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Motivational Interventions for Methadone-Treated Patients

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Summary

Implementing a motivational approach in MMT acts as a powerful resource in influencing in a positive way the dominant programme atmosphere, staff-client interactions, quality of services and programme functioning as a whole. There are various ways in which motivational interventions can be successfully applied in MMT. The evidence to date is very encouraging in suggesting that even brief interventions can enhance client motivation and trigger significant improvement and change. The use of these promising methods in the future will depend on the creativity of clinicians and researchers in adopting, adapting and evaluating motivational interventions to make them more widely and effectively implemented in MMT clinical practice for the good of our clients.

Key Words: Heroin Dependence - Neuroscientific Knowledge - Prejudices - Patient Education - Medical Education

1. Introduction

Since the late 1980s the development of Motivational Interviewing and its adaptations has been acknowledged as the most important recent advance in the field of addiction treatment. Effective strategies, brief interventions and structured approaches have been developed to enhance client motivation, while clinicians' interest in motivational interventions has substantially increased. Surprisingly, it seems that theseinterventions have still not been given an adequate role in MMT programmes.

This paper aims to provide the best practical guidelines to methadone maintenance programme managers, programme planners, counsellors and clinical staff, to make them aware of the power of motivational enhancement strategies, to provide them with a taste for, and understanding of. the spirit of the motivational style of interacting with clients, and to enrich their clinical view with a highly effective method for helping clients to achieve behavioural change. It presents an outline of the theoretical background, outcome research, rationale for use and state-of-the-art practical methods for implementing motivational interventions that can be integrated into the MMTP context and daily work.

This paper is closely based on a thorough view of the research literature and on well-grounded empirical findings; it is organized within the Transtheoretical Model, which offers an integrative framework for conceptualizing and implementing behaviour change among people who have a problem of substance abuse.

It presents a motivational communication style for working with clients, based on the most advanced technologies, which have been developed in the field of psychosocial addiction treatment and the enhancement of motivation and behaviour changes, and it is specifically designed to match the clinical needs of an MMTP.

There are many ways in which motivational concepts, principles and interventions can be applied in an MMT setting. The main aspects and practical implications of the motivational approach in an MMT are discussed

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with emphasis on style, spirit, strategies and ways of incorporating it into MMTP clinical work and into the treatment model. The principles, strategies, methods and interventions described here are explicitly intended to help clinicians facilitate change in MMT clients. They can be used as a stand-alone treatment, can be integrated with a broad range of other treatments and strategies, and can also be used to prepare a motivational foundation for other therapeutic approaches within MMT.

2. The role of counselling and psychosocial services in MMT

A number of studies have stressed that although methadone maintenance treatment has powerful effects in terms of stabilizing clients, keeping them in treatment and making them available for psychosocial interventions, a purely pharmacological approach will not be sufficient for most patients, and better outcomes are associated with higher levels of psychosocial treatments [4].

The best treatment retention percentages and the best outcomes, evaluated in terms of improved social functioning, were seen in the initial methadone clinical trials [7] in programmes characterized by the careful screening of clients, adequate dosing policies and extensive adjunctive services. The extent to which counselling is an important part of MMT was also addressed by Ball and Ross [1] in their correlational study. They noted that both staff and patients viewed counselling as the most important component of the rehabilitative aspect of methadone treatment. Their results strongly suggest that MMTPs which delivered more counselling tended to have better outcomes. The highly positive effect of psychosocial services was clearly confirmed by McLellan et al. [13]. These authors concluded that methadone alone may only be effective for a minority of patients, and argued that the addition of counselling, and of medical and psychosocial services brought dramatic improvements over the effect of methadone alone.

3. Theoretical framework: The transtheorethical model

In recent times, the treatment of addictions has been dominated by the so-called Transtheoretical Model (TTM), proposed by Prochaska and DiClemente [20, 21, 22, 23] and revised by Prochaska et al. [24, 25] and DiClemente and Prochaska [6]. The model is 'transtheoretical' in that it is not based on any school of therapy, but offers an integrative framework for understanding and intervening with human intentional behaviour change and practical guidelines, irrespective of the therapist's favoured approach. The model proposes three organizing constructs: the stages, the processes and the levels of change.

3.1 The stages of change

The stages represent the dynamic and motivational aspects of the process of change over time. Five sequential stages have been identified; people pass through each of these in the course of changing a problem. These stages seem to apply equally well to self-change and to therapy-assisted change. In or out of therapy, people seem to pass through similar stages and employ similar processes of change:

1. **Precontemplation:** During this stage, individuals are unaware of the nature and extent of a problem needing to be changed, or are unwilling to change problematic behaviour.

2. **Contemplation:** In this stage people are aware that a problem exists and have got to the point of seriously thinking about overcoming it, but have not yet made a commitment to take action.

3. **Preparation:** This stage constitutes a resolution of the decision-making task; in this stage, individuals intend to take action, and there is a commitment to a plan for change to be implemented in the near future.

4. **Action:** This is the stage when the plan for change is implemented, active coping is initiated, and the actual change in behaviour occurs. This is when individuals modify their behaviour, experiences and/or environment so as to overcome their problems.

5. **Maintenance**: In this stage, already achieved behaviour change is sustained, and people work to integrate it into their lifestyle, to stabilize behaviour, to prevent any relapse and consolidate the gains attained during the action stage.

Once change has become completely integrated into his/her lifestyle, an individual can exit from or terminate this process of change. It is normal to go through this whole process several times before a stable form of change is achieved. Relapse is viewed not necessarily as a failure, but as a normal, predictable part of the process, and as a stage of growth with its own opportunities. Working with patients during the period when a relapse is likely is essential to ensure continued change [8].

3.2 The processes of change

The processes have been derived from many diverse theories of behaviour change and are at the heart of the Transtheoretical Model. Ten processes have been reliably identified: raising of consciousness, self-re-evaluation, environmental re-evaluation, dramatic relief, social liberation, self-liberation, counterconditioning, stimulus control, reinforcement management and helping relationships.

The processes are intended to clarify the type of activity that is initiated or experienced by individuals in modifying their behaviour. According to the model, particular processes employed at particular stages are responsible for movement through the stages of change [6]. Generally speaking, cognitive strategies should be more appropriate to clients in the early stages of change, and behavioural strategies should be more appropriate at the action stage of change [2].

3.3 The levels of change

Individuals have multiple problems that interact with the process of changing any single addictive behaviour. The concept of levels of change incorporates the realization that individuals are at different stages of change with respect to different problem areas, and that addictive behaviour always occurs within various interrelated levels of human functioning. These levels are organized hierarchically as follows: symptom/situational, maladaptive cognitions, current interpersonal conflicts, family/system problems, intrapersonal conflicts.

The Transtheoretical Model provides a foundation for the development of practical strategies and interventions in countering addictive behaviours.

3.4 The concept of motivation

Motivation plays an important role in people's decisions to change their behaviour and substance use. It has been defined as "the probability that a person will enter into, continue, and adhere to a specific change strategy" [5]. A key dimension of motivation is adherence to or compliance with a change programme, so motivation may be thought of as the probability of a certain behaviour.

Miller and Rollnick [17] suggest that motivation should not be thought of as a personality problem, or as a trait that a person carries through the counsellor's doorway. Rather, motivation is a person's present state or stage of readiness for change, which may fluctuate from one time or situation to another. Most importantly, a person's motivation can be influenced by attuned clinical interventions and is affected by how he or she is treated by clinical staff. Thus, increasing motivation becomes an inherent and central part of the professional's task. It is the counsellor's responsibility to motivate — to increase the likelihood that the client will follow a recommended course of action directed towards change.

There is no doubt that for patients in MMT the intake of an adequate dose of methadone is of dominant importance, but it is also clear that the success of methadone programmes is closely related to strictly following a therapeutic regimen and programme rules, while applying a range of psychosocial interventions. The participation of patients in these activities is based on their level of motivation to do so [28].

3.5 Stage-specific interventions

What motivates people to engage in treatment, progress in therapy and continue to progress after therapy is receiving interventions and treatments that match their current stage of change. Motivational interventions are a powerful tool in assisting clients to move through the stages of change. They are invaluable and most appropriate for the early stages of precontemplation, contemplation and preparation, and again in the relapse stage. Individuals in the action and maintenance stages may need skills, training in addition to motivational strategies (Table 1).

- **Precontemplation Stage — Building Readiness:** A person in the precontemplation stage needs information and feedback to raise his/her awareness of the problem and of opportunities for change. The major strategy here is to raise doubts in clients about the harmlessness of their substance use patterns, and increase the clients' perceptions of risks and problems with their current behaviour.
- **Contemplation Stage — Increasing Commitment:** The key here is to help the contemplator think through the risks of the problem behaviour and the potential benefits of change, and to instil hope that change is possible.
- **Preparation Stage — Getting Started:** The main task here is to help the client develop plan for change that is acceptable, accessible, appropriate and effective, and determine the best course of action to take in seeking change.
- **Action Stage — Reaching Change:** The goal here is to help the client implement the action plan by achieving change.
- **Maintenance Stage — Stabilizing Change:** Helping the client maintain the achieved change, integrate it into his/her lifestyle, prevent relapse and keep the client in treatment are the main goals for the therapist at this stage.
- **Relapse — Stop and Start Again**: The counsellor's tasks here are to help the person avoid discouragement and demoralization, reframe the relapse crisis and help him/her see the crisis as an opportunity to learn rather than a failure, and to initiate another change attempt by renewing the processes of contemplation, preparation, action and maintenance.

Table 1: Appropriate Motivational Strategies for Each Stage of Change

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

3.6 Assessment of stage status

Several different methods of measuring a client's stage of change are now available. Of these, the most commonly reported in the current literature are the Staging Algorithm [24] and the University of Rhode Island Change Assessment (URICA) Scale [12, 11], along with the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) [16] and the Readiness to Change Questionnaire [27]. Given that the client's readiness for change tends to fluctuate, the therapist's judgment of the client's current stage of change based on material presented during the counselling session is of indispensable value.

4. The Method

The motivational approach begins with the assumption that the responsibility and capacity for change lies with the client. The style and strategies of the interventions are based on the use of empathy and warmth, not authority or power, and developing non-judgmental and collaborative therapeutic interactions. Increasing client motivation is seen as a central part of the clinician's task. The counsellor works to elicit the client's own concerns. When the client (rather than the counsellor) formulates the reasons for change, the client's internal motivation is harnessed, and he/she is more ready for change. Most of the work to be done involves exploring a client's ambivalence about change, matching interventions to the client's current stage and level of readiness for change, and employing motivational strategies to mobilize the client's own resources in achieving change.

4.1 Motivational interventions

A motivational intervention can be defined as any clinical strategy or method designed to enhance client motivation for change. Motivational interventions can involve a variety of approaches, ranging from brief interventions, client assessment and feedback, counselling, single or multiple sessions, to formal structured therapy, which may be thought of as elements of a continuum of care. The focus here is on interventions designed to enhance intrinsic motivation and readiness for change.

4.1.1 The FRAMES approach

Miller and Sanchez [15] analyzed the content of brief motivational strategies and described six counselling elements that appeared to be the commonly used 'active ingredients' in effective brief interventions. These are summarized in the acronym "FRAMES":

- Feedback regarding personal risk or impairment is given to the individual following an assessment of substance abuse patterns and associated problems.
- Responsibility for change is attributed squarely and explicitly to the individual.
- Advice about changing (reducing or stopping) substance use is clearly given to the client by the clinician in a non-judgmental manner.
- Menu of self-directed change options and treatment alternatives is offered to the client.
- Empathetic counselling, showing warmth, respect, and understanding, is emphasized. Empathy entails reflective listening.
- Self-efficacy or optimistic empowerment is engendered in the person to encourage them to change.

4.2 Structured motivational intervention models

4.2.1 Motivational interviewing

Motivational Interviewing (MI) is an approach designed to help clients reach a decision and build commitment to change. It is a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence [18].

The spirit and style of MI are central to the approach. The counselling style is a quiet and eliciting one. The therapeutic relationship is more like a partnership or companionship rather than a division of roles between expert and recipient. In MI the counsellor does not assume an authoritarian role, and avoids teaching and telling clients how to change or what they should do; rather, he/she works actively towards building a commitment to change. Responsibility for change is left to the client. It is the client's task, not the counsellor's, to articulate and resolve his/her ambivalence. The counsellor seeks to create a positive atmosphere that is conducive to change and is directed to helping the client examine and resolve ambivalence.

Readiness for change, as well as resistance and denial, are not viewed as a trait in the client, but as a fluctuating product of the interpersonal interaction between client and therapist, and feedback regarding therapist consulting behaviour. The overall goal is to increase the client's intrinsic motivation, so that change arises from within, rather than being imposed from without. When this approach is enacted properly, it is the client who presents and voices the arguments for change, rather than the therapist. The appearance of a motivational interviewing session is quite client-centred, yet the counsellor maintains a strong sense of focus, purpose and direction, along with clear strategies and skills for pursuing that purpose, and actively chooses the right moment to intervene in particular

ways at crucial moments [17].

There are five broad clinical principles in MI that give the context regarding the'why' of practice. These are: express empathy, develop discrepancy, avoid argumentation, roll with resistance, support self-efficacy. They underlie the specific practical strategies ('how-to' elements): ask open-ended questions, listen reflectively, affirm, summarize, and elicit self-motivational statements (Change Talk) (Table 2). A fundamental goal in MI is to have clients present and voice arguments for change. One major task of a counsellor is that of leading the therapeutic process in a way that facilitates clients to express self-motivational statements. Hearing oneself state the reasons for change is a powerful way of increasing personal motivation.

MI incorporates two major phases of the therapeutic process, building motivation for change and strengthening commitment to change.

4.2.2 Brief motivational interventions

The research literature shows brief adaptations of motivational interviewing (AMI) effective for a variety of problems, common in MMTP, which are not affected by methadone alone (like problem behaviour, problem drinking and non-opiate substance abuse). Also, brief AMIs have turned out to be as effective as much longer treatments.

In their review on the effectiveness of AMIs Burke, Arkowitz and Dunn [3] drew the following conclusions: AMIs are more effective than no treatment and are as effective as credible alternative treatments; AMIs are effective both as stand-alone treatments and as preludes to other treatments; outcomes of AMIs are not only statistically significant, but also clinically significant; most of the studies deal with alcohol-related problems and addictions, and most of them are quite strong in external validity (i.e. results can be generalized to other settings, problems and populations); brief AMIs perform as well as long AMIs and as more extensive alternative treatments.

4.2.3 Motivational enhancement therapy (MET)

MET is a brief adaptation of MI that incorporates a 'check-up' form of assessment feedback. It is a systematic intervention approach designed to produce rapid, internally motivated change through mobilizing the client's own change resources. The integrated MET approach was delineated in a detailed therapist manual for work with problem drinkers [19], developed for Project MATCH, and was later adapted for clinical work with drug abusers by W.R. Miller [14].

In MET, treatment is preceded by a battery of assessment instruments. The initial two sessions provide the client with objective feedback regarding his drug use and related problems and focus on building motivation and strengthening commitment for change. The subsequent sessions serve as periodic reinforcement and check-ups of progress towards change and make specific use of the follow-through strategies - reviewing process, renewing motivation, redoing commitment.

MET consists of four to twelve sessions to be completed within a period of three months.

Project MATCH [26], the largest psychotherapy outcome study conducted to date, found that 4 sessions of Motivational Enhancement Therapy proved to be as effective as two longer treatments (12 sessions of cognitive-behaviour therapy, and 12 sessions of AA-based treatment) in the case of problem drinkers.

4.2.4 The structured stepped model for motivational interventions in MMT

Examining the work carried out by clinical staff in MMTPs, Ball and Ross [1] concluded that most of it can be more properly described as casework, rather than counselling, which deals with day-to-day issues, mostly of a practical nature. How these interactions are conducted, and particularly the attitude of staff members, is probably the next most important determinant of treatment effectiveness after an adequate dose of methadone [10].

Based on these findings, a structured set of motivational interventions was developed as a stepped model, specifically tailored for dealing with everyday contacts with clients, routine problems, tough and conflicting situations, and difficult clients in methadone maintenance programmes [9]. It creates the programme's spirit and therapeutic context, which turn every contact with clients into part of the overall flow of interventions, which aim to achieve better psychosocial adjustment and positive behaviour change.

The Model is designed as a stepped scheme, with 5 levels of stepped interventions:

The first, most brief and most simple intervention is the Simple Reflection, performed by the nurse at methadone delivery. It is very brief and may take the form of an open-ended question, to be followed by a simple reflection, an amplified reflection, or a double-sided reflection, and concluding with a brief reframing or summary.

The 2nd level intervention is the Brief Motivational Intervention, delivered for 3-5 minutes by the case-manager; it is based on the FRAMES strategies. These two interventions are routinely practised in everyday contacts with clients and form the dominating style of staff communication with clients.

The 3rd level is the Brief Motivational Session, which is highly structured, and delivered by the case-

Table 2: Sample Questions To Evoke Self-Motivational Statements
Problem Recognition What things make you think that this is a problem? What difficulties have you had in relation to your drug use? In what ways do you think you or other people have been harmed by your drinking? In what ways has this been a problem for you? How has your use of tranquilizers stopped you from doing what you want to do?
Concern What is there about your drinking that you or other people might see as reasons for concern? What worries you about your drug use? What can you imagine happening to you? How much does this concern you? In what ways does this concern you? What do you think will happen if you don't make a change?
Intention to Change The fact that you're here indicates that at least part of you thinks it's time to do something. What are the reasons you see for making a change? What makes you think that you may need to make a change? If you were 100 percent successful and things worked out exactly as you would like, what would be different? What things make you think that you should keep on drinking the way you have been? And what about the other side? What makes you think it's time for a change? I can see that you're feeling stuck at the moment. What's going to have to change?
Optimism What makes you think that if you decide to make a change, you could do it? What encourages you that you can change if you want to? What do you think would work for you, if you needed to change?

manager in Motivational Interviewing style for 10-20 minutes.

The 4th level intervention is the Full Motivational Session; this takes 30-60 minutes and is delivered by a counsellor who is qualified and experienced in motivational interventions. It implies the principles and strategies of Motivational Interviewing, and has a strong focus on a particular problem or problem behaviour.

The last, 5th level, is the Motivational Encounter with the Team. It is applied with the most difficult clients — those that break programme rules in a harsh way, that are aggressive and impulsive, and capable of creating serious problems — the people that are most difficult to deal with. This encounter is structured in a non-judgmental, supportive, caring and empathetic way, and is concise, focused and directive.

The main principles of implementing the model imply routine implementation of less intensive interventions, while the more difficult clients and the more complex problems are assigned to more experienced counsellors, who are responsible for structuring more intensive and specific interventions. Interventions are matched up with specific problems, situations and the individual characteristics of clients.

4.2.5 Group work models

Many motivational activities and strategies can take place in increasing the effectiveness of group work. In recent years there has been a raising interest in developing structured motivational approaches for group work based on the Transtheoretical Model and on Motivational Interviewing principles (see the Resource List). It should be borne in mind that conducting motivational interviewing-based therapy in a group setting is considerably more complicated than individual treatment, and requires a high level of training and counselling skills.

5. Addressing specific problems in MMTP

Incorporating motivational interventions and approaches into MMTP services may greatly enhance the likelihood of client change, treatment effectiveness and the overall quality of services. Some of the ways in which motivational interventions can be used involve addressing specific problems and treatment issues; they can be applied as a means for: rapid engagement to facilitate treatment referral and treatment entry, an empowering brief consultation for clients already placed on waiting lists, a preparation for treatment to increase engagement, retention, participation and compliance, overcoming client defensiveness and resistance, working with difficult and coerced clients, dealing with conflicting situations in a positive way, providing an introductory motivational boost for the inclusion of other therapeutic components, or else a prelude to further treatments, stand-alone interventions or a counselling style to be used throughout the course of treatment.

Research testifies to these effects: clients who receive MI at the beginning of treatment are likely to stay in treatment longer, work harder, adhere more closely to treatment recommendations, and experience substantially better treatment outcomes than those who received the same treatment programme without MI. Additional MI was found to facilitate treatments as different as cognitive-behavioural skill training, twelve-step and disease model counselling, and methadone maintenance [18].

5.1 Engagement and retention in treatment

Motivational interventions can be a useful adjunct to increasing client engagement, retention and participation in treatment. A single session (or a couple of sessions) of motivational interviewing added to the routine protocol at the beginning of treatment, prior to entering treatment, or as part of the assessment or treatment entry procedure, may result in better forms of involvement in later treatment, better retention and more favourable outcomes.

5.2 Compliance and non-compliance

Here non-compliance is viewed as a largely motivational issue, and is discussed from the perspective of the Stages of Change Model. Client non-compliance may arise when the client is in the precontemplation or contemplation stage, and is not yet ready for action-oriented interventions, but may feel prematurely pushed to action. Such clients need specific interventions to resolve their ambivalence and enter the stages of preparation and action.

Another possibility is that the non-compliant behaviour arises as a result of underlying client resistance due to an inappropriate interaction with a counsellor, with staff or a prescribing physician. This is where the MI strategies for rolling with resistance should be applied.

5.3 Difficult clients, coerced clients, and conflicting situations

The motivational approach provides alternative ways for dealing with problem situations and clients in a positive way by implementing interventions that are directive, yet non-judgmental, empathetic and caring, while providing a basis for reframing the conflict into an opportunity for positive behavioural change, and for communicating with clients through therapeutic negotiation, instead of confrontation and conflict.

Difficult and coerced clients are at least as amenable to a motivational counselling style as any others. Research now demonstrates that positive treatment outcomes are associated with a high level of empathy in clinicians, as reflected in their warm, supportive listening. If clients receive interventions appropriate to their motivational stage, they may become invested in the treatment process and benefit from opportunities for positive change.

5.4 Use of motivational interventions in comprehensive MMT programs

Motivational interventions can be effectively integrated into more comprehensive treatment plans for clients in MMTPs. These approaches can be particularly useful in MMT when they are used to address specific client target behaviours, problems and issues in the treatment process that may be difficult to change by standard action-oriented approaches. Motivational interventions can be used with clients before, during and after substance abuse treatment.

The most obvious integration is to offer a motivational intervention as a first consultation and prelude to other services. Another option for integration is to use motivational interventions as a counselling and communication style that can be used in parallel with other methods throughout treatment. A third possibility is to keep motivational interventions in the background, to be returned to when motivational issues emerge in the further course of treatment.

These three applications can be integrated into a comprehensive intervention method, where the first session is strictly motivational interviewing, eliciting and listening to the person's concerns and reasons for change. Feedback of assessment results in an MI style begins in the second session, followed by a thorough functional analysis of substance use in the person's life. All this is then drawn together in a treatment plan, drawing on a menu of CBT skill-training modules to address specific goals for change. These modules are then delivered within an MI style, and the counsellor can fall back on MI whenever particular motivational issues or obstacles arise. Personal choice and autonomy are emphasized throughout treatment [18].

5.5 Use of motivational interventions in low-threshold MMT programmes

Motivational interventions can be particularly useful in treatment programmes with limited staff, resources, time, numbers of adjunctive services and treatment components, numbers of individual sessions and consultations per client, and particularly in cases where only one intervention can be offered. Brief motivational interventions may be applied in dealing with specific problems in helping to maintain a user-friendly atmosphere and good client-staff relations and

communication.

6. Training issues

Although brief interventions can be administered by a wide range of professionals, practicing therapy requires training in specific therapeutic modalities. Therapists should be sufficiently well-trained in the motivational approach and should not rely solely on reading texts to learn this approach. This chapter is not designed to teach clinical skills. To train clinical personnel, there is a need for specialized training courses. These are provided by qualified trainers from the Motivational Interviewing Network of Trainers. A key to acquiring the necessary skills for MI is practice with feedback and under supervision.

7. Conclusion

Implementing a motivational approach in MMT acts as a powerful resource in influencing in a positive way the dominant programme atmosphere, staff-client interactions, quality of services and programme functioning as a whole. There are various ways in which motivational interventions can be successfully applied in MMT. The evidence to date is very encouraging in suggesting that even brief interventions can enhance client motivation and trigger significant improvement and change. The use of these promising methods in the future will depend on the creativity of clinicians and researchers in adopting, adapting and evaluating motivational interventions to make them more widely and effectively implemented in MMT clinical practice for the good of our clients.

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Resource list

The following texts are highly recommended as key resources for detailed information on theory and practice of motivational interventions:

- Miller, W.R., and Rollnick, S. (1991). Motivational Interviewing: Preparing people to change addictive behaviour. New York: Guilford Press.
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- Velasquez, M.M., Maurer, G.G., Crouch, C. and DiClemente, C. (2001). Group Therapy for Substance Abuse: A Stages-of-Change Therapy Manual, Guilford Press.
- www.motivationalinterview.org
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)
  This instrument is in the public domain and may be obtained by contacting its author:
  William R. Miller, Ph.D.
  Director Center on Alcoholism, Substance Abuse, and Addictions 2350 Alamo SE University of New Mexico Albuquerque, NM 87106 Phone: (505) 768-0100 Fax: (505) 768-0113, E-mail: wrmiller@unm.edu
- University of Rhode Island Change Assessment Scale (URICA)
  This instrument is in the public domain and may be obtained by contacting its author:
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