USING MOTIVATIONAL INTERVIEWING IN SUBSTANCE ABUSE TREATMENT

Allegheny HealthChoices, Inc.

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This report is the second in a series on substance abuse treatment for the Allegheny County behavioral health system. Inside this report, you will:

- *Learn the basics of motivational interviewing (MI)*
- *Understand "Stages of Change" theory and how it works with MI*
- *Find out about training opportunities*

MOTIVATIONAL INTERVIEWING: WHAT IT IS AND WHY IT WORKS

In substance abuse treatment, figuring out how to motivate people to reduce or stop their substance abuse is an enormous challenge for clinicians. In the past, many people working in the field believed a person needed to be motivated in order to change, and a lack of motivation was often used to explain why someone "failed" in treatment. Motivation was a characteristic people had or didn't have.

Currently, motivation is better understood as a state that can be influenced, and as a key factor in helping people change. Ambivalence about change is considered a normal part of the process.

Motivational interviewing (MI) is a counseling method for enhancing a person's internal motivation for behavior change through exploring and resolving ambivalence. MI is person-centered. Clinicians meet people "where they are." It's collaborative, and focuses on the person's goals and values and what the person feels confident and ready to tackle, not what the clinician feels is a priority.

According to Mary Jo Simmen-Gray, a Senior Consultant with the Institute for Research, Education and Training in Addictions (IRETA), "MI is very realistic—there are barriers to change, and people will relapse. Talking about this makes the person feel better—it's not all or nothing… Bringing these [barriers] out and discussing them honors people's autonomy and individual differences. When they go home, it's on them to take the steps to implement the change."

When talking to others, people struggling with addiction often face confrontation, anger, and frustration. According to Dr. Allan Zuckoff, a trainer and researcher in MI from the Department of Psychiatry at the University of Pittsburgh, MI takes the opposite approach. "This piques people's interest, and increases people's willingness to talk honestly about their behavior and its effects," he says. This builds a stronger therapeutic relationship.

Dr. Brenda Freeman, a psychiatrist with Mercy Behavioral Health, agrees. "MI is effective in engaging people in treatment. Pushing abstinence often pushes people out the door. Using motivational interviewing and talking about harm reduction [reducing the harms or risks associate with use] gets them in the door. People don't respond positively to confrontation. These disorders are so

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Everyone experiences ambivalence when facing a life change. Through motivational interviewing, clinicians help people explore and resolve their ambivalence and ultimately commit to changing their behavior.

GETTING STARTED WITH MI

Clinicians and agencies often face time and financial constraints that limit training and consulting opportunities. However, there are numerous ways to overcome these barriers.

The first step in building motivational interviewing skills is training. A workshop can teach clinicians the basic principles and ideas to try out in their daily work.

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complex, and people are thinking about making serious lifestyle changes."

People are typically ambivalent about any decision, whether it's getting clean, changing jobs, or ending a relationship. "Rather than trying to overcome or push past people's ambivalence, counselors doing MI address it directly. When people are stuck in ambivalence, they tend to alternate between shifting back and forth among unpalatable options and putting the whole problem out of their minds. MI helps people to face their ambivalence, and in doing so to see the problem from a new perspective that allows them to find a positive way forward," says Dr. Zuckoff.

MI was originally described by Dr. William R. Miller in 1983 for problem drinkers. The ideas and techniques were further developed and published in 1991 by Dr. Miller and Dr. Stephen Rollnick. A growing body of research shows that motivational interviewing works in many different settings, from outreach in health clinics (see page 7) to traditional treatment programs, and for different behaviors, from substance abuse to smoking and diet.

The Basic Principles of MI

No matter where it is applied, MI can be broken into four principles that help people resolve their ambivalence, and therefore improve their motivation for moving forward in the change process.

1. Express Empathy.

Through empathy, the clinician can create an open, respectful environment. Through understanding the individual's experiences, feelings, and values, a strong therapeutic relationship begins. Building empathy and understanding does not mean the clinician agrees or approves of the person's actions or situation.

2. Develop Discrepancy.

Helping people to identify discrepancies (or differences) between their current situation or behavior and their hopes or ideals can help build motivation. Understanding the individual's values, spirituality, and his or her connections to family and community is essential for building discrepancy. "Developing this tension is very important," says Dr. Freeman. By focusing on these discrepancies, the clinician helps the person to express his or her own concerns and to begin to engage in "change" talk.

Exploring the pros and cons of change can help a person develop discrepancy and decide a change is necessary. Clinicians can ask the person to list the positive aspects (reasons not to change) and less-than-positive aspects (reasons to change) of substance use, and work with the person to understand the personal value she or he puts on each.

These "decisional balance exercises" help the person to articulate ambivalence, and help the clinician understand the individual's feelings of self-efficacy and determination to change.

3. Roll with Resistance.

Often, when a clinician tries to make a person acknowledge a substance abuse problem or a need for change, this builds resistance. Instead of interpreting an individual's resistance as defiance or denial, it is more productive for the clinician to recognize it as a signal that the person's perspective is different. Rather than arguing, which is never productive and can result in additional resistance or dropping out of treatment, clinicians can use an empathic, non-judgmental style of responding to help keep the person engaged.

Reflecting the resistant statements, emphasizing the individual's personal choice and control, shifting the focus of the discussion, or reframing what the person has said can lower resistance and increase openness to treatment and change.

4. Support Self-Efficacy.

Many people do not believe they can change. Through highlighting people's strengths, sharing information about addiction and recovery, and identifying role models, the clinician can help people develop confidence that they can change.

Taking the Tour Guide Approach

"MI is like taking the tour guide approach. Tour guides are experts of the area and provide options, but don't tell you where to go. For example, a tour guide in Pittsburgh may have several suggestions like the Science Center, the Incline or even Heinz Field. They may provide information about each site and how to get there, but it would be up to the visitor to decide what they want to see. In MI, the clinician balances between directing the client and following their lead."

- Mary Jo Simmen-Gray, describing William Miller's explanation of MI

The content of this report was adapted from SAMHSA's Treatment Improvement Protocol 35: Enhancing Motivation for Change in Substance Abuse Treatment, available at **http://tie.samhsa.gov/**.

EFFECTIVE TECHNIQUES TO BUILD RAPPORT AND EMPATHY

Using the following techniques helps clinicians build rapport and empathy, essential for engaging people in treatment.

- ✓ ***Ask open-ended questions.*** Open-ended questions encourage people to share information and allow the clinician to learn more about a person's situation and feelings.
- ✓ ***Listen reflectively.*** Rephrasing people's statements to capture the meanings and feelings implicit in what they've said shows the clinician is listening and understanding, and helps people to understand themselves more fully.
- ✓ ***Summarize.*** Summarizing a person's statements and the discussion so far shows, again, that the clinician is listening. It can also help point out discrepancies between the person's current situation and hopes or goals.
- ✓ ***Affirm.*** Affirming tells the person the clinician understands the person's feelings and situation, helping people feel validated and confident.
- ✓ ***Elicit change talk.*** Because we learn what we think as we hear ourselves speak, evoking statements from people of their desire, ability, reasons, and need for change helps them to literally talk themselves into changing their behavior. Examples of change talk statements include, "I'm worried about my drug use… I've got to do something about my situation… I can make this change."

While these techniques can be helpful, other strategies such as ordering, persuading with logic, lecturing, or providing solutions prematurely can build resistance and interfere with the person's willingness to communicate.

USING MI WITH PEOPLE WHO HAVE CO-OCCURRING MENTAL HEALTH DISORDERS

As a psychiatrist with one of Mercy Behavioral Health's Community Treatment Teams (CTT),* Dr. Brenda Freeman works with people who have significant co-occurring mental health and substance use disorders. She uses MI extensively to help people on CTT resolve their ambivalence and build motivation for change.

For example, Dr. Freeman uses MI often when medication adherence is an issue. Many people do not want to take their psychiatric medications; hospitalizations, difficulties working, and other consequences are often the result. Using MI techniques to educate people about their illness and where medications might fit in can be very effective. Over time, people will begin to internally understand the benefits of medications.

Making a list of benefits and negative aspects of medications visually on paper can create ambivalence. "By the end of the process, people are willing to try their medications, not because you say they have to, but because they see the benefits," says Dr. Freeman.

Building that tension between people's current behaviors and where they want to be can help people resolve that ambivalence and develop motivation. For the mother who wants to be with her children but can't pass her drug test, Dr. Freeman would explore what keeps her using drugs. This can give Dr. Freeman insight into how to help direct this motivation to actual behavior change, whether it's developing coping skills or prescribing a medication to help with anxiety and sleeplessness that may be fueling the person's use of alcohol and/or drugs.

Understanding each individual's motivation at each contact is essential for building and keeping a therapeutic and trusting relationship. Checking in with people, whether in an individual conversation or group setting to find out where they are in their recovery process, what barriers they are facing, and what they want to talk about guides CTT's interactions.

For example, the conversation with a person dependent on cannabis and arrested for possession with intent to distribute would be different if the person thought they had a drug problem or not. For someone who didn't think they had a problem despite the negative consequence of getting arrested, Dr. Freeman would explore what happened and then explore with the person the pros and cons of continuing to use vs. considering making a change in their use. For someone who was ready to change as a result of being arrested, Dr. Freeman would help the person find an AA/NA meeting and develop a plan for stopping their use.

"MI can help with many problems our consumers face," says Dr. Freeman, adding "MI is one of the first trainings we do with new CTT staff" because it is such a critical skill.

*CTTs provide intensive, team-delivered services in the community to people with serious mental illness and (often) co-occurring substance abuse. CTTs are expected to follow the Assertive Community Treatment (ACT) model, an evidence-based practice.

USING THE STAGES OF CHANGE IN MOTIVATIONAL INTERVIEWING

Quoting Dr. Miller, one of the originators of MI, the stages of change and motivational interviewing are cousins, says Dr. Allan Zuckoff of the University of Pittsburgh. They share the same values.

Through understanding where the person is in the change process from moment to moment and visit to visit, the clinician can tailor motivational strategies to most effectively resolve ambivalence and build motivation. Jumping directly to a strategy better suited to a later stage of change may build treatment resistance or result in the person leaving treatment.

Understanding the change process helps clinicians tailor their interactions with persons to most effectively resolve ambivalence and build motivation.

Most often, this change process is modeled in five parts, as shown in the figure below (based on Prochaska and DiClemente's Transtheoretical Model of Change).

The first step in making a change is recognizing a problem exists. Once an individual is aware of the problem and considering change, he or she develops a plan for change (preparation), then takes action, and works to stay committed to the new behavior or situation (maintenance). Most people will experience recurrence, or relapse, and start the change process again from an earlier stage.

The stages of change theory applies not just to people with substance abuse problems in treatment, but people making any kind of change in their lives.

Table 1 provides a description of each stage of the change process and strategies the clinician can use to engage people in treatment, help them decide to change, and support them through the process.

Ms. Simmen-Gray of IRETA summarizes, "In the MI process, understanding the stages of change reminds us that change is a cycle, an ongoing process, and that we need to be realistic. People may be in different stages for different issues, and each should be addressed differently."

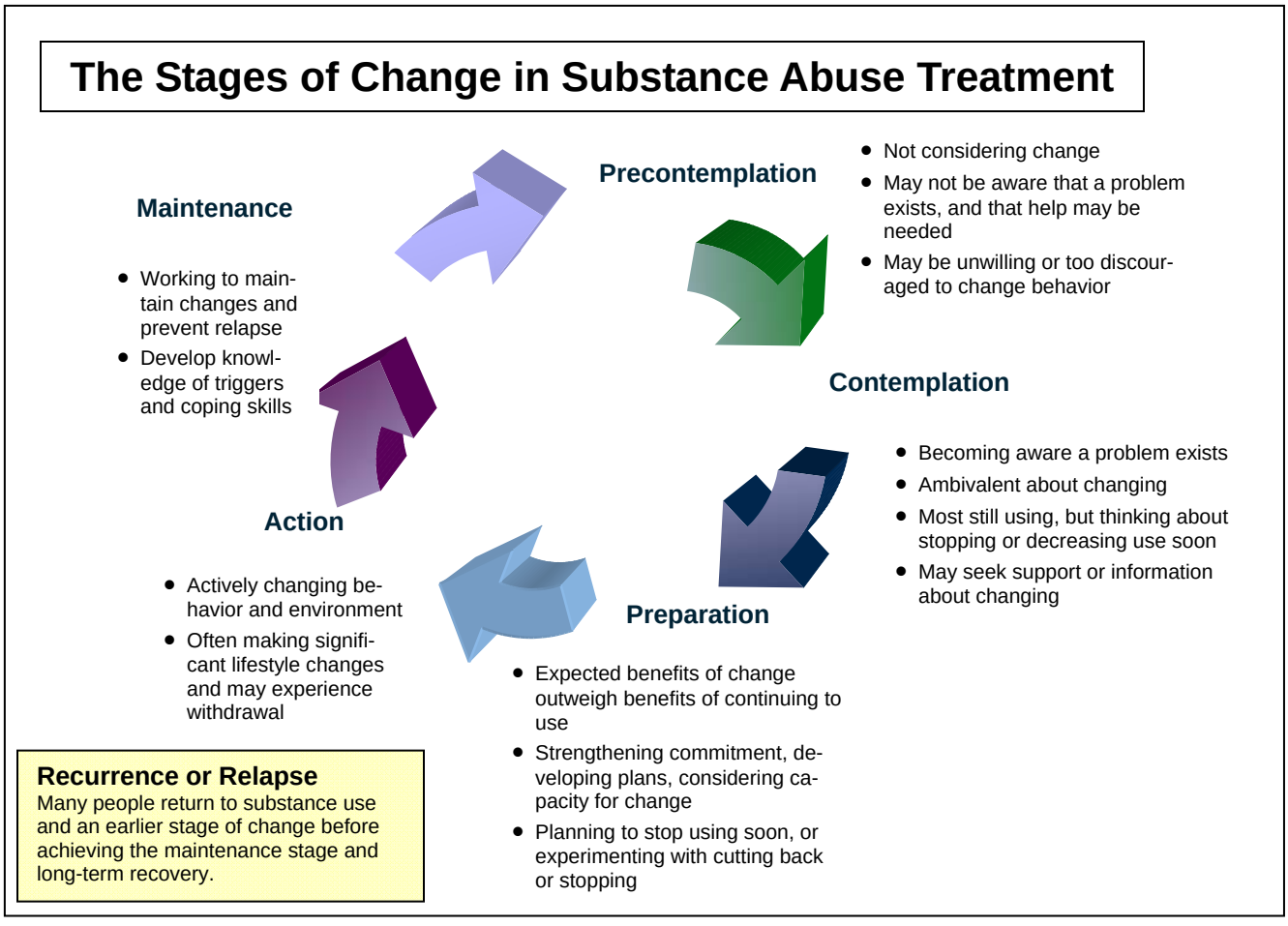

Table 1. Appropriate Motivational Strategies for Each Stage of Change

Stage of Change	Appropriate Motivational Strategies for the Clinician
Precontemplation The person is not yet considering change or is unwilling or unable to change.	**Focus on engagement:** • Establish rapport, ask permission, and build trust. • Express concern and keep the door open. • Raise doubts or concerns in the person about substance-using patterns by: – Exploring the meaning of events that brought the person to treatment or the results of previous treatment – Eliciting the person's perceptions of the problem – Offering factual information about the risks of substance use – Providing feedback about assessment findings – Exploring the pros and cons of substance use – Helping a significant other intervene – Examining discrepancies between the person's and others' perceptions of the behavior
Contemplation The person acknowledges concerns and is considering the possibility of change but is ambivalent and uncertain.	• Normalize ambivalence. Having conflicting feelings and concerns about change is normal. • Help the person "tip the decisional balance scales" toward change by: – Eliciting and weighing pros and cons of substance use and change. – Changing extrinsic (external) to intrinsic (internal) motivation. Examples of extrinsic, or external, motivation include a spouse, an employer or the court. – Examining the individual's personal values in relation to change. – Emphasizing the person's free choice, responsibility, and self-efficacy (self-confidence, hope) for change. • Elicit self-motivational statements of intent and commitment from the person. • Elicit ideas regarding the person's perceived self-efficacy and expectations regarding treatment. • Summarize self-motivational statements.
Preparation The person is committed to and planning to make a change in the near future but is still considering what to do.	• Clarify the person's own goals and strategies for change. • Offer a menu of options for change or treatment. • With permission, offer expertise and advice. • Negotiate a change or treatment plan and behavior contract. • Consider and lower barriers to change. • Help the person enlist social support. • Explore treatment expectancies and the person's role. • Elicit from the person what has worked in the past either for him or others whom he knows. • Assist the person to negotiate finances, child care, work, transportation, or other potential barriers. • Have the person publicly announce plans to change.
Action The person is actively taking steps to change but has not yet reached a stable state.	• Engage the person in treatment and reinforce the importance of remaining in recovery. • Support a realistic view of change through small steps. • Help the person identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these. • Acknowledge difficulties for the person in early stages of change. • Assist the person in finding new reinforcers of positive change. • Help the person assess whether she has strong family and social support.
Maintenance The person has achieved initial goals such as abstinence and is now working to maintain gains.	• Help the person identify and sample drug-free sources of pleasure (i.e., new reinforcers). • Support lifestyle changes. • Affirm the person's resolve and self-efficacy. • Help the person practice and use new coping strategies to avoid a return to use. • Maintain supportive contact (e.g., explain to the person that you are available to talk between sessions). • Develop a "fire escape" plan if the person resumes substance use. • Review long-term goals with the person.
Recurrence (relapse) The person has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next.	• Help the person reenter the change cycle and commend any willingness to reconsider positive change. • Explore the meaning and reality of the recurrence as a learning opportunity. • Assist the person in finding alternative coping strategies. • Maintain supportive contact.

Table 1 is reprinted from SAMHSA's Treatment Improvement Protocol 35: Enhancing Motivation for Change in Substance Abuse Treatment, Chapter 2, available at http://tie.samhsa.gov/.

GETTING STARTED WITH MI (CONT.)

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Ongoing supervision, coaching, and observation are critical for truly incorporating MI into practice. Both Dr. Zuckoff, a researcher and trainer from the University of Pittsburgh, and Ms. Simmen-Gray, a Senior Consultant from IRETA, recommend that clinicians new to MI have an experienced supervisor or coach to provide feedback, act as a resource, and help deal with frustration or obstacles.

Ultimately, says Dr. Zuckoff, clinicians learn MI from their clients. By attending to the rise and fall of "change talk" and resistance during interactions with people, clinicians learn the effect different strategies have. Noticing people's responses and being guided by them are key. Ongoing supervision helps develop these skills. Tape recording sessions and listening to them with a coach can also be very helpful.

Agencies can pursue different training models depending on the time and financial resources available, including:

- ✓ **Training with follow-up model.** One common model of training Dr. Zuckoff uses is a two-day introductory course, with a follow-up day scheduled six weeks later. This gives people the chance to try out their new skills, and bring questions and cases back for discussion.
- ✓ **System level coaching model.** Montgomery County, PA has invested in a coaching model to build MI skills within their system. On a regular basis, coaches who have received training spend time with clinicians to provide group supervision and individual consultation.
- ✓ **Train the trainer model.** Within an agency, supervisors can identify clinicians whose natural style fits the motivational interviewing approach and who are interested in building these skills. By providing training to a select group, these clinicians become in-house experts and spread the approach through the agency.
- ✓ **Online and multimedia education models.** Options for online courses are available at minimal cost (see "Local and Online Resources"). The Center on Alcoholism, Substance Abuse and Addiction (CASAA) at the University of New Mexico offers a VHS or DVD training series with helpful modeling of skills.
- ✓ **Training for supervisors.** Because ongoing supervision is so critical to building MI skills, training resources are also available for supervisors. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Drug Abuse (NIDA) have published "Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency." (See page 7.)

Visit www.motivationalinterview.org for resources and training information.

With all the resources available, selecting a place to start can be daunting. Dr. Zuckoff recommends reading Miller and Rollnick's **"Motivational Interviewing, Second Edition: Preparing People for Change"** as a helpful start for any clinician or supervisor in a variety of fields.

Also, **www.motivationalinterview.org** provides a excellent starting point to learn more about MI and to find helpful resources. The site includes the **Motivational Interviewing Network of Trainers (MINT)**, an active collective of trainers who have participated in Miller and Rollnick's "train the trainers" program and remain current in recent developments in the field.

LOCAL AND ONLINE RESOURCES: PLACES TO GET STARTED

- **www.motivationalinterview.org** provides a list of trainers in motivational interviewing, as well as information on clinical issues, research related to motivational interviewing, training materials, and clinical forms and assessments.
- **The Institute for Research, Education and Training in Addictions (IRETA)** offers workshops, conferences, and regional training institutes on a variety of topics. See www.ireta.org.
- **The Center on Alcoholism, Substance Abuse and Addiction (CASAA)** at the University of New Mexico provides research, training and resources on MI and other treatment-related topics. See http://casaa.unm.edu/mi.html.

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APPLYING MI IN OTHER COMMUNITY SETTINGS: THE SBIRT PROJECT

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an early intervention approach that screens people for substance use related problems, or who are at-risk for developing substance use related problems. SBIRT includes the following core components:

- **Screening**, through interviews or self-report, occurs in a medical or other community setting.
- People at moderate risk receive a **brief intervention** (either at the initial session or during additional sessions) focusing on raising awareness about their problematic use and its consequences, and motivating behavior change.
- People at moderate to high risk receive **brief treatment**, involving a motivational discussion, empowerment, and also assessment, problem-solving, coping strategies, and building a supportive environment. According to SAMHSA, brief treatment is a limited number of very focused sessions aimed at stopping the dangerous substance use.
- For people at severe risk or with substance dependence, **referral to treatment** for substance abuse is made.

MI is a key component to providing brief interventions and treatment and motivating people to complete their referral to specialized treatment.

Research has demonstrated that SBIRT can be effective in reducing or stopping problematic substance use. Ultimately, this should impact the number of people who develop addictions and facilitate an earlier entry to treatment for those with problems.

Pennsylvania is one of seven states that received a grant to implement SBIRT in healthcare settings. IRETA (see page 6) has provided training to healthcare providers on how to build these interventions into their daily practice. The project has been implemented in six practices in Allegheny County, including two family residency programs at UPMC Mercy and the West Penn Family Practice in Squirrel Hill.

For more information, visit http://sbirt.samhsa.gov or www.ireta.org/sbirt, or email mjgray@ireta.org.

LOCAL AND ONLINE RESOURCES (CONTINUED)

(Continued from page 6)

- **The National Institute of Drug Abuse (NIDA)** offers information for clinical practice and for people with substance abuse problems. See www.drugabuse.gov/.
- The Treatment Improvement Exchange at the **Substance Abuse and Mental Health Services Administration (SAMHSA)** provides a list of Treatment Improvement Protocols (TIPs) on different topics. See http://tie.samhsa.gov/.
  This report is based on TIP 35, Enhancing Motivation for Change in Substance Abuse Treatment. Appendix B of TIP 35 includes several screening and assessment tools.
- **NIDA and SAMHSA** have also published training materials for the clinical supervision of MI. See http://mia.nattc.org.
- **The Office of Education and Regional Programming (OERP)** at Western Psychiatric Institute and Clinic (WPIC) provides training and technical assistance for mental health and substance abuse providers in western Pennsylvania. You do not need to be an employee of WPIC to participate in the trainings. See www.wpic.pitt.edu/oerp/.
- **Mercy Behavioral Health** offers training and professional development opportunities. You do not need to be an employee of Mercy to participate in the trainings. See http://www.mercybh.org/poc/view_doc.php?type=doc&id=9153.
- **www.addictioned.org** offers a variety of online courses, including courses on motivational interviewing. They are low-cost and can be taken at the individual's convenience.
- **Essential Learning** (www.essentiallearning.com) and **Continued Learning** (www.continuedlearning.com) offer training packages for behavioral health providers. Organizations that are members of the Pennsylvania Community Provider's Association (PCPA) receive a discount.

ABOUT THE CONTRIBUTORS...

Dr. Brenda Freeman is a physician board-certified in psychiatry. She is also certified in addiction medicine through the American Society of Addiction Medicine (ASAM) and has received additional training in motivational interviewing. She is one of the doctors on Mercy's Community Treatment Teams (CTT) and also sees people in outpatient clinic settings. She provides training in motivational interviewing and harm reduction.

Mary Jo Simmen-Gray, BSW, MA is a Senior Consultant with IRETA. She has been a practicing clinician and supervisor in outpatient and community outreach programs for people with substance abuse problems. Currently, she coordinates the Allegheny County SBIRT Project and assists with the statewide SBIRT training and development. She provides ongoing coaching and technical assistance and trains healthcare providers in MI techniques.

Allan Zuckoff, PhD is an Assistant Professor of Psychiatry at the University of Pittsburgh. He is the author of multiple articles and the co-author of a book on MI. He is also a member of the Motivational Interviewing Network of Trainers (MINT), and editor of the MINT bulletin. His research focuses on the application of MI, particularly in engaging people in treatment.

Visit www.motivationalinterview.org for resources and training information.

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