health problems and its capacity to complement other counseling approaches and to mobilize client resources.

Chapter 4—From Precontemplation to Contemplation: Building Readiness

This chapter discusses strategies counselors can use to help clients raise doubt and concern about their substance use and move toward contemplating the possibility of change. It emphasizes the importance of assessing clients' readiness to change, providing personalized feedback to them about the effects and risks of substance misuse, involving their significant others in counseling to raise concern about clients' substance use behaviors, and addressing special considerations for treating clients who are mandated to treatment.

In Chapter 4, readers will learn that:

- A client in the Precontemplation stage is unconcerned about substance use or is not considering change.
- The counselor's focus in Precontemplation is to establish a strong counseling alliance and raise the client's doubts and concerns about substance use.
- Key strategies in this stage include eliciting the client's perception of the problem, exploring the events that led to entering treatment, and identifying the client's style of Precontemplation.
- Providing personalized feedback on assessment results and involving significant others in counseling sessions are key strategies for raising concern and moving the client toward contemplating change.
- Special considerations in motivational counseling approaches for clients mandated to treatment include acknowledging client ambivalence and emphasizing personal choice and responsibility.

Chapter 5—From Contemplation to Preparation: Increasing Commitment

This chapter describes strategies to increase clients' commitment to change by normalizing and resolving ambivalence and enhancing their decision-making capabilities. It emphasizes decisional balancing and exploring clients' self-efficacy as important to moving clients toward preparing to change substance use behaviors. Summarizing change talk and exploring the client's understanding of change prepare clients to take action.

In Chapter 5, readers will learn that:

- In the Contemplation stage, the client acknowledges concerns about substance use and is considering the possibility of change.
- The counselor's focus in Contemplation is to normalize and resolve client ambivalence and help the client tip the decisional balance toward changing substance use behaviors.
- Key motivational counseling strategies for resolving ambivalence include reassuring the client that ambivalence about change is normal; evoking DARN (**D**esire, **A**bility, **R**easons, and **N**eed) change talk; and summarizing the client's concerns.
- To reinforce movement toward change, the counselor reinforces the client's understanding of the change process, reintroduces personalized feedback, explores client self-efficacy, and summarizes client change talk.
- The counselor encourages the client to strengthen his or her commitment to change by taking small steps, going public, and envisioning life after changing substance use behaviors.

Chapter 6—From Preparation to Action: Initiating Change

This chapter describes the process of helping clients identify and clarify change goals. It also focuses on how and when to develop change plans with clients and suggests ways to ensure that plans are accessible, acceptable, and appropriate for clients.

In Chapter 6, readers will learn that:

- In the Preparation stage, the client is committed and planning to make a change but is unsure of what to do next. In the Action stage, the client is actively taking steps to change but has not reached stable recovery.
- In Preparation, the counselor focuses on helping the client explore change goals and develop a change plan. In Action, the counselor focuses on supporting client action steps and helping the client evaluate what is working and not working in the change plan.
- The client who is committed to change and who believes change is possible is prepared for the Action stage.
- Sobriety sampling, tapering down, and trial moderation are goal-sampling strategies that may be helpful to the client who is not committed to abstinence as a change goal.
- Creating a change plan is an interactive process between the counselor and client. The client should determine and drive change goals.
- Identifying and helping the client reduce barriers to the Action stage are important to the change-planning process.
- Counselors can support client action by reinforcing client commitment and continuing to evoke and reflect CAT (i.e., **C**ommitment, **A**ctivation, and **T**aking steps) change talk in ongoing conversations.

Chapter 7—From Action to Maintenance: Stabilizing Change

This chapter addresses ways in which motivational strategies can be used effectively to help clients maintain the gains they have made by stabilizing change, supporting lifestyle changes, managing setbacks during the Maintenance stage, and helping them reenter the cycle of change if they relapse or return to substance misuse. It emphasizes creating a coping plan to reduce the risk of recurrence in high-risk situations, identifying new behaviors that reinforce change, and establishing relapse prevention strategies.

In Chapter 7, readers will learn that:

- During the Maintenance stage, the client has achieved the initial change goals and is working toward maintaining those changes.

- In Maintenance, the counselor focuses on helping the client stabilize change and supports the client's lifestyle changes.
- During a relapse, the client returns to substance misuse and temporarily exits the change cycle. The counselor focuses on helping the client reenter the cycle of change and providing relapse prevention counseling in accordance with the principles of person-centered counseling.
- Maintenance of substance use behavior change in the SOC model must address the issue of relapse. Relapse should be reconceptualized as a return to or recurrence of substance use behaviors and viewed as a common occurrence.
- Relapse prevention counseling is a cognitive–behavioral therapy (CBT) method, but the counselor can use motivational counseling strategies to engage the client in the process and help the client resolve ambivalence about learning and practicing new coping skills.
- Strategies to help a client reenter the change cycle after a recurrence include affirming the client's willingness to reconsider positive change, exploring reoccurrence as a learning opportunity, helping the client find alternative coping strategies, and maintaining supportive contact with the client.

Chapter 8—Integrating Motivational Approaches in SUD Treatment Settings

This chapter discusses some of the adaptations of motivational counseling approaches applicable to SUD treatment programs and workforce development issues that treatment programs should address to fully integrate and sustain motivational counseling approaches. It emphasizes blending MI with other counseling approaches. It also explores ways in which ongoing training, supervision, and coaching are essential to successful workforce development and integration.

In Chapter 8, readers will learn that:

- Integrating motivational counseling approaches into a treatment program requires a broad integration of the philosophy and underlying spirit of MI throughout the organization.
- Adapted motivational interventions may be more cost effective, accessible to clients, and easily integrated into existing treatment approaches than expected and may ease some workload demands on counselors.
- Technology adaptations, including motivational counseling and brief interventions over the phone or via text messaging, are effective, cost effective, and adaptable to different client populations.
- MI is effective when blended with other counseling approaches including group counseling, the motivational interviewing assessment, CBT, and recovery management checkups.
- The key to workforce development is to train all clinical and support staffs in the spirit of MI so that the entire program's philosophy is aligned with person-centered principles, like emphasizing client autonomy and choice.
- Program administrators should assess the organization's philosophy and where it is in the SOC model before implementing a training program.
- Training counseling staff in MI takes more than a 1- or 2-day workshop. Maintenance of skills requires ongoing training and supervision.
- Supervision and coaching in MI should be competency based. These activities require directly observing the counselor's skill level and using coding instruments to assess counselor fidelity. Supervision should be performed in the spirit of MI.
- Administrators need to balance training, supervision, and strategies to enhance counselor fidelity to MI with costs, while partnering with counseling staff to integrate a motivational counseling approach throughout the organization.

TIP Development Participants

Consensus Panel

Each Treatment Improvement Protocol's (TIP) consensus panel is a group of primarily nonfederal addiction-focused clinical, research, administrative, and recovery support experts with deep knowledge of the TIP's topic. With the Substance Abuse and Mental Health Services Administration's Knowledge Application Program team, members of the consensus panel develop each TIP via a consensus-driven, collaborative process that blends evidence-based, best, and promising practices with the panel members' expertise and combined wealth of experience.

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Field reviewers represent each TIP's intended target audiences. They work in addiction, mental health, primary care, and adjacent fields. Their direct front-line experience related to the TIP's topic allows them to provide valuable input on a TIP's relevance, utility, accuracy, and accessibility. Additional advisors to this TIP include members of a resource panel and an editorial advisory board.

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Publication Information

Acknowledgements

This publication was prepared under contract numbers 270-95-0013, 270-14-0445, 270-19-0538, and 283-17-4901 by the Knowledge Application Program (KAP) for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA). Sandra Clunies, M.S., I.C.A.D.C., served as the Contracting Officer's Representative (COR) for initial Treatment Improvement Protocol (TIP) development. Suzanne Wise served as the COR; Candi Byrne as the Alternate COR; and Reed Forman, M.S.W., as the Project Champion for the TIP update.

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Recommended Citation

Substance Abuse and Mental Health Services Administration. Enhancing Motivation for Change in Substance Use Disorder Treatment. Treatment Improvement Protocol (TIP) Series No. 35. SAMHSA Publication No. PEP19-02-01-003. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

Originating Office

Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

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SAMHSA Publication No. PEP19-02-01-003
First printed 1999
Updated 2019

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Chapter 1—A New Look at Motivation

> Motivation to initiate and persist in change fluctuates over time regardless of the person's stage of readiness. From the client's perspective, a decision is just the beginning of change."
>
> —Miller & Rollnick, 2013, p. 293

KEY MESSAGES

- Motivation is the key to substance use behavior change.
- Counselor use of empathy, not authority and power, is essential to enhancing client motivation to change.
- The Transtheoretical Model (TTM) of the Stages of Change (SOC) approach is a useful overarching framework that can help you tailor specific counseling strategies to the different stages.

Why do people change? How is motivation linked to substance use behavior change? How can you help clients enhance their motivation to engage in substance use disorder (SUD) treatment and initiate recovery? This Treatment Improvement Protocol (TIP) will answer these and other important questions. Using the TTM of behavioral change as a foundation, Chapter 1 lays the groundwork for answering such questions. It offers an overview of the nature of motivation and its link to changing substance use behaviors. It also addresses the shift away from abstinence-only addiction treatment perspectives toward client-centered approaches that enhance motivation and reduce risk.

In the past three decades, the addiction treatment field has focused on discovering and applying science-informed practices that help people with SUDs enhance their motivation to stop or reduce alcohol, drug, and nicotine use. Research and clinical literature have explored how to help clients sustain behavior change in ongoing recovery. Such recovery support helps prevent or lessen the social, mental, and health problems that result from a recurrence of substance use or a relapse to previous levels of substance misuse.

This TIP examines motivational enhancement and substance use behavior change using two science-informed approaches (DiClemente, Corno, Graydon, Wiprovnick, & Knobloch, 2017):

1. Motivational interviewing (MI), which is a respectful counseling style that focuses on helping clients resolve ambivalence about and enhance motivation to change health-risk behaviors, including substance misuse

2. The TTM of the SOC, which provides an overarching framework for motivational counseling approaches throughout all phases of addiction treatment

KEY TERMS

Addiction*: The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.

Alcohol misuse: The use of alcohol in any harmful way, including use that constitutes alcohol use disorder (AUD).

Alcohol use disorder: Per the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; APA, 2013), a diagnosis applicable to a person who uses alcohol and experiences at least 2 of the 11 symptoms in a 12-month period. Key aspects of AUD include loss of control, continued use despite adverse consequences, tolerance, and withdrawal. AUD covers a range of severity and replaces what DSM-IV, termed "alcohol abuse" and "alcohol dependence" (APA, 1994).

Health-risk behavior: Any behavior (e.g., tobacco or alcohol use, unsafe sexual practices, nonadherence to prescribed medication regimens) that increases the risk of disease or injury.

Recovery*: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome their disorder and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called "being in recovery." Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.

Recurrence: An instance of substance use that occurs after a period of abstinence. Where possible, this TIP uses the terms "recurrence" or "return to substance use" instead of "relapse," which can have negative connotations (see entry below).

Relapse*: A return to substance use after a significant period of abstinence.

Substance*: A psychoactive compound with the potential to cause health and social problems, including SUDs (and their most severe manifestation, addiction). The table at the end of this exhibit lists common examples of such substances.

Substance misuse*: The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).

Substance use*: The use—even one time—of any of the substances listed in the table at the end of this exhibit.

Substance use disorder*: A medical illness caused by repeated misuse of a substance or substances. According to DSM-5 (APA, 2013), SUDs are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. SUDs range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse. A severe SUD is commonly called an addiction.

Substance Category	Representative Examples
Alcohol	• Beer • Wine • Malt liquor • Distilled spirits
Illicit Drugs	• Cocaine, including crack • Heroin • Hallucinogens, including LSD, PCP, ecstasy, peyote, mescaline, psilocybin • Methamphetamines, including crystal meth • Marijuana, including hashish* • Synthetic drugs, including K2, Spice, and "bath salts"** • Prescription-type medications that are used for nonmedical purposes – Pain Relievers - Synthetic, semi-synthetic, and non-synthetic opioid medications, including fentanyl, codeine, oxycodone, hydrocodone, and tramadol products – Tranquilizers, including benzodiazepines, meprobamate products, and muscle relaxants – Stimulants and Methamphetamine, including amphetamine, dextroamphetamine, and phentermine products; mazindol products; and methylphenidate or dexmethylphenidate products – Sedatives, including temazepam, flurazepam, or triazolam and any barbiturates
Over-the-Counter Drugs and Other Substances	• Cough and cold medicines** • Inhalants, including amyl nitrite, cleaning fluids, gasoline and lighter gases, anesthetics, solvents, spray paint, nitrous oxide

*As of June 2016, 25 states and the District of Columbia have legalized medical marijuana use, for states have legalized retail marijuana sales, and the District of Columbia has legalized personal use and home cultivation (both medical and recreational). It should be noted that none of the permitted uses under state laws alter the status of marijuana and its constituent compounds as illicit drugs under Schedule I of the federal Controlled Substances Act. See the section on Marijuana: A Changing Legal and Research Environment in the Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health (Office of the Surgeon General, 2016). The report is available online (https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf).

The definitions of all terms marked with an asterisk correspond closely to those in the Surgeon General's Report.

** These substances are not included in NSDUH and are not discussed in the Surgeon General's Report. However, important facts about these drugs are included in Appendix D - Important Facts About Alcohol and Drugs

Motivation and Behavior Change

Motivation is a critical element of behavior change (Flannery, 2017) that predicts client abstinence and reductions in substance use (DiClemente et al., 2017). You cannot give clients motivation, but you can help them identify their reasons and need for change and facilitate planning for change. Successful SUD treatment approaches **acknowledge motivation as a multidimensional, fluid state during which people make difficult changes to health-risk behaviors, like substance misuse.**

The Nature of Motivation

The following factors define motivation and its ability to help people change health-risk behaviors.

- **Motivation is a key to substance use behavior change.** Change, like motivation, is a complex construct with evolving meanings. One framework for understanding motivation and how it relates to behavior changes is the self-determination theory (SDT). SDT suggests that people inherently want to engage in activities that meet their need for autonomy, competency (i.e., self-efficacy), and relatedness (i.e., having close personal relationships) (Deci & Ryan, 2012; Flannery, 2017). SDT describes two kinds of motivation:
  - Intrinsic motivation (e.g., desires, needs, values, goals)
  - Extrinsic motivation (e.g., social influences, external rewards, consequences)

- **MI is a counseling approach that is consistent with SDT and emphasizes enhancing internal motivation to change.** In the SDT framework, providing a supportive relational context that promotes client autonomy and competence enhances intrinsic motivation, helps clients internalize extrinsic motivational rewards, and supports behavior change (Flannery, 2017; Kwasnicka, Dombrowski, White, & Sniehotta, 2016; Moyers, 2014).

- **Contingency management is a counseling strategy that can reinforce extrinsic motivation.** It uses external motivators or reinforcers (e.g., expectation of a reward or negative consequence) to enhance behavior change (Sayegh, Huey, Zara, & Jhaveri, 2017).

- **Motivation helps people resolve their ambivalence about making difficult lifestyle changes.** Helping clients strengthen their own motivation increases the likelihood that they will commit to a specific behavioral change plan (Miller & Rollnick, 2013). Research supports the importance of SDT-based client motivation in positive addiction treatment outcomes (Wild, Yuan, Rush, & Urbanoski, 2016). Motivation and readiness to change are consistently associated with increased help seeking, treatment adherence and completion, and positive SUD treatment outcomes (Miller & Moyers, 2015).
- **Motivation is multidimensional.** Motivation includes clients' internal desires, needs, and values. It also includes external pressures, demands, and reinforcers (positive and negative) that influence clients and their perceptions about the risks and benefits of engaging in substance use behaviors. Two components of motivation predict good treatment outcomes (Miller & Moyers, 2015):
  - The importance clients associate with changes
  - Their confidence in their ability to make changes

- **Motivation is dynamic and fluctuates.** Motivation is a dynamic process that responds to interpersonal influences, including feedback and an awareness of different available choices (Miller & Rollnick, 2013). Motivation is a strong predictor of addiction treatment outcomes (Miller & Moyers, 2015). Motivation can fluctuate over different stages of the SOC and varies in intensity. It can decrease when the client feels doubt or ambivalence about change and increase when reasons for change and specific goals become clear. In this sense, motivation can be an ambivalent state or a resolute commitment to act—or not to act.

- **Motivation is influenced by social interactions.** An individual's motivation to change can be positively influenced by supportive family and friends as well as community support and negatively influenced by lack of social support, negative social support (e.g., a social network of friends and associates who misuse alcohol), and negative public perception of SUDs.

- **Motivation can be enhanced.** Motivation is a part of the human experience. No one is totally unmotivated (Miller & Rollnick, 2013). Motivation is accessible and can be enhanced at many points in the change process. Historically, in addiction treatment it was thought that clients had to "hit bottom" or experience terrible, irreparable consequences of their substance misuse to become ready to change. Research now shows that counselors can help clients identify and explore their desire, ability, reasons, and need to change substance use behaviors; this effort enhances motivation and facilitates movement toward change (Miller & Rollnick, 2013).

- **Motivation is influenced by the counselor's style.** The way you interact with clients impacts how they respond and whether treatment is successful. Counselor interpersonal skills are associated with better treatment outcomes. In particular, an empathetic counselor style predicts increased retention in treatment and reduced substance use across a wide range of clinical settings and types of clients (Moyers & Miller, 2013). The most desirable attributes for the counselor mirror those recommended in the general psychology literature and include nonpossessive warmth, genuineness, respect, affirmation, and empathy. In contrast, an argumentative or confrontational style of counselor interaction with clients, such as challenging client defenses and arguing, tends to be counterproductive and is associated with poorer outcomes for clients, particularly when counselors are less skilled (Polcin, Mulia, & Jones, 2012; Roman & Peters, 2016).

- **Your task is to elicit and enhance motivation.** Although change is the responsibility of clients and many people change substance use behaviors on their own without formal treatment (Kelly, Bergman, Hoeppner, Vilsaint, & White, 2017), you can enhance clients' motivation for positive change at each stage of the SOC process. Your task is not to teach, instruct, or give unsolicited advice. Your role is to help clients recognize when a substance use behavior is inconsistent with their values or stated goals, regard positive change to be in their best interest, feel competent to change, develop a plan for change, begin taking action, and continue using strategies that lessen the risk of a return to substance misuse (Miller & Rollnick, 2013). Finally, you should be sensitive and responsive to cultural factors that may influence client motivation. For more information about enhancing cultural awareness and responsiveness, see TIP 59: Improving Cultural Competence (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a).

COUNSELOR NOTE: ARE YOU READY, WILLING, AND ABLE?

Motivation is captured, in part, in the popular phrase that a person is ready, willing, and able to change:

- "Ability" refers to the extent to which a person has the necessary skills, resources, and confidence to make a change.
- "Willingness" is linked to the importance a person places on changing—how much a change is wanted or desired. However, even willingness and ability are not always enough.
- "Ready" represents a final step in which a person finally decides to change a particular behavior.

Your task is to help the client become ready, willing, and able to change.

Why Enhance Motivation?

Although much progress has been made in identifying people who misuse substances and who have SUD and in using science-informed interventions such as motivational counseling approaches to treat them, the United States is still facing many SUD challenges. For example, the National Survey on Drug Use and Health (SAMHSA, 2018) reports that, in 2017, approximately:

- 140.6 million Americans ages 12 and older currently consumed alcohol, 66.6 million engaged in past-month binge drinking (defined as 5 or more drinks on the same occasion on at least 1 day in the past 30 days for men and 4 or more drinks on the same occasion on at least 1 day in the past 30 days for women), and 16.7 million drank heavily in the past month (defined as binge drinking on 5 or more days in the past 30 days).
- 30.5 million people ages 12 and older had past-month illicit drug use.
- 11.4 million people misused opioids (defined as prescription pain reliever misuse or heroin use) in the past year.
- 8.5 million adults ages 18 and older (3.4 percent of all adults) had both a mental disorder and at least one past-year SUD.
- 18.2 million people who needed SUD treatment did not receive specialty treatment.
- One-third of people who perceived a need for addiction treatment did not receive it because they lacked health insurance and could not pay for services.

Enhancing motivation can improve addiction treatment outcomes. In the United States, millions of people with SUDs are not receiving treatment. Many do not seek treatment because their motivation to change their substance use behaviors is low. Motivational counseling approaches are associated with greater participation in treatment and positive treatment outcomes. Such outcomes include increased motivation to change; reductions in consumption of alcohol, tobacco, cannabis, and other substances; increased abstinence rates; higher client confidence in ability to change behaviors; and greater treatment engagement (Copeland, McNamara, Kelson, & Simpson, 2015; DiClemente et al., 2017; Lundahl et al., 2013; Smedslund et al., 2011).

The benefits of motivational enhancement approaches include:

- Enhancing motivation to change.
- Preparing clients to enter treatment.
- Engaging and retaining clients in treatment.
- Increasing participation and involvement.
- Improving treatment outcomes.
- Encouraging rapid return to treatment if clients return to substance misuse.

Changing Perspectives on Addiction and Treatment

Historically, in the United States, different views about the nature of addiction and its causes have influenced the development of treatment approaches. For example, after the passage of the Harrison Narcotics Act in 1914, it was illegal for physicians to treat people with drug addiction. The only options for people with alcohol or drug use disorders were inebriate homes and asylums. The underlying assumption pervading these early treatment approaches was that alcohol and drug addiction was either a moral failing or a pernicious disease (White, 2014).

By the 1920s, compassionate treatment of opioid addiction was available in medical clinics. At the same time, equally passionate support for the temperance movement, with its focus on drunkenness as a moral failing and abstinence as the only cure, was gaining momentum.

The development of the modern SUD treatment system dates only from the late 1950s. Even "modern" addiction treatment has not always acknowledged counselors' capacity to support client motivation. Historically, motivation was considered a static client trait; the client either had it or did not have it, and there was nothing a counselor could do to influence it.

This view of motivation as static led to blaming clients for tension or discord in therapeutic

relationships. Clients who disagreed with diagnoses, did not adhere to treatment plans, or refused to accept labels like "alcoholic" or "drug addict" were seen as difficult or resistant (Miller & Rollnick, 2013).

SUD treatment has since evolved in response to new technologies, research, and theories of addiction with associated counseling approaches. Exhibit 1.1 summarizes some models of addiction that have influenced treatment methods in the United States (DiClemente, 2018).

EXHIBIT 1.1. Models of Addiction

MODEL	UNDERLYING ASSUMPTIONS	TREATMENT APPROACHES
Moral/legal	Addiction is a set of behaviors that violates religious, moral, or legal codes.	Abstinence and use of willpower External control through hospitalization or incarceration
Psychological	Addiction results from deficits in learning, emotional dysfunction, or psychopathology.	Cognitive, behavioral, psychoanalytic, or psychodynamic psychotherapies
Sociocultural	Addiction results from socialization and sociocultural factors. Contributing factors include socioeconomic status, cultural and ethnic beliefs, availability of substances, laws and penalties regulating substance use, norms and rules of families and other social groups, parental and peer expectations, modeling of acceptable behaviors, and the presence or absence of reinforcers.	Focus on building new social and family relationships, developing social competency and skills, and working within a client's culture
Spiritual	Addiction is a spiritual disease. Recovery is predicated on a recognition of the limitations of the self and a desire to achieve health through a connection with that which transcends the individual.	Integrating 12-Step recovery principles or other culturally based spiritual practices (e.g., American Indian Wellbriety principles) into addiction treatment Linking clients to 12-Step, faith- and spiritual-based recovery, and other support groups
Medical	Addiction is a chronic, progressive disease. Genetic predisposition and neurochemical brain changes are primary etiological factors.	Medical and behavioral interventions including pharmacotherapy, education, and behavioral change advice and monitoring
Integrated treatment	Addiction is a chronic disease that is best treated by collaborative and comprehensive approaches that address biopsychosocial and spiritual components.	Integrated treatment with a recovery focus across treatment settings

Earlier Perspectives

Although the field is evolving toward a more comprehensive understanding of SUD, **earlier views of addiction still persist in parts of the U.S. addiction treatment system**. For example, the psychological model of addiction treatment gave rise, in part, to the idea of an "addictive personality" and that psychological defenses (e.g., denial) need to be confronted. Remnants of earlier perspectives of addiction and their associated treatment approaches, which are not supported by research, include:

- **An addictive personality leads to SUDs.** Although it is commonly believed that people with SUDs possess similar personality traits that make treatment difficult, no distinctive personality traits have been found to predict that an individual will develop an SUD (Amodeo, 2015). The tendencies of an addictive personality most often cited are denial, projection, poor insight, and poor self-esteem. This idea is a deficit-based concept that can lead to counselors and clients viewing addiction as a fixed part of an underlying personality disorder and therefore difficult to treat (Amodeo, 2015).
- **Rationalization and denial are characteristics of addiction.** Another leftover from earlier psychological perspectives on addiction is that people with SUDs have strong psychological defenses, such as denial and rationalization, which lead to challenging behaviors like evasiveness, manipulation, and resistance (Connors, DiClemente, Velasquez, & Donovan, 2013). The clinical and research literature does not support the belief that people with SUDs have more or stronger defenses than other clients (Connors et al., 2013).
- **Resistance is a characteristic of "unmotivated" clients in addiction treatment** (Connors et al., 2013). When clients are labeled as manipulative or resistant, given no voice in selecting treatment goals, or directed authoritatively to do or not to do something, the result is a predictable response of resistance or reactivity to the counselor's directives (Beutler, Harwood, Michelson, Song, & Holman, 2011). Viewing resistance—along with rationalization and denial—as characteristic of addiction and making efforts to weaken these defenses actually strengthens them. This paradox seemed to confirm the idea that resistance and denial were essential components of addiction and traits of clients.
- **Confrontation of psychological defenses and substance misuse behaviors is an effective counseling approach.** Historically, the idea that resistance and denial are characteristic of addiction led to the use of confrontation as a way to aggressively break down these defenses (White & Miller, 2007). However, adversarial confrontation is one of the least effective methods for helping clients change substance use behaviors, can paradoxically reduce motivation for beneficial change, and often contributes to poor outcomes (Bertholet, Palfai, Gaume, Daeppen, & Saitz, 2013; Moos, 2012; Moyers & Miller, 2013; Romano & Peters, 2016). Yet there is a constructive type of confrontation. This kind of confrontation must be done within the context of a trusting and respectful relationship and is delivered it in a supportive way that also elicits hope for change (Polcin et al., 2012).

EXPERT COMMENT: A BRIEF HISTORY OF CONFRONTATION IN ADDICTION TREATMENT

For many reasons, the U.S. treatment field fell into some rather aggressive, argumentative, "denial-busting" methods for confronting people with alcohol and drug problems. This perspective was guided, in part, by the belief that substance misuse links to a particular personality pattern characterized by such rigid defense mechanisms as denial and rationalization. In this perspective, the counselor must take responsibility for impressing reality on clients, who cannot see it on their own. Such confrontation found its way into the popular Minnesota model of treatment and into Synanon (a drug treatment community known for group sessions in which participants verbally attacked each other) and other similar therapeutic community programs.

After the 1970s, the treatment field began to move away from such methods. The Hazelden Foundation officially renounced the "tear them down to build them up" approach in 1985, expressing regret that such confrontational approaches had become associated with the Minnesota model. Psychological studies have found no consistent pattern of personality or defense mechanisms associated with SUDs. Clinical studies have linked worse outcomes to more confrontational counselors, groups, and programs (Miller & Wilbourne, 2002; Moos, 2012; Romano & Peters, 2016). Instead, successful outcomes (Moyers, Houck, Rice, Longabaugh, & Miller, 2016) generally have been associated with counselors showing high levels of empathy as defined by Carl Rogers (1980). The Johnson Institute now emphasizes a supportive, compassionate style for conducting family interventions.

I was at first surprised when counselors attending my MI workshops and watching me demonstrate the style observed, "In a different way, you're very confrontational." This comes up in almost every training now. Some call it "gentle confrontation." This got me thinking about what confrontation really means.

The linguistic roots of the verb "to confront" mean "to come face-to-face." When you think about it that way, confrontation is precisely what we are trying to accomplish: to allow our clients to come face-to-face with a difficult and often threatening reality, to "let it in" rather than "block it out," and to allow this reality to change them. That makes confrontation a **goal** of counseling rather than a particular **style** or **technique.**

Once you see this—namely, that opening to new information, face-to-face, is a **goal** of counseling—then the question becomes, "What is the best way to achieve that goal?" Strong evidence suggests that direct, forceful, aggressive approaches are perhaps the **least** effective way to help people consider new information and change their perceptions. Such confrontation increases the very phenomenon it is supposed to overcome—defensiveness—and decreases clients' likelihood of change (Miller, Benefield, & Tonigan, 1993; Miller & Wilbourne, 2002; Moos, 2012; Romano & Peters, 2016). It is also inappropriate in many cultures. Getting in a client's face may work for some, but for most, it is exactly the opposite of what is needed—to come face-to-face with painful reality and to change.

William R. Miller, Ph.D., Consensus Panel Chair

A New Perspective

As the addiction treatment field has matured, it has tried to integrate conflicting theories and approaches and to incorporate research findings into a comprehensive model. The following sections address recent changes in addiction treatment with important implications for applying motivational methods.

Focus on client strengths

Historically the treatment field has focused on the deficits and limitations of clients. Today, greater emphasis is placed on **identifying, enhancing, and using clients' strengths, abilities, and competencies.** This trend parallels the principles of motivational counseling, which affirm clients, emphasize personal autonomy, support and strengthen self-efficacy, and reinforce that change is possible (see Chapter 4). The responsibility for recovery rests with clients, and the judgmental tone, which is a remnant of the moral model of addiction, is eliminated.

Individualized and person-centered treatment

In the past, clients frequently received standardized treatment, no matter what their problems or SUD severity. Today, **treatment is increasingly based on clients' individual needs, which are carefully and comprehensively assessed at intake.** Positive outcomes such as higher levels of engagement in psychosocial treatments, decreased alcohol use, and improved quality of life are associated with person-centered care and a focus on individualized treatment (Barrio & Gual, 2016; Bray et al., 2017; Jackson et al., 2014). In this perspective, clients have choices about desirable, suitable treatment options—they are not prescribed treatment. Motivational approaches emphasize choice by eliciting personal goals from clients and involving them in selecting the type of treatment needed or desired from a menu of options.

A shift away from labeling

Historically, a diagnosis or disease defined the client and became a dehumanizing attribute of the individual. Today, individuals with asthma or a psychosis are seldom referred to as "the asthmatic" or "the psychotic." Similarly, in the addiction treatment arena, there is a trend to avoid labeling clients with SUDs as "addicts" or "alcoholics." **Using a motivational style will help you avoid labeling clients,** especially those who may not agree with the diagnosis or do not see a particular behavior as problematic. Person-first language (e.g., a person with an SUD) is the new standard; it reduces stigma, helps clients disentangle addiction from identity, and eliminates the judgmental tone left over from the moral model of addiction (SAMHSA, Center for the Application of Prevention Technologies, 2017).

Therapeutic partnerships for change

In the past, especially in the medical model, the client passively **received** treatment. Today, treatment usually entails **a partnership in which you and the client agree on treatment goals** and together develop strategies to meet those goals. The client is seen as an active participant in treatment planning. Using motivational strategies fosters a therapeutic alliance with the client and elicits goals and change strategies from the client. The client has ultimate responsibility for making changes.

Use of empathy, not authority and power

Historically, addiction treatment providers were placed in the position of an authority with the power to recommend client termination for rule infractions, penalties for positive urine drug screens, or promotion to a higher phase of treatment for successfully following direction. Research now demonstrates that **counselors who operate from a more authority-driven way of relating to clients, such as confronting or being overly directive, are less effective than counselors who employ empathy, understanding, and support** with clients (Martin & Rehm, 2012). This style of counseling is a particularly poor match for clients who are angry or reactive to counselor direction (Beutler et al., 2011). Positive treatment outcomes, including decreased substance use, abstinence, and increased treatment retention, are associated with high levels of counselor empathy, good interpersonal skills, and a strong therapeutic alliance (Miller & Moyers, 2015; Moyers & Miller, 2013).

Focus on early and brief interventions

In the past, addiction treatment consisted of detoxification, inpatient rehabilitation, long-term rehabilitation in residential settings, and aftercare. When care was standardized, most programs had not only a routine protocol of services but also a fixed length of stay. Twenty-eight days was considered the proper length of time for successful inpatient (usually hospital-based) care in the popular Minnesota model of SUD treatment. Residential facilities and outpatient clinics also had standard courses of treatment. These services were geared to clients with chronic, severe SUDs. Addiction treatment was viewed as a discrete event instead of a range of services over a continuum of care as the treatment provided for other chronic diseases like heart disease (Miller, Forehimes, & Zweben, 2011).

Recently, with the shift to a continuum of care model, **a variety of treatment programs have been established to intervene earlier** with those whose drinking or drug use is causing social, financial, or legal problems or increases their risk of health-related harms. These early intervention efforts range from educational programs (e.g., sentencing review or reduction for people apprehended for driving while intoxicated who participate in such programs) to brief interventions in opportunistic settings such as general hospital units, emergency departments (EDs), clinics, and doctors' offices that use motivational strategies to offer personalized feedback, point out the risks of substance use and misuse, suggest behavior change, and make referrals to formal treatment programs when necessary.

Early and brief interventions demonstrate positive outcomes such as reductions in alcohol consumption and drug use, reductions in alcohol misuse, decreases in tobacco and cannabis use, lower mortality rates, reductions in alcohol-related injuries, and decreases in ED return visits (Barata et al., 2017; Blow et al., 2017; DiClemente et al., 2017; McQueen, Howe, Allan, Mains, & Hardy, 2011).

Recognition of a continuum of substance misuse

Formerly, substance misuse was viewed as a progressive condition that, if left untreated, would inevitably lead to full-blown dependence and, likely, early death. Today, the addiction treatment field recognizes that **substance misuse exists along a continuum** from misuse to an SUD that meets the diagnostic criteria in DSM-5 (APA, 2013). Not all SUDs increase in severity. Many individuals never progress beyond substance use that poses a health risk, and others cycle back and forth through periods of abstinence, substance misuse, and meeting criteria for SUD.

Recovery from SUDs is seen as a multidimensional process along a continuum (Office of the Surgeon General, 2016) that differs among people and changes over time within the individual. Motivational strategies can be effectively applied to a person throughout the addiction process. The crucial variable is not the severity of the substance use pattern but the client's readiness for change.

Recognition of multiple SUDs

Counselors have come to recognize not only that SUDs vary in intensity but also that **most involve more than one substance.** Formerly, alcohol and drug treatment programs were completely separated by ideology and policy, even though most individuals with SUDs also drink heavily and many people who misuse alcohol also experiment with other substances, including prescribed medications that can be substituted for alcohol or that alleviate withdrawal symptoms. Although many treatment programs specialize in serving particular types of clients for whom their treatment approaches are appropriate (e.g., methadone maintenance programs for clients with opioid use disorder [OUD]), most now also treat other SUDs, substance use, and psychological problems or at least identify these and make referrals as necessary. Some evidence shows that motivational counseling approaches (including individual and group MI and brief interventions) demonstrate positive

outcomes for clients who misuse alcohol and other substances (Klimas et al., 2014). Motivational counseling approaches with this client population should involve engaging clients and prioritizing their change goals.

Acceptance of new treatment goals

In the past, addiction treatment, at least for clients having trouble with alcohol, was considered successful only if the client became abstinent and never returned to substance use following discharge. The focus of treatment was almost entirely to have the client stop using and to start understanding the nature of addiction. Today, **treatment goals include a broad range of biopsychosocial measures,** such as improved health and psychosocial functioning, improved employment stability, and reduction in crime. In addition, recent efforts have focused on trauma-informed care and treating co-occurring disorders in an integrated treatment setting, where client concerns are addressed simultaneously with SUDs. For more information on treating clients with trauma and co-occurring disorders, see TIP 57: Trauma-Informed Care in Behavioral Health Services (SAMHSA, 2014b) and TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders (SAMHSA, 2013), respectively.

Focus on risk reduction

The field has **expanded the definition of positive treatment outcomes to include intermediate goals of risk reduction.** The goal of risk reduction is to decrease clients' risks for alcohol- and drug-related health risks, legal involvement, sexual behavior that can lead to sexually transmitted diseases, social and financial problems, ED visits, hospitalization and rehospitalization, and relapse of substance use and mental disorders. Risk-reduction interventions include medication-assisted treatment for AUD and OUD and reduction in substance use as an intermediate step toward abstinence for clients who are not ready or willing to commit to full abstinence. Risk-reduction strategies can be an important goal in early treatment and have demonstrated effectiveness in reducing substance-use–related consequences (Office of the Surgeon General, 2016).

Integration of addiction, behavioral health, and healthcare services

Historically, the SUD treatment system was isolated from mainstream health care by different funding streams, health insurance restrictions, and lack of awareness and training among healthcare providers on recognizing, screening, assessing, and treating addiction as a chronic illness. Today, a concerted effort is under way to **integrate addiction treatment with other behavioral health and primary care services** to build a comprehensive healthcare delivery system. Key findings of *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (Office of the Surgeon General, 2016) include the following:

- The separation of SUD treatment from mainstream healthcare services has created obstacles to successful treatment and care coordination.
- SUDs are medical conditions. Integration helps address health disparities, reduces healthcare costs, and improves general health outcomes.
- Many people with SUDs do not seek specialty addiction treatment but often enter the healthcare system through general medical settings. This is an important but neglected opportunity to screen for substance misuse and provide brief interventions or referrals to specialty care.

Motivational enhancement strategies delivered in all settings can support client engagement in treatment and improve substance use outcomes, whether in EDs, primary care offices, office-based opioid treatment programs, criminal justice settings, social service programs, or specialized addiction treatment programs. Screening, brief intervention, and referral to treatment (SBIRT), which includes motivational enhancement strategies, is an early intervention approach that can be a bridge from medical settings to specialty SUD treatment in an integrated healthcare system (McCance-Katz & Satterfeld, 2012). Chapter 2 provides detailed information on SBIRT.

TTM of the SOC

In developing a new understanding of motivation, substantial addiction research has focused on the determinants and mechanisms of change. By understanding better how people change without professional assistance, researchers and counselors have become better able to develop and apply interventions to facilitate changes in clients' substance use behaviors.

Natural Change

Many adults in the United States resolve an alcohol or drug use problem without assistance (Kelly et al., 2017). This is called "natural recovery." Recovery from SUDs can happen with limited treatment or participation in mutual-aid support groups such as Alcoholics Anonymous and Narcotics Anonymous. As many as 45 percent of participants in the National Prevalence Survey resolved their substance use problems through participation in mutual-aid support programs (Kelly et al., 2017).

Behavior change is a process that occurs over time; it is not an outcome of any one treatment episode (Miller et al., 2011). Everyone must make decisions about important life changes, such as marriage or divorce or buying a house. Sometimes, individuals consult a counselor or other specialist to help with these ordinary decisions, but usually people decide on such changes without professional assistance. Natural change related to substance use also entails decisions to increase, decrease, or stop substance use. Some decisions are responses to critical life events, others reflect different kinds of external pressures, and still others are motivated by personal values.

Exhibit 1.2 illustrates two kinds of natural change. Natural changes related to substance use can go in either direction. In response to an impending divorce, for example, one individual may begin to drink heavily whereas another may reduce or stop using alcohol. Recognizing the processes involved in natural recovery and self-directed change illustrates how changes related to substance use behaviors can be precipitated and stimulated by enhancing motivation.

EXHIBIT 1.2. Examples of Natural Changes

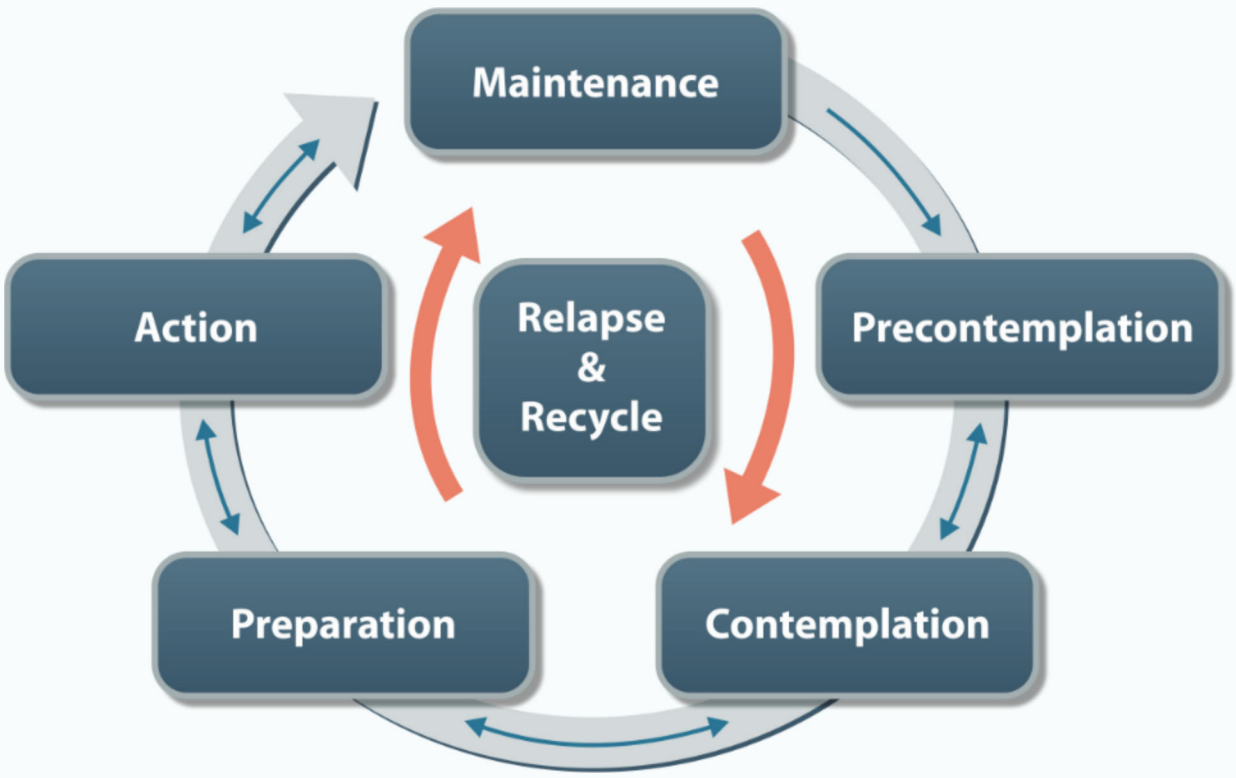
COMMON NATURAL CHANGES	NATURAL CHANGES IN SUBSTANCE USE
• Going to college	• Stopping drinking after an automobile accident
• Getting married	• Reducing alcohol use after college
• Getting divorced	• Stopping substance use before pregnancy
• Changing jobs	• Increasing alcohol use during stressful periods
• Joining the Army	• Decreasing cigarette use after a price increase
• Taking a vacation	• Quitting cannabis use before looking for employment
• Moving	• Refraining from drinking with some friends
• Buying a home	• Reducing consumption following a physician's advice
• Having a baby	
• Retiring	

SOC

Prochaska and DiClemente (1984) theorized that the change process is a journey through stages in which people typically think about behavior change, initiate behavior change, and maintain new behaviors. This model emerged from an examination of 18 psychological and behavioral theories about how change occurs, including components that compose a biopsychosocial framework for understanding addiction. In this sense, the model is "transtheoretical" (Prochaska & DiClemente, 1984). This model has come to be known as the TTM of the SOC. TTM is not the only SOC model, but it is the most widely researched (Connors et al., 2013).

SOC is not a specific counseling method but a framework that can help you tailor specific counseling strategies to clients in different stages. Although results are mixed regarding its usefulness, in the past 30 years, TTM has demonstrated effectiveness in predicting positive addiction treatment outcomes and has shown value as an overarching theoretical framework for counseling (Harrell, Trenz, Scherer, Martins, & Latimer, 2013; Norcross, Krebs, & Prochaska, 2011). Exhibit 1.3 displays the relationship among the five stages (i.e., Precontemplation, Contemplation, Preparation, Action, and Maintenance) in the SOC approach in the original TTM.

EXHIBIT 1.3. The Five Stages in the SOC in the TTM



Source: DiClemente, 2018.

The associated features of the SOC approach are (Connors et al., 2013):

- **Precontemplation:** People who use substances are not considering change and do not intend to change in the foreseeable future. They may be partly or completely unaware that a problem exists, that they have to make changes, and that they may need help to change. Alternatively, they may be unwilling or too discouraged to change their behavior. Individuals in this stage often are not convinced that their pattern of use is problematic.
- **Contemplation:** As these individuals become aware that a problem exists, they begin to perceive that there may be cause for concern and reasons to change. Typically, they are ambivalent, simultaneously seeing reasons to change and reasons not to change. Individuals in this stage are still using substances, but they are considering the possibility of stopping or cutting back in the near future. At this point, they may seek relevant information, reevaluate their substance use behavior, or seek help to support the possibility of changing. They typically weigh the positive and negative aspects of making a change. It is not uncommon for individuals to remain in this stage for extended periods, often for years, vacillating between wanting and not wanting to change.
- **Preparation:** When individuals perceive that the envisioned advantages of change and adverse consequences of substance use outweigh the benefits of maintaining the status quo, the decisional balance tips in favor of change. Once initiation of change occurs, individuals enter the Preparation stage and strengthen their commitment. Preparation entails more specific planning for change, such as making choices about whether treatment is needed and, if so, what kind. Preparation also entails examining clients' self-efficacy or confidence in their ability to change. Individuals in the Preparation stage are still using substances, but typically they intend to stop using very soon. They may already be making small changes, like cutting down on their substance use. They begin to set goals for themselves and make commitments to stop using, even telling close associates or significant others about their plans.
- **Action:** Here, individuals choose a strategy for change and begin to pursue it. Clients are actively engaged in changing substance use behaviors. They are making lifestyle changes and may face challenging situations (e.g., temptations to use, physiological effects of withdrawal). Clients may begin to reevaluate their self-image as they move from substance misuse to nonuse or safe use. Clients are committed to the change process and are willing to follow suggested change strategies.
- **Maintenance:** This stage entails efforts to sustain gains made during the Action stage and to prevent recurrence. Extra precautions may be necessary to keep from reverting to health-risk behaviors. Individuals learn to identify situations that may trigger a return to substance use and develop coping skills to manage such situations. During Maintenance, clients are building a new lifestyle that no longer includes the old substance use behaviors.

Most people who misuse substances progress through the stages in a circular or spiral pattern, not a linear one. Individuals typically move back and forth between the stages and cycle through the stages at different rates, as shown in the bidirectional arrows in Exhibit 1.3. As clients progress through the stages, they often have setbacks. However, most people do not typically return to the Precontemplation stage to start over again (Connors et al., 2013) and are unlikely to move from Precontemplation back to Maintenance. This movement through the stages can vary in relation to different behaviors or treatment goals. For example, a client might be in the Action stage with regard to quitting drinking but be in Precontemplation regarding his or her use of cannabis.

Relapse or recurrence of substance misuse is a common part of the process as people cycle through the different stages (note the circular movement of Relapse & Recycle in Exhibit 1.3). Although clients might return to substance misuse during any of the stages, relapse is most often discussed as a setback during the Maintenance stage (Connors et al., 2013). In this model, recurrence is viewed as a normal (not pathological) event because many clients cycle through different stages several times before achieving stable change. Recurrence is not considered a failure

but rather a learning opportunity. Remember that each time clients have a setback, they are learning from the experience and applying whatever skills or knowledge they have gained to move forward in the process with greater understanding and awareness.

COUNSELOR NOTE: MAKING DECISIONS

People make decisions about important life changes by weighing potential gains and losses associated with making a choice (Janis & Mann, 1977). Weighing the pros and cons of continuing to use substances or changing substance use behaviors is a key counseling strategy in the SOC model. During Contemplation, pros and cons tend to balance or cancel each other out. In Preparation, pros for changing substance use behavior outweigh cons. When the decisional balance tips toward commitment to change, clients are ready to take action.

Conclusion

Recent understanding of the key role motivation plays in addiction treatment has led to the development of clinical interventions to increase client motivation to change their substance use behaviors (DiClemente et al., 2017). Linking this new view of motivation, the strategies found to enhance it, and the SOC model, along with an understanding of what causes change, creates an effective motivational approach to helping clients with substance misuse and SUDs. This approach encourages clients to progress at their own pace toward deciding about, planning, making, and sustaining positive behavioral change.

In this treatment approach, motivation for change is seen as a dynamic state that you can help the client enhance. Motivational enhancement has evolved, and various myths about clients and what constitutes effective counseling have been dispelled. The notion of the addictive personality has lost credence, and a confrontational style has been discarded or significantly modified. Other factors in contemporary counseling practices have encouraged the development and implementation of motivational interventions, which are client centered and focus on client strengths. Counseling relationships are more likely to rely on empathy rather than authority and involve the client in all aspects of the treatment process. Less-intensive treatments have also become increasingly common.

Motivation is what propels people with SUDs to make changes in their lives. It guides clients through several stages of the SOC that are typical of people thinking about, initiating, and maintaining new behaviors. The remainder of this TIP examines how motivational interventions, when applied to SUD treatment, can help clients move from not even considering changing their behavior to being ready, willing, and able to do so.

Chapter 2—Motivational Counseling and Brief Intervention

> The prevalent clinical focus on denial and motivation as client traits was misguided. Indeed, client motivation clearly was a dynamic process responding to a variety of interpersonal influences including advice, feedback, goal setting, contingencies, and perceived choice among alternatives."
>
> —Miller & Rollnick, 2013, p. 374

KEY MESSAGES

- Personalized feedback about a client's use of substances relative to others and level of health-related risk can enhance client motivation to change substance use behaviors.
- Counselor focus and motivational counseling strategies should be tailored to the client's stage in the Stage of Change (SOC) model.
- Effective motivational counseling approaches can be brief and include a brief intervention (BI) and brief treatment (BT) or comprehensive and include screening, brief intervention, and referral to treatment (SBIRT).

Chapter 2 examines science-informed elements of motivational approaches that are effective in treating substance use disorders (SUDs). Any clinical strategy that enhances client motivation for change is a motivational intervention. Such interventions can include counseling, assessment, and feedback. They can occur over multiple sessions or during one BI, and they can be used in specialty SUD treatment settings or in other healthcare settings. Chapter 2 also highlights what you should focus on in each stage of the SOC approach and discusses how to adapt motivational interventions to be culturally responsive and suitable for clients with co-occurring substance use and mental disorders (CODs).

Elements of Effective Motivational Counseling Approaches

Motivational counseling strategies have been used in a wide variety of settings and with diverse client populations to increase motivation to change substance use behaviors. The following elements are important parts of motivational counseling:

- FRAMES approach
- Decisional balancing
- Developing discrepancy between personal goals and current behavior
- Flexible pacing
- Maintaining contact with clients

FRAMES Approach

Miller and Sanchez (1994) identified six common elements of effective motivational counseling, which are summarized by the acronym FRAMES:

- **F**eedback on personal risk relative to population norms is given to clients after substance use assessment.
- **R**esponsibility for change is placed with the client.
- **A**dvice about changing the client's substance use is given by the counselor nonjudgmentally.
- **M**enu of options and treatment alternatives is offered to the client.
- **E**mpathetic counseling style (i.e., warmth, respect, an understanding) is demonstrated and emphasized by the counselor.
- **S**elf-efficacy is supported by the counselor to encourage client change.

Since FRAMES was developed, research and clinical experience have expanded and refined elements of this motivational counseling approach. FRAMES is often incorporated into SBIRT interventions. It has also been combined with other interventions and tested in diverse settings and cultural contexts (Aldridge, Linford, & Bray, 2017; Manuel et al., 2015; Satre, Manuel, Larios, Steiger, & Satterfield, 2015).

Feedback

Give personalized feedback to clients about their substance use; feedback presented in this way is effective in reducing substance misuse and other health-risk behaviors (Davis, Houck, Rowell, Benson, & Smith, 2015; DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017; Field et al., 2014; Kahler et al., 2018; McDevitt-Murphy et al., 2014; Walker et al., 2017). This type of feedback usually compares a client's scores or ratings on standard screening or assessment instruments with normative data from a general population or treatment groups. Feedback should address cultural differences and norms related to substance misuse. For example, a review of the research on adaptations of BI found that providing feedback specifically related to cultural and social aspects of drinking to Latino clients reduced drinking among these clients to a greater degree than standard feedback (Manuel et al., 2015; Satre et al., 2015).

Presenting and discussing assessment results can enhance client motivation to change health-risk behaviors. Providing personalized feedback is sometimes enough to move clients from the Precontemplation stage to Contemplation without additional counseling and guidance.

Structure a feedback session thoughtfully. Establish rapport before giving a client his or her score. Strategies to focus the conversation before offering feedback include the following:

- **Express appreciation** for the client's efforts in providing the information.
- **Ask whether the client had any difficulties** with answering questions or filling out forms. Explore specific questions that might need clarification.
- **Make clear that you may need the client's help** to interpret the findings accurately.
- **Encourage questions:** "I'll be giving you lots of information. Please stop me if you have a question or don't understand something. We have plenty of time today or in the next session, if needed."
- **Stress that the instruments provides objective data.** Give some background, if appropriate, about how the tests are standardized for all populations and how widely they are used.

When you provide feedback, show the client his or her score on any screening or assessment instrument and explain what the score means. Exhibit 2.1 is a sample feedback handout to share with a client after completing the Alcohol Use Disorders Identification Test (AUDIT). Appendix B presents the U.S AUDIT questionnaire and scoring instructions.

COUNSELOR NOTE: MOTIVATIONAL ENHANCEMENT THERAPY

Motivational enhancement therapy (MET) is an early offshoot of the "drinker's check-up," which gave feedback nonjudgmentally to clients about their drinking. MET is a brief motivational counseling approach that provides personalized, neutral, motivational interviewing (MI)-style feedback to clients. Counselors elicit clients' understanding of feedback, followed by reflections and listening for signs that clients are considering behavioral changes based on the feedback (Miller & Rollnick, 2013). Research on MET shows moderate to strong support for reductions in substance use versus no intervention (DiClemente et al., 2017; Lenz, Rosenbaum, & Sheperis, 2016).

EXHIBIT 2.1. The Drinker's Pyramid Feedback

The AUDIT questionnaire was developed by the World Health Organization to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Your AUDIT score shows the level of health-related risks and other problems associated with your drinking. Higher scores can reflect more serious alcohol-related problems. AUD refers to an alcohol use disorder as defined by the American Psychiatric Association (2013).

Your score indicates _____

Check here if applicable _____

Your response to AUDIT Question 3 indicates that you have experienced episodes of binge drinking (e.g., 5 drinks for men and 4 drinks for women consumed within 2 hours on a single occasion). The immediate risks of intoxication or binge drinking include:

- Motor crashes or other serious accidents.
- Falls and other physical injuries.
- Intimate partner violence.
- Depressed mood.
- Suicidal or homicidal thoughts or behavior.
- Unintended firearm injuries.
- Alcohol poisoning.
- Assaults and sexual assaults.
- Unprotected sex (leading to sexually transmitted diseases and unintended pregnancy).
- Child abuse and neglect.
- Property and other crime.
- Fires.

Check here if applicable _____

Your responses to AUDIT Questions 1 (frequency) and 2 (number of drinks consumed) indicate that you are drinking more than the recommended limits (no more than 3 drinks on a single day and 7 drinks per week for all women and for men older than 65; no more than 4 drinks on a single day and 14 drinks per week for men ages 65 and younger). Long-term risks of alcohol misuse use include:

- Gastric distress.
- Hypertension.
- Cardiovascular disease.
- Permanent liver damage.
- Cancer.
- Pancreatitis.
- Diabetes.
- Chronic depression.
- Neurologic damage.
- Fetal alcohol spectrum disorders in newborns (which include physical, behavioral, and learning disabilities).

Sources: Babor, Higgins-Biddle, & Robaina, 2016; Venner, Sánchez, Garcia, Williams, & Sussman, 2018.

Use a motivational style to present the information. Do not pressure clients to accept a diagnosis or offer unsolicited opinions about the meaning of results. Instead, preface explanations with statements like, "I don't know whether this will concern you, but …" or "I don't know what you'll make of this result, but…." Let clients form their own conclusions, but help them by asking, "What do you make of this?" or "What do you think about this?" Focus the conversation on clients' understanding of the feedback.

Strategies for presenting personalized feedback to clients include:

- Asking about the client's initial reaction to the tests (e.g., "Sometimes people learn surprising things when they complete an assessment. What were your reactions to the questionnaire?").
- Providing a handout or using visual aids that show the client's scores on screening instruments, normative data, and risks and consequences of his or her level of substance use (see Exhibit 2.1 above). Written materials should be provided in the client's first language.
- Offering information in a neutral, nonjudgmental, and respectful way.
- Using easy-to-understand and culturally appropriate language.
- Providing small chunks of information.
- Using open questions to explore the client's understanding of the information.
- Using reflective listening and an empathetic counseling style that emphasizes the client's perspective on feedback and how it may have affected the client's readiness to change.
- Summarizing results, including risks and problems that have emerged, the client's reactions, and any change talk the feedback has prompted, then asking the client to add to or correct the summary.
- Providing a written summary to the client.

Clients' responses to feedback differ. One may be alarmed to find that she drinks much more in a given week than comparable peers but be unconcerned about potential health risks of drinking. Another may be concerned about his potential health risks at this level of drinking. The key to using feedback to enhance motivation is to **continue to explore the client's understanding of the information and what it may suggest about possible behavior change.** Personalized feedback is applicable to other health-risk behaviors issues, such as tobacco use (Steinberg, Williams, Stahl, Budsock, & Cooperman, 2015).

Responsibility

Use a motivational approach to encourage clients to actively participate in the change process by reinforcing personal autonomy. Individuals have the choice of continuing their behavior or changing it. Remind clients that it is up to them to make choices about whether they will change their substance use behaviors or enter treatment. Reinforcing personal autonomy is aligned with the self-determination theory discussed in Chapter 1 (Deci & Ryan, 2012; Flannery, 2017).

Strategies for emphasizing client responsibility include the following:

- Ask clients' permission to talk about their substance use; invite them to consider the information you are presenting. If clients have choices, they feel less need to oppose or dismiss your ideas.
- State clearly that you will not ask clients to do anything they are unwilling to do. Let them know that it is up to them to make choices about behavior change.
- Determine a common agenda for each session.
- Agree on treatment goals that are acceptable to clients.

When clients realize they are responsible for the change process, they feel empowered and more invested in it. This results in better treatment outcomes (Deci & Ryan, 2012).

Advice

Practice the act of giving advice; this simple act can promote positive behavioral change. BI that includes advice delivered in the MET/MI counseling style can be effective in changing substance use behaviors such as drinking, drug use, and tobacco use (DiClemente et al., 2017; Steinberg et al., 2015). As with feedback, the

manner in which you advise clients influences how or whether the client will use your advice. It is better **not to tell** people what to do; **suggestions** yield better results. A motivational approach to offering advice may be either directive (making a suggestion) or educational (providing information). Educational advice should be based on credible scientific evidence, such as safe drinking limits recommended by the National Institute on Alcohol Abuse and Alcoholism or facts that relate to the client's conditions (e.g., blood alcohol concentration levels at the time of an automobile crash).

EXPERT COMMENT: A REALISTIC MODEL OF CHANGE—ADVICE TO CLIENTS

Throughout the treatment process, clients should have permission to talk about their problems with substance use. During these dialogs, I often point out some of the realities of the recovery process:

- Most change does not occur overnight.
- Change is best viewed as a gradual process with occasional setbacks, much like hiking up a bumpy hill.
- Difficulties and setbacks can be reframed as learning experiences, not failures.

Linda C. Sobell, Ph.D., Consensus Panel Member

Strategies for offering advice include the following:

- **Ask permission** to offer suggestions or provide information. For example, "Would you like to hear about safe drinking limits?" or "Can I tell you what tolerance to alcohol is?" Such questions provide a nondirective opportunity to share your knowledge about substance use in a respectful manner.
- **Ask what the client thinks** about your suggestions or information.
- **Ask for clarification** if the client makes a specific request, rather than give advice immediately.
- **Offer simple suggestions** that match the client's level of understanding and readiness, the urgency of the situation, and his or her culture. In some cultures, a directive approach is required to convey the importance of advice or situations; in others, a directive style is considered rude and intrusive.

This style of giving advice requires patience. The timing of any advice is important, relying on your ability to hear what clients are requesting and willing to receive. Chapter 3 provides more information about the structured format used in MI for offering clients feedback or giving advice.

EXPERT COMMENT: THE PIES APPROACH

In World War I, military psychiatrists first realized that motivational interventions, done at the right time, could return many stressed soldiers to duty. To remember this method, they used the acronym PIES:

- Proximity: Provide treatment near the place of duty; don't evacuate to a hospital.
- Immediacy: Intervene and treat at the first sign of the problem.
- Expectancy: Expect the intervention to be successful and return the person to duty.
- Simplicity: Listen, offer empathy, and show understanding; this simple approach works best.

Highlight that the person's reactions are normal; it is the situation that is abnormal. The person will recover with rest and nourishment. No prolonged or complex therapy is needed for most cases. In the context of World War I, evacuation to higher levels of care was reserved for the low percentage of individuals who did not respond to this straightforward approach.

Kenneth J. Hoffman, M.D., Field Reviewer

Menu of options

Offer choices to facilitate treatment initiation and engagement. These choices have been shown to enhance the therapeutic alliance, decrease dropout rates, and improve outcomes (Van Horn et al., 2015). Clients are more likely to adhere to a specific change strategy if they can choose from a menu of options. Giving clients choices for treatment goals and types of available service increases their motivation to participate in treatment.

Strategies for offering a menu of options include the following:

- Provide accurate information on each option and potential implications for choosing that option.
- Elicit from clients which options they think would work or what has worked for them in the past.
- Brainstorm alternative options if none offered are acceptable to clients.

Providing a menu of options is consistent with the motivational principle of supporting client autonomy and responsibility. Clients feel more empowered when they take responsibility for their choices. Your role is to enhance their ability to make informed choices. When clients make independent decisions, they are likely to be more committed to them. This concept is examined more fully in Chapter 6.

Empathic counseling style

Use an empathic counseling style by showing active interest in understanding clients' perspectives (Miller & Rollnick, 2013). Counselors who show high levels of empathy are curious, spend time exploring clients' ideas about their substance use, show an active interest in what clients are saying, and often encourage clients to elaborate on more than just the content of their story (Miller & Rollnick, 2013). Counselor empathy is a moderately strong predictor of client treatment outcomes (Elliot, Bohart, Watson, & Murphy, 2018).

As explained in Chapter 3, reflective listening effectively communicates empathy. The client does most of the talking when a counselor uses an empathic style. It is your responsibility to create a safe environment that encourages a free flow of communication with the client. An empathic style appears easy to adopt, but it requires training and significant effort on your part. This counseling style can be particularly effective with clients in the Precontemplation stage.

Self-efficacy

Help clients build self-efficacy by being supportive, identifying their strengths, reviewing past successes, and expressing optimism and confidence in their ability to change (Kaden & Litt, 2011). To succeed in changing, clients must believe they can undertake specific tasks in a specific situation (Bandura, 1977). In addiction treatment, self-efficacy usually refers to clients' ability to identify high-risk situations that trigger their urge to drink or use drugs and to develop coping skills to manage that urge and not return to substance use. Considerable evidence points to self-efficacy as an important factor in addiction treatment outcomes (Kadden & Litt, 2011; Kuerbis, Armeli, Muench, & Morgenstern, 2013; Litt & Kadden, 2015; Morgenstern et al., 2016).

Ask clients to identify how they have successfully coped with problems in the past: "How did you get from where you were to where you are now?" or "How have you resisted the urge to use in stressful situations?" Once you identify strengths, you can help clients build on past successes. Affirm small steps and reinforce any positive changes. Self-efficacy is discussed again in Chapters 3, 5, and 7.

Decisional Balancing

Explore with the client the benefits and drawbacks of change (Janis & Mann, 1977). Individuals naturally explore the pros and cons of any major life choice, such as changing jobs or getting married. In SUD recovery, the client weighs the pros and cons of changing versus not changing substance use behaviors. You assist this process by asking the client to articulate the positive and negative aspects of using substances. This process is usually called decisional balancing and is further described in Chapter 5.

Exploring the pros and cons of substance use behaviors can tip the scales toward a decision for positive change. The actual number of reasons

a client lists on each side of a decisional balance sheet is not as important as the weight—or personal value—of each. For example, a 20-year-old who smokes cigarettes may put less weight on getting lung cancer than an older adult, but he may be very concerned that his diminished lung capacity interferes with playing basketball.

Developing Discrepancy

To enhance motivation for change, **help clients recognize any discrepancy or gap between their future goals and their current behavior.** You might clarify this discrepancy by asking, "How does drinking fit or not fit with your goal of improving your family relationships?" When individuals see that present actions conflict with important personal goals, such as good health, job success, or close personal relationships, change is more likely to occur (Miller & Rollnick, 2013). This concept is expanded in Chapter 3.

Flexible Pacing

Assess the client's readiness for change; resist your urges to go faster than the client's pace. Every client moves through the SOC at his or her own pace. Some will cycle back and forth numerous times between stages. Others need time to resolve their ambivalence about current substance use before making a change. A few are ready to get started and take action immediately. Knowing where a client has been and is now in the SOC helps you facilitate the change process at the right pace. Be aware of any discrepancies between where you want the client to be and where he or she actually is in the SOC. For example, if a client is still in the Contemplation stage, your suggestion to take steps that are in the Action stage can create discord.

Flexible pacing requires you to meet clients at their level and allow them as much or as little time as they need to address the essential tasks of each stage in the SOC. For example, with some clients, you may have to schedule frequent sessions at the beginning of treatment and fewer later. In other cases, clients might need a break from the intensity of treatment to focus on specific aspect of recovery. If you push clients at a faster pace than they are ready to take, the treatment alliance may break down.

Maintaining Contact With Clients

Employ simple activities to enhance continuity of contact between you and the client. Such activities may include personal handwritten letters, telephone calls, texts, or emails. Use these simple motivation-enhancing interventions to encourage clients to return for another counseling session, return to treatment following a missed appointment, and stay involved in treatment.

Activities that foster consistent, ongoing contact with clients strengthen the therapeutic alliance. The treatment alliance is widely recognized as a significant factor in treatment outcomes in most treatment methods including addiction counseling (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013). Low alliance predicts higher risk of clients dropping out of treatment (Brorson et al., 2013).

Make sure you and your clients follow all agency policies and ethical guidelines for making contact outside of sessions or after discharge. For more information on using technology to maintain contact with clients, see Treatment Improvement Protocol (TIP) 60: *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015b).

Motivational Counseling and the SOC

People considering major changes in their lives, such as adopting an alcohol- or drug-free lifestyle, go through different change processes. Your job as a counselor is to match your treatment focus and counseling strategies with these processes throughout the SOC.

Catalysts for Change

Understand how catalysts for change operate. This will help you use motivational counseling strategies that support and enhance changes clients are contemplating. Prochaska (1979) identified common personal growth processes linked to different behavioral counseling approaches. These processes or catalysts for change have been further developed and applied to the SOC model (Connors, DiClemente,

Velasquez, & Donovan, 2013). Catalysts are experiential or behavioral (Exhibit 2.2). Experiential catalysts are linked more frequently with early SOC phases and behavioral catalysts with later SOC phases.

EXHIBIT 2.2. Catalysts for Change

TYPE	SPECIFIC CLIENT CHANGE PROCESSES	SOC
Experiential	**Consciousness raising:** Gains new awareness and understanding of substance use behavior.	Precontemplation/ Contemplation
	Emotional arousal: Is motivated to contemplate change after an important emotional reaction to current substance use behavior or the need to change.	Precontemplation/ Contemplation
	Environmental reevaluation: Evaluates pros and cons of current substance use behavior and its effects on others and the community.	Precontemplation/ Contemplation
	Self-reevaluation: Explores the current substance use behavior and the possibility of change in relation to own values.	Contemplation
	Social liberation: Recognizes and increases available positive social supports.	Contemplation/ Preparation
Behavioral	**Counterconditioning:** Begins to recognize the links between internal and external cues to use substances and experiments with substituting more healthful behaviors and activities in response to those cues.	Preparation/Action
	Helping relationships: Seeks and cultivates relationships that offer support, acceptance, and reinforcement for positive behavioral change.	Preparation/Action/ Maintenance
	Self-liberation: Begins to believe in ability to make choices/ to change. Develops enhanced self-efficacy and commits to changing substance use behaviors.	Preparation/Action/ Maintenance
	Stimulus control: Avoids stimuli and cues that could trigger substance use.	Action
	Reinforcement management: Begins to self-reward positive behavioral changes and eliminates reinforcements for substance use.	Action/Maintenance

Counselor Focus in the SOC

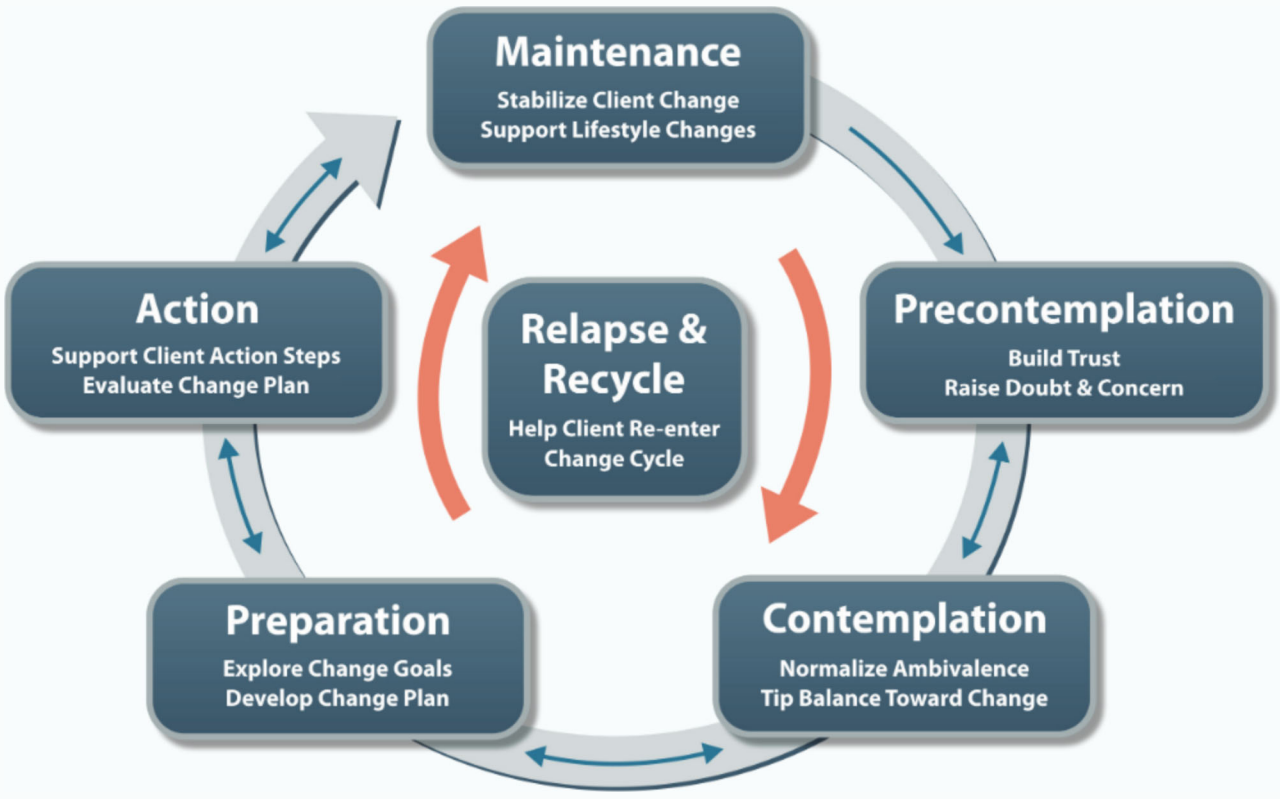
Use motivational supports that match the client's SOC. If you try to use strategies appropriate to a stage other than the one the client is in, the client might drop out or not follow through on treatment goals. For example, if a client in Contemplation is ambivalent about changing substance use behaviors and you argue for change or jump into the Preparation stage, the client is likely to become reactive.

Examples of how to tailor motivation support to the client's stage in the SOC include helping the client:

- In Precontemplation consider change by increasing awareness of behavior change.
- In Contemplation resolve ambivalence by helping him or her choose positive change over the current situation.
- In Preparation identify potential change strategies and choose the most appropriate one for the circumstances.
- In Action carry out and follow through with the change strategies.
- In Maintenance develop new skills to maintain recovery and a lifestyle without substance misuse. If misuse resumes, help the client recover as fast as possible; support reentering the change cycle.

Exhibit 2.3 depicts the overarching counseling focus in each stage. Chapters 4 through 7 examine specific counseling strategies for each stage.

EXHIBIT 2.3. Counselor Focus in the SOC



Source: DiClemente, 2018.

Special Applications of Motivational Interventions

The principles underlying motivational counseling approaches have been applied across cultures, to different types of problems, in various treatment settings, and with many different populations (Miller & Rollnick, 2013). The research literature suggests that motivational interventions (i.e., MI, MET, and BI) are associated with successful outcomes including adherence to and retention in SUD treatment; reduction in or abstinence from alcohol, cannabis, illicit drugs, and tobacco use; and reductions in substance misuse consequences and related problems (DiClemente et al., 2017). Motivational interventions have demonstrated efficacy across ages (i.e., adolescents, young adults, and older adults), genders, and racial and ethnic groups (Lenz et al., 2016).

Special applications of motivational approaches have been successfully employed as stand-alone or add-on interventions for people with diabetes, chronic pain, cardiovascular disease, HIV, CODs, eating disorders, and opioid use disorder, as well as for pregnant women who drink or use illicit drugs (Alperstein & Sharpe, 2016; Barnes & Ivezaj, 2015; Dillard, Zuniga, & Holstad, 2017; Ekong & Kavookjian, 2016; Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2013,: Ingersoll, Ceperich, Hettema, Farrell-Carnahan, & Penberthy, 2013; Lee, Choi, Yum, Yu, & Chair, 2016; Moore, Flamez, & Szirony, 2017; Mumba, Findlay, & Snow, 2018; Osterman, Lewis, & Winhusen, 2017; Soderlund, 2017; Vella-Zarb, Mills, Westra, Carter, & Keating, 2014). The universality of motivational intervention concepts permits broad application and offers great potential to reach diverse clients with many types of problems and in many settings.

Cultural Responsiveness

Clients in treatment for SUDs differ in ethnic, racial, and cultural backgrounds. Research and experience suggest that the change process is similar across different populations. The principles and mechanisms of enhancing motivation to change seem to be broadly applicable. For example, one study found that MI was one of two evidence-based treatments endorsed as culturally appropriate by a majority of surveyed SUD treatment programs serving American Indian and Alaska Native (AI/AN) clients (Novins, Croy, Moore, & Rieckmann, 2016).

> "Processes for engaging do differ across cultures, but listening lies at the heart of nearly all of them. Good listening crosses cultures as well. It stretches the imagination to think of people who don't appreciate being welcomed, heard, understood, affirmed, and recognized as autonomous human beings. In our experience these are universally valued."
>
> —Miller & Rollnick, 2013, p. 349

There may be important differences among populations and cultural contexts regarding expression of motivation for change and the importance of critical life events. Get familiar with the populations with whom you expect to establish treatment relationships, be open to listening to and learning from clients about their cultures and their own theories of change, and adapt motivational counseling approaches in consideration of specific cultural norms (Ewing, Wray, Mead, & Adams, 2012). For example, a manual for adapting MI for use in treating AI/AN populations includes a spiritual component that uses a prayer to describe MI and several spiritual ceremonies to explain MI (Venner, Feldstein, & Tafoya, 2006).

MI's core elements, including its emphasis on collaboration, evoking clients' perspectives, and honoring clients' autonomy, align well culturally with African Americans (Harley, 2017; Montgomery, Robinson, Seaman, & Haeny, 2017). However, some African American women may be less comfortable with a purely client-centered approach (Ewing et al., 2012). Viable approaches to adapting MI for African Americans include training peers to deliver MI, incorporating moderate amounts of advice, and implementing MI approaches in community settings such as a local church (Harley, 2017).

Because motivational strategies emphasize the client's responsibility to voice personal goals and values as well as to select among options for change, you should respond in a nonjudgmental way to cultural differences. Cultural differences might be reflected in the value of health, the meaning of time, the meaning of alcohol or drug use, or responsibilities to community and family. Try to understand the client's perspective rather than impose mainstream values or make quick judgments. This requires knowledge of the influences that promote or sustain substance use and enhance motivation to change among different populations. Motivation-enhancing strategies should be congruent with a client's cultural and social principles, standards, and expectations. Exhibit 2.4 provides a mnemonic to help you remember the basic principles of cultural responsiveness.

EXHIBIT 2.4. RESPECT: A Mnemonic for Cultural Responsiveness

Respect	Understand how respect is shown in different cultures and demonstrate it through verbal and nonverbal communication.
Explanatory model	Explore the client's understanding about his or her substance use and any cultural beliefs or attitudes about substance misuse and how people change.
Sociocultural context	Recognize how class, gender, race, ethnicity, sexual or gender identity, age, socioeconomic status, and other personal characteristics that might affect treatment.
Power	Acknowledge the power differential between the counselor and the client.
Empathy	Express empathy in ways that communicate that you are genuinely interested in the client's perspective and concerns.
Concerns and fears	Elicit client concerns about seeking help and entering treatment.
Trust/therapeutic alliance	Recognize that trust must be earned, and demonstrate actions that enhance the therapeutic relationship.

Source: SAMHSA, 2014a.

EXPERT COMMENT: CULTURAL RESPONSIVENESS

In my practice with persons who have different worldviews, I've made a number of observations on the ways in which culture influences the change process. I try to pay attention to cultural effects on a person's style of receiving and processing information, making decisions, pacing, and being ready to act. The more clients are assimilated into the surrounding culture, the more likely they are to process information, respond, and make choices that are congruent with mainstream beliefs and styles. The responsibility for being aware of different cultural value systems lies with the provider, not the client being treated.

More specifically, the manner in which a person communicates, verbally and nonverbally, is often directly related to culture. One young American Indian stated on initial contact that he "might not be able to come back because his shoes were too tight." This was his way of saying he had no money.

However, ethnicity doesn't always determine the culture or values one chooses to live by. For example, White Americans may adopt Eastern worldviews and value systems. Furthermore, an advanced education doesn't necessarily indicate one's degree of assimilation or acculturation. Asian Americans or African Americans who are well educated may choose to live according to their traditional cultural value system and process information for change accordingly.

Culture is a powerful contributor to defining one's identity. Not having a healthy ethnic sense of self affects all stages of the change process. To have a strong sense of self, you have to be powerful in the areas of being, knowing, doing, and having. Racially and ethnically diverse individuals who have been raised in environments that isolate them from their own cultures may not have accurate information about their ethnicity and may not develop a healthy ethnic sense of self.

I believe counselors who use MET need to know different cultural value systems and be culturally sensitive. If in doubt of the client's beliefs, explore them with the client. Acknowledging and honoring differing cultural worldviews greatly influence both motivational style and therapeutic outcome.

Rosalyn Harris-Offutt, Consensus Panel Member

Understand not just how a client's cultural values encourage change, but how they may present barriers to change. Some clients identify strongly with cultural or religious traditions and work hard to gain respect from elders or group leaders. Others find membership or participation in such groups unhelpful. Some cultures support involvement of family members in counseling; others find this disrespectful.

Know what personal and material resources are available to clients, and be sensitive to issues of poverty, social isolation, historical trauma, and recent losses. Recognize that access to financial and social resources is an important part of the motivation for and process of change. Poverty and lack of resources make change more difficult. It is hard to affirm self-efficacy and stimulate hope and optimism in clients who lack material resources and have experienced discrimination. You can firmly acknowledge the facts of the situation yet still enhance hope and motivation to change by affirming clients' strengths and capacity for endurance and growth despite difficult circumstances. For more information on cultural issues in treatment, see TIP 59: *Improving Cultural Competence* (SAMHSA, 2014a).

Adults With COD

Substance use and mental disorders often co-occur. According to 2017 data from the National Survey on Drug Use and Health (SAMHSA, 2018), 46.6 million adults ages 18 and older (19 percent of all U.S. adults) had any mental illness during the previous year, including 11.2 million (4.5 percent of all adults) with serious mental illness (SMI). Of this 46.6 million, 18 percent also had an SUD versus only 5 percent of adults without any mental illness in the past year. Of the 11.2 million adults with an SMI in the previous year, almost 28 percent also had a co-occurring SUD.

Even low levels of substance misuse can have a serious impact on the functioning of people with SMI (Hunt et al., 2013). For example, AUD often co-occurs with major depressive disorder (MDD), which results in greater disease burdens than either disorder separately (Riper et al., 2014). MI and MI combined with cognitive–behavioral therapy produce positive treatment outcomes, such as reductions in alcohol consumption, cannabis use, alcohol misuse, and depression and other psychiatric symptoms like anxiety (Baker et al., 2014; Baker, Thornton, Hiles, Hides, & Lubman, 2012; Riper et al., 2014; Satre, Delucchi, Lichtmacher, Sterling, & Weisner, 2013; Satre, Leibowitz, et al., 2016).

Having any mental disorder increases the risk of substance misuse. As indicated in TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (SAMHSA, 2013), clients with mental illness or COD may find it harder to engage and remain in treatment. **Motivational interventions that engage and retain clients in treatment, increase motivation to adhere to treatment interventions, and reduce substance use are a good fit for these clients.** A meta-analysis of randomized controlled treatment studies of people with SMI and substance misuse found that, although MI was not any more effective, in general, than other psychosocial treatments, clients who participated in an MI group reported to their first aftercare appointment significantly more often than clients in other treatment interventions and these clients had greater alcohol abstinence rates (Hunt et al., 2013). Another meta-analysis found that MI-based interventions emphasizing adherence to treatment significantly improved adherence and psychiatric symptoms (Wong-Anuchit, Chantamit-O-Pas, Schneider, & Mills, 2018). Dual Diagnosis MI (DDMI), a modified version of MI for adults with CODs, can effectively increase task-specific motivation and adherence to cognitive training interventions (Fiszdon, Kurtz, Choi, Bell, & Martino, 2015).

COUNSELOR NOTE: DUAL DIAGNOSIS MOTIVATIONAL INTERVIEWING

DDMI is a two-session intervention for substance misuse in clients with psychotic disorders (Fiszdon et al., 2015). It includes accommodations for cognitive impairments such as:

- Asking questions and reflecting in simple terms.
- Repeating information and summarizing session content frequently.
- Providing more structure to sessions.
- Being sensitive to emotional material.
- Using simple, concrete examples.
- Presenting information using visual aids and written materials.
- Restating information frequently.
- Going at a slower pace.
- Allowing pauses so clients can process questions, reflections, and information.

Motivational interventions for SMI and co-occurring SUDs should be modified to take into account potential cognitive impairment and focused on specific tasks that lead to the accomplishment of treatment goals, as defined by each client. For more information, see TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (SAMHSA, 2013).

EXPERT COMMENT: MI FOR ADULTS WITH COD

I became interested in MI when my team and I were trying to improve the rate of attendance at aftercare appointments for clients with COD discharged from our psychiatric units. So, my team and I decided to investigate MI's effectiveness with clients with COD. We randomly assigned half of our clients to standard treatment, in which they received standard inpatient psychiatric care, including standard discharge planning where the team would encourage and explain the importance of aftercare. The other half were assigned to standard treatment but also received a motivational assessment, feedback on the results at admission, and a 1-hour MI just before discharge.

We found that clients in the MI group attended their first outpatient appointment at a rate that was two and a half times greater than the standard treatment group. MI with virtually no modification, was effective, particularly for clients with very low motivation. This could have been because these clients were more verbal about their ambivalence than others and because we viewed MI as a perfect way to resolve ambivalence. Another thing we learned was that asking clients about why they would **not attend** aftercare had surprise value and greatly enhanced the rapport between therapist and client. It appeared to let clients know that we were not only going to tell them about the importance of aftercare, but that we were actually willing to discuss their ambivalence about it.

Clients were also surprised when we did not directly counter their reasons for not going to aftercare. For example, if a client said, "I'm better now, I don't need aftercare," we would not say, "But to stay well, you need to continue your treatment." Instead, we used **open end questions** (e.g., "What do you think helped you get better?" or "Tell me more about that") or **amplified reflection** (e.g., "So, you're saying you probably won't need any other treatment ever again" or, for more fragile clients, "It's hard for you to imagine a reason why you might continue to need treatment"). When clients offered specific disadvantages of pursuing aftercare, such as loss of time from work or negative reactions from family, we similarly responded with open end questions and reflective listening (e.g., "It sounds like your job is very important to you and that you wouldn't want anything to get in the way of that"). Frequently such questions and reflections would lead a client to counter his or her own statements. It turned out that client could sell themselves on the idea of aftercare better than we ever could, and MI gave us the perfect method for facilitating this process. What was most important, however, was what we did **not** do—namely, argue with the client or even attempt to therapeutically dispute his or her (sometimes) illogical ideas about aftercare. Instead, we waited for kernels of motivation and simply shaped them along until the client finally heard himself or herself arguing in favor of seeking further services.

Michael V. Pantalon, Ph.D., Field Reviewer

Brief Motivational Interventions

A growing trend worldwide is to view substance misuse in a much broader context than diagnosable SUDs. The recognition that people who misuse substances make up a much larger group—and pose a serious and costly public health threat—than the smaller number of people needing specialized addiction treatment is not always reflected in the organization and availability of treatment services. As part of a movement toward early identification of alcohol misuse and the development of effective and low-cost methods to ameliorate this widespread problem, BI strategies, which include motivational components, are widely disseminated in the United States and other countries (Joseph & Basu, 2016).

The impetus to expand the use of BI is a response to:

- The need for a broader base of treatment and prevention components to serve all segments of the population that have minimal to severe use and misuse patterns.
- The need for cost-effective interventions that satisfy cost-containment policies in an era of managed health care (Babor, Del Boca, & Bray, 2017).
- A growing body of research findings that consistently demonstrate the efficacy of BI relative to no intervention (DiClemente et al., 2017).

BI is a structured, person-centered counseling approach that can be delivered by trained health and behavioral health professionals in one to four sessions and typically lasts from 5 to 30 minutes (Mattoo, Prasad, & Gosh, 2018). Even single-session interventions incorporating MET/MI modalities have demonstrated effectiveness in reducing substance use behaviors (Samson & Tanner-Smith, 2015). BI for individuals who use substances are applied most often outside specialty addiction treatment settings (in what are often referred to as **opportunistic** settings), where clients are not seeking help for an SUD but have come, for example, to seek medical attention or treatment for a mental disorder (Mattoo et al., 2018). In these situations, people seeking services are routinely screened for substance misuse or asked about their substance use patterns. Those found to be misusing substances or who have related problems receive a specific BI.

EXPERT COMMENT: BI IN THE EMERGENCY DEPARTMENT

When I apply an MI style in my practice of emergency medicine, I experience considerable professional satisfaction. Honestly, it's a struggle to let go of the need to be the expert in charge. It helps to recognize that the person I'm talking with in these medical encounters is also an expert—an expert in her own lifestyle, needs, and choices.

After learning about the FRAMES principles in 1987, I tried them once or twice, and they worked, so I tried them again and again. This is not to say that I don't fall back to old ways and sometimes ask someone, "Do you want to go to detox?" But more often than not, I try to ask permission to discuss each individual's substance use. I ask clients to help me understand what they enjoy about using substances and then what they enjoy less about it. Clients often tell me they like to get high because it helps them relax and forget their problems and it's a part of their social life. But they say they don't like getting sick from drugs. They don't like their family avoiding them or having car crashes. I listen attentively and reflect back what I understood each person to have said, summarize, and ask, "Where does this leave you?" I also inquire about how ready they are to change their substance use on a scale of 1 to 10. If someone is low on the scale, I inquire about what it will take to move forward. If someone is high on the scale, indicating readiness to change, I ask what this person thinks would work to change his or her substance use.

If a client expresses interest in treatment, I explore pros and cons of different choices. An emergency department (ED) specialist in SUDs then works with the person to find placement in a program and, if needed, provides a transportation voucher. This systematic approach, which incorporates MI principles, is helpful to me in our hectic practice setting. It's not only ethically sound, based as it is on respect for the individual's autonomy, but it's less time consuming and frustrating. Each person does the work for himself or herself by naming the problem and identifying possible solutions. My role is to facilitate that process.

Ed Bernstein, M.D., Consensus Panel Member

The purpose of a BI is usually to counsel individuals, using a motivational approach, about substance misuse patterns; increase awareness about the negative effects of substance misuse; and advise them to limit or stop their use altogether, depending on the circumstances (Nunes, Richmond, Marzano, Swenson, & Lockhart, 2017). If the initial intervention does not result in substantial improvement, the provider can make a referral for specialized SUD treatment. A BI also can explore the pros and cons of entering treatment and present a menu of options for treatment, as well as facilitate contact with the treatment system. There are several BI models, but FRAMES is the dominant BI method for substance misuse (Mattoo et al., 2018).

BI strategies have been used effectively in SUD treatment settings where people seek assistance but are placed on waiting lists, as a motivational prelude to engagement and participation in more intensive treatment, and as a first attempt to facilitate behavior change. A series of BI can constitute BT, an approach that applies motivational and other treatment methods (e.g., cognitive–behavioral therapy) for a limited timeframe, making the modality particularly effective for clients who want to abstain from, instead of reduce, alcohol or drug use (Barbosa et al., 2017). Research has found that BT may be more effective than BI in reducing illicit drug use patterns (Aldridge, Dowd, & Bray, 2017).

Screening, Brief Intervention, and Referral to Treatment

A specific BI called SBIRT, which adds screening and referral components, has been implemented widely in the United States in diverse settings, including EDs, primary care offices, and community-based health clinics, through a SAMHSA multisite initiative (Babor et al., 2017). It is the largest SBIRT dissemination effort in the United States (Aldridge, Linford, & Bray, 2017). SBIRT was specifically developed for nonspecialized treatment settings. It has demonstrated effectiveness in primary care offices, EDs, and general inpatient medical units in reducing substance use and misuse among adolescents, young adults, and adults, as well as in increasing participation in follow-up care (Barata et al., 2017; DiClemente et al., 2017; Kohler & Hoffman, 2015; McQueen, Howe, Allan, Mains, & Hardy, 2015; Merchant, Romanoff, Zhang, Liu, & Baird, 2017; Timko, Kong, Vittorio, & Cucciare, 2016; Woolard et al., 2013).

People often seek treatment for medical concerns that may be related to or impacted by substance misuse but are not specifically seeking help for substance use problems. Screening has become an integral component of BI in these opportunistic settings (Mattoo et al., 2018). The results of the screening determine whether the person seeking services is offered a BI such as FRAMES or is referred to specialized addiction treatment when the person meets the criteria for moderate or severe SUD. From a public health perspective, SBIRT is seen as both a prevention and a treatment strategy. Although, research results about the effectiveness of SBIRT for illicit drug use are mixed (Hingson & Compton, 2014), recent outcome data from a SAMHSA initiative demonstrate its effectiveness to lower alcohol consumption, alcohol misuse, and illicit drug use (Aldridge, Linford, & Bray, 2017). Other studies found that initiation of buprenorphine treatment in the ED significantly increased clients' engagement in specialty addiction treatment and decreased illicit drug use (Bernstein & D'Onofrio, 2017) and that motivational interventions in ED and public health settings reduced overdose risk behaviors and nonmedical use of opioids (Bohnert et al., 2016; Coffin et al., 2017).

In addition, a growing body of evidence supports the use of SBIRT with adolescents, young adults, adults, and older adults, as well as ethnically and culturally diverse populations, particularly with careful selection of screening tools and tailoring the BI and referrals to each client's needs (Appiah-Brempong, Okyere, Owusu-Addo, & Cross, 2014; Gelberg et al., 2017; Manuel et al., 2015; Satre et al., 2015; Schonfeld et al., 2010; Tanner-Smith & Lipsey, 2015). For information about an SBIRT initiative for older adults (the BRITE Project), see the upcoming TIP on *Treating Addiction in Older Adults* (SAMHSA, planned).

Conclusion

Motivational interventions can be used in BI, in BT, and throughout the SOC process. Some strategies, like screening and FRAMES, are more applicable to BI methods whereas others, like developing discrepancy and decisional balancing, are more useful in specialized addiction counseling settings where clients receive longer and more intensive treatment. What is common in all motivational interventions, no matter the treatment setting or the client population, is the focus on engaging clients, building trust through empathetic listening, and demonstrating respect for clients' autonomy and cultural customs and perspectives.