Enhancing Motivation for Change in Substance Use Disorder Treatment

UPDATED 2019

TREATMENT IMPROVEMENT PROTOCOL

TIP 35

SAMHSA
Substance Abuse and Mental Health Services Administration

Chapter 5—From Contemplation to Preparation: Increasing Commitment

"The reasons for change need to be important and substantive enough to move the individual into deciding to make the effort to change. The task for individuals in Contemplation is to resolve their decisional balance consideration in favor of change. The decision to change marks the transition out of the Contemplation stage and into Preparation."

DiClemente, 2018, p. 29

Key Messages

- Clients in Contemplation begin to recognize concerns about substance use but are ambivalent about change.
- You can use motivational counseling strategies to help clients resolve ambivalence about change.
- When using a decisional balance (DB) strategy, you briefly reflect clients' reasons for continuing substance use (i.e., sustain talk) but emphasize clients' reasons for change (i.e., change talk).
- Motivational counseling strategies to enhance commitment to change move clients closer to the Preparation stage and taking steps to change.

Chapter 5 describes strategies to increase clients' commitment to change by normalizing and resolving ambivalence about change and enhancing clients' decision-making capabilities. Central to most strategies is the process of evoking and exploring reasons to change through asking open question and reflective listening. The chapter begins with a discussion of ambivalence, extrinsic (external) and intrinsic (internal) motivation, and ways to help clients connect with internal motivators to enhance decision making and their commitment to change. It then focuses on DB strategies—ways to explore the costs and benefits of change and clients' values about changing substance use behaviors. Chapter 5 also addresses the importance of self-efficacy in clients' decisions to change and provides strategies for enhancing commitment to change once clients decide to change.

Exhibit 5.1 presents counseling strategies for Contemplation.

Exhibit 5.1. Counseling Strategies for Contemplation

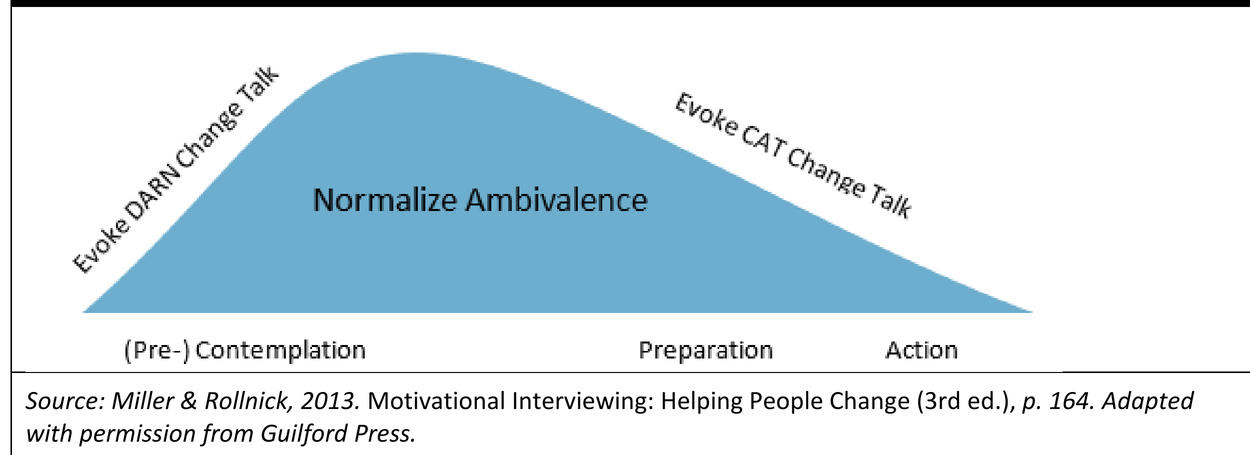
Client Motivation	Counselor Focus	Counseling Strategies
• The client acknowledges concerns and is considering the possibility of change but is ambivalent and uncertain. • The client begins to reflect on his or her substance use behavior and considers choices and options for change.	• Normalize and resolve client's ambivalence about change. • Help the client tip the DB scales toward change.	• Shift focus from extrinsic to intrinsic motivation. • Summarize client concerns. • Assess where the client is on the decisional scale. • Explore pros/cons of substance use and behavior change. • Reexplore values in relation to change. • Emphasize personal choice and responsibility. • Explore client's understanding of change and expectations of treatment. • Reintroduce feedback. • Explore self-efficacy. • Summarize change talk.

		• Enhance commitment to change.

Normalize and Resolve Ambivalence

You must be prepared to address ambivalence to help clients move through the Stages of Change (SOC) process. Ambivalence is a normal part of any change process. Ambivalence is uncomfortable because it involves conflicting motivations about change (Miller & Rollnick, 2013). For example, a client may enjoy drinking because it relaxes him or her but may feel guilty about losing a job because of drinking and putting his or her family in financial risk. Clients often have conflicting feelings and motivations (Miller & Rollnick, 2013). During Contemplation, ambivalence is strong. As you help clients move toward Preparation and Action, ambivalence lessens. Miller and Rollnick (2013) use the metaphor of a hill of ambivalence wherein clients move up the hill during Precontemplation/Contemplation and then journey down the hill through the resolution of ambivalence, which moves them into Preparation and Action (Exhibit 5.2). Chapter 2 provides a thorough description of DARN CAT (**D**esire, **A**bility, **R**easons, **N**eed, **C**ommitment **A**ctivation, **T**aking steps) change talk.

Exhibit 5.2. The Motivational Interviewing (MI) Hill of Ambivalence



Source: Miller & Rollnick, 2013. Motivational Interviewing: Helping People Change (3rd ed.), *p. 164. Adapted with permission from Guilford Press.*

The two key motivational strategies you can use to resolve ambivalence in Contemplation are:

1. **Normalizing ambivalence.** As they move closer to a decision to change, clients often feel increasing conflict and doubt about whether they can or want to change. **Reassure clients that conflicting feelings, uncertainties, and reservations are common.** Normalize ambivalence by explaining that many clients experience similar strong ambivalence at this stage, even when they believe they have resolved their mixed feelings and are nearing a decision. Clients need to understand that many people go back and forth between wanting to maintain the status quo and wanting to change and yet have been able to stay on track by continuing to explore and discuss their ambivalence.

2. **Evoking DARN change talk.** DARN refers to clients' **d**esire, **a**bility, **r**easons, and **n**eed to change. During Contemplation, help clients move up the hill of ambivalence and guide them toward Preparation by evoking and reflecting DARN change talk. Use open questions: "How would you like things to change so you don't feel scared when you can't remember what happened after drinking the night before?" Exhibit 3.8 in Chapter 3 offers more examples of open questions that evoke DARN change talk. Use reflective listening responses to highlight the change talk. **Remember that the goal is to guide clients to make the arguments for change** (Miller & Rollnick, 2013). The key is to avoid jumping too quickly into evoking CAT (i.e., **c**ommitment, **a**ctivation, and **t**aking steps)

change talk, solving problems in response to ambivalence, or making a plan of action. The client has to climb up the hill of ambivalence before easing down the other side.

Shift the Focus From Extrinsic to Intrinsic Motivation

To help clients prepare for change, explore the range of both extrinsic and intrinsic motivators that have brought them to this point. Many clients move through the Contemplation stage acknowledging only the extrinsic motivators that push them to change and that brought them to treatment. External motivators may pressure clients into treatment, including a spouse, employer, healthcare provider, family member, friend, or the child welfare or criminal justice system. **Extrinsic motivators can help bring clients into and stay in treatment, but intrinsic motivators are important for significant, long-lasting change** (Flannery, 2017; Kwasnicka, Dombrowski, White, & Sniehotta, 2016; Mahmoodabad, Tonekaboni, Farmanbar, Fallahzadeh, & Kamalikhah, 2017).

You can help clients develop intrinsic motivation by assisting them in recognizing the discrepancies between "where they are" and "where they want to be":

- Invite clients to explore their life goals and values, which can strengthen internal motivation. In searching for answers, clients often reevaluate past mistakes and activities that were self-destructive or harmful to others.
- Encourage this exploration through asking open questions about client goals: "Where would you like to be in 5 years?" and "How does your substance use fit or not fit with your goals?"
- Highlight clients' recognition of discrepancies between the current situation and their hopes for the future through reflective listening. Awareness of discrepancy often evokes desire change talk, an essential source of intrinsic motivation.

Sometimes, intrinsic motivation emerges from role conflicts and family or community expectations. For example, a single mother who lost her job because of substance use may have a strong motivation to get and keep another job to provide for her children. For other clients, substance misuse has cut their cultural or community ties. For example, they stop going to church or neglect culturally affirmed roles, such as helping others or serving as role models for young people. A desire to reconnect with cultural traditions as a source of identity and strength can be a powerful motivator for some clients, as can the desire to regain others' respect. Positive change also leads to improved self-image and self-esteem.

Expert Comment: Linking Family, Community, and Cultural Values to a Desire for Change

Working with a group of Latino men in the Southwest who were mandated into treatment as a condition of parole and had spent most of their lives in prisons, we found that as these men aged, they seemed to tire of criminal life. In counseling, some expressed concerns about losing touch with their families and culture, and many reported a desire to serve as male role models for their sons and nephews. They all wanted to restore their own sense of pride and self-worth in the small community where many of their families had lived for generations.

Newly trained in MI, we recognized a large, untapped source of self-motivation in a population that we had long before decided did not want help. We had to change our previous beliefs about this population as not wanting treatment to seeing these men as requesting help and support to maintain themselves outside the prison system and in the community.

Carole Janis Otero, M.A., Consensus Panel Member

Helping clients shift from extrinsic to intrinsic motivation helps them move from contemplating change to deciding to act. Start with clients' current situations, and find a natural link between existing

external motivators and intrinsic ones that they may not be aware of or find easy to describe. Through compassionate and respectful exploration, you may discover untapped intrinsic motivation.

Along with MI techniques presented in Chapter 3, use these strategies to identify and strengthen intrinsic motivation:

- **Show genuine curiosity about clients.** Show interest in their lives at the first meeting and over time. Because clients' desire to change is rarely limited to substance use, they may find it easier to talk about changing other behaviors. Most clients have concerns about several areas of their lives and wish to reconnect with their community, improve their finances, find work, or fall in love. Many are highly functional and productive in some aspects of their lives and take great pride in special skills, knowledge, or other abilities they do not want to lose.
- **Do not wait for clients to talk spontaneously about their substance use.** Show interest, and ask how their substance use affects these aspects of their lives. Even with clients who do not acknowledge any problems, question them about their lives to show concern and strengthen the counseling alliance.
- **Reframe clients' negative statements about external pressure to get treatment.** For example, help clients reframe anger expressed toward their spouse who has pressured them to enter treatment as seeing their spouse as caring and invested in the marriage
- **Identify and strengthen intrinsic motivation of clients who have been mandated to treatment.** Emphasize personal choice and responsibility with these clients. Help clients understand that they can freely choose to change because doing so makes good sense and is desirable, not because negative consequences will happen if they choose not to change.

Summarize Client Concerns

As you evoke DARN change talk and explore intrinsic and extrinsic motivations, you gather important information for helping the client resolve ambivalence about change. You have a working knowledge, and perhaps even a written list, of issues and areas about which the client has conflicting feelings and which are important intrinsic motivators for changing substance use behaviors. **A first step in helping the client to weigh the pros and cons of change is to organize the list of concerns and present them to the client in a careful summary that expresses empathy, develops discrepancy, and shifts the balance toward change.** Because you should reach agreement on these issues, the summary should end by asking whether the client agrees that these are his or her concerns about the substance use. You might ask, "Is this accurate?" or "Did I leave anything out?"

Help Tip the Decisional Balance Toward Change

For any decision, most people naturally weigh costs and benefits of the potential action. In behavioral change, these considerations are called "decisional balancing." This is a process of appraising or evaluating the "good" aspects of substance use—the reasons **not to change** (expressed through sustain talk)—and the "less-good" aspects—the reasons **to change** (expressed through change talk). DB originated with Janis and Mann (1977) as a motivational counseling strategy. It is used widely in substance use disorder (SUD) treatment to explore benefits and costs of continued substance use and of changing substance use behaviors**.** Research on DB in SUD treatment has shown that DB is associated with increased motivation to change in diverse client populations and favorable client outcomes (Elliot & Carey, 2013; Foster & Neighbors, 2013; Hennessy, Tanner-Smith, & Steinka-Fry, 2015).

Motivation to reduce or stop substance use increases when the costs of use outweigh the benefits and

when the pros of changing substance use outweigh the cons (Connors, DiClemente, Velasquez, & Donovan, 2013). **Your task is to help clients recognize and weigh negative aspects of substance use to tip the scale in favor of change.**

Assess Where the Client Is on the Decisional Scale

Start by getting a sense of where the client is with regard to the decision-making process. The Alcohol Decisional Balance Scale and the Drug Use Decisional Balance Scale in Appendix B are validated instruments that ask clients to rate, on a scale of 1 to 5, the importance of statements like "Having to lie to others about my drinking bothers me" in making a decision about changing substance use behaviors (Prochaska et al., 1994). The scores give you and the client a sense of where the client is with regard to reporting more pros versus more cons for continued substance use. You can also explore specific items on the measure on which the client scores high (e.g., "Some people close to me are disappointed in me because of my drug use") as a way to build discrepancy between the client's values and substance use, thus evoking change talk.

Explore the Pros and Cons of Substance Use and Behavior Change

Weighing benefits and costs of substance use and change is at the heart of DB work. To accomplish this, **invite the client to write out a list of positives and negatives of substance use and changing substance use behaviors.** This can be a homework assignment that is discussed at the next session, or the list can be generated during a session. Putting the items on paper makes it seem more "real" to the client and can help structure the conversation. You can generate a list of the pros and cons of substance use and a list of pros and cons of changing substance use behaviors separately or use a grid like the one in Exhibit 5.3.

Exhibit 5.3. Decisional Balance Sheet for Substance Use

Reasons to Continue Substance Use (Status Quo)	Reasons to Change Substance Use (Change)
Positives of substance use	Negatives of substance use
Negatives of changing substance use	Positives of changing substance use
Source: Connors et al., 2013.	

Presenting to clients a long list of reasons to change and a short list of reasons not to change may finally upset the balance and tip the scale toward change. However, the opposite (i.e., a long list of reasons not to change and a short life of reason to change) can show how much work remains and can be used to prevent premature decision making.

Recognize that many clients find that one or two reasons to change counterbalance the weight of many reasons not to change and vice versa. Therefore, it is not just the number of reasons to change or not change but the strength of each reason that matters. **Explore the relative strength of each motivational factor, and highlight the weight clients place on each change factor.** Reasons for and against continuing substance use, or for and against aspects of change, are highly individual. Factors that shift the balance toward positive change for one person may barely matter to another. Also, the value or weight given to a particular item in this inventory of pros and cons is likely to change over time.

Whether or not you use a written worksheet, **always listen carefully when clients express ambivalence.** Both sides of ambivalence, expressed through sustain talk and change talk, are present in clients at the same time (Miller & Rollnick, 2013). You may hear both in a single client statement—for example, "I get

so energized when I snort cocaine, but it's so expensive. I'm not sure how I'll pay the bills this month." Although discussing with clients what they like about drinking or using drugs may establish rapport, increasing expressions of sustain talk is associated with negative client outcomes (Foster, Neighbors, & Pai, 2015; Houck & Moyers, 2015; Lindqvist, Forsberg, Enebrink, Andersson, & Rosendahl, 2017; Magill et al., 2014).

In DB, explore both sides of ambivalence, but avoid reinforcing sustain talk, which can be counterproductive (Krigel et al., 2017; Lindqvist et al., 2017; Miller & Rose, 2013). Once a client decides to change a substance use behavior, a DB exercise on the pros and cons of change may increase commitment to change (Miller & Rose, 2013). Carefully consider your own intention and the client's stage in the SOC before using a structured DB that explores both sides of client ambivalence equally.

Exhibit 5.4 describes other issues that may arise as clients explore pros and cons of change.

Exhibit 5.4. Other Issues in Decisional Balance	
Loss and grief	Giving up a way of life can be as intense as the loss of a close friend. Many clients need time for grieving. They have to acknowledge and mourn this loss before they are ready to build a strong attachment to recovery. Pushing them to change too fast can weaken determination. Patience and empathy are reassuring at this time.
Reservations or reluctance	Serious reservations about change can be a signal that you and clients have different views. As clients move into the Preparation stage, they may become defensive if pushed to commit to change before they are ready or if their goals conflict with yours. They may express this reluctance in behaviors rather than words. For example, some will miss appointments, sending a message that they need more time and want to slow the process. Continue to explore ambivalence with these clients, and reassess where they are in the change process.
Premature decision making	DB exercises give you a sense of whether clients are ready for change. If clients' description of pros and cons is unclear, they may express goals for change that are unrealistic or reflect a lack of understanding of their abilities and resources. Clients may say what they think you want to hear. Clients who are not ready to decide to change will let you know. Allowing clients to set themselves up for failure can result in them stopping the change process altogether or losing trust in you. Delay the commitment process, and return to Contemplation.
Keeping pace	Some clients enter treatment after they have stopped using substances on their own. Others stop substance use the day they call the program for the first appointment. They have already made a commitment to stop. If you try to elicit these clients' concerns or conduct DB exercises, you might evoke sustain talk unnecessarily and miss an important opportunity to provide the encouragement, incentives, and skills needed to help action-oriented and action-ready individuals make progress. Move with these clients immediately to create a change plan and enter the Action stage, but be alert for ambivalence that may remain or develop.
Free choice	Clients may begin using drugs or alcohol out of rebelliousness toward their family or society. Substance use may be an expression of continued freedom—freedom from the demands of others to act or live in a certain way. You may hear clients say that they cannot change because they do not want to lose their freedom. Because this belief is tied to some clients' early-forged identities, it may be a strong factor in their list of reasons not to change. However, as clients age, they may be more willing to explore whether "freedom to rebel" is actually freedom or its opposite. If you address this issue, you can reframe the rebellion as reflection of a limitation of choices (i.e., the person must do the opposite of what is expected). As clients age, they may be

	more open to making a choice that represents real freedom—the freedom not to rebel but to do what they truly choose.

Reexplore Values in Relation to Change

Use DB exercises as opportunities to help clients explore and articulate their values and to connect these values with positive change. Clients' values influence their reasons for and against change. For example, an adolescent involved in drug dealing with a neighborhood gang may say that leaving the gang is not possible because of his loyalty to the other members. Loyalty and belonging are important values to him. Relate them to other groups that inspire similar allegiance, such as a sports team or scouting—organizations that create a sense of belonging and reflect his core values. A young woman with a family history of hard work and academic achievement may wish to return to those values by finishing high school and becoming financially independent.

Hearing themselves articulate their core values helps clients increase their commitment to positive change. If they can frame the process of change within the larger context of values shared with their family, community, and culture, they may find it easier to contemplate change.

Emphasize Personal Choice and Responsibility

In a motivational approach to counseling, you don't "give" a client a choice. The choice is not yours to give; rather, it is the client's to make. Your task is to help the client make choices that are in his or her best interest and that align with his or her values and goals. Consistently emphasize the client's responsibility and freedom of choice. The client should be used to hearing you make statements such as:

- "It's up to you to decide what to do about this."
- "No one can decide this for you."
- "No one can change your drug use for you. Only you can."
- "You can decide to go on drinking or to change."

Explore the Client's Understanding of Change and Expectations of Treatment

In working toward a decision, understand what change means to clients and what their expectations of treatment are. Some clients believe that quitting or cutting down means changing their entire life—moving from their neighborhood or cutting ties with all their friends, even their family. Some believe they have to change everything overnight. This can be overwhelming. Tell clients who have never been in treatment before about the level of motivation and openness required to get the most from their treatment experience (Raylu & Kaur, 2012).

In exploring these meanings and expectations with the client, you will get a sense of which actions the client might consider and which he or she will not. For example, a client might state that she could never move from her neighborhood, a well-known drug market, because her family is there. Another says he will not consider anything but cutting down on his drinking. A third client may just as strongly state that total abstinence and a stay in a therapeutic community are the only options, as all others have failed.

By exploring treatment expectations with clients, you introduce information about the benefits of treatment and can begin a discussion about available options. When clients' expectations about treatment match what actually happens and they have positive expectations about treatment, they have better outcomes (Kuusisto, Knuuttila, & Saarnio, 2011). It is never too soon to elicit clients' expectations about treatment through reflective listening. Show that you understand their concerns, and provide accurate information about your treatment program and the benefits of treatment using motivational strategies like Elicit-Provide-Elicit (described in Chapter 3).

Reintroduce Feedback

Use personalized feedback after assessments to motivate clients. Continue to use assessment results to influence clients' decisional considerations. Objective medical, social, and neuropsychological feedback prompts many clients to contemplate change. Reviewing assessment information can refocus clients on the need for change. Reintroducing objective assessment data reminds clients of earlier insights into the need for change.

For example, a client may be intrinsically motivated to stop alcohol misuse because of health concerns yet feel overwhelmed by fear that quitting is impossible. Reintroducing feedback from the medical assessment about the risk of serious liver damage or a family history of heart disease could add significant additional weight to the DB and tip the balance in the direction of change.

Explore Self-Efficacy

By listening for self-efficacy statements from clients, you can discover what they feel they can and cannot do. Self-efficacy is a critical determinant of behavior change—it is the belief that they can act in a certain way or perform a particular task. Even clients who admit to having a serious problem are not likely to move toward positive change unless they have some hope of success. Self-efficacy can be thought of as hope or optimism, but clients do not have to have an overall optimistic view to believe a certain behavior can be changed.

Statements about self-efficacy could include the following:

- "I can't do that."
- "That is beyond my powers."
- "That would be easy."
- "I think I can manage that."

Self-efficacy is not a global measure, like self-esteem. Rather, it is behavior specific. Underlying any discussion of self-efficacy is the question "Efficacy to perform what specific behavior?" There are five categories of self-efficacy related to SUDs (DiClemente, Carbonari, Montgomery, & Hughes, 1994: Glozah, Adu, & Komesuor, 2015):

- **Coping self-efficacy** is dealing successfully with situations that tempt one to use substances, such as by being assertive with friends or talking with someone when upset rather than using the substance.
- **Treatment behavior self-efficacy** involves the client's ability to perform behaviors related to treatment, such as self-monitoring or stimulus control.
- **Recovery self-efficacy** is the ability to recover from a recurrence of the addictive behavior.
- **Control self-efficacy** is confidence in one's ability to control behavior in risky situations.
- **Abstinence self-efficacy** is confidence in one's ability to abstain despite cues or triggers to use.

Explore clients' sense of self-efficacy as they move toward Preparation. This may help you determine

more specifically whether self-efficacy is a potential support or obstacle to change. Remember, you can enhance client self-efficacy by using the Confidence Ruler (see Exhibit 3.10) and eliciting confidence talk (see the section "Evoking hope and confidence to support self-efficacy" in Chapter 3).

Summarize Change Talk

As the client transitions from Contemplation to Preparation, you will notice that the client has moved to the top of the MI Hill of Ambivalence (see Exhibit 5.2 above) and is expressing less sustain talk and more change talk. This is a good time to offer a recapitulation summary, as described in Exhibit 5.5.

Exhibit 5.5. Recapitulation Summary

At the end of DB exercises, you may sense that the client is ready to commit to change. At this point, you should summarize the client's current situation as reflected in your interactions thus far. The purpose of the summary is to draw together as many reasons for change as possible while pointing out the client's reluctance or ambivalence.

Your summary should include as many of the following elements as possible:

- A summary of the client's own perceptions of the problem
- A summary of the client's ambivalence, including what remains positive or attractive about substance use
- A review of objective evidence you have regarding the presence of risks and problems
- Your assessment of the client's situation, particularly when it aligns with the client's own concerns
- A summary of the client's change talk, emphasizing desire, ability, reasons, and need to change

Remember to recognize the client's sustain talk (i.e., reasons for staying with the status quo), but emphasize client change talk to tip the balance in favor of change.

Enhance Commitment to Change

You should still reinforce the client's commitment to change even after the client has decided to change and has begun to set goals. You should expect client indecision at any point in the change process. Additional strategies that enhance commitment at this point include asking key questions, taking small steps, going public, and envisioning.

Asking key questions

After the summary, ask a key question—for example, "What do you think you will do now?" (see the section "Asking key questions" in Chapter 3)—to help the client move over the top of the MI Hill of Ambivalence toward Preparation. Key questions will elicit CAT change talk. One of the main signs that the client is intending and committed to taking steps is an increase in CAT change talk (Miller & Rollnick, 2013). The client is making statements of **commitment** (e.g., "I will call the treatment facility to set up an intake"), **activation** (e.g., "I am willing to stop smoking marijuana for a month), and **taking steps** (e.g., "I looked up the schedule for Narcotics Anonymous meetings on its website") (Miller & Rollnick, 2013). **Reinforce CAT change talk through reflective listening and summarizing.**

Taking small steps

You have asked the client key questions such as "What's next?" and have presented options to emphasize the client's choice to change and to select areas of focus. Remind the client that he or she has choices and can control the change process to reinforce commitment. **Reassure the client who is overwhelmed by thinking of change that he or she can set the pace and begin with small steps.** Some clients respond well to stories of others who made large, seemingly impossible life changes one step at a

time. Don't underestimate the value of such stories and models in enhancing motivation.

Going public

Sharing a commitment to change with at least one other person besides the counselor can keep clients accountable. Telling a significant other about one's desire to change usually enhances commitment to change. "Going public" can be a critical step for a client who may not have been ready to tell others until this point. Alcoholics Anonymous (AA) has applied the clinical wisdom of public commitment to change through use of the "white chip." An attendee at an AA meeting who has an intention to quit drinking can pick up a white chip. The white chip is also called a Beginner's Chip or Surrender Chip and is a public acknowledgment of the person's intention to start recovery.

Envisioning

Helping clients visualize their life after change can be a powerful motivator and an effective means of strengthening their commitment. In addition, stories about how others have successfully achieved their goals can be excellent motivators. An exercise for envisioning change is to ask clients to picture themselves after a year has passed, during which time they have made the changes they desire in the areas of their lives most hurt by their substance use. Some clients may find it valuable to write a letter to themselves that is dated in the future and describes what life will be like at that point. The letter can have the tone of a vacation postcard ("Wishing you were here!"). Others will be more comfortable describing these scenes to you. Chapter 3 provides more information MI strategies to strengthen commitment.

Conclusion

To help clients move from Contemplation to Preparation, explore and resolve ambivalence about change. Help clients climb the MI Hill of Ambivalence and journey down the other side toward commitment and change. DB exercises can help clients explore ambivalence, clarify reasons to change, and identify barriers to change (e.g., reasons to continue substance use). When tipping the balance in favor of change, emphasize reflections of change talk, minimize the focus on sustain talk, and use motivational strategies to enhance commitment and facilitate clients' movement into Preparation.

Chapter 6—From Preparation to Action: Initiating Change

”The Preparation stage of change entails developing a plan of action and creating the commitment needed to implement that plan. Decisions do not translate automatically into action. To change a behavior, one needs to focus attention on breaking the old pattern and creating a new one. Planning is the activity that organizes the environment and develops the strategies for making change.”

DiClemente, 2018, pp. 29–30

Key Messages

- During the Preparation stage, clients are considering possible paths toward changing substance use behaviors and beginning to take small steps to reach the final change goal.
- You can support clients’ movement from Preparation to Action by exploring client change goals and helping them develop a change plan.
- You can maintain a client-centered focus by eliciting clients’ change goals and not imposing goals on them.

Chapter 6 describes the process of identifying and clarifying change goals. It also focuses on how and when to develop a change plan with the client and suggests ways to ensure a sound plan by offering the client a menu of options, contracting for change, identifying and lowering barriers to action, and enlisting social support. This chapter also describes your tasks while the client moves into the Action stage, like helping the client initiate the plan and evaluating the effectiveness of the plan.

In earlier stages of the Stages of Change (SOC) approach, you use motivational strategies to increase clients’ readiness. **In Preparation, you use motivational strategies to strengthen clients’ commitment and help them make a firm decision to change.** Clients who commit to change and believe change is possible are prepared for the Action stage. Clients who are actively taking steps to change substance use behaviors have better long-term outcomes after treatment than clients who have not reached this stage of the SOC (Heather & McCambridge, 2013).

Your task is to help clients set clear goals for change in preparation for developing a change plan. Changing any longstanding behavior requires preparation and planning. Clients must see change as being in their best interest before they can move into the Action stage. Developing a change plan that is accessible, acceptable, and appropriate for each client is key. The negative consequences of ignoring the Preparation stage can be a brief course of action followed by rapid return to substance use. By the end of the Preparation stage, clients should have a plan for change that guides them into the Action stage.

Exhibit 6.1 presents counseling strategies for Preparation and Action.

Exhibit 6.1. Counseling Strategies for Preparation and Action

SOC	Client Motivation	Counselor Focus	Counseling Strategies
Preparation	The client is committed and planning to make a change in the near future but is still considering what to do.	• Explore client change goals. • Develop a change plan.	• Clarify the client’s own goals. • Sample goals; encourage experimenting. • Elicit change strategies from the client. • Offer a menu of change options. • Negotiate a behavioral contract.

Exhibit 6.1. Counseling Strategies for Preparation and Action			
SOC	Client Motivation	Counselor Focus	Counseling Strategies
			• Explore and lower barriers to action. • Enlist social support.
Action	The client actively takes steps to change but is not yet stable.	• Support the client's action steps. • Evaluate the change plan.	• Help the client determine which change strategies are working and which are not. • Change the strategies as needed.

Explore Client Change Goals

Once the client has decided to make a positive change and the commitment is clear, goals should be set. Setting goals is part of the exploring and envisioning activities in the early and middle parts of the Preparation stage. Having summarized and reviewed the client's decisional considerations, you should now be prepared to ask about ways in which the client might want to address some of the reasons to change listed on the positive side of the decisional balance sheet. **The process of talking about and setting goals strengthens commitment to change.**

Clarify the Client's Goals

Help the client set goals that are as realistic and specific as possible and that address the concerns he or she described earlier about substance use. The client may set goals in multiple areas, not just substance use. He or she may work toward goals such as regaining custody of children, getting a job, becoming financially independent, leaving an abusive relationship, and returning to school. The client who sets several goals may need help deciding which to focus on first.

Early on, goals should be short term, measurable, and realistic so that clients can begin measuring success and feeling good about themselves as well as hopeful about the change. If goals seem unreachable to you, discuss your concerns. Use OARS (**O**pen questions, **A**ffirmations, **R**eflective listening, and **S**ummarization) to help clients clarify their goals, decide on which goal to focus first, and identify steps to achieving their goals. For example, if one goal is to get a job, you can start with an open question: "What do you think is the first step toward meeting this goal?" The goal is the vision, and the steps are the specific tasks that clients perform to meet the goal.

Setting goals is a joint process. The counselor and client work together, moving from general ideas and visions to specific goals. Seeing how the client sets goals and the types of goals he or she sets provides information on the client's sense of self-efficacy, level of commitment, and readiness for change. The more hopeful a client feels about the future, the more likely he or she is to achieve treatment goals.

Make identifying and clarifying treatment goals a client-driven process. Doing so is consistent with the principles of person-centered counseling and the spirit of motivational interviewing (MI). It is up to the client to decide what actions to take or treatment options to seek to address a substance use problem. Matching the client to the preferred substance use disorder (SUD) treatment options can help reduce alcohol consumption and improve drug-related outcomes (Friedrichs, Spies, Härter, & Buchholz, 2016). In a systematic review, brief motivational alcohol interventions for adolescents had significantly larger effects on alcohol consumption if they included goal-setting exercises (Tanner-Smith & Lipsey, 2015).

Your task is to help clients identify their preferred change goals and to enhance their decision making by teaching them about their treatment options. (See Chapter 3 for more information about and

strategies for identifying change goals using MI.)

Remember that the client's preferred treatment goals may not match what you prefer. A client might choose a course of action with which you do not agree or that is not in line with the treatment agency's policies. A decision to reduce but not completely stop substance use, for example, may go against the agency's policy of zero tolerance for illicit substance use. Exhibit 6.2 offers some strategies for addressing these types of situations.

Exhibit 6.2. When Treatment Goals Differ

What do you do when the client's goals differ from yours or those of your agency? This issue arises in all behavioral health services but especially in a motivational approach, where you listen reflectively to a client and actively involve him or her in decision making. As you elicit goals for change and treatment, a client may not choose goals that you think are right for him or her.

Before exploring different ways of handling this common situation, try to clarify how the client's goals and your own (or your agency's goals) do not match. For a client, goals are by definition the objectives he or she is motivated (ready, willing, and able) to work toward. If the client is not motivated to work toward it, it is not a goal. You or your agency, however, may have specific plans or hopes for the client. You cannot push your hopes and plans onto the client. This situation can become an ethical problem if you focus too much on trying to get a client to change in the direction of your or the agency's goals (Miller & Rollnick, 2013).

What are your clinical options when goals differ? You can choose from the following strategies:

- **Negotiate** (i.e., figure out how to work out the differences)
  - Rework the agenda and be open about your concerns as well as your hopes for the client (Miller & Rollnick, 2013).
  - Find goals on which you and the client can agree, and work together on those.
  - Start with areas in which the client is motivated to change. Women with alcohol or drug use disorders, for example, often come to treatment with a wide range of other problems, many of which they see as more pressing than making a change in substance use.
  - Start with the problems that the client feels are most urgent, and then address substance use when its relationship to other problems becomes obvious.
- **Approximate** (i.e., try to find an agreed-on goal that is similar)
  - Even if a client is not willing to accept your recommendations, consider the possibility of agreeing on a goal that is still a step in the right direction. Your hope, for example, might be that the client would eventually become free from all psychoactive substance use. The client, however, is most concerned about cocaine and is not ready to talk about changing cannabis, tobacco, or alcohol use.
  - Rather than dismiss the client for not accepting a goal of immediate abstinence from all substances, focus on stopping cocaine use, and then consider next steps.
- **Refer**
  - If you can't help the client with treatment goals even after trying to negotiate or approximate, refer the client to another provider or program.
  - Work within state licensing and professional ethical codes to avoid suddenly ending treatment.
  - Offer a menu of options, and take an active role in linking the client to other treatment and community-based services.
  - Be open in a nonjudgmental and neutral way about the fact that you cannot help the client with his or her treatment goal (Moyers & Houck, 2011).

Sample Goals and Encourage Experimenting

You may need to help some clients sample or try out their goals before getting them to commit to long-term change. For instance, some clients benefit from experimenting with abstinence or cutting

down their substance use for a short period. The following approaches to goal sampling may be helpful for clients who are not committed to abstinence as a change goal:

- **Sobriety sampling.** This trial period of abstinence is commonly used with clients who (Boston Center for Treatment Development and Training [BCTDT], 2016):
  - Are not interested in abstinence as a treatment goal.
  - Express significant need or desire to address misuse but are not ready to commit to abstinence.
  - Have had many past unsuccessful attempts at moderate use.

  A successful trial of sobriety sampling can enhance clients' commitment to a goal of abstinence. Even a 2-to-3–week period of abstinence before treatment can lead to positive client outcomes, including reductions in alcohol misuse (Gueorguieva et al., 2014). However, longer periods of trial abstinence may give clients more of an opportunity to experience the benefits of abstinence, like clearer thinking, a better ability to recognize substance use triggers, and more time to experience the positive feeling of living without substance use (BCTDT, 2016).

- **Tapering down.** This approach has been widely used with people who smoke to reduce physical dependence and cravings before the quit date and is an option for some substances like alcohol or cannabis. This approach consists of setting increasingly lower daily and weekly limits on use of the substance while working toward a long-range goal of abstinence. The client keeps careful daily records of consumption and schedules sessions with the counselor as needed. **Tapering off opioids, benzodiazepines, or multiple substances should be done under medical supervision.**
- **Trial moderation.** Trial moderation (i.e., clients try to reduce substance use with careful monitoring) may be the only acceptable goal for some clients who are in Precontemplation. Don't assume that clients will fail at moderation; however, if the moderation experiment fails after a reasonable effort, try to get clients to reconsider abstinence as a change goal. Clients can gain insight into their ability to reduce their substance use, and many will ultimately decide to abstain if they cannot reduce their use without negative consequences. Research indicates that clients whose goal is moderation have larger social networks of people who drink daily (Gueorguieva et al., 2014). Therefore, you should address clients' drinking social network as a potential barrier to moderation as a long-term goal.

Develop a Change Plan

Your final step in readying the client to act is to work with him or her in creating a plan for change. (Chapter 3 provides a summary of MI-specific strategies for developing a change plan.) Think of a change plan as a roadmap for the client to reach his or her change goals. A solid plan for change enhances the client's self-efficacy and provides an opportunity to consider potential barriers and the likely outcomes of each change strategy. As mentioned in Chapter 3, some clients need no structured change plan.

Use these strategies to work with clients to create a sound change plan:

- Elicit change strategies from the client.
- Offer a menu of change options.
- Negotiate a behavioral contract.
- Explore and lower barriers to action.
- Enlist social support.

Elicit Change Strategies From the Client

Work with clients to develop a change plan by eliciting their own ideas about what will work for them. This approach is a particularly helpful if clients have made past attempts to address substance use behaviors or have been in treatment before. For example, you might begin with a reflection of commitment talk and follow with an open question: "You clearly think that giving up cocaine is the best thing for you right now. What steps do you think you can take to reach this goal?"

Help clients create plans to match their concerns and goals. Plans will differ among clients:

- The plan can be very general or very specific and can be short term or long term.
- Some clients can commit only to a very limited plan, like going home, thinking about change, and returning on a specific date to talk further. Even a small, short-term plan like this can include specific steps for helping clients avoid high-risk situations as well as identifying specific coping strategies.
- Some plans are very simple, such as stating only that clients will enter outpatient treatment and attend an Alcoholics Anonymous (AA) meeting every day.
- Other plans include details (e.g., transportation to treatment, new ways to spend weekends).
- Many plans include specific steps to overcome anticipated barriers to success (Exhibit 6.3). Some plans lay out a sequence of steps. For example, working mothers with children who must enter inpatient treatment may develop a sequenced plan for arranging for child care.

Exhibit 6.3. Change Plan Worksheet
The most important reasons I want to make this change are:
My main goals for myself in making this change are:
I plan to do these things to reach my goals: Specific action When?
The first steps I plan to take in changing are:
Other people could help me in changing in these ways: Person Possible ways he or she can help
These are some possible obstacles to change and ways I could handle them: Possible obstacles to change How to respond
I will know that my plan is working when I see these results:

Source: Miller & Rollnick, 2002. Motivational Interviewing: Preparing People for Change (2nd ed). *Adapted with permission from Guildford Press.*

Create a change plan using a joint process in which you and the client work together. One of your most important tasks is to ensure that the plan is realistic and can be carried out. When the client offers a plan that seems unrealistic, too ambitious, or not ambitious enough, use shared decision making to rework the plan. The following areas are often part of such discussions:

- **Intensity and amount of help needed.** Encourage participation in community-based recovery support groups (e.g., AA, Narcotics Anonymous [NA], SMART Recovery, Women for Sobriety), enrolling in intensive outpatient treatment (IOP), or entering a 2-year therapeutic community.
- **Timeframe.** Choose a short-term rather than a long-term plan and a start date for the plan.
- **Available social support.** Discuss who will be involved in treatment (e.g., family, Women for Sobriety members, community members), where it will take place (e.g., at home, in the community), and when it will occur (e.g., after work, weekends, twice a week).
- **The order of subgoals and strategies or steps in the plan.** For example:
  1. Stop dealing marijuana.
  2. Stop smoking marijuana.
  3. Call friends or family to tell them about the plan.
  4. Visit friends or family who know about the plan.
  5. Learn relaxation techniques.
  6. Use relaxation techniques when feeling stressed at work.
- **Ways to address multiple problems.** Consider legal, financial, and health problems, among others.

Clients may ask you for information and advice about specific steps to add to the plan. You should:

- Ask permission to offer advice.
- Use the Elicit-Provide-Elicit (EPE) approach to keep the client in the center of the conversation (see the section "Developing discrepancy: A values conversation" in Chapter 3).
- Provide accurate and specific facts, and always ask whether they understand them.
- Elicit responses to such information by asking, "What do you think about this?"

The last step in EPE is key to completing the information exchange between you and the client.

How specific should you be when clients ask what **you** think they should do? Providing your best advice is an important part of your role. It is also appropriate to share your own views and opinions, although it is helpful to "soften" your statements and give clients permission to disagree. For example, you might soften your suggestion by saying, "This may or may not work for you, but a lot of people find it helpful to go to NA meetings to meet others who are trying to stay away from cocaine." Other techniques of MI, such as developing discrepancy, empathizing, and avoiding arguments, also are useful during this process.

The Change Plan Worksheet in Exhibit 6.3 helps clients focus their attention on the details of the plan, increase commitment to change, enlist social support, and troubleshoot potential roadblocks to change.

Use the Importance and Confidence Rulers in Exhibit 3.9 and Exhibit 3.10 to determine the client's readiness and self-efficacy about each change goal. These tools can help you and the client determine which goals to address first and which strategies to begin with. Ideally, the top goal will be one with

higher ratings on both importance and confidence. If the client rates one goal as high in importance and low in confidence, focus on exploring self-efficacy and evoking confidence talk to prepare the client for taking action.

Offer a Menu of Change Options

Enhance clients' motivation to take action by offering them a variety of treatment choices. Choices can be about treatment options or about other types of services. For example, clients who will not go to AA meetings might be willing to go to a Rational Recovery, SMART Recovery, or Women for Sobriety group; clients who will not consider abstinence might be willing to decrease their consumption. **Encourage clients to learn about their options and make informed choices to enhance their commitment to the change plan.**

Expert Comment: Treatment Options and Resources

In our alcohol treatment program, I found that having lists of both community resources and diverse treatment modules helps counselors and case managers engage clients, offer individualized programming, and meet clients' multiple needs. The following are some options we offer our clients:

Treatment Module Options

- Values clarification/decision making
- Social-skills training (e.g., assertiveness, communication)
- Anxiety management/relaxation
- Anger management
- Marital and family therapy
- Adjunctive medication (i.e., disulfiram, naltrexone, or acamprosate)
- Problem-solving groups
- Intensive group therapy

Community Treatment Resources

- Halfway houses
- Support groups (e.g., AA, NA, Rational Recovery, SMART Recovery, Women for Sobriety)
- Social services (e.g., child care, vocational rehabilitation, food, shelter)
- Medical care
- Transportation
- Legal services
- Psychiatric services
- Academic and technical schools

Carlo C. DiClemente, Ph.D., Consensus Panel Member

Know your community's treatment facilities and resources. This helps you provide clients with suitable options and makes you an invaluable resource for clients. Offer clients information on:

- Specific contact people.
- Program graduates.
- Typical space availability.
- Funding issues.
- Eligibility criteria.
- Program rules and characteristics.

- Community resources in other service areas, such as:
  - Food banks
  - Job training programs
  - Special programs for clients with co-occurring medical and mental disorders
  - Safe shelters for clients experiencing intimate partner violence

In addition, knowledge about clients' resources, insurance coverage, job situation, parenting responsibilities, and other factors is crucial in considering options. Initial assessment information also helps establish treatment options and priorities.

When discussing treatment options with clients, be sure to:

- Provide basic information in simple language about levels, intensities, and appropriateness of care.
- Avoid professional jargon and technical terms for treatment types or philosophies.
- Limit options to several that are appropriate, and describe these, one at a time, in language that is understandable and matches clients' concerns.
- Describe the purpose of a particular treatment, how it works, and what clients can expect.
- Ask clients to wait to make a decision about treatment until they understand all the options.
- Ask clients if they have questions, and ask their opinions about how to handle each option.
- Review the concept of the SOC; note that it is common for people to go through the stages several times as they move closer to maintaining substance use behavior change and stable recovery.
- Remind clients that not completing a treatment program and returning to substance use are not failures, but opportunities to reevaluate which change strategies are working or not working.
- Point out that, with all the options, they are certain to find some form of treatment that will work.
- Reassure clients that you are willing to work with them until they find the right choice.

Exhibit 6.4 provides a change-planning strategy for situations with many possible change options.

Exhibit 6.4. Mapping a Path for Change When There Are Multiple Options
• **Confirm the change goal.** If there are action steps to meet the change goal, decide which step to take first. For example, the client's goal might be to stop drinking completely. Some action steps might include talking with a healthcare provider about medication, going to an AA meeting, and telling a spouse about the decision. Which step does the client think is most important? • **Make a list of the change options available to the client** (e.g., inpatient treatment, community-based recovery support groups, IOP treatment, a sober living house or therapeutic community, medication-assisted treatment). • **Elicit the client's feelings, preferences, or both on the best way to proceed.** For example, ask, "Here are the different options we have discussed that might work for you. Which one do you like the most?" You can also discuss the pros and cons of different options (i.e., perform a decisional balance). • **Summarize the plan and strengthen commitment.** Summarize the action steps and change goal, then evoke and reflect CAT (**C**ommitment, **A**ctivation, and **T**aking steps) change talk. • **Troubleshoot.** Explore barriers to taking steps; raise any concerns about how realistic the plan is. Avoid the expert trap (see Chapter 3), and elicit the client's own ideas about how to manage barriers to change.
Source: Miller & Rollnick, 2013.

Negotiate a Behavioral Contract

Develop a written or oral contract to help clients start working on their change plans. A contract is a formal agreement between two parties. Clients may choose to make a signed statement at the bottom of the Change Plan Worksheet or may prefer a separate document. Be sure to:

- Explain that others have found contracts useful at this stage, and invite them to try writing one.
- Avoid writing contracts for clients. **Composing and signing it is a small but important ritual of "going public" that can enhance commitment** (Connors, DiClemente, Velasquez, & Donovan, 2013).
- Encourage clients to use their own words.
- Be flexible. With some clients, a handshake is a good substitute for a written contract, particularly with clients who have challenges with reading and writing or whose first language is not English.

Establishing a contract raises issues for discussion about the client's reasons for change. What parties does the contract involve? Some contracts include the counselor as a party in the contract, specifying the counselor's functions and responsibilities. Other clients regard the contract as a promise to themselves, to a spouse, or to other family members.

Contracts are often used in treatment programs that employ behavioral techniques, such as contingency management (CM). For many counselors, contracts mean **contingencies** (i.e., rewards and consequences), and programs often build contingencies into the structure of their programs. For example, in many methadone maintenance programs, take-home medications are contingent on substance-free urinalyses. Rewards or incentives have been shown to be highly effective external reinforcers. For instance, CM rewards are effective in reducing use and misuse of a range of substances including alcohol, tobacco, cannabis, and stimulants, as well as polysubstance use (Aisncough, McNeill, Strang, Calder, & Brose, 2017; Litt, Kadden, & Petry, 2013; Sayegh, Huey, Zara, & Jhaveri, 2017).

Clients may decide to include contingencies, especially rewards or positive incentives, in the contract. Rewards can:

- Be highly individual.
- Include enjoyable activities, favorite foods, desired objects, or rituals and ceremonies, all of which can be powerful objective markers of change and reinforcers of commitment.
- Be tied to length of abstinence, quit-date anniversaries, or achievement of subgoals. For instance:
  - A client may plan an afternoon at a baseball game with her son to celebrate a month of abstinence.
  - One client might go out to dinner with friends after attending his 50th AA meeting.
  - Another client may light a candle at church.
  - Still another client might hike to the top of a nearby mountain to mark an improvement in energy and health.

Explore and Lower Barriers to Action

One category in the Change Plan Worksheet in Exhibit 6.3 addresses possible obstacles to change and ways to handle them. Identifying barriers to action is an important part of the change plan. Potential roadblocks to taking action on change goals might include:

- A lack of non-substance–using social supports.
- Unsupportive family members.
- Co-occurring medical or mental disorders.
- Distressing side effects from medication-assisted treatment or psychiatric medications.

- Physical cravings or withdrawal symptoms.
- Legal issues, money-related problems, or both.
- Lack of child care.
- Transportation issues.
- A lack of cultural responsiveness of some agencies, programs, or services.

Clients can predict some barriers better than you can, so **allow them to identify and discuss possible problems.** Specifically:

- Do not try to predict everything that could go wrong.
- Focus on events or situations that are likely to be problematic.
- Build alternatives and solutions into the plan.
- Before offering advice, explore clients' ideas about how they might handle issues as they arise.
- Explore the ways clients may have overcome these or similar barriers in the past. This is a way to open a conversation about their strengths and coping skills.

Some problems are evident immediately. For instance, a highly motivated client may plan to attend an IOP treatment program 50 miles away 3 times a week, even though this requires bus and train rides and late-night travel. Explore the pros and cons of this part of the change plan with the client, and brainstorm alternative solutions, like finding a program closer to home or a family member, case manager, peer support specialist, or program volunteer who can drive the client to the program. **Remember, the change plan should include strategies that are accessible, acceptable, and appropriate for each client.**

You may need to refer clients to another treatment program or other services following initial consultation or evaluation, but this too is another common barrier to action. When you refer clients:

- Ensure they have **information** about how to get to the program, whom and when to telephone, and what to expect on the call (e.g., what type of personal information may be requested).
- Give them any **"insider information"** you have about the program or provider, which can reduce clients' anxiety and makes the process easier. For example, you may know that the receptionist at the program is a friendly person or that many people get lost by entering the building on the wrong side or that a nearby diner serves good food.
- Use **active linkage and referral interventions**, which enhance client engagement and retention in SUD treatment and ancillary services and improve outcomes (Rapp, Van Den Noortgate, Broekaert, & Vanderplasschen, 2014). Strategies for active referral procedures include:
  - **Helping the client make the telephone call to set up the intake appointment at the chosen program.** Some clients may want to make the phone call from your office; others might wish to call from home and call you later to tell you that they made an appointment. Some clients prefer to think things over first and make the call from your office at the next session.
  - **Following up with clients and the program**, if possible and with client permission, to ensure that clients are connected to the new service.
  - **Offering a "warm handoff,"** if possible, which involves introducing clients to the new provider.
  - Linking clients to a case manager, peer recovery support specialist, program alumnus, or community-based recovery support group volunteer to act as a liaison and actively engage clients in treatment programs; social, legal, or employment services; or community-based recovery support programs.

Enlist Social Support

Help clients enlist social support and build or enhance social networks that support recovery from SUDs. Positive social support for substance use behavior change is an important factor in clients' initiating and sustaining behavior change (Black & Chung, 2014; Fergie et al., 2018; Rhoades et al., 2018).

As a counselor, you are a central support for clients, but you cannot provide all the support they need. In general, a supportive person is someone who will listen and not be judgmental. This supportive person should have a helpful and encouraging attitude toward clients. Ideally, this person does not use or misuse substances and understands the processes of addiction and change. The Change Plan Worksheet (Exhibit 6.3) includes space for listing supportive individuals and describing how they can help. As discussed in Chapter 4, concerned significant others can offer support by learning some MI skills (e.g., offering simple reflective listening responses, becoming effective partners in change).

Encourage clients to include social support strategies in their change plans. These include:

- **Engaging in activities with friends that don't involve substance use.** Social support often entails participating in non-substance–use activities, so close friends with whom clients have a history of shared interests other than substance use are good candidates for this helpful role. Members of social groups who drink and use drugs are not likely to offer the support clients need in recovery.
- **Repairing or resuming connections with supportive family members and significant others.** Clients can find supportive people among their family members and close friends as well as in faith-based and spiritual organizations, recreational centers, and community volunteer organizations. To make these connections, encourage clients to explore and discuss a time in their lives before substance use became a central focus. Ask them what gave meaning to their lives at that time.
- **Participating in AA or other recovery support groups.** Recovery groups provide clients with social support for behavior change, positive role models of recovery, recovering friendship networks, and hope that recovery is possible. Research confirms that participation in AA is associated with positive alcohol-related, psychological, and social outcomes (Humphreys, Blodgett, & Wagner, 2014).
- **Connecting with addiction-focused peer support.** Peer recovery support specialists can be recovery role models and an important source of social support for clients. Client participation in peer recovery support services with a peer specialist leads to positive social support and improved substance use outcomes, including decreased alcohol use and hospitalizations as well as better adherence to treatment goals after discharge (Bassuk, Hanson, Greene, Richard, & Laudet, 2016). Oxford Houses and similar sober living housing options have built-in social support systems.
- **Connecting clients with a case manager.** For some clients, especially those with chronic medical or serious mental illness, case management teams provide a sense of safety, structure, and support. A case manager can also actively link clients to community-based social services, federal and state financial assistance, and other ancillary services that support clients' recovery efforts.

When helping clients enlist social support, be particularly alert for clients who have limited social skills or social networks. Some clients may have to learn social skills and ways to structure leisure time. Add social skill-building steps into the change plan. Some clients may not be connected to any social network that is not organized around substance use. Furthermore, addiction may have so narrowed their focus to the point where they have trouble recalling activities that once held their interest or appealed to them. However, most people have unfulfilled desires to pursue an activity at some time in their lives. Ask about these wishes. One client may want to learn ballroom dancing, another to learn a martial art, or still another to take a creative writing class. Planning for change can be a particularly productive time for clients to reconnect with this desire to find fulfilling activities, and seeking such activities provides

opportunities for making new friends.

Clients with a carefully drafted change plan, knowledge of both high-risk situations and potential barriers to getting started, and a group of supportive friends, family members, or recovery supports should be fully prepared and ready to move into the Action stage.

Support the Client's Action Steps

DiClemente (2018) describes four main tasks for client in the Action stage of the SOC:

1. Breaking free of the addiction using the strategies in the change plan
2. Continuing commitment to change and establishing a new pattern of behavior
3. Managing internal/external barriers to change (e.g., physical cravings, lack of positive social support)
4. Revising and refining the change plan

Your role is to continue using motivational counseling approaches to support the client in completing these tasks and moving into the Maintenance stage and stable recovery. To support clients in breaking free of substance use behaviors:

- Encourage clients to set a specific start date for each behavior change (e.g., a smoking quit date, date to enter an inpatient addiction treatment program). Setting a start date increases commitment.
- Help clients create rituals that symbolize them leaving old behaviors behind. For example, some clients may make a ritual of burning or disposing of substance paraphernalia, cigarettes, beer mugs, or liquor. Support clients in creating personally meaningful rituals. As mentioned previously, picking up a chip at an AA meeting is a ritual that supports clients' action steps toward abstinence and a new lifestyle.

To reinforce clients' commitment to change:

- Continue to evoke and reflect CAT change talk in your ongoing conversations with clients.
- Use reflective listening, summaries, and affirmations.
- Manage barriers to change by identifying those barriers (as described above in the section "Explore and Lower Barriers to Action"), working with clients to brainstorm personally relevant strategies for lowering or reducing the impact of those barriers, and offering a menu of treatment options. For example, if a client experiences intense alcohol or drug cravings, you might explore the possibility of referring the client to a medical provider for a medication evaluation, encouraging participation in a mindfulness meditation group, or both.
- Evaluate, revise, and refine the change plan as the final step in the Action stage.

Evaluate the Change Plan

Your goal of this stage of the change cycle is to help the client sustain successful actions for a long enough time that he or she gains stability and moves into Maintenance (Connors et al., 2013). It is not likely that you and the client will be able to predict all of the issues that will come up as the client initiates the change plan. The client's circumstances likely will change (e.g., a spouse might file for divorce), unanticipated issues arise (e.g., the client's drug-using social network might put pressure on the client to return to drug use), and change strategies may not turn out to work well for the client (e.g., the client loses his or her driver's license and has to find alternative transportation to NA meetings). These unanticipated issues can become a barrier to sustaining change plan actions and may require

revisions to the change plan (Connors et al., 2013).

Your task is to work with the client at each encounter to evaluate the change plan and revise it as necessary. Ask the client, "What's working?" and "What's not working?" Miller and Rollnick (2013) suggest that counselors think about this process as "flexible revisiting." The same strategies used in the planning process of MI apply to revising the change plan, including confirming the change goal, eliciting the client's ideas about how to change, offering a menu of options, summarizing the change plan, and exploring obstacles (see Chapter 3). Some strategies for change may need to be removed, whereas others can be adjusted. For example, one client's goal is to quit drinking, and her action steps include attending three AA meetings a week, including one women's meeting. The client stops going to the women's meeting because one of the regular attendees is a coworker who likes to gossip, and the client is afraid that the coworker will break her anonymity at work. Your first step is to identify the issue, and then elicit the client's ideas about what else might work for her.

Open questions to start this process if a change strategy is not working include (Miller & Rollnick, 2013):

- "What now?"
- "What else might work?"
- "What's your next step?

Avoid jumping in too quickly with your own ideas. Adjusting a change plan, like creating the initial change plan, is a joint process between you and the client; the client's own ideas and resources are key (Miller & Rollnick, 2013). Finally, summarize the new change strategy and explore how the client might respond to any new obstacles that might come up while initiating the revised change plan (Miller & Rollnick, 2013).

Conclusion

As clients move from contemplating change into preparing for change, your task is to continue to reinforce clients' commitment to change and take action. You can support clients to take this next step by working together to develop a change plan, imagining possible barriers to change that might occur, and enlisting social support for taking action. Change plans are client driven and based on clients' own goals. Continue to use motivational counseling strategies to help clients identify and clarify their change goals, develop a change plan, and refine and revise the change plan as needed. Your role is to help clients sustain their goals for change, gain stability, and move into the Maintenance stage of the SOC.

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Chapter 7—From Action to Maintenance: Stabilizing Change

”To become habitual, the new behavior must become integrated into the individual’s lifestyle. This is the task of the Maintenance stage of change. During this stage, the new behavior pattern becomes automatic, requiring less thought or effort to sustain it…. However, even during Maintenance there is an ever-present danger of reverting to the old pattern. In fact, the new behavior becomes fully maintained only when there is little or no energy or effort needed to continue it and the individual can terminate the cycle of change.”

DiClemente, 2018, p. 31

Key Messages

- In the Maintenance stage of the Stages of Change (SOC) model, clients work toward stabilizing the substance use behavioral changes they have made.
- You can support clients in the Maintenance stage by helping them stay motivated, identify triggers that might lead to a return to substance misuse, and develop a plan for coping with situational triggers when they arise.
- Relapse prevention counseling (RPC) using a motivational counseling style can prevent a return to substance misuse and help clients reenter the cycle of change quickly if they do return to substance use.

Maintaining change is often more challenging than taking one’s first steps toward change. Chapter 7 addresses ways that you can use motivational strategies to help clients maintain their success in recovering from substance use disorders (SUDs). It presents strategies for stabilizing change, supporting lifestyle changes, managing setbacks during Maintenance, and helping clients reenter the cycle of change if a relapse or a return to substance misuse occurs.

Using a motivational counseling style with clients in the Precontemplation through Preparation stages helps them move toward initiating behavioral change. Yet when clients do take action, they face the reality of stopping or reducing substance use. This obstacle is more difficult than just contemplating action. Once clients have decided to take action, they are on the downslope of the Motivational Interviewing (MI) Hill of Ambivalence presented in Exhibit 5.2.

Exhibit 7.1 presents counseling strategies for Action and Relapse.

Exhibit 7.1. Counseling Strategies for Action and Relapse

SOC	Client Motivation	Counselor Focus	Counseling Strategies
Maintenance	The client has achieved initial goals, such as abstinence, reduced substance use behaviors, or entering treatment, and is now working to maintain these goals.	• Stabilize client change. • Support the client’s lifestyle changes.	• Engage and retain the client in SUD treatment. • Create a coping plan. • Identify new behaviors that reinforce change. • Identify recovery capital (RC). • Reinforce family and social support.

Exhibit 7.1. Counseling Strategies for Action and Relapse			
SOC	Client Motivation	Counselor Focus	Counseling Strategies
Relapse and Recycle	The client returns to substance misuse and temporarily exits the change cycle.	Help the client reenter the change cycle.	• Provide RPC. • Reenter the cycle of change.

Stabilize Client Change

One of the key change goals for many clients is entry into a specialized addiction treatment program. Options include outpatient, intensive outpatient, inpatient, and short- or long-term residential treatment; methadone maintenance treatment; and office-based opioid treatment. Making the decision to enter treatment is an action step. **To maintain that behavior change, you should engage and retain clients in treatment.** Unfortunately, many clients enter and stop treatment before they achieve their other change goals. Engaging and retaining clients in treatment are important strategies for stabilizing substance use behavior change. Other stabilization strategies include identifying high-risk situations and triggers for substance use, creating a coping plan, and helping clients practice and use new coping skills.

Engage and Retain Clients in SUD Treatment

You play an important role in preventing clients from stopping or dropping out of treatment before completion—a major concern for SUD treatment providers. A consistent predictor of positive client outcomes across SUD treatment services is treatment completion (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013). Longer lengths of stay in treatment are consistent indicators of reliable behavior change and positive treatment outcomes (Running Bear, Beals, Novins, & Manson, 2017; Jason, Salina, & Ram, 2016; Turner & Deanne, 2016).

Causes of stopping treatment early vary:

- For some clients, dropping out, missing appointments, or nonadherence with other aspects of the treatment program are clear messages of **disappointment, hopelessness, or changes of heart.**
- Some clients drop out of treatment **because their treatment or behavior change goals don't match** those of the counselor or program (Connors, DiClemente, Velasquez, & Donovan, 2013).
- Strong evidence shows that **low treatment alliance** is linked to client dropout in SUD treatment (Brorson et al., 2013).
- Clients with **co-occurring substance use and mental disorders (CODs)** and those with **cognitive problems** are especially likely to end treatment early (Running Bear et al., 2017; Brorson et al., 2013; Krawczyk et al., 2017; Teeson et al., 2015). For more information about engaging clients with CODs, see Treatment Improvement Protocol (TIP) 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013).
- For others, dropping out may mean they have **successfully changed their substance use behaviors on their own** (Connors et al., 2013).
- Perhaps the strongest predictor of dropout in SUD treatment is **addiction severity at treatment entry.** For example, one study of men and women in treatment for posttraumatic stress disorder found that a diagnosis of both an alcohol use disorder (AUD) and a drug use disorder strongly predicted higher dropout rates, drug use severity predicted worse adherence to treatment, and drug use severity or a lifetime diagnosis of an alcohol or drug use disorder predicted worse treatment outcomes (Bedard-Gilligan, Garcia, Zoellner, & Feeny 2018).

MI and motivational enhancement therapy are effective in improving treatment adherence to and retention in SUD treatment for certain substances (e.g., cocaine), especially for clients who enter treatment with low motivation to change (DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017). Motivational-based strategies that increase client engagement and retention in SUD treatment and reduce client dropout are addressed below.

Build a strong counseling alliance

As noted in Chapters 3 and 4, **your counseling style is an important element for establishing rapport and building a trusting relationship with clients.** MI strategies appropriate during the engaging process (see Chapter 3) help you connect with and understand clients' unique perspectives and personal values. For example, empathy, as expressed through reflective listening, is key in developing rapport with clients and predicts positive treatment alliance and client outcomes (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016; Miller & Moyers, 2015; Moyers, 2014; Moyers, Houck, Rice, Longabaugh, & Miller, 2016).

To help clients confide in you, make them feel comfortable and safe within the treatment setting. Clients' natural reactions may depend on such factors as their gender, age, race, ethnicity, sexual or gender identity, and previous experience. For example, some ethnic or racial groups may be hesitant to enter treatment based on negative life experiences, discrimination, or problems encountered with earlier episodes of treatment. Initially, for these clients and others who have been marginalized or experienced trauma, safety in the treatment setting is a particularly important issue. (See the section "Special Applications of Motivational Interventions" in Chapter 2 for culturally responsive ways to engage clients in treatment.) You should also consider gender differences regarding the importance of establishing a strong counseling alliance. For example, one study found that women who received intensive MI over nine sessions (versus a single session) showed significantly higher counseling alliance and better alcohol use outcomes than men did (Korcha, Polcin, Evans, Bond, & Galloway, 2015).

Inform clients about program rules and expectations

Clients must become acquainted with you and the treatment program. To accomplish this:

- Tell clients explicitly what treatment involves, what is expected of them, and what rules they must follow. If clients have not been prepared by a referring source, review exactly what will happen in treatment to eliminate and confusion.
- Use language clients understand.
- Encourage questions, and provide clarification of anything that seems confusing.
- Explain what information must be reported to a referring agency that has mandated the treatment, including what it means to consent to release of information. This discussion is part of the regular informed consent process that should happen when clients enter treatment.

Address client expectations about treatment

One of the first things you should discuss with new clients is their expectations about the treatment process. Ask clients about their past treatment experiences and what they think the current treatment experience will be like. Clients who are in SUD treatment for the first time do not know much about what the counseling process entails and tend to underestimate the level of motivation, personal commitment, and responsibility required to take action to change (Raylu & Kaur, 2012). This suggests that **clients without previous SUD treatment experience benefit from discussions about treatment expectations and the importance of being open to the counseling process** (Raylu & Kaur, 2012).

Ask clients for permission to explore their treatment expectations. Ask for elaboration on their initial impressions as well as their expectations, hopes, and fears. Some common client fears about treatment are that:

- The counselor will be confrontational and force treatment goals on them.
- Treatment will take too long and require the client to give up too much.
- The rules are too strict, and clients will be discharged for the smallest mistake.
- Medication will not be prescribed for painful withdrawal symptoms.
- The program does not understand women, members of different ethnic/racial groups, or people who use certain substances or combinations of substances.
- A spouse or other family member will be required to participate.

Many clients have negative expectations based on previous treatment. A motivational approach can help you understand their concerns, which is especially important for clients who feel forced into treatment by someone else (e.g., by an employer, the court, a spouse). When clients have unrealistic expectations, like believing the treatment program will get their driver's license reinstated or restore a marriage, be open and honest about what the program can and cannot do. **Use OARS (Open questions, Affirmations, Reflective listening, and Summarization) to explore negative expectations about treatment and the client's hopes about what treatment can accomplish.**

Explore and resolve barriers to completing treatment

Work with clients to brainstorm and explore solutions to common issues. As treatment progresses, clients may experience barriers that slow their success and could result in them stopping treatment early. Sometimes clients do not feel ready to participate or suddenly rethink their decision to enter treatment. Rethinking participation in treatment is a sign that clients may have returned to the Contemplation stage. If this is the case, reengage the client using the motivational strategies discussed in Chapter 5. **If clients are clearly not ready to participate in specialized treatment, leave the door open for them to return at another time, and provide a menu of options for referral to other services.**

During treatment, clients may have negative reactions or embarrassing moments when they:

- Share with you more than they had planned to share.
- Experience intense or overwhelming emotions.
- Realize the mismatch in information they have given you.
- Realize how they have hurt others or their own futures.

You can deal with these difficult reactions by:

- Anticipating and discussing such problems before they occur.
- Letting clients know that these reactions are a normal part of the recovery process.
- Working with clients to develop a plan to handle these difficult reactions.
- Exploring previous treatment, including their reasons for leaving early and how to better match current treatment to their needs.

If this is the client's first treatment experience, get his or her ideas about what might be a roadblock to completing treatment:

- Start with an affirmation, and ask an open question:

  "It took a lot of determination and effort for you to be here. Good for you! Sometimes things come

up during counseling sessions that are difficult and might make you wonder if staying in treatment is worth the effort. That's normal. What are some things you can imagine that might make it challenging for you to follow through with your commitment to completing the program?"

- Follow with reflective listening responses.
- Ask the client for ideas about strategies to deal with ambivalence about staying in treatment.
- Be culturally aware as you help the client manage or try to prevent common difficulties.

Increase congruence between intrinsic and extrinsic motivation

Exploring with clients their internal and external reasons for entering and staying in treatment can help reduce their chances of early dropout. Self-determination theory proposes that intrinsic (internal) motivation may have a stronger impact on maintaining behavior change than extrinsic (external) motivation, which may be more effective in helping clients initiate behavior change. A meta-analysis of MI (which emphasizes increasing internal motivation) and contingency management (which emphasizes external motivators) found that both approaches were effective in reducing use of a wide variety of substances (Sayegh, Huey, Zara, & Jhaveri, 2017). The analysis also found evidence to suggest that extrinsically focused counseling strategies produced short-term treatment effects, whereas intrinsically focused counseling strategies produced long-term treatment effects.

Help clients increase congruence, or agreement, between internal and external motivations. You can explore external motivations clients may view as forced or unwanted and reframe them as positive reasons that align with their internal reasons for staying in treatment to increase congruence.

Explore client nonadherence

Clients' nonadherence to treatment is often a sign that they are unhappy with the counseling process. For example, clients may miss appointments, arrive late, fail to complete required forms, or remain silent when asked to participate. Any occurrence of such behavior provides an opportunity to discuss the reasons for the behavior and learn from it. Often clients are expressing their ambivalence and are not ready to make a change. Explore the behavior in a nonjudgmental, problem-solving manner that helps you discover whether the behavior was intentional or whether a reasonable explanation for the behavior exists. For example, clients might be late as a sign of "rebelling" against what they think will be a stressful session, or it could simply be that their car broke down.

As with all motivational strategies, **you need to draw out clients' views of and thoughts about the event.** Generally, if you can get clients to voice their frustrations, they will come up with the answers themselves. Asking a question such as "What do you think is getting in the way of being here on time?" is likely to open a dialog. Respond with reflective listening, open questions that evoke change talk, and affirmations. For example, you might ask, "How does being late fit or not fit with your goal of getting the most out of this treatment experience?" Remember to praise the client for simply getting to the session.

Missed appointments or not showing up for scheduled activities require a more proactive approach. Some strategies for responding to missed appointments are listed in Exhibit 7.2.

Exhibit 7.2. Options for Responding to a Missed Appointment
• Place a telephone call. • Send a text message. • Write an email. • Mail a personal letter.

- Contact preapproved relatives or significant or concerned others.
- Pay the client a personal visit (if appropriate for your role and agency policy).
- Contact the referral source.

As part of the informed consent process, find out from clients which contact methods they prefer, discuss confidentiality and security issues (e.g., protection of clients' personal health information, agency policies regarding email and texting), and obtain appropriate releases to contact other individuals or organizations.

Reach out and follow up

You might need to reach out to the client following certain events, such as a wedding, birth of a child, traumatic injury or illness, or several missed appointments. Doing so shows your personal concern and genuine interest in protecting the counseling relationship and enhancing the recovery process. As mentioned previously, explore the client's preferred methods for you to reach out if he or she misses appointments or drops out of treatment. Make sure to get written consent to contact relatives, friends, or others. In addition, you should be aware of and abide by the client's cultural rules and values about having contact outside the SUD setting.

If clients complete their initial treatment goals and end treatment, follow up with them periodically. Setbacks, particularly with maintenance of substance use behavior change, often occurs between 3 and 6 months after treatment, and you should plan regular follow-up sessions with clients to reinforce and support maintenance of treatment gains (Miller, Forcehimes, & Zweben, 2011).

Create a Coping Plan

To help clients move fully into Maintenance, help them stabilize actual change in their substance use behavior. Support clients' stabilization by helping them develop a coping plan that lists strategies for managing thoughts, urges, and impulses to drink or use drugs. This planning process includes:

- Assessing and enhancing self-efficacy.
- Identifying high-risk situations that trigger the impulse to drink or use drugs.
- Identifying coping strategies to manage high-risk situations.
- Helping clients practice and use effective coping skills.

Assess and enhance self-efficacy

Help clients improve their self-efficacy. Self-efficacy is important for changing substance use behaviors as well as sustaining those changes. There is a strong relationship between client self-efficacy and SUD treatment outcomes across a variety of substances (e.g., alcohol, cannabis, cocaine) and different counseling approaches. There is also evidence that a strong counseling alliance helps clients enhance self-efficacy and increase positive treatment outcomes for alcohol use (Kadden & Litt, 2011).

Clients may have high self-efficacy in some situations and low self-efficacy in others. Several validated tools can help assess clients' level of self-efficacy or confidence in how well they would cope with the temptation to use substances in high-risk situations. Scores provide feedback about clients' self-efficacy for a specific behavior over a range of high-risk situations. Some computerized versions of these instruments generate charts that present clients' scores in an easy-to-understand way. Descriptions of the Situational Confidence Questionnaire (SCQ)/Brief SCQ (BSCQ) and the Alcohol Abstinence Self-Efficacy Scale (AASES), three of the most widely used instruments, follow:

- The **SCQ** and **BSCQ** have been used with people who misuse alcohol. The 100-item SCQ asks clients to identify their level of confidence in resisting drinking in 8 circumstances (Breslin, Sobell, Sobell, &

Agrawal, 2000):

  - Unpleasant emotions
  - Physical discomfort
  - Testing personal control over substance use
  - Urges and temptations to drink
  - Pleasant times with others
  - Conflicts with others
  - Pleasant emotions
  - Social pressure to drink

  Clients are asked to imagine themselves in each situation and rate their confidence on a 6-point scale, ranging from not at all confident (a rating of 0) to totally confident (a rating of 6), that they can resist the urge to drink heavily. The BSCQ is a shortened 8-question form that asks clients to rate these circumstances using a scale of 0% to 100%, with 0% indicating not at all confident and 100% indicating totally confident. The BSCQ and its scoring instruments are available in Appendix B.

- The **AASES** measures an individual's self-efficacy in abstaining from alcohol (DiClemente, Carbonari, Montgomery, & Hughes, 1994). Although similar to the SCQ/BSCQ, the AASES focuses on clients' confidence in their ability to abstain from drinking across 20 different situations. The AASES consists of 20 items and can be used to assess both the temptation to drink and the confidence to abstain. The AASES and its scoring instructions are available in Appendix B.

By using these tools, clients can better understand the high-risk situations in which they have low self-efficacy. This information can be helpful in setting realistic goals and developing an individualized coping plan. Clients who rank many situations as high risk (i.e., low self-efficacy) may need to identify and develop new coping strategies.

Other **strategies to enhance client self-efficacy in Maintenance include** (Miller & Rollnick, 2013):

- Expressing confidence in the client's ability to change.
- Reviewing past success with changing substance use or other health behaviors.
- Reviewing the client's current strengths.
- Using the Confidence Ruler (Exhibit 3.10) to measure coping strategies.
- Presenting a menu of coping strategies that have a high likelihood of success.

Identify high-risk situations and coping strategies

Another approach to helping clients identify high-risk situations is to use a structured interview that identifies the high-risk situation (i.e., who, where, and when), external triggers (i.e., what), and internal triggers (i.e., thoughts, feelings, and physical cravings) that led to substance use in the past. Once these situations are identified, clients explore coping strategies to manage these triggers that have worked in the past and that might work now and in the future. Understanding these triggers helps clients target specific strategies for coping with these triggers.

Strategies for conducting the interview include the following:

- **Let the client know the purpose of the interview, and ask permission to conduct it.** For example, you might say, "It can be helpful to explore some of the situations when you drank or used drugs in the past and what led to your decision to use in those situations. Sometimes those can be thoughts or feelings or the situation itself. We sometimes call what led to substance use internal and external

triggers. Once we know what has 'triggered' your drinking or drug use in the past, we can brainstorm ways to cope with those triggers now, instead of drinking or using. Is that okay?"

- **Draw a four-column table on a piece of paper and label the columns** High-Risk Situation, External Triggers, Internal Triggers, and Coping Strategies as in Exhibit 7.3.

Exhibit 7.3. Triggers and Coping Strategies

High-Risk Situation (who, where, when)	External Triggers (what)	Internal Triggers (thoughts, feelings, impulses, cravings)	Coping Strategies
Example: "Watching a football game with my drinking buddies."	Example: "A beer commercial comes on."	Example: "My mouth waters, and I think about how good a beer would taste."	Example: "I could go to the refrigerator and get a cold soft drink instead of a beer."

- **Ask an open question to start the discussion.** "Tell me about situations in which you have been most likely to drink or use drugs in the past, or times when you have tended to drink or use more than expected. These might be when you were with specific people, in specific places, or at certain times of day, or perhaps when you were feeling a particular way."
- **Elicit ideas from the client about ways he or she might have resisted temptation to use in the past.**
- **Elicit ideas from the client about strategies he or she could use now** to avoid high-risk situation or external triggers as well as ways to manage the internal triggers without resorting to substance use.
- **Ask the client to elaborate on possible coping strategies.**
- **Use the Confidence Ruler** (Exhibit 3.10) to evaluate the client's confidence in applying these coping strategies. Evoke confidence talk to reinforce and enhance self-efficacy (see Chapter 3).

As you explore triggers, do not solely use reflective listening. This technique might accidentally evoke sustain talk from the client and decrease his or her commitment to engaging in coping strategies. Instead, **use affirmations and reflective listening responses to reinforce the client's commitment to engaging in coping strategies as an alternative to substance use.**

If the client has difficulty identifying coping strategies:

- Offer some ideas that others have found helpful.
- Brainstorm with the client.
- Offer a menu of possible coping strategies.
- Explore with the client which options are more likely to work as in the examples in Exhibit 7.4.

Exhibit 7.4. A Menu of Coping Strategies

Coping strategies are not mutually exclusive; different ones can be used at different times. In addition, not all are equally good; some involve getting uncomfortably close to trigger situations. Here are some examples of a menu of strategies that might help clients in different high-risk situations.

Example #1: Client X typically uses cocaine whenever his cousin, who uses regularly, drops by the house. Coping strategies to consider include (1) call the cousin and ask him not to come by anymore; (2) call the cousin and ask him not to bring cocaine when he visits; (3) if there is a pattern to when the cousin comes, plan to be out of the house at that time; or (4) if someone else lives in the house, ask him or her to be present for the cousin's visit.

Example #2: Client Y typically uses cocaine when she goes with a particular group of friends, one of whom often brings drugs along. She is particularly vulnerable when they all drink alcohol. Coping strategies to consider might include (1) go out with a different set of friends; (2) go along with this group only for activities that do not involve drinking; (3) leave the group as soon as drinking seems imminent; (4) tell the supplier that she is trying to stay off cocaine and would appreciate not being offered any; or (5) ask all of her friends, or one especially close friend, to help her out by not using when she is around or by telling the supplier to stop offering it to her.

Example #3: Client Z typically uses cocaine when feeling tired or stressed. Coping strategies might include (1) scheduling activities to get more sleep at night, (2) scheduling activities to have 1 hour per day of relaxation time, (3) learning and practicing specific stress reduction and relaxation techniques, or (4) learning problem-solving techniques that can reduce stress in high-risk situations.

Use the coping strategies identified in the structured interview to develop a written coping plan. This could be as simple as jotting down a few ideas for managing triggers in high-risk situations on a file card or it could be as detailed as creating a change plan using the Change Plan Worksheet in Exhibit 6.3.

Help the clients practice new coping skills

Just as you would monitor and reevaluate a change plan with clients, revisit the coping plan, and modify it as necessary. Ask clients to rehearse coping strategies in counseling sessions and to try to implement those strategies in everyday life. For example, growing evidence shows that practicing mindfulness is an effective strategy for managing cravings and urges to use substances (Grant et al., 2017). If this coping strategy is new to clients, help them develop a change plan that might include attending a mindfulness class or group and practicing mindfulness at home or in a counseling session that focuses on managing cravings. **Rehearsing new skills reinforces them and helps build self-efficacy.**

Support the Client's Lifestyle Changes

Your task in the Maintenance stage is to support and praise clients' positive lifestyle and identify behaviors that reinforce these changes. Clients must put forth ongoing and sustained effort to maintain their change of substance use behaviors. As clients successfully maintain changes, they develop a strong sense of self-efficacy. They use less effort to cope with temptations and triggers, and new behaviors become the norm (DiClemente, 2018). As substance use behavior change becomes a new lifestyle, the client develops a new sense of identity. For some, this is expressed in self-identification as a "nonsmoker" or a "recovering addict." For others, the new story of identity is about becoming an integral member of the family or community.

Identify New Behaviors that Reinforce Change

You should examine all areas of clients' life for new reinforcers, which should come from multiple sources and be of various types. A setback in one area can be counterbalanced by a positive reinforcer from another area. As the motivation for positive change becomes harder to sustain, clients need strong reasons for overcoming the challenges they will face. Help them select positive reinforcers that will prevail over substance use over time.

Small steps are helpful, but they cannot fill a whole life. Abstaining from substances is a sudden change and often leaves a large space in clients' lives. You can help clients fill this space by exploring activities that will support their healthy new identity such as:

- **Doing volunteer work** links clients to the community. Clients can fill time, decrease isolation, and improve self-efficacy through this prosocial activity, making positive contributions to the community.
- **Becoming involved in 12-Step activities.** Similar to volunteering, this fills a need to be involved with

a group and contributes to a worthwhile organization.

- **Setting goals** to improve work, education, health, and nutrition.
- **Spending more time with family, significant others, and friends.**
- **Participating in spiritual or cultural activities.**
- **Learning new skills or improving old ones** in such areas as sports, art, music, and hobbies.

Identify Recovery Capital

Help clients tap into and build new sources of positive RC and lessen the impact of negative sources of RC as a way to support the maintenance of change. "Recovery capital" refers to internal and external resources a person draws on to begin and sustain recovery. Internal resources include, but are not limited to, values, knowledge, skills, self-efficacy, and hope. External resources include, but are not limited to, employment; safe housing; financial resources; access to health care; and social, family, spiritual, cultural, and community supports (Granfield & Cloud, 1999). RC can be positive (e.g., drug-free social network) or negative (e.g., drug-using social network) (Hennesey, 2017). Positive and negative RC interact with each other in the recovery process and change over time (Hennessy, 2017). RC is linked with clients' natural recovery resources. (See also the "Natural Change" section in Chapter 1.)

Reinforce Family and Social Support

Family and social support are important sources of RC. They can help clients permanently break free from addiction and engage in a new lifestyle (DiClemente, 2018). Family and friends who are supportive of the clients' recovery can be especially helpful in stabilizing change because they can reinforce new behavior and provide positive incentives to continue in recovery. They can involve clients in new social and recreational activities and be a source of emotional and financial support. Other types of support they provide can be instrumental (e.g., babysitting, carpooling), romantic, spiritual, and communal (i.e., belonging to a particular group or community).

Identify different types of social supports that clients have available to help determine gaps in their support system and help them build a larger, more diverse social network. Clients with more severe AUD tend to have smaller, less diverse social networks (i.e., supports other than family or close friends) than those with no history of AUD or less severe alcohol misuse experiences (Mowbray, Quinn, & Cranford, 2014). More extensive social networks in which individuals with addiction exchange support with one another can help individuals sustain recovery over time (Panebianco, Gallupe, Carrington, & Colozzi, 2016). An extended and diverse social network might comprise:

- Family members.
- Friends.
- Peer support specialists.
- Members of recovery support groups.
- Healthcare providers.
- Employers.
- 12-Step sponsors.
- Spiritual advisors.
- Members of a church or spiritual community.
- Neighbors.
- Members of community groups.

- Participants in organized recreational activities.

Use motivational counseling strategies to explore current and potential sources of social support and how those supports could help clients maintain recovery and lifestyle changes. For example, family members can act as a warning system if they see early signs of possible relapse. A peer recovery support specialist can link clients to alcohol- and drug-free recreational events in the community or other recovery support. Exhibit 7.5 describes a brief clinical scenario with a client who lacks social support.

Exhibit 7.5. Susan's Story: A Client Lacking Social Support

Client context: Susan is 41 years old and has a long history of AUD and multiple treatment episodes. The longest period Susan has been able to maintain abstinence from alcohol has been 1 month. She has tried to participate in Alcoholics Anonymous (AA); however, she finds that most of the meetings she can get to without a car are primarily attended by men, and she does not feel comfortable there. Susan's mother has been diagnosed with schizophrenia. Susan reports that her father has been diagnosed with AUD. Her father sexually abused her for years when she was a child. Susan is divorced and has only one friend she talks to, infrequently. Her only source of regular support is her father.

Susan recently participated in an IOP addiction treatment program where she also attended a Seeking Safety support group for women with histories of trauma. (For more information about Seeking Safety, see Chapter 6 of TIP 57: *Trauma-Informed Care in Behavioral Health Services* [SAMHSA, 2014b].) This is the first treatment experience in which Susan's history of trauma has been addressed simultaneously with her AUD. Susan completes the program and is referred to outpatient counseling. Once she leaves the IOP treatment program, however, her only recovery support is her outpatient counselor, Arlene.

Counseling strategies: Arlene recognizes that Susan lacks an effective social support network that can help her maintain the progress she made in the IOP program. Arlene explores Susan's recent treatment experience, her prior involvement in AA, and her transportation needs. She affirms Susan's persistence in returning to treatment and completing the IOP program and then elicits from Susan what she thinks was different for her this time in treatment. Susan says that she felt safe and supported by the women in the Seeking Safety group.

Arlene works with Susan to develop a plan to re-create that experience of support now that she is back home. The plan includes introducing Susan to a peer recovery support specialist who can help Susan remove any barriers to becoming more engaged in community-based recovery support services, like transportation. Arlene also suggests a menu of social support options to Susan, including a Women for Sobriety group, a small women's AA meeting, and an outpatient trauma recovery support group. Finally, Arlene lets Susan know that she is available by phone and between sessions until Susan has connected with other women who will be part of her ongoing support network. They discuss the boundaries around between-session contact and agree on an initial plan for weekly counseling sessions for the next 12 weeks.

Arlene sees that she can't be Susan's only source of recovery support. With motivational counseling strategies, she helps Arlene build a new support network to reinforce her recovery, maintain her long-term recovery goal of abstinence, and help her heal from trauma and previous disruptions to her social support network.

Help the Client Reenter the Change Cycle

To help clients maintain substance use behavior change, you must address the issue of relapse. Historically, the term "relapse" in addiction treatment had come to mean an all-or-nothing understanding of clients' return to substance use after a period of abstinence and judgment about their lack of motivation. This TIP uses the term "relapse" in part because the SOC model uses the term to describe points in the recovery process when clients leave the change cycle and then recycle through the SOC again with more awareness and a better understanding of how to reach the Maintenance stage. In addition, addiction treatment clinical research refers to relapse prevention as a key counseling approach to supporting clients' ongoing recovery maintenance.

A return to substance use after a period of abstinence does not mean a client has failed or is no longer in recovery. The consensus panel of this TIP seeks to reconceptualize the recurrence of substance use after treatment as **a common aspect of recovery from SUDs** based on well-documented observations:

- **Recurrence of substance use is common.** Although relapse is not technically a stage in the SOC, it is a normal part of change and recovery processes.
- **The term "relapse" itself implies only two possible outcomes—success or failure—that do not fully describe what actually occurs.** Client outcomes are much more complex than this. Often in the course of recovery, clients manage to have longer and longer periods between episodes of use, and use episodes themselves grow shorter and less severe.
- **The assumption that abstinence equals success and return to use equals failure creates a self-fulfilling prophecy.** It implies that once substance use resumes, there is nothing to lose and little that can be done. Instead, the point is to get back on track as soon as possible.
- **Recurrence of symptoms is common** to substance use behaviors and chronic illness in general.

Part of a motivational approach in Maintenance has to do with your perspective on a client's return to substance misuse and how you respond to it. You should:

- Avoid the expert and labeling traps when a client returns to substance use or substance misuse.
- Avoid the "righting reflex" and any temptation to lecture, educate, blame, or judge the client (Miller & Rollnick, 2013).
- Explore the client's understanding of his or her return to substance use.
- Use the same motivational counseling approaches as in Precontemplation, Contemplation, Preparation, and Action, depending on which stage the client is in after the recurrence.

Counselor Note: The Righting Reflex

Miller and Rollnick (2013) use the term "righting reflex" to describe the natural response to "fix" a person's problems from a desire to help. This impulse can lead you to becoming overly directive and **telling** a client what to do instead of **evoking the client's own motivation and strategies** for change.

Provide Relapse Prevention Counseling

Recurrence is common in recovery; offer RPC during Maintenance. RPC is a cognitive–behavioral therapy (CBT) approach to identifying and managing triggers to use, developing coping skills, building self-efficacy, and managing setbacks. Although this is a CBT method, you can use motivational counseling strategies to engage clients in the process and help them resolve ambivalence about learning and practicing new coping skills. (Chapter 8 provides more information about blending motivational interviewing and CBT.)

The two major components of RPC are:

- **Addressing the nature of the relapse process** through education and an analysis of high-risk situations, warning signs, and other factors that contribute to relapse, as well as clients' strengths.
- **Providing coping-skills training.** Identify and develop clients' coping strategies that are useful in maintaining both cognitive and behavioral changes that promote recovery and lessen the likelihood of relapse. (See the section "Identify high-risk situations and coping strategies" above in this chapter.)

The Marlatt model (Witkiewitz & Marlatt, 2007) is the most widely researched and implemented RPC approach in behavioral health services. Many of its strategies have been applied to counseling for

relapse prevention with people with SUDs and CODs. The two key features of the Marlatt model are:

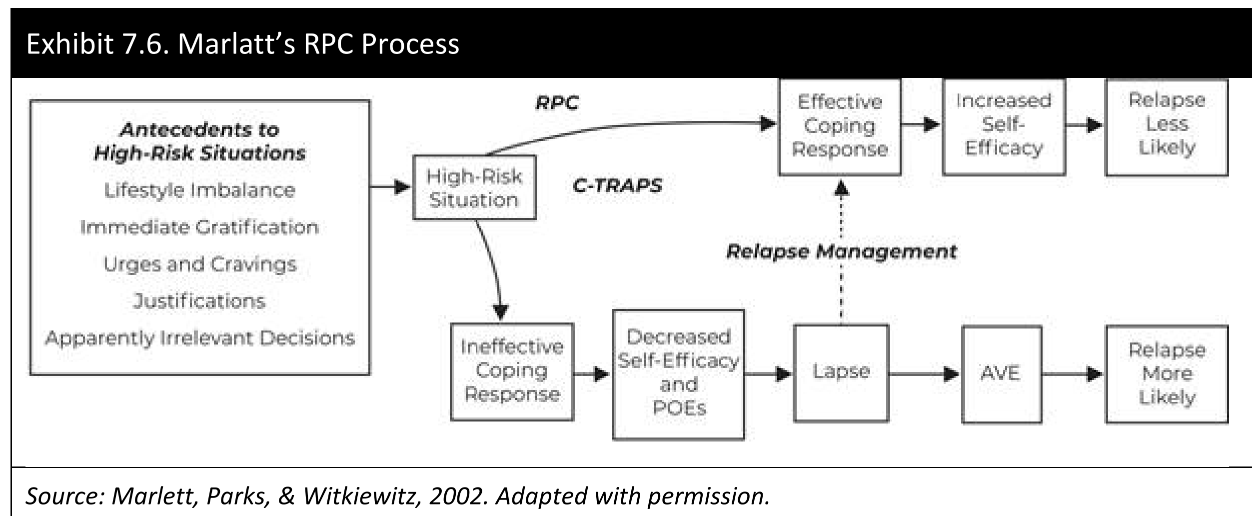
1. Helping clients recognize and manage high-risk situations in which they are most likely to be tempted to immediately use substances or engage in other risky behaviors.
2. Creating a relapse management plan that includes positive coping strategies to lessen the impact of a recurrence, if it happens, and avoid a full relapse.

The two elements of a high-risk situation that increase the client's risk of relapse are:

- **Internal factors**, which include the client's
  - Cognitive distortions.
  - Intense positive and negative feelings.
  - Ineffective coping responses.
  - Low self-efficacy.
  - Positive outcome expectancies (POEs): positive thoughts and associations with drinking or using drugs.
  - Abstinence violation effect (AVE) such as feelings of guilt and shame associated with recurrence.
- **Environmental factors,** which include the client's
  - Social influences.
  - Access to substances.
  - Exposure to conditioned cues for substance use or risk behaviors.

Exhibit 7.6 shows the dynamic process of relapse and how RPC strategies help clients develop effective coping mechanisms and increase self-efficacy to decrease the probability of a relapse.

Exhibit 7.6. Marlatt's RPC Process



Source: Marlett, Parks, & Witkiewitz, 2002. Adapted with permission.

C-TRAPS

RPC has five components (Marlatt et al., 2002). C-TRAPS is a handy acronym to remember them:

- **C**ognitive traps
- **T**emptations
- **R**eplacement **A**ctivities
- **P**reparation for relapse

- **S**trategies for coping

Cognitive traps, also known as cognitive distortions, are the ways the mind works against the client's commitment to recovery and intention to refrain from substance use. They are cognitive early warning signs that a recurrence might be close at hand. They include:

- **All-or-nothing thinking** (e.g., "I got off my regular eating plan today; I'm a failure, so I might as well go all the way and eat whatever I want tonight!") and **overt justifications** (e.g., "My divorce was finalized today, and I really need something to take the edge off") for a return to substance use.
- **Minimizing the impact of a recurrence** (e.g., "Just one cigarette won't push me over the edge").
- **Apparently irrelevant decisions** or decisions that seem unimportant but set up high-risk situations where the likelihood of recurrence is very high. (For example, Ginny decides to buy a bottle of wine, just in case her friend Pam comes over to play cards. She puts the bottle in the liquor cabinet that she had just cleaned out with the help of her AA sponsor, thinking she won't be tempted.)

Cognitive traps bring clients closer to situations where temptation is strong and difficult to resist. **Help clients lessen the power of cognitive traps by:**

- Teaching them how to slow down their thinking process.
- Identifying all the steps in the process leading up to an apparently irrelevant decision.
- Inviting them to evaluate whether those choices are consistent with their recovery goals.
- Exploring possible alternative choices.

Temptations are urges or impulses closely linked to feelings or physical cravings. To distinguish between cravings and urges, note that cravings are the desire and urges are the intentions to use a substance (Witkiewitz & Marlatt, 2007). Temptation is the attraction of the immediate, positive effects of drinking or using drugs. These impulses can be powerful and seem to come out of the blue. In *Alcoholics Anonymous* (also known as "The Big Book"), the authors depicted the unpredictable lure of temptation: "Remember that we deal with alcohol—cunning, baffling, powerful!" (Alcoholics Anonymous, 2001, p. 10). **Help clients map out temptations and develop strategies for responding to them.**

Replacement activities reinforce clients' lifestyle changes through actions that support their recovery. This involves helping clients identify and engage in activities that provide fulfillment, long-term satisfaction, and a substitute for the short-term pleasure of substance use. Use OARS to ask open questions and affirm, reflect, and summarize clients' ideas for replacement activities. Brainstorming is also an effective way to help clients discover new ideas for replacement activities.

Preparation for relapse include:

- Working with clients to anticipate and prepare for this possibility.
- Taking a nonjudgmental stance with clients if they lapse.
- Explaining to them that relapse is avoidable but that they should be prepared for possible setbacks and describing how to manage a return to substance use if it occurs.
- Reframing a recurrence as a learning opportunity and reevaluating their coping strategies.

Strategies for coping are helpful ways of thinking and acting that reduce relapse risk, enhance self-efficacy, manage impulses and cravings, reduce stress, and solve problems that arise in early recovery. Elicit clients' positive coping strategies, and engage them in coping-skills training activities, such as:

- Providing psychoeducation.
- Teaching stress reduction and mindfulness practices.

- Brainstorming strategies with clients to avoid high-risk situations and manage impulses or cravings.
- Deconstructing negative thinking patterns.
- Sharing problem-solving skills and coping strategies that have been helpful to others.
- Modeling positive self-talk and communication skills.
- Rehearsing how to handle high-risk situations.
- Teaching alcohol and drug refusal skills.
- Exchanging in nonjudgmental feedback with other clients in RPC groups.

Relapse management strategies

If clients return to substance use, help them avoid full relapse by teaching them to (Witkiewitz & Marlatt, 2007):

- **Stop, look, and listen.** Clients can learn how to become aware of events as they are unfolding and stop the process of a recurrence before it goes further. Taking a step back from events as an observer can help clients gain perspective and allow them the emotional and cognitive space to assess the situation before reacting. The AA slogan "think…think…think" aids in relapse prevention by providing a cognitive reminder to stop, look, and listen before reacting or taking action.
- **Keep calm.** Staying calm is the emotional equivalent of stop, look, and listen. Thoughts, feelings, and behaviors are often tightly intertwined. Sometimes, clients don't remember that, just because they feel anxious or have an impulse to use substances or reengage in risk behaviors, they don't have to act on those feelings or impulses. Practicing calmness and not overreacting emotionally to a recurrence can help clients break this pattern of impulsivity.
- **Renew their commitment to recovery.** People are often discouraged by a recurrence, which can lower motivation and confidence about continuing on the recovery journey. To allay hopelessness, remind clients of previous successes with behavior change (no matter how "small"). Keep them looking forward by exploring their reasons for recovery and hopes, dreams, and goals for the future.
- **Review what led up to the recurrence.** Review the events leading up to the recurrence and do a mini-relapse assessment taking into account lifestyle imbalance, thoughts of immediate gratification, urges and cravings, justifications, apparently irrelevant decisions, and the nature of the high-risk situation that triggered the lapse. Review early warning signs clients may have noticed but disregarded and explore the cognitive traps that led to disregarding the warning signs.
- **Make an immediate plan for recovery.** Work with clients to develop an immediate action plan for recommitting to recovery. The plan should include specific action steps clients can take to avoid a full relapse that are acceptable, accessible, and appropriate from their point of view. Write the plan on paper or a file card. Include client-generated strategies for handling a recurrence, such as:
  - **Call a sponsor or recovery support person.** Include specific names and phone numbers.
  - **Go to a recovery support meeting.** Include specific meeting times and locations.
  - Engage in cognitive, emotional, physical, and behavioral strategies for managing cravings.
  - Engage in specific self-care or stress reduction activities.
  - **Return to medication** (if applicable). Include adherence strategies and names of prescribers.
  - **Call you or the treatment program** to schedule a counseling session.
- **Deal with the AVE.** Help clients deal with the emotional aftereffects of recurrence, such as guilt, shame, and the cognitive dissonance that happens when people act in ways that do not align with their values and recovery goals. This cognitive and emotional disagreement can increase the

likelihood of a return to substance use. Engage clients in exploration with compassion and understanding; encourage them to learn from recurrence and identify new coping strategies.

Reenter the Cycle of Change

If clients return to substance misuse, help them reenter the cycle as soon as possible. Most clients do not return to the Precontemplation stage (Connors et al., 2013). Rather, clients are more likely to recycle back into Contemplation, Preparation, or Action. They can use the recurrence experience as an opportunity to identify which strategies for the Maintenance stage worked and which did not work. **Your task is to debrief clients about relapse and assess where they are now in the SOC** (Connors et al., 2013). If the client has returned to Contemplation, start with resolving ambivalence and evoking change talk. Clients who have returned to Preparation or Action should revisit and revise the change plan or coping plan.

Strategies for helping clients manage a return to substance misuse include:

- **Helping them reenter the change cycle; affirming any willingness to reconsider positive change.**
  - Explore their perceptions and reactions to resumed use.
  - Use affirmations to praise them for reengaging in the change process.
  - Elicit DARN (**D**esire, **A**bility, **R**easons, and **N**eed) change talk; reflect on the client's reasons to get back on track.
- **Exploring the meaning of the recurrence as a learning opportunity.**
  - Explore what can be learned from the experience.
  - Remind them that the experience is a common and temporary part of the recovery process.
  - Elicit their positive experiences in recovery and the advantages of abstinence.
  - Use reflective listening.
  - Avoid the question-and-answer trap.
  - Explore their values, hopes, purpose, and goals in life. Ask, "What do you want to do now?"
- **Helping clients find and continuously review and evaluate current and alternative coping strategies.**
  - Review coping strategies that have and have not worked to maintain stated goals for change.
  - Help them identify new coping strategies.
- **Maintaining supportive contact** until clients exit the change cycle for each behavior change goal.

Conclusion

Maintaining substance use behavior change is often more challenging for clients than taking action toward change. Help clients stabilize and maintain changes made in the Preparation and Action stages by:

- Using motivational counseling strategies to engage and retain clients in treatment.
- Helping them develop and practice coping strategies for high-risk situations.
- Reinforcing social support.
- Helping them reenter the cycle of change quickly if they do return to substance use.

MI strategies are useful during all stages in the SOC and are used in conjunction with other counseling approaches, like CBT—particularly during the Preparation, Action, and Maintenance stages. An

important way to help clients throughout the SOC is to continuously assess and reassess which stage they are in the SOC and match your counseling approach accordingly.

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Chapter 8—Integrating Motivational Approaches in SUD Treatment Settings

"From its inception MI [motivational interviewing] has been organic, emerging, and evolving through collaborative processes….Our decision was to focus on promoting quality in MI practice and training…."

Miller & Rollnick, 2013, p. 377

Key Messages

- Motivational counseling approaches have been widely disseminated to substance use disorder (SUD) treatment programs.
- Adaptations of MI in group counseling, the use of technology, and blended counseling approaches enhance the implementation and integration of motivational interventions into standard treatment methods.
- Training and ongoing supervision of counselors are essential for workforce development and integration of motivational counseling approaches into SUD treatment.

Chapter 8 discusses adaptations for using motivational counseling approaches in group counseling, with technology, and in blended counseling approaches that are applicable to SUD treatment programs. It also addresses workforce development issues that treatment programs may face in fully integrating and sustaining motivational counseling approaches.

Over the past three decades, MI and motivational counseling approaches have been widely and successfully disseminated across the United States and internationally to specialty SUD treatment programs (Hall, Staiger, Simpson, Best, & Lubman, 2015). Research supports the integration of motivational counseling strategies into treatment as a prelude to ongoing treatment to increase client retention and enhance participation in treatment. Motivational counseling can increase adherence to treatment medication and behavioral change plans and makes achievement and maintenance of positive substance use behavior outcomes more likely (Miller & Rollnick, 2013). Depending on the SUD treatment setting, different adaptions of motivational interventions (e.g., individual or group counseling, blended with other counseling approaches) may be effective both clinically and programmatically.

Integrating motivational counseling approaches into a treatment program requires more than providing counseling staff with a few workshops on MI. It requires broad integration of the philosophy and underlying spirit of MI throughout the organization. Just as a counselor using a motivational approach works in partnership with clients to help them move through the Stages of Change (SOC) to achieve long-term behavioral change, organizations wishing to integrate a motivational counseling approach should work in partnership with staff to implement program changes. Organizations also go through a process of change until the treatment approach becomes a new "lifestyle."

Adaptations of Motivational Counseling Approaches

The most common delivery of motivational counseling approaches has been through brief or ongoing individual counseling. For example, MI in SUD treatment was specifically developed as a counseling approach to be delivered in face-to-face conversations between a counselor and a client. Depending on the treatment program, adaptations of motivational interventions may make treatment more cost effective, more accessible to clients, and easier to integrate into existing treatment approaches, as well

as ease workload demands on counselors.

Chapter 8 discusses the following adaptations of motivational counseling approaches:

- Group counseling
- Technology adaptations (e.g., Internet-based applications and telephone-based MI)
- Blended counseling approaches

Group Counseling

The current context of service delivery in SUD treatment programs places heavy emphasis on group counseling. Many motivation-enhancing activities can take place in group counseling that cannot occur in individual treatment (e.g., clients can receive feedback from peers). Because social support is intrinsic to group treatment, clients in a group can reinforce and help maintain each other's substance use behavior changes (Holstad, Diiorio, Kelley, Resnicow, & Sharma, 2010).

However, several significant clinical issues arise when conducting groups using MI including (Feldstein Ewing, Walters, & Baer, 2013; Miller & Rollnick, 2013):

- The counselor's ability to translate MI skills to the group context
- The counselor's skill in managing group dynamics
- Fewer opportunities for group members to express change talk and receive reflective listening responses from the counselor
- Varying needs and experiences of group participants
- The counselor's ability to respond to various participant needs (e.g., reflecting commitment language of one participant while responding to another participant's ambivalence about changing substance use behaviors)
- Actively managing social pressures of peer interactions, which are not present in individual sessions
- Responding to and managing sustain talk in a group setting

Perhaps the most challenging aspect of group-based MI is the possibility of group members reinforcing each other's sustain talk instead of reflecting change talk (Miller & Rollnick, 2013). An important adaptation of MI in group is to minimize the opportunities for clients to evoke and reflect sustain talk and maximize opportunities to evoke and reflect change talk (Houck et al., 2015; Miller & Rollnick, 2013). Strategies for accomplishing this include:

- Teaching group members OARS (asking **O**pen question, **A**ffirming, **R**eflective listening, and **S**ummarizing) skills (Wagner & Ingersoll, 2013).
- Identifying the general parameters for group interactions that are in line with the spirit of MI (e.g., group members should support each other without pressure to change, avoid giving advice, focus on positives and possibilities for change) (Miller & Rollnick, 2013).
- Modeling MI skills in groups (Wagner & Ingersoll, 2013).
- Acknowledging sustain talk but emphasizing and reinforcing change talk (D'Amico et al., 2015).

Expert Comment: Motivational Enhancement in Group Counseling
Conducting motivational interventions in a group versus individual format is more difficult, more complex, and more challenging. Personally, however, I find it much more rewarding. In group counseling, particularly using motivational techniques and strategies, clients learn through the group. It is like a hall of mirrors; clients get the feel of how they come across. For me, when a client uses reflective listening with another client or points out

another client's ambivalence, the group is like a living, learning laboratory of experiences practiced first in a safe environment before being tried in the real world. In the end, what the members have is a common goal to reduce or stop substance misuse, and it is here that their mutual support and peer pressure is effective.

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

Evidence shows that, despite some challenges, MI can be delivered successfully in a group context, particularly when group participants hear more change talk than sustain talk (Osilla et al., 2015). Positive outcomes from MI in groups include decreased alcohol use and alcohol misuse among adolescents, greater retention in SUD treatment after detoxification, increased retention in methadone maintenance treatment, and adherence to risk-reduction behaviors in women infected with HIV (Bachiller et al., 2015; D'Amico et al., 2015; Holstad et al., 2010; Navidian, Kermansaravi, Tabas, & Saeedinezhad, 2016).

Integrating MI into group treatment requires group counselors to have training and ongoing supervision in both MI strategies and group process. The **Assessment of Motivational Interviewing Groups—Observer Scale (AMIGOS–v 1.2)** is a validated tool that assesses counselor skills in group processes, client-centered focus, and using MI in groups (Wagner & Ingersoll, 2017). Appendix C provides a link to a downloadable version of AMIGOS. This tool may be helpful for assessing and enhancing counselor competence in delivering MI in groups.

Technology Adaptations

Some evidence shows the effectiveness of adaptations of MI and motivational enhancement therapy (MET) through interactive computer applications, Internet-based applications, and telephone or video conferencing when used selectively to deliver motivational interventions (Miller & Rollnick, 2013). For example, the "drinker's checkup," the original method to give personalized feedback in MET, has been delivered in interactive computer-based applications and has had positive outcomes in reducing alcohol misuse (Hester, Delaney, & Campbell, 2012).

Benefits of brief motivational interventions delivered by interactive computer applications include (Hester et al., 2012):

- Ease of use.
- Cost effectiveness.
- Adaptability to different client populations.
- Flexibility of design.

Although computer- or Internet-based adaptations of motivational interventions may be useful in providing personalized feedback to clients, computers cannot provide empathetic listening responses or evoke change talk. They also limit use of brief interventions that provide feedback to increase client engagement in treatment.

Telephone MI is the most widely used alternative to face-to-face MI and is effective for addressing tobacco cessation, alcohol misuse, and use of illicit drugs (Jiang, Wu, & Gao, 2017). Telephone counseling with, if possible, the addition of a video component has the advantage of reaching client populations in rural settings that do not have access to transportation to the treatment setting. Telephone MI approaches also have the added benefit over computer-based interventions of giving the counselor the opportunity to offer interactive motivational interventions like reflective listening, affirmations, and evoking change talk. For more information about using technology in SUD treatment, see Treatment Improvement Protocol (TIP) 60: *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015b).

Blended Counseling Approaches

MI as a counseling style is compatible with a wide range of clinical approaches that have been used in SUD treatment including cognitive–behavioral therapy (CBT), psychoeducation, medication-assisted treatment, and case management approaches (Miller & Rollnick, 2013). When thinking about ways to integrate MI into current treatment approach, treatment staff should address some open questions like, "How does MI fit with what we already do?" and "At what points in our treatment approach are we most concerned about engaging clients in treatment, helping clients resolve ambivalence about change, and retaining clients in treatment?" (Miller & Rollnick, 2013). Three examples of blending MI with other SUD counseling approaches supported by research are motivational interviewing assessment (MIA), CBT, and recovery management checkup (RMC).

MIA

The National Institute on Drug Abuse Clinical Trials Network, in cooperation with SAMHSA, developed a protocol to incorporate MI into a one-session assessment intake to improve client engagement in SUD treatment programs (Carroll et al., 2006). This blended approach to the standard initial assessment in SUD treatment sandwiches a standard assessment between a brief MI counseling segment at the beginning and end of the session (Martino et al., 2006).

A challenge of doing a standard assessment with clients just entering treatment is that counselors and clients tend to fall into the question-and-answer trap (see Chapter 3). Counselors ask closed questions to elicit information needed for the assessment, and clients answer with yes, no, or short-answer responses. This pattern of interaction sets up an expectation that the counselor is the expert and the client is a passive recipient of services. It can become an obstacle to client engagement (Miller & Rollnick, 2013). MIA incorporates MI into typical SUD treatment program intake/assessment processes and facilitates client engagement while addressing the organization's need to collect assessment information for treatment planning and to comply with licensing and insurance requirements.

Research supports MIA as a method to blend MI with standard assessment approaches. An initial study found that clients who participated in the MIA-blended protocol were significantly more likely than clients who participated in the standard assessment to be enrolled in the program after 1 month (Martino et al., 2006). A more recent study found that incorporating MI into the initial intake and assessment processes (whether standard MI or MIA) promoted client retention (e.g., 70 percent remained in treatment after 4 weeks) and enhanced treatment outcomes (e.g., a 50 percent increase in days abstinent) (Martino et al., 2016). This same study found that supervision of counselors in both groups (standard MI and MIA) improved counselor performance of MI, but the counselors who received supervision in MIA showed significantly greater improvements in MI competency, although training and supervision in MIA was more costly. A link to a manual for training and supervising counselors in MIA, *Motivational Interviewing Assessment: Supervisor Tools for Enhancing Proficiency Manual*, is available for download at no cost in Appendix C (Martino et al., 2006). Another study found that the addition of motivational feedback to a standard assessment enhanced SUD treatment entry for a group of veterans with co-occurring disorders (Lozano, Larowe, Smith, Tuerk, & Roitzsch, 2013).

MI and CBT

Perhaps the most widely adopted counseling approach used in SUD treatment is CBT. CBT focuses on helping clients change thoughts (e.g., drinking is the only way to relax) and behaviors (e.g., drinking to intoxication) that interfere with everyday functioning. CBT strategies include helping clients identify and manage triggers for substance use and practicing new behaviors that reinforce abstinence. CBT is also an

evidence-based approach that is widely used to treat mental disorders (e.g., anxiety, depression, posttraumatic stress disorder) that often co-occur with SUDs. However, some CBT providers have acknowledged difficulties with initial client engagement, low motivation, and nonadherence to CBT practices, such as completing out-of-session assignments (Arkowitz, Miller, & Rollnick, 2015). **Integrating MI strategies to address ambivalence and enhance motivation of clients with co-occurring disorders can improve client adherence to CBT treatment components.**

Strategies for blending MI and CBT include (Copeland, Gates, & Pokorski, 2017; Miller & Rollnick, 2013; Naar-King, Safren, & Miller, 2017):

- Engaging in a brief motivational conversation before a client moves into a CBT-focused component of treatment (e.g., a relapse prevention group).
- Alternating between MI and CBT, depending on the goals of each session.
- Using MI when the clinical focus is on engaging, focusing, evoking, and emphasizing the more directive style of CBT during the planning process.
- Shifting to MI during CBT interventions when counselor–client discord or client ambivalence about a specific change goal arises.
- Using the spirit of MI as a framework and interactional style in which to use CBT strategies.

Integrating MI into CBT approaches that the SUD treatment program already supports can enhance client motivation to engage in CBT and improve long-term maintenance of behavior change (Naar-King et al., 2017). Blending MI and CBT may actually create a more powerful approach for behavioral change in SUD treatment than either approach alone (Copeland et al., 2017; Naar-King et al., 2017). For example, a review of psychosocial interventions for cannabis use disorder found that the most consistent evidence for reducing cannabis use among a variety of interventions was a combination of CBT and MET (Gates, Sabioni, Copeland, Foll, & Gowing, 2016). Other research that evaluated studies on the integrated approach of CBT and MI found a clinically significant effect in treatment outcomes for co-occurring alcohol use disorder (AUD) and major depressive disorder compared with treatment as usual (Riper et al., 2014).

At times, CBT may require counselors to take on the role of a teacher or guide who is more directive, but counselors' overall stance should remain that of an empathetic partner–consultant instead of an expert. For example, in one study, counselors using CBT who explored and connected with clients in treatment for AUD were more successful in evoking discussions about behavior change than counselors who emphasized teaching clients behavior-change skills (Magill et al., 2016). Counselors' most important goal is to develop a relationship of mutual trust and respect with the client. They should view the client as the expert in his or her own recovery. Exhibit 8.1 provides a brief clinical scenario that depicts a counselor blending the spirit of MI with CBT relapse prevention strategies (see Chapter 7) in a counseling approach with a military veteran.

Exhibit 8.1. Blending the Spirit of MI With CBT

Jordan is 40 years old. He has been married for 12 years and has two young children. He served in the military and did two tours in Iraq. After discharge, he was arrested twice for driving under the influence and was mandated to alcohol and drug counseling. He was also referred for a psychiatric evaluation and was diagnosed with posttraumatic stress disorder.

Dan is a licensed clinical social worker in a co-occurring services program at a comprehensive behavioral health services program and has been seeing Jordan for 6 months for outpatient counseling. Initially, Jordan was angry

about having to go to counseling and Dan's suggestion to try Alcoholics Anonymous (AA) as part of a recovery plan; however, Jordan has been attending AA meetings and asked another veteran to be his sponsor.

Jordan has returned to heavy drinking on three occasions in the past 6 months. His relapse risk is that he stops going to meetings and stops calling his sponsor. Then he finds himself at a local sports bar, thinking that he'll just watch the game (an apparently irrelevant decision), but he ends up getting drunk. Jordan now speaks highly of AA and has been working the 12 Steps with his sponsor. He tells Dan, "I am doing everything my sponsor tells me to do and am committed to my recovery now. I know that if I follow his suggestions and work the program, I will be okay. I just don't understand why I keep slipping."

Dan has established a good rapport with Jordan. He has done a relapse risk assessment, provided information to Jordan about the relapse process, and given Jordan homework to track high-risk situations and the coping strategies he uses to manage them. Jordan seems to respond well to Dan's directive approach but continues to return to drinking. Dan shifts gears in the current session and decides to explore Jordan's understanding of his pattern of disengagement from AA and his sponsor instead of cautioning him again about his behavioral pattern leading up to a return to drinking.

Dan: I'm wondering what you make of this pattern: not going to meetings, not calling your sponsor just before you have a slip. If you could name that pattern, what would you call it? *(Open question)*

Jordan: I guess I would call it my version of "Stinkin' Thinkin'." I work so hard at trying to do the right thing in my recovery, but then I start to think that I am not getting anywhere, you know? I'm not drinking, but I don't feel any better, so I feel like a failure and get tired of trying. It's like I need to take a break from recovery.

Dan: So, you work hard to do the right thing in recovery and really want to feel better, but sometimes you feel discouraged and think you need to take a break. *(Reflection)*

Jordan: Yeah. That describes where I am right now.

Dan: I am curious about that. Would you say you are taking a break from recovery or taking a break from the program? *[Reframe in the form of a question that leaves open the possibility for the client to reject the new perspective]*

Jordan: Gee, I never thought about it that way. I guess I'm still working on my recovery, even if I don't talk to my sponsor. Like the other day, I started to feel like I wanted to go to the bar to watch the game, but I remembered what you and I had talked about last time—that this is a warning flag, and that I could do something different. So, instead of going to the bar, I asked one of my sober friends over, and we watched the game at my house. We didn't talk about the program; we just watched the game.

Dan: You really worked that one out for yourself and didn't let "Stinkin' Thinkin'" take over. Good for you. *(Affirmation)*

At the end of the session, Dan summarizes Jordan's successful approach to "doing something different" and asks Jordan how their conversation was for him. Jordan responds that it was very helpful that Dan didn't lecture him, but rather asked him what he thought. This helped him realize for himself that he is still working on his recovery, even if he doesn't call his sponsor or go to a meeting. Jordan also mentioned that now he doesn't feel like he is failing at recovery, so he thinks he will get back to his AA program.

MI and RMC

RMC is a fairly new addiction treatment approach that uses motivational strategies; it is modeled after approaches used for staying connected to people with chronic medical illnesses like diabetes. RMC is a proactive strategy for monitoring a client's progress in recovery after intensive SUD treatment and for intervening quickly if the client returns to substance use. RMC involves regular telephone calls (more frequently at first, then less frequently) to the client to find out how he or she is coping with recovery.

RMC incorporates MI strategies to enhance motivation to return to treatment if needed. Counselors or

peer recovery support specialists can perform RMC. Telephone-based motivational interventions are efficacious in treating and preventing substance use behaviors (Jiang et al., 2017). RMC is an effective method of monitoring clients' progress in recovery in the Action and Maintenance stages and intervening quickly to reengage clients into treatment after a substance use recurrence. It is linked to improved long-term substance use outcomes and increased participation in SUD treatment and recovery support services (Dennis & Scott, 2012; Dennis, Scott, & Laudet, 2014; Scott, Dennis, & Lurigio, 2017).

Workforce Development

MI is not only a counseling style but a conversational style that emphasizes guiding, rather than directing, clients toward changing substance use behaviors (Miller & Rollnick, 2013). Depending on the type of treatment program, an organization might provide aspects of MI training to only a few counselors, the entire clinical staff, or all staff, including support staff and peer providers. As increasingly more programs, including certified community behavioral health clinics (SAMHSA, 2016), adopt a client-centered treatment philosophy and MI as an evidence-based treatment, **organizations should train all staff in the spirit of MI.** This means all personnel—from the first person the client encounters walking through the door to the staff working in the billing department—understand the importance of client autonomy and choice, listening, and guiding instead of lecturing or directing in creating a welcoming environment and engaging clients in the treatment process (Miller & Rollnick, 2013).

> "MI is a complex skill, like playing a musical instrument. Watching others play the piano or attending a 2-day workshop is not likely in itself to turn one into a competent pianist" (Miller & Rollnick, 2014, p. 3).

MI has been widely disseminated as an evidence-based treatment, yet dissemination is not the same as implementation. Counselors lose their MI skills after a workshop if there is no supervision or coaching after training (Hall et al., 2015; Schwalbe, Oh, & Zweben, 2014). The key to workforce development of clinical staff in MI is to move beyond 1- or 2-day workshops and integrate ongoing training, supervision, and coaching of clinical staff to maintain fidelity to MI-consistent counseling techniques.

Another factor in whether a treatment program implements a motivational counseling approach is how closely the organization's mission and philosophy are aligned with the principles of motivational counseling. Counselors are more likely to adopt an MI counseling style when the organization's philosophy is aligned with MI principles (Ager et al., 2010).

Training

MI is an integrated and comprehensive set of listening and interviewing skills (Miller & Rollnick, 2013). For counselors to learn these skills and consistently integrate them into everyday practice, staff training and learning tasks should include (Miller & Rollnick, 2013):

- Understanding the spirt of MI.
- Developing skill in OARS.
- Identifying change goals.
- Exchanging information (i.e., Elicit-Provide-Elicit [EPE]) and giving advice skillfully.
- Recognizing change talk and sustain talk.
- Evoking change talk.
- Strengthening change talk.
- Responding skillfully to sustain talk and counselor–client discord.

- Developing hope and confidence.
- Negotiating a change plan.
- Strengthening commitment.
- Integrating MI with other counseling approaches.

These learning tasks apply to training counselors in any motivational counseling approach, including brief interventions that use FRAMES (**F**eedback, **R**esponsibility, **A**dvice, **M**enu of options, **E**mpathy, and **S**elf-efficacy) and MET, where the counselor gives personalized feedback and advice. Some tasks are foundational, like learning reflective listening, and are best learned through face-to-face, interactive training experiences. Other tasks, like recognizing change talk and sustain talk, can be learned through reading material, like coded transcripts of counselor–client interactions (Miller & Rollnick, 2013).

An initial workshop that covers the foundational components of MI (e.g., understanding the spirit of MI, OARS, recognizing and responding to change talk and sustain talk) may be a good beginning. This workshop should include both knowledge exchange and interactive skill-building exercises. A meta-analysis of MI training found that training produces medium-to-large–sized effects in MI proficiency both before and after training and medium-sized effects in MI proficiency compared with controls (de Roten, Zimmermann, Ortega, & Despland, 2013). Furthermore, an initial 12-to-15–hour workshop of MI training that included didactic, face-to-face instruction, and interactive exercises increased counselor skills as did more enhanced workshops that used video, web-based, or computer technology (Schwalbe et al., 2014). For an initial workshop, a simple format may be appropriate and potentially more cost effective than complex formats.

Ongoing training is the key to learning and sustaining motivational counseling skills if skills learned during training are not practiced. MI counselor skills introduced in training can erode after only 3 months if they are not used and practiced (Schwalbe et al., 2014). Spreading out training activities over a 6-month period and increasing the practice training hours to 5 or more hours increase counselor skill level and enhance skill retention (Schwalbe et al., 2014). Ongoing training in MI should be integrated into SUD treatment over 24 months as part of professional development to ensure counselor competency (Hall et al., 2015).

There are multiple ways to train staff, and the path an organization chooses is based on many factors. Before implementing MI training, an organization should consider the following questions when developing a strategic plan:

- **Assessing organizational philosophy and the SOC**
  - Is a person-centered approach to service delivery a key component of the organization's mission statement and philosophy?
  - Is MI a new counseling approach for the organization or will MI be blended with current treatment approaches?
  - At what stage of the SOC is staff with regard to integrating a new approach?
  - What kind of preparation is needed to implement a training program?
- **Assessing staff needs**
  - Does support staff need an introduction to the spirit of MI?
  - Which counseling staff members have already been trained and are using MI skills in their counseling approach? Which staff need a foundational workshop?
  - Which clinical supervisors have been trained in MI and demonstrate skill competence?

- **Tailoring a training program to meet staff needs**
  - How will the organization assess current counselor skill level in MI and tailor the training to different counselor skill levels?
  - Which would be most effective for the program:
    - Sending all counseling staff to a series of trainings provided by outside experts?
    - Training one or two clinical supervisors to provide in-house training and ongoing supervision of staff?
    - Bringing an outside expert into the organization to provide training?
    - A combination of outside and in-house training?
  - What strategies will the organization use to balance effective training, supervision, and professional development given cost considerations?

In developing the training plan, the organization should consider integrating a new counseling approach into the SUD treatment program a long-term project that needs buy-in by the entire organization.

Counselor Note: Implementation of MET in SUD Treatment Services in the Veterans Health Administration

In 2011, the Veterans Health Administration (VHA) implemented a national initiative to provide evidence-based MET counseling to veterans with SUDs. VHA developed a competency-based training program (Drapkin et al., 2016) that consisted of an initial 3.5-day training on MI plus assessment feedback, followed by 6 months of consultation with experienced MI training consultants (TCs). TCs provided ongoing supervision and coaching based on direct observation of counseling sessions using audio recordings. Training materials were adapted to address the specific needs of veterans. The VHA model of implementation was based on research in the training and supervision of clinical staff in MI to enhance implementation and fidelity.

Implementation of this competency-based model of training and supervision was enhanced by encouraging training participants to actively engage with the VHA MET community by becoming TCs and "MET champions," who provided information and consultation on how local VHA facilities could best disseminate and implement MET into their SUD treatment approach. TCs participate in monthly national conference calls with other TCs covering advanced MET topics. This model combines the use of outside trainers with in-house workforce development of new trainers and MET champions to create learning communities that sustain the use of MET in VHA facilities.

Supervision and Coaching

Training counselors in MI is the first step in integrating this approach into SUD treatment programs. Maintenance of skills and staying up to date with new developments in any counseling approach require ongoing supervision.

Supervision in MI should be competency based. This means supervision should address counselors' knowledge and proficiency in MI skills (e.g., the spirit of MI, OARS, EPE, recognizing and responding to change talk and sustain talk, evoking change talk, negotiating a change plan) needed to practice effectively. Competency-based supervision of MI includes directly observing counselor sessions, using feedback to monitor counselor proficiency, and coaching to help counselors continue developing their knowledge and skills (Martino et al., 2016). One study on competency-based supervision in MI found that anywhere from 4 to 20 supervision sessions were needed for doctoral-level interns to reach MI competency benchmarks (Schumaker et al., 2018).

Competency-based supervision requires direct observation of counselors, not simply a counselor's self-report or subjective evaluation. **Direct observation is one of the most effective ways of building and monitoring counselor skills** and can include use of video or audio taping sessions, live observation of

counseling sessions in person or via one-way mirrors, or both (SAMHSA, 2009). For more information on competency-based supervision, see TIP 52: *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (SAMHSA, 2009).

The program should get permission from clients before engaging in direct observation. Written consent forms should include the nature and purpose of the direct observation, a description of how clients' privacy and confidentiality will be maintained, and what will happen to any video or audio recordings after supervision or research is completed. Program should refer to in-house policies and state licensing board and professional ethics code requirements for the use of video and audio recordings for clinical supervision or research.

In addition to being competency based, **MI supervision should be performed in the spirit of MI.** Clinical supervisors should reach a level of skill in using MI to be able to:

- Describe the underlying theoretical foundations of MI.
- Explore and resolve counselor ambivalence about learning and integrating MI into treatment.
- Teach counselors MI skills.
- Model the spirit of MI and its skills in individual and group supervision sessions.
- Give respectful and nonjudgmental feedback to counselors to support self-efficacy and enhance professional development.

Coaching counselors in MI involves coding a recorded or live observation session for consistent (e.g., OARS responses) and inconsistent (e.g., giving unsolicited advice, confrontation) MI responses and using this information to provide feedback to the counselor (Miller & Rollnick, 2013). Because listening to and coding a full session are labor intensive, coaches can code brief sections of a session and produce reliable ratings of counselor fidelity to MI (Caperton, Atkins, & Imel, 2018). Two coding systems for MI have been widely used in research and clinical practice to evaluate counselor fidelity to MI (Miller & Rollnick, 2013):

- **MI Integrity (MITI)** focuses on counselor responses and provides global ratings and specific counts of MI-consistent responses. The most recent version of MITI (MITI 4) has added global ratings and greater accuracy in assessing counselor support for client autonomy and the use of persuasion when giving information and advice (Moyers, Manuel, & Ernst, 2014). The MITI 4 is a reliable way to assess counselor fidelity to MI in both its relational and its technical components (Moyers, Houck, Rice, Longbaugh, & Miller, 2016). Appendix C provides a link to the MITI 4 manual.
- **MI Skills Code (MISC)** counts both counselor and client responses (e.g., change talk, sustain talk) (Miller, Moyers, Ernst, & Amrhein, 2008). MISC is a reliable way to monitor counselor fidelity to MI and can provide an accurate measure of the ratio of client change talk to sustain talk (Lord et al.,2014). The MISC can provide not only feedback to counselors about their use of MI skills but also information about the effects of MI on counselor–client interactions. Appendix C provides a link to the MISC manual.

A positive aspect of using coding systems to assess counselor fidelity to MI is that they provide reliable and accurate measures of counselor skill level. A less-positive aspect of using coding systems is that they require considerable training and quality assurance checks to establish and maintain the reliability of the coach who is doing the coding (Miller & Rollnick, 2013). In addition, counselors may be ambivalent about recording client sessions and having a supervisor, who is responsible for performance evaluations, code the counselor's speech. Potential solutions to consider include:

- Addressing counselor ambivalence in supervision about having sessions coded.

- Creating small learning communities in the organization where counselors, case managers, and peer providers can learn and practice coding snippets of actual sessions or uncoded audio, video, or written transcripts with one another. Appendix C provides links to uncoded transcripts, audio, and video examples of MI counseling sessions.
- Sending audio sessions or short excerpts to an outside coder who can perform the coding and return written feedback for supervisors to discuss with counselors.
- Encouraging counselors to listen to their own recorded sessions and use a simplified method of counting their use of OARS, their inconsistent responses (e.g., giving advice without permission), change talk and sustain talk prompts, and client expressions of change talk and sustain talk (Miller & Rollnick, 2013). Counselors can then review their "self-coding" with their supervisors.

Whichever strategies the SUD organization employs to enhance counselor fidelity to and proficiency in delivering MI, the organization will need to balance cost considerations with effective training, supervision, and professional development. **Administrators and supervisors should partner with counseling staff to move the organization along the SOC toward integrating motivational approaches into SUD treatment.**

Conclusion

Many different motivational approaches have been discussed in this TIP including MI; MET; motivational interventions in the SOC; brief interventions; screening, brief intervention, and referral for treatment; and blending MI with other counseling methods. A growing body of evidence demonstrates that motivational interventions can enhance client motivation and improve SUD treatment outcomes. Integrating MI and other motivational approaches into SUD treatment settings requires the entire organization to adopt a client-centered philosophy and administrative support for ongoing training and supervision of counselors. Motivational counseling approaches are respectful and culturally responsive methods for helping people break free from addiction and adopt new lifestyles that are consistent with the values of good health, well-being, and being integral member of the community.

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Appendix A—Bibliography

Ager, R., Roahen-Harrison, S., Toriello, P. J., Kissinger, P., Morse, P., Morse, E., … Rice, J. (2010). Predictors of adopting motivational enhancement therapy. *Research on Social Work Practice, 21*(1), 65–76. doi:10.1177/1049731509353170

Ainscough, T. S., McNeill, A., Strang, J., Calder, R., & Brose, L. S. (2017). Contingency management interventions for non-prescribed drug use during treatment for opiate addiction: A systematic review and meta-analysis. *Drug and Alcohol Dependence*, *178*, 318–339.

Alcoholics Anonymous. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (4th ed.). New York, NY: Alcoholics Anonymous World Services.

Aldridge, A., Dowd, W., & Bray, J. (2017). The relative impact of brief treatment versus brief intervention in primary health-care screening programs for substance use disorders. *Addiction, 112*, 54–64. doi:10.1111/add.13653

Aldridge, A., Linford, R., & Bray, J. (2017). Substance use outcomes of patients served by a large U.S. implementation of screening, brief intervention and referral to treatment (SBIRT). *Addiction*, *112*, 43–53.

Alperstein, D., & Sharpe, L. (2016). The efficacy of motivational interviewing in adults with chronic pain: A meta-analysis and systematic review. *Journal of Pain, 17*(4), 393–403. doi:10.1016/j.jpain.2015.10.021

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Amodeo, M. (2015). The addictive personality. *Substance Use and Misuse, 50*(8–9), 1031–1036. doi:10.3109/10826084.2015.1007646

Anderson, T., Crowley, M. E., Himawan, L., Holmberg, J. K., & Uhlin, B. D. (2016). Therapist facilitative interpersonal skills and training status: A randomized clinical trial on alliance and outcome. *Psychotherapy Research, 26*(5), 511–529. doi:10.1080/10503307.2015.1049671

Apodaca, T. R., Borsari, B., Jackson, K. M., Magill, M., Longabaugh, R., Mastroleo, N. R., & Barnett, N. P. (2014). Sustain talk predicts poorer outcomes among mandated college student drinkers receiving a brief motivational intervention. *Psychology of Addictive Behaviors, 28*(3), 631–638. doi:10.1037/a0037296

Apodaca, T. R., Jackson, K. M., Borsari, B., Magill, M., Longabaugh, R., Mastroleo, N. R., & Barnett, N. P. (2016). Which individual therapist behaviors elicit client change talk and sustain talk in motivational interviewing? *Journal of Substance Abuse Treatment, 61*, 60–65. doi:10.1016/j.jsat.2015.09.001

Apodaca, T. R., & Longabaugh, R. (2009). Mechanisms of change in motivational interviewing: A review and preliminary evaluation of the evidence. *Addiction,104*(5), 705–715. doi:10.1111/j.1360-0443.2009.02527.x

Apodaca, T. R., Magill, M., Longabaugh, R., Jackson, K. M., & Monti, P. M. (2013). Effect of a significant other on client change talk in motivational interviewing. *Journal of Consulting and Clinical Psychology,81*(1), 35–46. doi:10.1037/a0030881

Appiah-Brempong, E., Okyere, P., Owusu-Addo, E., & Cross, R. (2014). Motivational interviewing interventions and alcohol abuse among college students: A systematic review. *American Journal of Health Promotion, 29*(1). doi:10.4278/ajhp.130502-lit-222

Arkowitz, H., Miller, W. R., & Rollnick, S. (2015). *Motivational interviewing in the treatment of psychological problems* (2nd ed.). New York, NY: Guilford Publications.

Babor, T. F., Del Boca, F. D., & Bray, J. W. (2017). Screening, brief intervention and referral to treatment: Implications of SAMHSA's SBIRT initiative for substance abuse policy and practice. *Addiction, 112*, 110–117. doi:10.1111/add.13675

Babor, T. F., Higgins-Biddle, J. C., & Robaina, K. (2016). *USAUDIT: The Alcohol Use Disorders Identification Test, Adapted for use in the United States: A guide for primary care practitioners.* Retrieved from www.ct.gov/dmhas/lib/dmhas/publications/USAUDIT-2017.pdf

Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). *The Alcohol Use Disorders Identification Test: Guidelines for use in primary care* (2nd ed.). Geneva, Switzerland: World Health Organization.

Bachiller, D., Grau-López, L., Barral, C., Daigre, C., Alberich, C., Rodríguez-Cintas, L., … Roncero C. (2015). Motivational interviewing group at inpatient detoxification: Its influence in maintaining abstinence and treatment retention after discharge. *Adicciones*, *27*(2), 109–118.

Baker, A. L., Kavanagh, D. J., Kay-Lambkin, F. J., Hunt, S. A., Lewin, T. J., Carr, V. J., & McElduff, P. (2014). Randomized controlled trial of MICBT for co-existing alcohol misuse and depression: Outcomes to 36-months. *Journal of Substance Abuse Treatment, 46*(3), 281–290.

Baker, A. L., Thornton, L. K., Hiles, S., Hides, L., & Lubman, D. I. (2012). Psychological interventions for alcohol misuse among people with co-occurring depression or anxiety disorders: A systematic review. *Journal of Affective Disorders, 139*(3), 217–229. doi:10.1016/j.jad.2011.08.004

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*, 191–215.

Barata, I. A., Shandro, J. R., Montgomery, M., Polansky, R., Sachs, C. J., Duber, H. C., … Macias-Konstantopoulos, W. (2017). Effectiveness of SBIRT for alcohol use disorders in the emergency department: A systematic review. *Western Journal of Emergency Medicine*, *18*(6), 1143–1152.

Barbosa, C., Cowell, A., Dowd, W., Landwehr, J., Aldridge, A., & Bray, J. (2017). The cost-effectiveness of brief intervention versus brief treatment of screening, brief intervention and referral to treatment (SBIRT) in the United States. *Addiction, 112*, 73–81. doi:10.1111/add.13658

Barnes, R. D., & Ivezaj, V. (2015). A systematic review of motivational interviewing for weight loss among adults in primary care. *Obesity Reviews, 16*(4), 304–318. doi:10.1111/obr.12264

Barnett, E., Moyers, T. B., Sussman, S., Smith, C., Rohrbach, L. A., Sun, P., & Spruijt-Metz, D. (2014). From counselor skill to decreased marijuana use: Does change talk matter? *Journal of Substance Abuse Treatment, 46,* 498–505.

Barnett, E., Spruijt-Metz, D., Moyers, T. B., Smith, C., Rohrbach, L. A., Sun, P., & Sussman, S. (2014). Bidirectional relationships between client and counselor speech: The importance of reframing. *Psychology of Addictive Behaviors, 28*(4), 1212–1219. doi:10.1037/a0036227

Barrio, P., & Gual, A. (2016). Patient-centered care interventions for the management of alcohol use disorders: A systematic review of randomized controlled trials. *Patient Preference and Adherence, 10,* 1823–1845. doi:10.2147/PPA.S109641

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment, 63*, 1–9. doi:10.1016/j.jsat.2016.01.003

Bedard-Gilligan, M., Garcia, N., Zoellner, L. A., & Feeny, N. C. (2018). Alcohol, cannabis, and other drug use: Engagement and outcome in PTSD treatment. *Psychology of Addictive Behaviors, 32*(3), 277–288.

Belmontes, K. C. (2018). When family gets in the way of recovery. *Family Journal*, *26*(1), 99–104. doi:10.1177/1066480717753013

Bernstein, S. L., & D'Onofrio, G. (2017). Screening, treatment initiation, and referral for substance use disorders. *Addiction Science and Clinical Practice, 12*(1). doi:10.1186/s13722-017-0083-z

Bertholet, N., Palfai, T., Gaume, J., Daeppen, J., & Saitz, R. (2013). Do brief alcohol motivational interventions work like we think they do? *Alcoholism: Clinical and Experimental Research*, *38*(3), 853–859. doi:10.1111/acer.12274

Beutler, L. E., Harwood, T. M., Michelson, A., Song, A., & Holman, J. (2011). Resistance/reactance level. *Journal of Clinical Psychology*, *67*(2), 133–142.

Black, J. J., & Chung, T. (2014). Mechanisms of change in adolescent substance use treatment: How does treatment work? *Substance Abuse*, *35*(4), 344–351.

Blow, F. C., Walton, M. A., Bohnert, A. S., Ignacio, R. V., Chermack, S., Cunningham, R. M., … Barry, K. L. (2017). A randomized controlled trial of brief interventions to reduce drug use among adults in a low-income urban emergency department: The HealthiER You study. *Addiction, 112*(8), 1395–1405. doi:10.1111/add.13773

Bohnert, A. S. B., Bonar, E. E., Cunningham, R., Greenwald, M. K., Thomas, L., Chermack, S., … Walton, M. (2016). A pilot randomized clinical trial of an intervention to reduce overdose risk behaviors among emergency department patients at risk for prescription drug overdose. *Drug and Alcohol Dependence, 163*, 40–47.

Borsari, B., Apodaca, T. R., Jackson, K. M., Fernandez, A., Mastroleo, N. R., Magill, M., … Carey, K. B. (2018). Trajectories of in-session change language in brief motivational interventions with mandated college students. *Journal of Consulting and Clinical Psychology, 86*(2), 158–168. doi:10.1037/ccp0000255

Boston Center for Treatment Development and Training. (2016). *Module 10: Sobriety sampling*. Retrieved from www.mass.gov/files/documents/2016/07/ty/bt-manual-module10.pdf

Bourke, E., Magill, M., & Apodaca, T. R. (2016). The in-session and long-term role of a significant other in motivational enhancement therapy for alcohol use disorders. *Journal of Substance Abuse Treatment, 64*, 35–43. doi:10.1016/j.jsat.2016.01.008

Bray, J. W., Aden, B., Eggman, A. A., Hellerstein, L., Wittenberg, E., Nosyk, B., … Schackman, B. R. (2017). Quality of life as an outcome of opioid use disorder treatment: A systematic review. *Journal of Substance Abuse Treatment*, *76*, 88–93.

Breslin, F. C., Sobell, L. C., Sobell, M. B., & Agrawal, S. (2000). A comparison of a brief and long version of the Situational Confidence Questionnaire. *Behaviour Research and Therapy, 38*(12), 1211–1220.

Brorson, H. H., Arnevik, E. A., Rand-Hendriksen, K., & Duckert, F. (2013). Drop-out from addiction treatment: A systematic review of risk factors. *Clinical Psychology Review, 33*(8), 1010–1024. doi:10.1016/j.cpr.2013.07.007

Caperton, D. D., Atkins, D. C., & Imel, Z. E. (2018). Rating motivational interviewing fidelity from thin slices. *Psychology of Addictive Behaviors, 32*(4), 434–441. doi:10.1037/adb0000359

Carey, K. B., Leontieva, L., Dimmock, J., Maisto, S. A., & Batki, S. L. (2007). Adapting motivational interventions for comorbid schizophrenia and alcohol use disorders. *Clinical Psychology*, *14*(1), 39–57.

Carroll, K. M., Ball, S. A., Nich, C., Martino, S., Frankforter, T. L., Farentinos, C., … Woody, G. E. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence*, *81*, 301–312.

Caviness, C. M., Hagerty, C. E., Anderson, B. J., Dios, M. A., Hayaki, J., Herman, D., & Stein, M. D. (2013). Self-efficacy and motivation to quit marijuana use among young women. *American Journal on Addictions, 22*(4), 373–380. doi:10.1111/j.1521-0391.2013.12030

Chariyeva, Z., Golin, C. E., Earp, J. A., Maman, S., Suchindran, C., & Zimmer, C. (2013). The role of self-efficacy and motivation to explain the effect of motivational interviewing time on changes in risky sexual behavior among people living with HIV: A mediation analysis. *AIDS and Behavior, 17*(2), 813–823. doi:10.1007/s10461-011-0115-8

Coffin, P. O., Santos, G.-M., Matheson, T., Behar, E., Rowe, C., Rubin, T., … Vittinghoff, E. (2017). Behavioral intervention to reduce opioid overdose among high-risk persons with opioid use disorder: A pilot randomized controlled trial. *PLOS One*, *12*(10), 1–15. Retrieved from www.ncbi.nlm.nih.gov/pubmed/29049282

Connors, G. J., DiClemente, C. C., Velasquez, M. M., & Donovan, D. M. (2013). *Substance abuse treatment and the stages of change: Selecting and planning interventions*. New York, NY: Guilford Press.

Copeland, J., Gates, P., & Pokorski, I. (2017). A narrative review of psychological cannabis use treatments with and without pharmaceutical adjunct. *Current Pharmaceutical Design, 22*(42), 6397–6408. doi:10.2174/1381612822666160831094811

Copeland, L., McNamara, R., Kelson, M., & Simpson, S. (2015). Mechanisms of change within motivational interviewing in relation to health behaviors outcomes: A systematic review. *Patient Education and Counseling*, *98*(4), 401–411. doi:10.1016/j.pec.2014.11.022

Cunningham, J. A., Sobell, L. C., Gavin, D. R., Sobell, M. B., & Breslin, F. C. (1997). Assessing motivation for change: Preliminary development and evaluation of a scale measuring the costs and benefits of changing alcohol or drug use. *Psychology of Addictive Behaviors*, *11*(2), 107–114.

D'Amico, E. J., Houck, J. M., Hunter, S. B., Miles, J. N., Osilla, K. C., & Ewing, B. A. (2015). Group motivational interviewing for adolescents: Change talk and alcohol and marijuana outcomes. *Journal of Consulting and Clinical Psychology, 83*(1), 68–80. doi:10.1037/a0038155

Davis, J. P., Houck, J. M., Rowell, L. N., Benson, J. G., & Smith, D. C. (2015). Brief motivational interviewing and normative feedback for adolescents: Change language and alcohol use outcomes. *Journal of Substance Abuse Treatment*, *65*, 66–73.

Deci, E. L., & Ryan, R. M. (2012). Overview of self-determination theory: An organismic dialectical perspective. In E. Deci & R. M. Ryan (Eds.), *Handbook of self-determination research* (pp. 3–38). Rochester, NY: University of Rochester Press.

Dennis, M. L., & Scott, C. K. (2012). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence, 121*(1–2), 10–17. doi:10.1016/j.drugalcdep.2011.07.026

Dennis, M. L., Scott, C. K., & Laudet, A. (2014). Beyond bricks and mortar: Recent research on substance use disorder recovery management. *Current Psychiatry Reports, 16*(4). doi:10.1007/s11920-014-0442-3

de Roten, Y., Zimmermann, G., Ortega, D., & Despland, J.-N. (2013). Meta-analysis of the effects of MI training on clinicians' behavior. *Journal of Substance Abuse Treatment, 45*(2), 155–162. Retrieved from www.ncbi.nlm.nih.gov/pubmed/23537923

DiClemente, C. C. (2018). *Addiction and change: How addictions develop and addicted people recover* (2nd ed.). Guilford, NY: Guilford Publications.

DiClemente, C. C., Carbonari, J. P., Montgomery, R. P. G., & Hughes, S. O. (1994). The Alcohol Abstinence Self-Efficacy Scale. *Journal of Studies on Alcohol, 55*(2), 141–148.

DiClemente, C. C., Corno, C. M., Graydon, M. M., Wiprovnick, A. E., & Knoblach, D. J. (2017). Motivational interviewing, enhancement, and brief interventions over the last decade: A review of reviews of efficacy and effectiveness. *Psychology of Addictive Behaviors, 31*(8), 862–887. doi:10.1037/adb0000318

Dillard, P. K., Zuniga, J. A., & Holstad, M. M. (2017). An integrative review of the efficacy of motivational interviewing in HIV management. *Patient Education and Counseling, 100*(4), 636–646. doi:10.1016/j.pec.2016.10.029

Drapkin, M. L., Wilbourne, P., Manuel, J. K., Baer, J., Karlin, B., & Raffa, S. (2016). National dissemination of motivation enhancement therapy in the Veterans Health Administration: Training program design and initial outcomes. *Journal of Substance Abuse Treatment, 65*, 83–87. doi:10.1016/j.jsat.2016.02.002

Dufett, I., & Ward, C. I. (2015). Can a motivational-interviewing-based outpatient substance abuse treatment achieve success? A theory-based evaluation. *African Journal of Drug and Alcohol Studies*, *14*(1), 1–12.

Ekong, G., & Kavookjian, J. (2016). Motivational interviewing and outcomes in adults with type 2 diabetes: A systematic review. *Patient Education and Counseling, 99*(6), 944–952. doi:10.1016/j.pec.2015.11.022

Elliott, J. C., & Carey, K. B. (2013). Pros and cons: Prospective predictors of marijuana use on a college campus. *Psychology of Addictive Behaviors, 27*(1), 230–235. doi:10.1037/a0029835

Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy, 55*(4), 399–410. Retrieved from www.researchgate.net/publication/324562138_Therapist_Empathy_and_Client_Outcome_An_Updated_Meta-Analysis

Ewing, S. W., Wray, A. M., Mead, H. K., & Adams, S. K. (2012). Two approaches to tailoring treatment for cultural minority adolescents. *Journal of Substance Abuse Treatment, 43*(2), 190–203. doi:10.1016/j.jsat.2011.12.005

Feldstein Ewing, S. W., Walters, S., & Baer, J. C. (2013). Motivational interviewing groups for adolescents and emerging adults. In C. C. Wagner & K. S. Ingersoll (Eds.), *Motivational interviewing in groups* (pp. 387–406). New York, NY: Guilford Press.

Fergie, L., Campbell, K. A., Coleman-Haynes, T., Ussher, M., Cooper, S., & Coleman, T. (2018). Identifying effective behavior change techniques for alcohol and illicit substance use during pregnancy: A systematic review. *Annals of Behavioral Medicine*. doi:10.1093/abm/kay085

Field, C. A., Adinoff, B., Harris, T. R., Ball, S. A., & Carroll, K. M. (2009). Construct, concurrent and predictive validity of the URICA: Data from two multi-site clinical trials. *Drug and Alcohol Dependence*, *101*(1–2), 115–123.

Field, C., Walters, S., Marti, C. N., Jun, J., Foreman, M., & Brown, C. (2014). A multisite randomized controlled trial of brief intervention to reduce drinking in the trauma care setting. *Annals of Surgery, 259*(5), 873–880. doi:10.1097/sla.0000000000000339

Fiszdon, J. M., Kurtz, M. M., Choi, J., Bell, M. D., & Martino, S. (2015). Motivational interviewing to increase cognitive rehabilitation adherence in schizophrenia. *Schizophrenia Bulletin*, *42*(2), 327–334.

Flannery, M. (2017). Self-determination theory: Intrinsic motivation and behavioral change. *Oncology Nursing Forum, 44*(2), 155–156. Retrieved from www.ncbi.nlm.nih.gov/pubmed/28222078

Forman, D. P., & Moyers, T. B. (2019). With odds of a single session, motivational interviewing is a good bet. *Psychotherapy*. doi:10.1037/pst0000199

Foster, D., & Neighbors, C. (2013). A review of decisional balance research and directions for brief alcohol intervention among college students. *OA Alcohol, 1*(1). doi:10.13172/2053-0285-1-1-575

Foster, D. W., Neighbors, C., & Pai, A. (2015). Decisional balance: Alcohol decisional balance intervention for heavy drinking undergraduates. *Substance Use and Misuse*, *50*(13), 1717–1727.

Friedrichs, A., Spies, M., Härter, M., & Buchholz, A. (2016). Patient preferences and shared decision making in the treatment of substance use disorders: A systematic review of the literature. *PLOS One, 11*(1). doi:10.1371/journal.pone.0145817

Gates, P. J., Sabioni, P., Copeland, J., Foll, B. L., & Gowing, L. (2016). Psychosocial interventions for cannabis use disorder. *Cochrane Database of Systematic Reviews*. doi:10.1002/14651858.cd005336.pub4

Gaume, J., Magill, M., Mastroleo, N. R., Longabaugh, R., Bertholet, N., Gmel, G., & Daeppen, J. (2016). Change talk during brief motivational intervention with young adult males: Strength matters. *Journal of Substance Abuse Treatment, 65*, 58–65. doi:10.1016/j.jsat.2016.01.005

Gelberg, L., Andersen, R., Vahidi, M., Rico, M., Baumeister, S., & Leake, B. (2017). A multi-component brief intervention for risky drug use among Latino patients of a federally qualified health center in East Los Angeles: A randomized controlled trial of the quit using drugs intervention trial (quit) brief intervention. *Drug and Alcohol Dependence,171*. Retrieved from https://eurekamag.com/research/064/949/064949750.php

Glozah, F. N., Adu, N. A., & Komesuor, J. (2015). Assessing alcohol abstinence self-efficacy in undergraduate students: Psychometric evaluation of the alcohol abstinence self-efficacy scale. *Health and Quality of Life Outcomes, 13*(1). doi:10.1186/s12955-015-0387-1

Gordon, T. (1970). *Parent effectiveness training: The no-lose program for raising responsible children.* New York, NY: Wyden.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York, NY: New York University Press.

Grant, S., Colaiaco, B., Motala, A., Shanman, R., Booth, M., Sorbero, M., & Hempel, S. (2017). Mindfulness-based relapse prevention for substance use disorders: A systematic review and meta-analysis. *Journal of Addiction Medicine, 11*(5), 386–396. doi:10.1097/adm.0000000000000338

Gueorguieva, R., Wu, R., O'Connor, P. G., Weisner, C., Fucito, L. M., Hoffmann, S., … O'Malley, S. S. (2014). Predictors of abstinence from heavy drinking during treatment in COMBINE and external validation in PREDICT. *Alcoholism: Clinical and Experimental Research*, *38*(10), 2647–2656.

Hall, K., Staiger, P. K., Simpson, A., Best, D., & Lubman, D. I. (2015). After 30 years of dissemination, have we achieved sustained practice change in motivational interviewing? *Addiction, 111*(7), 1144–1150. doi:10.1111/add.13014

Harley, D. A. (2017). Motivational interviewing and motivational enhancement therapy: Cultural implications in addiction intervention for African Americans. *SciFed Journal of Addiction and Therapy, 1*(1). doi:10.23959/sfjat-1000005

Harrell, P. T., Trenz, R., Scherer, M., Martins, S., & Latimer, W. (2013). A latent class approach to treatment readiness corresponds to a transtheoretical ("Stages of Change") model. *Journal of Substance Abuse Treatment, 45*(3), 249–256. doi:10.1016/j.jsat.2013.04.004

Hausotter, W. (2006). *Motivational interviewing assessment: Supervisory tools for enhancing proficiency.* Salem, OR: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University. Retrieved from www.motivationalinterviewing.org/sites/default/files/mia-step.pdf

Heather, N., & Honekopp, J. (2008). A revised edition of the readiness to change questionnaire (treatment version). *Addiction Research and Theory, 16*(5), 421–433.

Heather, N., & McCambridge, J. (2013). Post-treatment stage of change predicts 12-month outcome of treatment for alcohol problems. *Alcohol and Alcoholism, 48*(3), 329–336. doi:10.1093/alcalc/agt006

Hennessy, E. A. (2017). Recovery capital: A systematic review of the literature. *Addiction Research and Theory, 25*(5), 349–360. doi:10.1080/16066359.2017.1297990

Hennessy, E. A., Tanner-Smith, E. E., & Steinka-Fry, K. T. (2015). Do brief alcohol interventions reduce tobacco use among adolescents and young adults? A systematic review and meta-analysis. *Journal of Behavioral Medicine, 38*(6), 899–911.

Hester, R. K., Delaney, H. D., & Campbell, W. (2012). The college drinker's check-up: Outcomes of two randomized clinical trials of a computer-delivered intervention. *Psychology of Addictive Behaviors*, *26*(1), 1–12.

Hingson, R., & Compton, W. M. (2014). Screening and brief intervention and referral to treatment for drug use in primary care: Back to the drawing board. *JAMA, 312*(5), 488. doi:10.1001/jama.2014.7863

Holstad, M. M., Diiorio, C., Kelley, M. E., Resnicow, K., & Sharma, S. (2010). Group motivational interviewing to promote adherence to antiretroviral medications and risk reduction behaviors in HIV infected women. *AIDS and Behavior, 15*(5), 885–896. doi:10.1007/s10461-010-9865-y

Houck, J. M., Hunter, S. B., Benson, J. G., Cochrum, L. L., Rowell, L. N., & Damico, E. J. (2015). Temporal variation in facilitator and client behavior during group motivational interviewing sessions. *Psychology of Addictive Behaviors, 29*(4), 941–949. doi:10.1037/adb0000107

Houck, J. M., Manuel, J. K., & Moyers, T. B. (2018). Short- and long-term effects of within-session client speech on drinking Outcomes in the COMBINE study. *Journal of Studies on Alcohol and Drugs, 79*(2), 217–222. doi:10.15288/jsad.2018.79.217

Houck, J. M., & Moyers, T. B. (2015). Within-session communication patterns predict alcohol treatment outcomes. *Drug and Alcohol Dependence, 157*, 205–209. doi:10.1016/j.drugalcdep.2015.10.025

Humphreys, K., Blodgett, J. C., & Wagner, T. H. (2014). Estimating the efficacy of Alcoholics Anonymous without self-selection bias: An instrumental variables re-analysis of randomized clinical trials. *Alcoholism: Clinical and Experimental Research*, *38*(11), 2688–2694. doi:10.1111/acer.12557

Hunt, G. E., Siegfried, N., Morley, K., Sitharthan, T., & Cleary, M. (2013). Psychosocial interventions for people with both severe mental illness and substance misuse. *Cochrane Database of Systematic Reviews*, *10*. Art. No.: CD001088. doi:10.1002/14651858.CD001088.pub3

Ingersoll, K. S., Ceperich, S. D., Hettema, J. E., Farrell-Carnahan, L., & Penberthy, J. K. (2013). Preconceptional motivational interviewing interventions to reduce alcohol-exposed pregnancy risk. *Journal of Substance Abuse Treatment, 44*(4), 407–416. doi:10.1016/j.jsat.2012.10.001

Jackson, L. A., Buxton, J. A., Dingwell, J., Dykeman, M., Gahagan, J., Gallant, K., … Davison, C. (2014). Improving psychosocial health and employment outcomes for individuals receiving methadone treatment: A realist synthesis of what makes interventions work. *BMC Psychology*, *2*(1), 26. doi:10.1186/s40359-014-0026-3

Janis, L. L., & Mann, L. (1977). *Decision making: A psychological analysis of conflict, choice, and commitment.* London, England: Cassel and Collier Macmillan.

Jason, L. A., Salina, D., & Ram, D. (2016). Oxford recovery housing: Length of stay correlated with improved outcomes for women previously involved with the criminal justice system. *Substance Abuse, 37*(1), 248–254. doi:10.1080/08897077.2015.1037946

Jiang, S., Wu, L., & Gao, X. (2017). Beyond face-to-face individual counseling: A systematic review on alternative modes of motivational interviewing in substance abuse treatment and prevention. *Addictive Behaviors, 73*, 216–235

Joseph, J., & Basu, D. (2016). Efficacy of brief interventions in reducing hazardous or harmful alcohol use in middle-income countries: Systematic review of randomized controlled trials. *Alcohol and Alcoholism, 52*(1), 56–64. doi:10.1093/alcalc/agw054

Kadden, R. M., & Litt, M. D. (2011). The role of self-efficacy in the treatment of substance use disorders. *Addictive Behaviors*, *36*(12), 1120–1126.

Kahler, C. W., Pantalone, D. W., Mastroleo, N. R., Liu, T., Bove, G., Ramratnam, B., … Mayer, K. J. (2018). Motivational interviewing with personalized feedback to reduce alcohol use in HIV-infected men who have sex with men: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 86*(8), 645–656.

Kanfer, F. H., & Schefft, B. K. (1988). *Guiding the process of therapeutic change.* Champaign, IL: Research Press.

Kelly, J. F., Bergman, B. G., Hoeppner, B., Vilsaint, C., & White, W. L. (2017). Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy. *Drug and Alcohol Dependence*, *181*, 162–169.

Kiluk, B. D., Serafini, K., Malin-Mayor, B., Babuscio, T. A., Nich, C., & Carroll, K. M. (2015). Prompted to treatment by the criminal justice system: Relationships with treatment retention and outcome among cocaine users. *American Journal on Addictions, 24*(3), 225–232. doi:10.1111/ajad.12208

Klimas, J., Field, C., Cullen, W., O'Gorman, C., Glynn, L., Keenan, E., … Dunne, C. (2014). Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users: Cochrane Review. *Drug and Alcohol Dependence, 140*. doi:10.1016/j.drugalcdep.2014.02.305

Kohler, S., & Hofmann, A. (2015). Can motivational interviewing in emergency care reduce alcohol consumption in young people? A systematic review and meta-analysis. *Alcohol and Alcoholism, 50*(2), 107–117. doi:10.1093/alcalc/agu098

Korcha, R. A., Polcin, D. L., Evans, K., Bond, J. C., & Galloway, G. P. (2015). Intensive motivational interviewing for women with alcohol problems. *Counselor (Deerfield Beach), 16*(3), 62–69.

Krawczyk, N., Feder, K. A., Saloner, B., Crum, R. M., Kealhofer, M., & Mojtabai, R. (2017). The association of psychiatric comorbidity with treatment completion among clients admitted to substance use treatment programs in a U.S. national sample. *Drug and Alcohol Dependence, 175*, 157–163. doi:10.1016/j.drugalcdep.2017.02.006

Krigel, S. W., Grobe, J. E., Goggin, K., Harris, K. J., Moreno, J. L., & Catley, D. (2017). Motivational interviewing and the decisional balance procedure for cessation induction in smokers not intending to quit. *Addictive Behaviors, 64*, 171–178. doi:10.1016/j.addbeh.2016.08.036

Kuerbis, A., Armeli, S., Muench, F., & Morgenstern, J. (2013). Motivation and self-efficacy in the context of moderated drinking: Global self-report and ecological momentary assessment. *Psychology of Addictive Behaviors, 27*(4), 934–943. doi:10.1037/a0031194

Kuusisto, K., Knuuttila, V., & Saarnio, P. (2011). Clients' self-efficacy and outcome expectations. *Addictive Disorders and Their Treatment, 10*(4), 157–168. doi:10.1097/adt.0b013e31820dd4ec

Kwasnicka, D., Dombrowski, S. U., White, M., & Sniehotta, F. (2016). Theoretical explanations for maintenance of behaviour change: A systematic review of behaviour theories. *Health Psychology Review, 10*(3), 277–296. doi:10.1080/17437199.2016.1151372

Lee, W. W., Choi, K., Yum, R. W., Yu, D. S., & Chair, S. (2016). Effectiveness of motivational interviewing on lifestyle modification and health outcomes of clients at risk or diagnosed with cardiovascular diseases: A systematic review. *International Journal of Nursing Studies, 53*, 331–341. doi:10.1016/j.ijnurstu.2015.09.010

Lenz, A. S., Rosenbaum, L., & Sheperis, D. (2016). Meta-analysis of randomized controlled trials of motivational enhancement therapy for reducing substance use. *Journal of Addictions and Offender Counseling, 37*(2), 66–86. doi:10.1002/jaoc.12017

Lindqvist, H., Forsberg, L., Enebrink, P., Andersson, G., & Rosendahl, I. (2017). Relational skills and client language predict outcome in smoking cessation treatment. *Substance Use and Misuse, 52*(1), 33–42. doi:10.1080/10826084.2016.1212892

Litt, M. D., & Kadden, R. M. (2015). Willpower versus "skillpower": Examining how self-efficacy works in treatment for marijuana dependence*. Psychology of Addictive Behaviors*, *29*(3), 532–540. doi:10.1037/adb0000085

Litt, M. D., Kadden, R. M., & Petry, N. M. (2013). Behavioral treatment for marijuana dependence: Randomized trial of contingency management and self-efficacy enhancement. *Addictive Behaviors, 38*(3), 1764–1775. doi:10.1016/j.addbeh.2012.08.011

Lord, S. P., Can, D., Yi, M., Marin, R., Dunn, C. W., Imel, Z. E., … Atkins, D. C. (2014). Advancing methods for reliably assessing motivational interviewing fidelity using the motivational interviewing skills code. *Journal of Substance Abuse Treatment*, *49*, 50–57.

Lozano, B. E., Larowe, S. D., Smith, J. P., Tuerk, P., & Roitzsch, J. (2013). Brief motivational feedback may enhance treatment entry in veterans with comorbid substance use and psychiatric disorders. *American Journal on Addictions, 22*(2), 132–135. doi:10.1111/j.1521-0391.2013.00315.x

Lundahl, B., Moleni, T., Burke, B. L., Butters, R., Tollefson, D., Butler, C., & Rollnick, S. (2013). Motivational interviewing in medical care settings: A systematic review and meta-analysis of randomized controlled trials. *Patient Education and Counseling, 93*(2), 157–168. doi:10.1016/j.pec.2013.07.012

Magill, M., Apodaca, T. R., Borsari, B., Gaume, J., Hoadley, A., Gordon, R. E. F., … Moyers, T. (2018). A meta-analysis of motivational interviewing process: Technical, relational, and conditional process models of change. *Journal of Consulting and Clinical Psychology, 86*(2), 140–157.

Magill, M., Gaume, J., Apodaca, T. R., Walthers, J., Mastroleo, N. R., Borsari, B., & Longabaugh, R. (2014). The technical hypothesis of motivational interviewing: A meta-analysis of MI's key causal model. *Journal of Consulting and Clinical Psychology, 82*(6), 973–983.

Magill, M., Stout, R. L., & Apodaca, T. R. (2013). Therapist focus on ambivalence and commitment: A longitudinal analysis of motivational interviewing treatment ingredients. *Psychology of Addictive Behaviors, 27*(3), 754–762. doi:10.1037/a0029639

Magill, M., Walthers, J., Mastroleo, N. R., Gaume, J., Longabaugh, R., & Apodaca, T. R. (2016). Therapist and client discussions of drinking and coping: A sequential analysis of therapy dialogues in three evidence-based alcohol use disorder treatments. *Addiction, 111*(6), 1011–1020. doi:10.1111/add.13313

Mahmoodabad, S. S., Tonekaboni, N. R., Farmanbar, R., Fallahzadeh, H., & Kamalikhah, T. (2017). The effect of motivational interviewing-based intervention using self-determination theory on promotion of physical activity among women in reproductive age: A randomized clinical trial. *Electronic Physician, 9*(5), 4461–4472. doi:10.19082/4461

Manuel, J. K., Satre, D. D., Tsoh, J., Moreno-John, G., Ramos, J. S., McCance-Katz, E. F., & Satterfield, J. M. (2015). Adapting screening, brief intervention, and referral to treatment for alcohol and drugs to culturally diverse clinical populations. *Journal of Addiction Medicine, 1.* doi:10.1097/adm.0000000000000150

Marlatt, G., A., Parks, G. A., & Witkiewitz, K. (2002*). Clinical guidelines for implementing relapse prevention therapy: A guideline developed for behavioral health recovery management project.* Chicago, IL: University of Chicago. Retrieved from www.researchgate.net/publication/235326763_Clinical_Guidelines_for_Implementing_RelapsePrevention_Therapy_A_Guideline_Developed_for_the_Behavioral_Health_Recovery_Management_Project

Martin, G. W., & Rehm, J. (2012). The effectiveness of psychosocial modalities in the treatment of alcohol problems in adults: A review of the evidence. *Canadian Journal of Psychiatry, 57*(6), 350–358. doi:10.1177/070674371205700604

Martino, S., Ball, S. A., Gallon, S. L., Hall, D., Garcia, M., Ceperich, S., … Hausotter, W. (2006). *Motivational interviewing assessment: Supervisory tools for enhancing proficiency.* Salem, OR: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University. Retrieved from www.motivationalinterviewing.org/sites/default/files/mia-step.pdf

Martino, S., Paris, M., Añez, L., Nich, C., Canning-Ball, M., Hunkele, K., … Carroll, K. M. (2016). The effectiveness and cost of clinical supervision for motivational interviewing: A randomized controlled trial. *Journal of Substance Abuse Treatment*, *68*, 11–23.

Mattoo, S. K., Prasad, S., & Ghosh, A. (2018). Brief intervention in substance use disorders. *Indian Journal of Psychiatry*, *60*(Suppl 4), S466–S472.

McCance-Katz, E. F., & Satterfield, J. (2012). SBIRT: A key to integrate prevention and treatment of substance abuse in primary care. *American Journal on Addictions, 21*(2), 176–177. doi:10.1111/j.1521-0391.2011.00213.x

McConnaughy, E. A., Prochaska, J. O., & Velicer, W. F.(1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research and Practice, 20*, 368–375.

McDevitt-Murphy, M. E., Murphy, J. G., Williams, J. L., Monahan, C. J., Bracken-Minor, K. L., & Fields, J. A. (2014). Randomized controlled trial of two brief alcohol interventions for OEF/OIF veterans. *Journal of Consulting and Clinical Psychology, 82*(4), 562–568. doi:10.1037/a0036714

McQueen, J., Howe, T. E., Allan, L., Mains, D., & Hardy, V. (2011). Brief interventions for heavy alcohol users admitted to general hospital wards. *Cochrane Database of Systematic Reviews,* (8).

McQueen, J. M., Howe, T. E., Ballinger, C., & Godwin, J. (2015). Effectiveness of alcohol brief intervention in a general hospital: A randomized controlled trial. *Journal of Studies on Alcohol and Drugs, 76*(6), 838–844. doi:10.15288/jsad.2015.76.838

Merchant, R. C., Romanoff, J., Zhang, Z., Liu, T., & Baird, J. R. (2017). Impact of a brief intervention on reducing alcohol use and increasing alcohol treatment services utilization among alcohol- and drug-using adult emergency department patients. *Alcohol, 65*, 71–80. doi:10.1016/j.alcohol.2017.07.003

Miller, M. B., Leffingwell, T., Claborn, K., Meier, E., Walters, S., & Neighbors, C. (2013). Personalized feedback interventions for college alcohol misuse: An update of Walters & Neighbors (2005). *Psychology of Addictive Behaviors*, *27*(4), 909–920.

Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61*(3), 455–461.

Miller, W. R., & Brown, J. M. (1994). *What I want from treatment* (2.0). Retrieved from https://casaa.unm.edu/inst/What%20I%20Want%20From%20Treatment.pdf

Miller, W. R., Forcehimes, A. A., & Zweben, A. (2011). *Treating addiction: A guide for professionals*. New York, NY: Guilford Press.

Miller, W. R., & Moyers, T. B. (2017). Motivational interviewing and the clinical science of Carl Rogers. *Journal of Consulting and Clinical Psychology, 85*(8), 757–766. doi:10.1037/ccp0000179

Miller, W. R., & Moyers, T. B. (2015). The forest and the trees: Relational and specific factors in addiction treatment. *Addiction*, *110*(3), 401–413.

Miller, W. R., Moyers, T. B., Ernst, D. B., & Amrhein, P. C. (2008). *Manual for the Motivational Interviewing Code* (version 2.1). Albuquerque, NM: Center on Alcoholism, Substance Abuse, and Addictions, University of New Mexico. Retrieved from https://casaa.unm.edu/download/misc.pdf

Miller, W. R., & Rollnick, S. (2014). The effectiveness and ineffectiveness of complex behavioral interventions: Impact of treatment fidelity. *Contemporary Clinical Trials, 37*(2), 234–241. doi:10.1016/j.cct.2014.01.005

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

Miller, W. R., & Rollnick, S. (2010). *Looking forward to MI-3: A work in progress* [PowerPoint slides]. Retrieved from http://motivationalinterviewing.org/sites/default/files/Forum_2010_Plenary_Bill.ppt

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York, NY: Guilford Press.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press.

Miller, W. R., & Rose, G. S. (2013). Motivational interviewing and decisional balance: Contrasting responses to client ambivalence. *Behavioural and Cognitive Psychotherapy, 43*(02), 129–141. doi:10.1017/s1352465813000878

Miller, W. R., & Sanchez, V. C. (1994). Motivating young adults for treatment and lifestyle change. In G. Howard & Nathan (Eds.), *Alcohol use and misuse by young adults* (pp. 55–82). Notre Dame, IN: University of Notre Dame Press.

Miller, W. R., & Tonigan, J. S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors, 10*(2), 81–89.

Miller, W. R., Tonigan, J. S., & Longabaugh, R. (1995*). The Drinker Inventory of Consequences (DrInC): An instrument for assessing adverse consequences of alcohol abuse, Test manual* (vol. 4). Project MATCH Monograph Series. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism. Retrieved from https://pubs.niaaa.nih.gov/publications/projectmatch/match04.pdf

Miller, W. R., & Wilbourne, P. L. (2002). Mesa Grande: A methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction*, *97*(3), 265–277. doi:10.1046/j.1360-0443.2002.00019.x

Montgomery, L., Robinson, C., Seaman, E. L., & Haeny, A. M. (2017). A scoping review and meta-analysis of psychosocial and pharmacological treatments for cannabis and tobacco use among African Americans. *Psychology of Addictive Behaviors, 31*(8), 922–943. www.ncbi.nlm.nih.gov/pubmed/29199844

Monti, P. M., Colby, S. M., Mastroleo, N. R., Barnett, N. P., Gwaltney, C. J., Apodaca, T. R., … Cioffi, W. G. (2014). Individual versus significant-other-enhanced brief motivational intervention for alcohol in emergency care. *Journal of Consulting and Clinical Psychology, 82*(6), 936–948. doi:10.1037/a0037658

Moore, M., Flamez, B., & Szirony, G. M. (2017). Motivational interviewing and dual diagnosis clients: Enhancing self-efficacy and treatment completion. *Journal of Substance Use, 23*(3), 247–253. doi:10.1080/14659891.2017.1388856

Moos, R. H. (2012). Iatrogenic effects of psychosocial interventions: Treatment, life context, and personal risk factors. *Substance Use and Misuse*, *47*(13–14), 1592–1598. doi:10.3109/10826084.2012.705710

Morgenstern, J., Kuerbis, A., Houser, J., Muench, F. J., Shao, S., & Treloar, H. (2016). Within-person associations between daily motivation and self-efficacy and drinking among problem drinkers in treatment. *Psychology of Addictive Behaviors, 30*(6), 630–638. doi:10.1037/adb0000204

Mowbray, O., Quinn, A., & Cranford, J. A. (2014). Social networks and alcohol use disorders: Findings from a nationally representative sample. *American Journal of Drug and Alcohol Abuse, 40*(3), 181–186. doi:10.3109/00952990.2013.860984

Moyers, T. B. (2014). The relationship in motivational interviewing. *Psychotherapy, 51*(3), 358–363. Retrieved from https://media.wcwpds.wisc.edu/motivational-interviewing/files/The-Relationship-in-Motivational-Interviewing.pdf

Moyers, T. B., & Houck, J. (2011). Combining motivational interviewing with cognitive–behavioral treatments for substance abuse: Lessons from the COMBINE research project. *Cognitive and Behavioral Practice, 18*(1), 38–45. doi:10.1016/j.cbpra.2009.09.005

Moyers, T. B., Houck, J., Glynn, L. H., Hallgren, K. A., & Manuel, J. K. (2017). A randomized controlled trial to influence client language in substance use disorder treatment. *Drug and Alcohol Dependence, 172,* 43–50. doi:10.1016/j.drugalcdep.2016.11.036

Moyers, T. B., Houck, J., Rice, S. L., Longabaugh, R., & Miller, W. R. (2016). Therapist empathy, combined behavioral intervention, and alcohol outcomes in the COMBINE research project. *Journal of Consulting and Clinical Psychology, 84*(3), 221–229. doi:10.1037/ccp0000074

Moyers, T. B., Manuel, J. K., & Ernst, D. (2014). *Motivational Interviewing Treatment Integrity Coding Manual 4.1.* Unpublished manual. Retrieved from https://motivationalinterviewing.org/sites/default/files/miti4_2.pdf

Moyers, T. B., Martin, T., & Christopher, P. (2005). *Motivational interviewing knowledge test.* Albuquerque, NM: Center on Alcoholism, Substance Abuse, and Addictions, University of New Mexico. Retrieved from https://casaa.unm.edu/download/ELICIT/MI%20Knowledge%20Test.pdf

Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors, 273,* 878–884. doi:10.1037/a0030274

Mumba, M. N., Findlay, L. J., & Snow, D. E. (2018). Treatment options for opioid use disorders. *Journal of Addictions Nursing, 29*(3), 221–225.

Naar-King, S., Safren, S. A., & Miller, W. R. (2017). *Motivational interviewing and CBT: Combining strategies for maximum effectiveness*. New York, NY: Guilford Press.

Navidian, A., Kermansaravi, F., Tabas, E. E., & Saeedinezhad, F. (2016). Efficacy of group motivational interviewing in the degree of drug craving in the addicts under the methadone maintenance treatment (MMT) in South East of Iran. *Archives of Psychiatric Nursing, 30*(2), 144–149. doi:10.1016/j.apnu.2015.08.002

Norcross, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of Change. *Journal of Clinical Psychology, 67*(2), 143–154. Retrieved from www.researchgate.net/publication/49683193_Stages_of_Change

Novins, D. K., Croy, C. D., Moore, L. A., & Rieckmann, T. (2016). Use of evidence-based treatments in substance abuse treatment programs serving American Indian and Alaska Native communities. *Drug and Alcohol Dependence*, *161*, 214–221.

Nunes, A. P., Richmond, M. K., Marzano, K., Swenson, C. J., & Lockhart, J. (2017). Ten years of implementing screening, brief intervention, and referral to treatment (SBIRT): Lessons learned. *Substance Abuse, 38*(4), 508–512. doi:10.1080/08897077.2017.1362369

Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. Washington, DC: U.S. Department of Health and Human Services. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

Osilla, K. C., Ortiz, J. A., Miles, J. N., Pedersen, E. R., Houck, J. M., & Damico, E. J. (2015). How group factors affect adolescent change talk and substance use outcomes: Implications for motivational interviewing training. *Journal of Counseling Psychology, 62*(1), 79–86. doi:10.1037/cou0000049

Osterman, R., Lewis, D., & Winhusen, T. (2017). Efficacy of motivational enhancement therapy to decrease alcohol and illicit-drug use in pregnant substance users reporting baseline alcohol use. *Journal of Substance Abuse Treatment, 77*, 150–155. doi:10.1016/j.jsat.2017.02.003

Pace, B. T., Dembe, A., Soma, C. S., Baldwin, S. A., Atkins, D. C., & Imel, Z. E. (2017). A multivariate meta-analysis of motivational interviewing process and outcome. *Psychology of Addictive Behaviors, 31*(5), 524–533. doi:10.1037/adb0000280

Panebianco, D., Gallupe, O., Carrington, P. J., & Colozzi, I. (2016). Personal support networks, social capital, and risk of relapse among individuals treated for substance use issues. *International Journal of Drug Policy, 27*, 146–153. doi:10.1016/j.drugpo.2015.09.009

Polcin, D. L., Mulia, N., & Jones, L. (2012). Substance users' perspectives on helpful and unhelpful confrontation: Implications for recovery. *Journal of Psychoactive Drugs*, *44*(2), 144–152.

Prochaska, J. O. (1979). *Systems of psychotherapy: A transtheoretical analysis.* Homewood, IL: Dorsey Press.

Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy*. Malabar, FL: R. E. Krieger.

Prochaska, J., Norcross, J., & DiClemente, C. (2013). Applying the Stages of Change. *Psychotherapy in Australia*, *19*, 10–15. doi:10.1093/med:psych/9780199845491.003.0034

Prochaska, J. O., Velicer, W. F., Rossi, J. S., Goldstein, M. G., Marcus, B.H., Rakowski, W., … Rossi, S.R. (1994). Stages of Change and decisional balance for 12 problem behaviors. *Health Psychology*, *13*, 39–46.

Rapp, R. C., Van Den Noortgate, W., Broekaert, E., & Vanderplasschen, W. (2014). The efficacy of case management with persons who have substance abuse problems: A three-level meta-analysis of outcomes. *Journal of Consulting and Clinical Psychology*, *82*(4), 605–618. Retrieved from www.ncbi.nlm.nih.gov/books/NBK241643/

Raylu, N., & Kaur, I. (2012). Factors that affect treatment expectations of outpatients with substance use problems. *International Journal of Mental Health and Addiction, 10*(6), 804–817. doi:10.1007/s11469-012-9377-2

Rhoades, H., Motte-Kerr, W. L., Duan, L., Woo, D., Rice, E., Henwood, B., … Wenzel, S. L. (2018). Social networks and substance use after transitioning into permanent supportive housing. *Drug and Alcohol Dependence, 191*, 63–69. doi:10.1016/j.drugalcdep.2018.06.027

Riper, H., Andersson, G., Hunter, S. B., Wit, J. D., Berking, M., & Cuijpers, P. (2014). Treatment of comorbid alcohol use disorders and depression with cognitive–behavioural therapy and motivational interviewing: A meta-analysis. *Addiction*, *109*(3), 394–406. doi:10.1111/add.12441

Rodriguez, M., Walters, S. T., Houck, J. M., Ortiz, J. A., & Taxman, F. S. (2017). The language of change among criminal justice clients: Counselor language, client language, and client substance use outcomes. *Journal of Clinical Psychology, 74*(4), 626–636. doi:10.1002/jclp.22534

Rogers, C. R. (1980). *A way of being*. Boston, MA: Houghton Mifflin.

Rogers, C. R. (1965). *Client-centered therapy*. New York, NY: Houghton Mifflin.

Rollnick, S., Heather, N., Gold, R., & Hall, W. (1992). Development of a short "readiness to change" questionnaire for use in brief, opportunistic interventions among excessive drinkers. *British Journal of Addiction, 87*, 743–754.

Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational interviewing in health care: Helping patients change behavior*. New York, NY: Guilford.

Romano, M., & Peters, L. (2016). Understanding the process of motivational interviewing: A review of the relational and technical hypotheses. *Psychotherapy Research, 26*(2), 220–240. doi:10.1080/10503307.2014.954154

Rosengren, D. B. (2018). *Building motivational interviewing skills: A practitioner workbook* (2nd ed.). New York, NY: Guilford Press.

Running Bear, U. R., Beals, J., Novins, D. K., & Manson, S. M. (2017). Alcohol detoxification completion, acceptance of referral to substance abuse treatment, and entry into substance abuse treatment among Alaska Native people. *Addictive Behaviors, 65*, 25–32. doi:10.1016/j.addbeh.2016.09.009

Samson, J. E., & Tanner-Smith, E. E. (2015). Single-session alcohol interventions for heavy drinking college students: A systematic review and meta-analysis. *Journal of Studies on Alcohol and Drugs, 76*(4), 530–543.

Sarpavaara, H. (2015). Significant others in substance abusers change talk during motivational interviewing sessions in the Finnish Probation Service. *Nordic Studies on Alcohol and Drugs, 32*(1), 91–103. doi:10.1515/nsad-2015-0010

Satre, D. D., Delucchi, K., Lichtmacher, J., Sterling, S. A., & Weisner, C. (2013). Motivational interviewing to reduce hazardous drinking and drug use among depression patients. *Journal of Substance Abuse Treatment*, *44*(3), 323–329.

Satre, D. D., Leibowitz, A., Sterling, S. A., Lu, Y., Travis, A., & Weisner, C. (2016). A randomized clinical trial of motivational interviewing to reduce alcohol and drug use among patients with depression. *Journal of Consulting and Clinical Psychology, 84*(7), 571–579.

Satre, D. D., Manuel, J. K., Larios, S., Steiger, S., & Satterfield, J. (2015). Cultural adaptation of screening, brief intervention and referral to treatment using motivational interviewing. *Journal of Addiction Medicine, 9*(5), 352–357. doi:10.1097/adm.0000000000000149

Sayegh, C. S., Huey, S. J., Zara, E. J., & Jhaveri, K. (2017). Follow-up treatment effects of contingency management and motivational interviewing on substance use: A meta-analysis. *Psychology of Addictive Behaviors, 31*(4), 403–414. doi:10.1037/adb0000277

Schonfeld, L., King-Kallimanis, B. L., Duchene, D. M., Etheridge, R. L., Herrera, J. R., Barry, K. L., & Lynn, N. (2010). Screening and brief intervention for substance misuse among older adults: The Florida BRITE project. *American Journal of Public Health*, *100*(1), 108–114.

Schumacher, J. A., Williams, D. C., Burke, R. S., Epler, A. J., Simon, P., & Coffey, S. F. (2018). Competency-based supervision in motivational interviewing for advanced psychology trainees: Targeting an a priori benchmark. *Training and Education in Professional Psychology, 12*(3), 149–153. doi:10.1037/tep0000177

Schwalbe, C. S., Oh, H. Y., & Zweben, A. (2014). Sustaining motivational interviewing: A meta-analysis of training studies. *Addiction, 109*(8), 1287–1294. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.1111/add.12558

Scott, C. K., Dennis, M. L., & Lurigio, A. J. (2017). The effects of specialized probation and recovery management checkups (RMCs) on treatment participation, substance use, HIV risk behaviors, and recidivism among female offenders: Main findings of a 3-year experiment using subject by intervention interaction analysis. *Journal of Experimental Criminology*, *13*(1), 53–77.

Shepard, D. S., Lwin, A. K., Barnett, N. P., Mastroleo, N., Colby, S. M., Gwaltney, C., & Monti, P. M. (2016). Cost-effectiveness of motivational intervention with significant others for patients with alcohol misuse. *Addiction, 111*(5), 832–839. doi:10.1111/add.13233

Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behavior, 7*(4), 363–371.

Smedslund, G., Berg, R. C., Hammerstrom, K. T., Steiro, A., Leiknes, K. A., Dahl, H. M., & Karlsen, K. (2011). Motivational interviewing for substance abuse. *Cochrane Database of Systematic Reviews, 5*, CD008063

Smeerdijk, M., Keet, R., Raaij, B. V., Koeter, M., Linszen, D., Haan, L. D., & Schippers, G. (2015). Motivational interviewing and interaction skills training for parents of young adults with recent-onset schizophrenia and co-occurring cannabis use: 15-month follow-up. *Psychological Medicine, 45*(13), 2839–2848. doi:10.1017/s0033291715000793

Soderlund, P. D. (2017). Effectiveness of motivational interviewing for improving physical activity self-management for adults with type 2 diabetes: A review. *Chronic Illness, 14*(1), 54–68. doi:10.1177/1742395317699449

Steinberg, M. L., Williams, J. M., Stahl, N. F., Budsock, P. D., & Cooperman, N. A. (2015). An adaptation of motivational interviewing increases quit attempts in smokers with serious mental illness. *Nicotine and Tobacco Research, 18*(3), 243–250. doi:10.1093/ntr/ntv043

Stinson, J. D., & Clark, M. D. (2017). *Motivational interviewing with offenders: Engagement, rehabilitation, and reentry*. New York, NY: Guilford Press.

Substance Abuse and Mental Health Services Administration. (2019). *Mental health and substance use disorders*. Retrieved from www.samhsa.gov/find-help/disorders

Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health.* HHS Publication No. (SMA) 18-5068, NSDUH Series H-53. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from www.samhsa.gov/data/

Substance Abuse and Mental Health Services Administration. (2016). *Criteria for the demonstration program to improve community mental health centers and to establish certified community behavioral health clinics*. Retrieved from Retrieved from www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

Substance Abuse and Mental Health Services Administration. (2015a). *Substance abuse treatment and family therapy.* Treatment Improvement Protocol (TIP) Series 39. HHS Publication No. (SMA) 15-4219. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/product/TIP-39-Substance-Abuse-Treatment-and-Family-Therapy/SMA15-4219

Substance Abuse and Mental Health Services Administration. (2015b). *Using technology-based therapeutic tools in behavioral health services.* Treatment Improvement Protocol (TIP) Series 60. HHS Publication No. (SMA) 15-4924. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/product/TIP-60-Using-Technology-Based-Therapeutic-Tools-in-Behavioral-Health-Services/SMA15-4924

Substance Abuse and Mental Health Services Administration. (2014a). *Improving cultural competence*. Treatment Improvement Protocol (TIP) Series 59. HHS Publication No. (SMA) 14-4849. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849

Substance Abuse and Mental Health Services Administration. (2014b). *Trauma-informed care in behavioral health services.* Treatment Improvement Protocol (TIP) Series 60. HHS Publication No. (SMA) 14-4816. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Substance Abuse and Mental Health Services Administration. (2013). *Substance abuse treatment for persons with co-occurring disorders.* Treatment Improvement Protocol (TIP) Series 42. HHS Publication No. (SMA) 13-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

Substance Abuse and Mental Health Services Administration. (2009). *Clinical supervision and professional development of the substance abuse counselor*. Treatment Improvement Protocol (TIP) Series 52. HHS Publication (SMA) 14–4435. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/product/TIP-52-Clinical-Supervision-and-Professional-Development-of-the-Substance-Abuse-Counselor/SMA14-4435.html

Substance Abuse and Mental Health Services Administration. (planned). *Treating addiction in older adults.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies. (2017). *Words matter: How language choice can reduce stigma*. Retrieved from https://facesandvoicesofrecovery.org/wp-content/uploads/2019/06/Words-Matter-How-Language-Choice-Can-Reduce-Stigma.pdf

Substance Abuse and Mental Health Services Administration & National Institute on Alcohol Abuse and Alcoholism. (2015). *Medication for the treatment of alcohol use disorder: A brief guide.* HHS Publication No. (SMA) 15-4907. Retrieved from Rockville, MD. Retrieved from https://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907

Taleff, M.J. (1997). *A handbook to assess and treat resistance in chemical dependency.* Dubuque, IA: Kendall/Hunt.

Tanner-Smith, E. E., & Lipsey, M. W. (2015). Brief alcohol interventions for adolescents and young adults: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment*, *51*, 1–18.

Teeson, M., Marel, C., Darke, S., Ross, J., Slade, T., Burns, L., … Mills, K. L. (2015). Long-term mortality, remission, criminality and psychiatric comorbidity of heroin dependence: 11-year findings from the Australian Treatment Outcome Study. *Addiction, 110*(6), 986–983.

Timko, C., Kong, C., Vittorio, L., & Cucciare, M. A. (2016). Screening and brief intervention for unhealthy substance use in patients with chronic medical conditions: A systematic review. *Journal of Clinical Nursing, 25*(21–22), 3131–3143. doi:10.1111/jocn.13244

Truax, C. B., & Carkhuff, R. R. (1967). *Toward effective counseling and psychotherapy.* Chicago, IL: Aldine.

Turner, B., & Deane, F. P. (2016). Length of stay as a predictor of reliable change in psychological recovery and well-being following residential substance abuse treatment. *Therapeutic Communities, 37*(3), 112–120. doi:10.1108/tc-09-2015-0022

Van Horn, D. H., Drapkin, M., Lynch, K. G., Rennert, L., Goodman, J. D., Thomas, T., … McKay, J. R. (2015). Treatment choices and subsequent attendance by substance-dependent patients who disengage from intensive outpatient treatment. *Addiction Research and Theory*, *23*(5), 391–403.

Vella-Zarb, R. A., Mills, J. S., Westra, H. A., Carter, J. C., & Keating, L. (2014). A randomized controlled trial of motivational interviewing self-help versus psychoeducation self-help for binge eating. *International Journal of Eating Disorders, 48*(3), 328–332. doi:10.1002/eat.22242

Venner, K. L., Feldstein, S. W., & Tafoya, N. (2006). *Native American motivational interviewing: Weaving Native American and Western practices*. Retrieved from www.integration.samhsa.gov/clinical-practice/Native_American_MI_Manual.pdf

Venner, K. L., Sánchez, V., Garcia, J., Williams, R. L., & Sussman, A. L. (2018). Moving away from the tip of the pyramid: Screening and brief intervention for risky alcohol and opioid use in underserved patients. *Journal of the American Board of Family Medicine, 31*(2), 243–251.

Wagner, A. J., Garbers, R., Lang, A., Borgert, A. J., & Fisher, M. (2016). Increasing follow-up outcomes of at-risk alcohol patients using motivational interviewing. *Journal of Trauma Nursing, 23*(3), 165–168. doi:10.1097/jtn.0000000000000200

Wagner, C. C., & Ingersoll, K. S. (2017). Development and initial validation of the Assessment of Motivational Interviewing Groups—Observer Scales (AMIGOS). *International Journal of Group Psychotherapy, 68*(1), 69–79. doi:10.1080/00207284.2017.1315587

Wagner, C. C., & Ingersoll, K. S. (2013). *Motivational interviewing in groups*. New York, NY: Guilford Press.

Walker, D. D., Walton, T. O., Neighbors, C., Kaysen, D., Mbilinyi, L., Darnell, J., … Roffman, R. A. (2017). Randomized trial of motivational interviewing plus feedback for soldiers with untreated alcohol abuse. *Journal of Consulting and Clinical Psychology, 85*(2), 99–110. doi:10.1037/ccp0000148

White, W. L. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America* (2nd ed.). Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.

White, W., & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor, 8*(4), 12–30.

Wild, T. C., Yuan, Y., Rush, B. R., & Urbanoski, K. A. (2016). Client engagement in legally mandated addiction treatment: A prospective study using self-determination theory. *Journal of Substance Abuse Treatment*, *69*, 35–43. doi:10.1016/j.jsat.2016.06.006

Witkiewitz, K., & Marlatt, G. A. (Eds.). (2007). *Therapist's guide to evidence-based relapse prevention.* Boston, MA: Elsevier Academic Press.

Wong-Anuchit, C., Chantamit-O-Pas, C., Schneider, J. K., & Mills, A. C. (2018). Motivational interviewing–based compliance/adherence therapy interventions to improve psychiatric symptoms of people with severe mental illness: Meta-analysis. *Journal of the American Psychiatric Nurses Association,* 107839031876179. doi:10.1177/1078390318761790

Woolard, R., Baird, J., Longabaugh, R., Nirenberg, T., Lee, C. S., Mello, M. J., & Becker, B. (2013). Project Reduce: Reducing alcohol and marijuana misuse, Effects of a brief intervention in the emergency department. *Addictive Behaviors, 38*(3), 1732–1739. doi:10.1016/j.addbeh.2012.09.006

Yeh, M., Tung, T., Horng, F., & Sung, S. (2017). Effectiveness of a psychoeducational programme in enhancing motivation to change alcohol-addictive behaviour. *Journal of Clinical Nursing, 26*(21–22), 3724–3733. doi:10.1111/jocn.13744

Yudko, E., Lozhkina, O., & Fouts, A. (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *Journal of Substance Abuse Treatment, 32,* 189–198.

Appendix B—Screening and Assessment Instruments

Appendix B presents the following tools:

1. U.S. Alcohol Use Disorders Identification Test (U.S. AUDIT)
2. Drug Abuse Screening Test (DAST-10)
3. Drinker Inventory of Consequences (DrInC) (Lifetime)
4. What I Want From Treatment (2.0)
5. Readiness to Change Questionnaire (Treatment Version) (RCQ-TV) (Revised)
6. Stages of Change Readiness and Treatment Eagerness Scale–Alcohol (SOCRATES 8A)
7. Stages of Change Readiness and Treatment Eagerness Scale–Drugs (SOCRATES 8D)
8. University of Rhode Island Change Assessment (URICA) Scale
9. Alcohol and Drug Consequences Questionnaire (ADCQ)
10. Alcohol Decisional Balance Scale
11. Drug Use Decisional Balance Scale
12. Brief Situational Confidence Questionnaire (BSCQ)
13. Alcohol Abstinence Self-Efficacy Scale (AASES)
14. Motivational Interviewing Knowledge Test

1. U.S. Alcohol Use Disorders Identification Test (AUDIT)

Instructions: Alcohol can affect your health and treatment. We ask all clients these questions. Your answers will remain confidential. Circle the best answer to each question. Think about your drinking in the past year. A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

1.How often do you have a drink containing alcohol? (0) Never *[Skip to Questions 9 and 10]* (1) Less than monthly (2) Monthly (3) Weekly (4) 2 to 3 times a week (5) 4 to 6 times a week (6) Daily	**6. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2.How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 (1) 2 (2) 3 (3) 4 (4) 5 to 6 (5) 7 to 9 (6) 10 or more	**7. How often during the last year have you had a feeling of guilt or remorse after drinking?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3.How often do you have X (5 for men; 4 for women and men over age 65) or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) 2-3 times a week (5) 4-6 times a week (6) Daily *[Skip to Questions 9 and 10 if total score for Questions 2 and 3 = 0]*	**8.How often during the last year have you been unable to remember what happened the night before because you had been drinking?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5.How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year

Scoring			
Risk Level	Intervention	USAUDIT Score	Possible AUD (DSM-5, ICD-10)
Zone I	Feedback	0–6/7 (Women/Men)	None
Zone II	Feedback/brief intervention	7/8–15 (Women/Men)	Mild AUD, hazardous use
Zone III	Feedback/monitoring/brief outpatient treatment	16–24	Moderate AUD, harmful use
Zone IV	Referral to evaluation and treatment	25+	Moderate/severe AUD, alcohol dependence
Note: Questions 1 to 3 of U.S. AUDIT have been modified to reflect standard drink size in the United States and differences for men, women, and older adults.			
Source: Babor, Higgins-Biddle, & Robaina, 2016. Adapted from material in the public domain.			

2. Drug Abuse Screening Test (DAST-10)

NAME: ______________________ DATE: ______________

DRUG USE QUESTIONNAIRE (DAST-10)

The following questions concern information about your possible involvement with drugs, not including alcoholic beverages, during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No." Then, circle the appropriate response beside the question.

In the statements, "drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquillizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.	Circle your response	
1. Have you used drugs other than those required for medical reasons?	YES	NO
2. Do you abuse more than one drug at a time?	YES	NO
3. Are you always able to stop using drugs when you want to?	YES	NO
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	YES	NO
5. Do you ever feel bad or guilty about your drug use?	YES	NO
6. Does your spouse (or parents) ever complain about your involvement with drugs?	YES	NO
7. Have you neglected your family because of your use of drugs?	YES	NO
8. Have you engaged in illegal activities in order to obtain drugs?	YES	NO
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	YES	NO
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	YES	NO

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5958a / 03-2019 / PZ074

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Sources: Skinner, 1982. Adapted with permission. Available online at no cost (http://adai.washington.edu/instruments/pdf/Drug_Abuse_Screening_Test_105.pdf).

3. Drinker Inventory of Consequences (DrInC) (Lifetime)

Instructions: Here are a number of events that drinkers sometimes experience. Read each one carefully and circle the number that indicates whether this has *EVER* happened to you (0 = No, 1 = Yes). If an item does not apply to you, circle zero (0).

	Has this *EVER* happened to you? Circle one answer for each item.	**No**	**Yes**
1.	I have had a hangover or felt bad after drinking.	0	1
2.	I have felt bad about myself because of my drinking.	0	1
3.	I have missed days of work or school because of my drinking.	0	1
4.	My family or friends have worried or complained about my drinking.	0	1
5.	I have enjoyed the taste of beer, wine, or liquor.	0	1
6.	The quality of my work has suffered because of my drinking.	0	1
7.	My ability to be a good parent has been harmed by my drinking.	0	1
8.	After drinking, I have had trouble with sleeping, staying asleep, or nightmares.	0	1
9.	I have driven a motor vehicle after having three or more drinks.	0	1
10.	My drinking has caused me to use other drugs more.	0	1
11.	I have been sick and vomited after drinking.	0	1
12.	I have been unhappy because of my drinking.	0	1
13.	Because of my drinking, I have not eaten properly.	0	1
14.	I have failed to do what is expected of me because of my drinking.	0	1
15.	Drinking has helped me to relax.	0	1
16.	I have felt guilty or ashamed because of my drinking.	0	1
17.	While drinking, I have said or done embarrassing things.	0	1
18.	When drinking, my personality has changed for the worse.	0	1
19.	I have taken foolish risks when I have been drinking.	0	1
20.	I have gotten into trouble because of drinking.	0	1
21.	While drinking or using drugs, I have said harsh or cruel things to someone.	0	1
22.	When drinking, I have done impulsive things that I regretted later.	0	1
23.	I have gotten into a physical fight while drinking.	0	1
24.	My physical health has been harmed by my drinking.	0	1
25.	Drinking has helped me to have a more positive outlook on life.	0	1
26.	I have had money problems because of my drinking.	0	1
27.	My marriage or love relationship has been harmed by my drinking.	0	1
28.	I have smoked tobacco more when I am drinking.	0	1
29.	My physical appearance has been harmed by my drinking.	0	1
30.	My family has been hurt by my drinking.	0	1
31.	A friendship or close relationship has been damaged by my drinking.	0	1
32.	I have been overweight because of my drinking.	0	1
33.	My sex life has suffered because of my drinking.	0	1
34.	I have lost interest in activities and hobbies because of my drinking.	0	1
35.	When drinking, my social life has been more enjoyable.	0	1
36.	My spiritual or moral life has been harmed by my drinking.	0	1
37.	Because of my drinking, I have not had the kind of life that I want.	0	1
38.	My drinking has gotten in the way of my growth as a person.	0	1

39.	My drinking has damaged my social life, popularity, or reputation.	0	1
40.	I have spent too much or lost a lot of money because of my drinking.	0	1
41.	I have been arrested for driving under the influence of alcohol.	0	1
42.	I have had trouble with the law (other than driving while intoxicated) because of drinking.	0	1
43.	I have lost a marriage or a close love relationship because of my drinking.	0	1
44.	I have been suspended/fired from or left a job or school because of drinking.	0	1
45.	I drank alcohol normally, without any problems.	0	1
46.	I have lost a friend because of my drinking.	0	1
47.	I have had an accident while drinking or intoxicated.	0	1
48.	While drinking or intoxicated, I have been physically hurt, injured, or burned.	0	1
49.	While drinking or intoxicated, I have injured someone else.	0	1
50.	I have broken things while drinking or intoxicated.	0	1

Physical	Inter-personal	Intra-personal	Impulse Control	Social Responsibility		Control Scale*
1 ____						
		2 ____		3 ____		
	4 ____					5 ____
				6 ____		
	7 ____					
8 ____			9 ____			
			10 ____			
11 ____		12 ____				
13 ____				14 ____		15 ____
		16 ____				
	17 ____	18 ____	19 ____	20 ____		
	21 ____		22 ____			
			23 ____			
24 ____						25 ____
				26 ____		
	27 ____		28 ____			
29 ____	30 ____					
	31 ____		32 ____			
33 ____		34 ____				35 ____
		36 ____				
		37 ____				
		38 ____				
	39 ____			40 ____		
			41 ____			
			42 ____			
	43 ____			44 ____		45 ____
	46 ____		47 ____			
48 ____			49 ____			
			50 ____			
____ Physical	+ ____ Inter-personal	+ ____ Intra-personal	+ ____ Impulse Control	+ ____ Social Responsibility	= ____ Total DrInC Score	____ Control Scale*

Scoring: For each item, copy the circled number from the answer sheet next to the item number above. Then sum each column to calculate scale totals. Sum these totals to calculate the Total DrInC Score.

*Zero scores on Control Scale items may indicate careless or dishonest responses. The Total DrInC Score reflects the overall number of alcohol problems that have occurred during the person's lifetime.

*See the test manual for this instrument for more information about scoring and interpreting the score. It also provides the instruments and scoring information for other versions of DrInC including one for drug use and a short version (SIP) of the instrument for alcohol and drugs.

Source: Miller, Tonigan, & Longabaugh (1995). Adapted from material in the public domain. Available online at no cost (https://pubs.niaaa.nih.gov/publications/projectmatch/match04.pdf).

4. What I Want From Treatment (2.0)

Instructions: People have different ideas about what they want, need, and expect from treatment. This questionnaire is designed to help you explain what you would *like* to have happen in your treatment. Many possibilities are listed. For each one, please indicate how much you would like for this to be part of your treatment. You can do this by circling one number (0, 1, 2, or 3) for each item. This is what the numbers mean:

0 = No Means that you definitely do NOT want or need this from treatment.

1 = ? Means that you are UNSURE. MAYBE you want this from treatment.

2 = Yes Means that you DO want or need this from treatment.

3 = Yes! Means that you DEFINITELY want or need this from treatment.

For example: Consider item #1, which says, "I want to receive detoxification." If you definitely do NOT want or need to receive detoxification, you would circle 0. If you are UNSURE whether you want or need detoxification, you would circle 1. If you DO want detoxification, you would circle 2. If you DEFINITELY know that detoxification is an important goal for your treatment, you would circle 3.

If you have any questions about how to use this questionnaire, ask for assistance before you begin.

Do you want this from treatment?	**No** **0**	**Maybe** **1**	**Yes** **2**	**Yes!** **3**
1. I want to receive detoxification, to ease my withdrawal from alcohol or other drugs.	0	1	2	3
2. I want to find out for sure whether I have a problem with alcohol or other drugs.	0	1	2	3
3. I want help to stop drinking alcohol completely.	0	1	2	3
4. I want help to decrease my drinking.	0	1	2	3
5. I want help to stop using drugs (other than alcohol).	0	1	2	3
6. I want help to decrease my use of drugs (other than alcohol).	0	1	2	3
7. I want to stop using tobacco.	0	1	2	3
8. I want to decrease my use of tobacco.	0	1	2	3
9. I want help with an eating problem.	0	1	2	3
10. I want help with a gambling problem.	0	1	2	3
11. I want to take Antabuse (medication to help stop drinking).	0	1	2	3
12. I want to take Trexan (medication to help stop using heroin).	0	1	2	3
13. I want to take methadone.	0	1	2	3
14. I want to learn more about alcohol/drug problems.	0	1	2	3
15. I want to learn some skills to keep from returning to alcohol or other drugs.	0	1	2	3
16. I would like to learn more about 12-Step programs like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).	0	1	2	3
17. I would like to talk about some personal problems.	0	1	2	3
18. I need to fulfill a requirement of the courts.	0	1	2	3
19. I would like help with problems in my marriage or close relationship.	0	1	2	3
20. I want help with some health problems.	0	1	2	3
21. I want help to decrease my stress and tension.	0	1	2	3
22. I would like to improve my health by learning more about nutrition and exercise.	0	1	2	3

Do you want this from treatment?	**No** **0**	**Maybe** **1**	**Yes** **2**	**Yes!** **3**
23. I want help with depression or moodiness.	0	1	2	3
24. I want to work on my spiritual growth.	0	1	2	3
25. I want to learn how to solve problems in my life.	0	1	2	3
26. I want help with angry feelings and how I express them.	0	1	2	3
27. I want to have healthier relationships.	0	1	2	3
28. I would like to discuss sexual problems.	0	1	2	3
29. I want to learn to express my feelings in a more healthy way.	0	1	2	3
30. I want to learn how to relax better.	0	1	2	3
31. I want help in overcoming boredom.	0	1	2	3
32. I want help with feelings of loneliness.	0	1	2	3
33. I want to discuss having been physically abused.	0	1	2	3
34. I want help to prevent violence at home.	0	1	2	3
35. I want to discuss having been sexually abused.	0	1	2	3
36. I want to work on having better self-esteem.	0	1	2	3
37. I want help with sleep problems.	0	1	2	3
38. I want help with legal problems.	0	1	2	3
39. I want advice about financial problems.	0	1	2	3
40. I would like help in finding a place to live.	0	1	2	3
41. I could use help in finding a job.	0	1	2	3
42. I want help in overcoming shyness.	0	1	2	3
43. Someone close to me died or left; I would like to talk about it.	0	1	2	3
44. I have thoughts about suicide, and I would like to discuss this.	0	1	2	3
45. I want help with personal fears and anxieties.	0	1	2	3
46. I want help to be a better parent.	0	1	2	3
47. I feel very confused and would like help with this.	0	1	2	3
48. I would like information about or testing for HIV/AIDS.	0	1	2	3
49. I want someone to listen to me.	0	1	2	3
50. I want to learn to have fun without drugs or alcohol.	0	1	2	3
51. I want someone to tell me what to do.	0	1	2	3
52. I want help in setting goals and priorities in my life.	0	1	2	3
53. I would like to learn how to manage my time better.	0	1	2	3
54. I want help to receive SSI/disability payments.	0	1	2	3
55. I want to find enjoyable ways to spend my free time.	0	1	2	3
56. I want help in getting my child(ren) back.	0	1	2	3
57. I would like to talk about my past.	0	1	2	3
58. I need help in getting motivated to change.	0	1	2	3
59. I would like to see a female counselor.	0	1	2	3
60. I would like to see a male counselor.	0	1	2	3
61. I would like to see the counselor I had before.	0	1	2	3
62. I would like to see a doctor or nurse about medical problems.	0	1	2	3
63. I want to receive medication.	0	1	2	3
64. I would like my spouse or partner to be in treatment with me.	0	1	2	3
65. I would like to have private, individual counseling.	0	1	2	3

Do you want this from treatment?	**No** **0**	**Maybe** **1**	**Yes** **2**	**Yes!** **3**
66. I would like to be in a group with people who are dealing with problems similar to my own.	0	1	2	3
67. I need childcare while I am in treatment.	0	1	2	3
68. I want my treatment to be short.	0	1	2	3
69. I believe I will need to be in treatment for a long time.	0	1	2	3

Is there anything else you would like from treatment? If so, please write it here.

____

____

____

____

Source: Miller & Brown, 1994. Available online at no cost (https://casaa.unm.edu/inst/What%20I%20Want%20From%20Treatment.pdf).

5. Readiness to Change Questionnaire (Treatment Version) (RCQ-TV) (Revised)

Instructions: The following questions are designed to identify how you personally feel about your drinking right now. Please think about your current situation and drinking habits, even if you have given up drinking completely. Read each question below carefully, and then decide whether you agree or disagree with the statements. Please tick the answer of your choice to each question. If you have any problems, please ask the questionnaire administrator.

Your answers are completely private and confidential.

Key: SD = Strongly disagree; **D** = Disagree; **U** = Unsure; **A** = Agree; **SA** = Strongly agree

	SD	D	U	A	SA	For office use only
1. It's a waste of time thinking about my drinking because I do not have a problem.	❑	❑	❑	❑	❑	PC
2. I enjoy my drinking but sometimes I drink too much.	❑	❑	❑	❑	❑	C
3. There is nothing seriously wrong with my drinking.	❑	❑	❑	❑	❑	PC
4. Sometimes I think I should quit or cut down on my drinking.	❑	❑	❑	❑	❑	C
5. Anyone can talk about wanting to do something about their drinking, but I'm actually doing something about it.	❑	❑	❑	❑	❑	A
6. I am a fairly normal drinker.	❑	❑	❑	❑	❑	PC
7. My drinking is a problem sometimes.	❑	❑	❑	❑	❑	C
8. I am actually changing my drinking habits right now (either cutting down or quitting).	❑	❑	❑	❑	❑	A
9. I have started to carry out a plan to cut down or quit drinking.	❑	❑	❑	❑	❑	A
10. There is nothing I really need to change about my drinking.	❑	❑	❑	❑	❑	PC
11. Sometimes I wonder if my drinking is out of control.	❑	❑	❑	❑	❑	C

12. I am actively working on my drinking problem.	❑	❑ ❑	❑ ❑		A

For Office Use Only

Please enter the subject's scores below:

Scale Scores

PC Score ________

C Score ________

A Score ________

Scoring: The scale score codes represent each of the Stages of Change:

- Items numbered 1,3,6,10 = Precontemplation (PC)
- Items numbered 2,4,7,11 = Contemplation (C)
- Items numbered 5,8,9,12 = Action (A)

All items should be scored on a 5-point scale ranging from:

-2 = Strongly Disagree

-1 = Disagree

0 = Unsure

+1 = Agree

+2 = Strongly Agree

To calculate the score for each scale, simply add the item scores for the scale in question. The range of each scale is -10 through 0 to +10. A negative scale score reflects an overall disagreement with items measuring the stage of change, whereas a positive score represents overall agreement. The highest scale score represents the Stage of Change Designation.

If two or more scale scores are equal, then the scale farther along the continuum of change (Precontemplation-Contemplation-Action) represents the subject's Stage of Change Designation. For example, if a subject scores 6 on the Precontemplation scale, 6 on the Contemplation scale and -2 on the Action scale, then the subject is assigned to the Contemplation stage.

If one of the five items on a scale is missing, the subject's score for that scale should be prorated (i.e., multiplied by 4/3 or 1.33). If two or more items are missing, the scale score cannot be calculated. In this case the Stage of Change Designation will be invalid.

Source: Heather & Honekopp, 2008. Adapted with permission. Source article and questionnaire are available online at no cost (https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.019.pdf).

6. Stages of Change Readiness and Treatment Eagerness Scale–Alcohol (SOCRATES 8A)

Instructions: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5 to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	No! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	Yes! Strongly Agree
1. I really want to make changes in my drinking.	1	2	3	4	5
2. Sometimes I wonder if I am an alcoholic.	1	2	3	4	5
3. If I don't change my drinking soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my drinking.	1	2	3	4	5
5. I was drinking too much at one time, but I've managed to change my drinking.	1	2	3	4	5
6. Sometimes I wonder if my drinking is hurting other people.	1	2	3	4	5
7. I am a problem drinker.	1	2	3	4	5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10. I have serious problems with drinking.	1	2	3	4	5
11. Sometimes I wonder if I am in control of my drinking.	1	2	3	4	5
12. My drinking is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop drinking.	1	2	3	4	5
14. I want help to keep from going back to the drinking problems that I had before.	1	2	3	4	5
15. I know that I have a drinking problem.	1	2	3	4	5
16. There are times when I wonder if I drink too much.	1	2	3	4	5
17. I am an alcoholic.	1	2	3	4	5
18. I am working hard to change my drinking.	1	2	3	4	5
19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.	1	2	3	4	5

See the scoring and interpretation information presented in the SOCRATES 8D tool below for the SOCRATES 8A tool presented on this page.

7. Stages of Change Readiness and Treatment Eagerness Scale–Drug (SOCRATES 8D)

Instructions: Please read the following statements carefully. Each describes a way you might (or might not) feel *about your drug use*. For each statement, circle one number from 1 to 5 to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for each statement.

	No! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	Yes! Strongly Agree
1. I really want to make changes in my use of drugs.	1	2	3	4	5
2. Sometimes I wonder if I am an addict.	1	2	3	4	5
3. If I don't change my drug use soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my use of drugs.	1	2	3	4	5
5. I was using drugs too much at one time, but I've managed to change that.	1	2	3	4	5
6. Sometimes I wonder if my drug use is hurting other people.	1	2	3	4	5
7. I have a drug problem.	1	2	3	4	5
8. I'm not just thinking about changing my drug use, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10. I have serious problems with drugs.	1	2	3	4	5
11. Sometimes I wonder if I am in control of my drug use.	1	2	3	4	5
12. My drug use is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop my use of drugs.	1	2	3	4	5
14. I want help to keep from going back to the drug problems that I had before.	1	2	3	4	5
15. I know that I have a drug problem.	1	2	3	4	5
16. There are times when I wonder if I use drugs too much.	1	2	3	4	5
17. I am a drug addict.	1	2	3	4	5
18. I am working hard to change my drug use.	1	2	3	4	5
19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.	1	2	3	4	5

SOCRATES Scoring Form (19-Item Version 8A & 8D): Transfer the client's answers from questionnaire:

Recognition (Re)	Ambivalence (Am)	Taking Steps (Ts)
1 ________	2 ________	4 ________
3 ________		5 ________
	6 ________	
7 ________		8 ________
		9 ________
10 ________	11 ________	
12 ________		13 ________
		14 ________

	15 ________	16 ________	
	17 ________		18 ________
			19 ________
Totals:	Re: ________	Am: ________	Ts: ________
Possible Range:	**7–35**	**4–20**	**8–40**

SOCRATES Profile Sheet (19-Item Version 8A & 8D)

Instructions: From the SOCRATES Scoring Form above (19-Item Version) transfer the Totals to the appropriate Raw Scores cells below. Then for each scale, CIRCLE the same value above it to determine the decile range.

Decile Scores	Recognition	Ambivalence	Taking Steps
90 (Very High)		19–20	39–40
80		18	37–38
70 (High)	35	17	36
60	34	16	34–35
50 (Medium)	32–33	15	33
40	31	14	31–32
30 (Low)	29–30	12–13	30
20	27–28	9–11	26–29
10 (Very Low)	7–26	4–8	8–25
Raw Scores (from Scoring Sheet)	Re=	Am=	Ts=

These interpretive ranges are based on a sample of 1,726 adult men and women presenting for treatment of alcohol problems through Project MATCH. Note that individual scores are therefore being ranked as low, medium, or high *relative to people already presenting for alcohol treatment.*

Guidelines for Interpretation of SOCRATES-8A Scores: Using the SOCRATES Profile Sheet, circle the client's Raw Score within each of the three columns. This provides information as to whether the client's scores are low, average, or high *relative to people already seeking treatment for alcohol problems.* The following descriptions are provided as general guidelines for interpretation of scores, but it is wise in an individual case also to examine individual item responses for additional information. The information should be adjusted as necessary when addressing drug problems.

Recognition	High scorers directly acknowledge that they are having problems related to their drinking, tending to express a desire for change and to perceive that harm will continue if they do not change.
	Low scorers deny that alcohol is causing them serious problems, reject diagnostic labels such as "problem drinker" and "alcoholic," and do not express a desire for change.
Ambivalence	High scorers say that they sometimes *wonder* if they are in control of their drinking, are drinking too much, are hurting other people, and/or are alcoholic. Thus a high score reflects ambivalence or uncertainty. A high score here reflects some openness to reflection, as might be particularly expected in the Contemplation stage of change.
	Low scorers say that they *do not wonder* whether they drink too much, are in control, are hurting others, or are alcoholic. Note that a person may score low on ambivalence either because they "know" their drinking is causing problems (high Recognition), or because they "know" that they do not have drinking problems (low Recognition). Thus a low Ambivalence score should be interpreted in relation to the Recognition score.
Taking Steps	High scorers report that they are already doing things to make a positive change in their drinking and may have experienced some success in this regard. Change is underway, and they may want help to persist or to prevent backsliding. A high score on this scale has been found to be predictive of successful change.

	Low scorers report that they are not currently doing things to change their drinking, and have not made such changes recently.
Source: Miller & Tonigan, 1996. SOCRATES-8A and SOCRATES-8D are in the public domain and available online at no cost (https://casaa.unm.edu/inst/socratesv8.pdf).	

8. University of Rhode Island Change Assessment (URICA) Scale

Instructions: Each statement below describes how a person might feel when starting therapy or approaching problems in his life. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all the statements that refer to your "problem," answer in terms of problems related to your drinking (or illicit drug use). The words "here" and "this place" refer to your treatment center.

There are five possible responses to each of the items in the questionnaire:

1 = Strongly Disagree
2 = Disagree
3 = Undecided
4 = Agree
5 = Strongly Agree

Circle the number that best describes how much you agree or disagree with each statement.

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. As far as I'm concerned, I don't have any problems that need changing.	1	2	3	4	5
2. I think I might be ready for some self-improvement.	1	2	3	4	5
3. I am doing something about the problems that had been bothering me.	1	2	3	4	5
4. It might be worthwhile to work on my problem.	1	2	3	4	5
5. I'm not the problem one. It doesn't make much sense for me to consider changing.	1	2	3	4	5
6. It worries me that I might slip back on a problem I have already changed, so I am looking for help.	1	2	3	4	5
7. I am finally doing some work on my problem.	1	2	3	4	5
8. I've been thinking that I might want to change something about myself.	1	2	3	4	5
9. I have been successful in working on my problem, but I'm not sure I can keep up the effort on my own.	1	2	3	4	5
10. At times my problem is difficult, but I'm working on it.	1	2	3	4	5
11. Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
12. I'm hoping that I will be able to understand myself better.	1	2	3	4	5
13. I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
14. I am really working hard to change.	1	2	3	4	5
15. I have a problem, and I really think I should work on it.	1	2	3	4	5

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
16. I'm not following through with what I had already changed as well as I had hoped, and I want to prevent a relapse of the problem.	1	2	3	4	5
17. Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
18. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
19. I wish I had more ideas on how to solve my problem.	1	2	3	4	5
20. I have started working on my problem, but I would like help.	1	2	3	4	5
21. Maybe this place will be able to help me.	1	2	3	4	5
22. I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5
23. I may be part of the problem, but I don't really think I am.	1	2	3	4	5
24. I hope that someone will have some good advice for me.	1	2	3	4	5
25. Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
26. All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5
27. I'm here to prevent myself from having a relapse of my problem.	1	2	3	4	5
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
29. I have worries, but so does the next guy. Why spend time thinking about them?	1	2	3	4	5
30. I am actively working on my problem.	1	2	3	4	5
31. I would rather cope with my faults than try to change them.	1	2	3	4	5
32. After all I had done to try to change my problem, every now and again it comes back to haunt me.	1	2	3	4	5

Scoring

Precontemplation items	1, 5, 11, 13, 23, 26, 29, 31
Contemplation items	2, 4, 8, 12, 15, 19, 21, 24
Action items	3, 7, 10, 14, 17, 20, 25, 30
Maintenance items	6, 9, 16, 18, 22, 27, 28, 32

High scores on a SOC subscale indicate that the respondent is likely in that SOC. However, the SOC subscales are designed to be a continuous measure, therefore, the stages are not discrete and respondents can score high on more than one of the four stages.

Source: McConnaghy, Prochaska, & Velcier, 1983. Reprinted from material in the public domain. Available online at no cost (https://web.uri.edu/cprc/psychotherapy-urica).

9. Alcohol and Drug Consequences Questionnaire (ADCQ)

Instructions: There can be good and bad consequences to any change. These consequences may not be the same for everyone. In thinking about your decision to change your alcohol or drug use, we would like to know what consequences are important to you. This is not a test: There are no right or wrong answers. We simply want to know what you think.

My primary problem drug is (write in name of primary drug, e.g., alcohol, cocaine)

____

All questions below refer to my primary drug use.

When I consider stopping or cutting down my primary drug use, the following reasons are important to me. "IF I STOP OR CUT DOWN . . . ."

Circle the number which applies to you.

Item	Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important	Not Applicable
1. I will feel better physically.	1	2	3	4	5	0
2. I will have difficulty relaxing.	1	2	3	4	5	0
3. I will change a lifestyle I enjoy.	1	2	3	4	5	0
4. I will have fewer problems with my family.	1	2	3	4	5	0
5. I will feel frustrated and anxious.	1	2	3	4	5	0
6. I will have more money to do other things with.	1	2	3	4	5	0
7. I will be more active and alert.	1	2	3	4	5	0
8. I will get depressed.	1	2	3	4	5	0
9. I will have fewer problems with friends.	1	2	3	4	5	0
10. I will feel better about myself.	1	2	3	4	5	0
11. I will regain some self-respect.	1	2	3	4	5	0
12. I will accomplish more of the things I want to get done.	1	2	3	4	5	0
13. I will have a better relationship with my family.	1	2	3	4	5	0
14. I will have difficulty coping with my problems.	1	2	3	4	5	0
15. I will feel withdrawal or craving.	1	2	3	4	5	0
16. I will have too much time on my hands.	1	2	3	4	5	0
17. I will have difficulty not drinking or using drugs.	1	2	3	4	5	0
18. My health will improve.	1	2	3	4	5	0
19. I will live longer.	1	2	3	4	5	0
20. I will be more in control of life.	1	2	3	4	5	0
21. I will feel bored.	1	2	3	4	5	0
22. I will be irritable.	1	2	3	4	5	0
23. I will be more financially stable.	1	2	3	4	5	0
24. I will miss the taste.	1	2	3	4	5	0

Item	Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important	Not Applicable
25. I will have a better relationship with my friends.						
26. I will feel stressed out.	1	2	3	4	5	0
27. I will save more money.	1	2	3	4	5	0
28. I will miss the feeling of being high.	1	2	3	4	5	0

Scoring: Scale scores are derived by summing benefits and cost items, dividing by the maximum possible subscale score, and multiplying by 100.

Benefits Score: Total the scores on items 1, 4, 6, 7, 9, 10, 11, 12, 13, 18, 19, 20, 23, 25, and 27. Divide the total score by the maximum score of 75 (15 items X 5). Multiple by 100. Score: ______

Costs Score: Total the scores on items 2, 3, 5, 8, 14, 15, 16, 17, 21, 22, 24, 26, and 28. Divide the total score by the maximum score of 65 (13 items X 5). Multiple by 100. Score: ______

Source: Cunningham, Sobell, Gavin, Sobell, & Breslin, 1997. Adapted with permission.

10. Alcohol Decisional Balance Scale

Client ID#: _________________ Date: ______/______/______ Assessment Point: _____________

Instructions: The following statements may play a part in making a decision about using alcohol. We would like to know how important each statement is to you at the present time in relation to making a decision about your using alcohol. Please rate the level of importance to each statement on the following 5 points:

1 = Not important at all
2 = Slightly important
3 = Moderately important
4 = Very important
5 = Extremely important

Please read each statement and circle the number on the right to indicate how you rate its level of importance as it relates to your making a decision about whether to drink at the present time.

How important is this to me?	Not at All	Slightly	Moderately	Very	Extremely
1. My drinking causes problems with others.	1	2	3	4	5
2. I like myself better when I am drinking.	1	2	3	4	5
3. Because I continue to drink some people think I lack the character to quit.	1	2	3	4	5
4. Drinking helps me deal with problems.	1	2	3	4	5
5. Having to lie to others about my drinking bothers me.	1	2	3	4	5
6. Some people try to avoid me when I drink.	1	2	3	4	5
7. Drinking helps me to have fun and socialize.	1	2	3	4	5
8. Drinking interferes with my functioning at home or/and at work.	1	2	3	4	5
9. Drinking makes me more of a fun person.	1	2	3	4	5
10. Some people close to me are disappointed in me because of my drinking.	1	2	3	4	5
11. Drinking helps me to loosen up and express myself.	1	2	3	4	5
12. I seem to get myself into trouble when drinking.	1	2	3	4	5
13. I could accidentally hurt someone because of my drinking.	1	2	3	4	5
14. Not drinking at a social gathering would make me feel too different.	1	2	3	4	5
15. I am losing the trust and respect of my coworkers and/or spouse because of my drinking.	1	2	3	4	5
16. My drinking helps give me energy and keeps me going.	1	2	3	4	5
17. I am more sure of myself when I am drinking.	1	2	3	4	5
18. I am setting a bad example for others with my drinking.	1	2	3	4	5
19. Without alcohol, my life would be dull and boring.	1	2	3	4	5

How important is this to me?	Not at All	Slightly	Moderately	Very	Extremely
20. People seem to like me better when I am drinking.	1	2	3	4	5

Scoring:

Pros of Drinking	Cons of Drinking
2, 4, 7, 9, 11, 14, 16, 17, 19, 20	1, 3, 5, 6, 8, 10, 12, 13, 15, 18

To get the average number of Pros endorsed, add up the total number of points from the items and divide by 10. Pros of drinking alcohol (2+4+7+9+11+14+16+17+19+20) / (10 possible items for drinking) = Sum of items

To get the average number of Cons endorsed, add up the total number of points from the items and divide by 10. Cons of drinking alcohol (1+3+5+6+8+10+12+13+15+18) / (10 possible items for not drinking) = Sum of items

To calculate the difference score, subtract the Cons from the Pros. If the number is positive, the individual is endorsing more Pros than Cons for drinking alcohol or using drugs. If the number is negative, the individual is endorsing more Cons then Pros for drinking alcohol.

Source: Prochaska et al., 1994. Reprinted from material in the public domain. Available online at no cost (https://habitslab.umbc.edu/files/2014/07/Alcohol-Decisional-Balance-scale.pdf).

11. Drug Use Decisional Balance Scale

Client ID#: _________________ Date: ______/______/______ Assessment Point: _____________

Instructions: The following statements may play a part in making a decision about using drugs. We would like to know how important each statement is to you at the present time in relation to making a decision about your using drugs. Please rate the level of importance to each statement on the following 5 points:

1=Not important at all
2=Slightly important
3=Moderately important
4=Very important
5=Extremely important
Please read each statement and circle the number on the right to indicate how you rate its level of importance as it relates to your making a decision about whether to use drugs at the present time

How important is this to me?	Not at All	Slightly	Moderately	Very	Extremely
1. My drug use causes problems with others.	1	2	3	4	5
2. I like myself better when I am using drugs.	1	2	3	4	5
3. Because I continue to use drugs some people think I lack the character to quit.	1	2	3	4	5
4. Using drugs helps me deal with problems.	1	2	3	4	5
5. Having to lie to others about my drug use bothers me.	1	2	3	4	5
6. Some people try to avoid me when I use drugs.	1	2	3	4	5
7. Drug use helps me to have fun and socialize.	1	2	3	4	5
8. Drug use interferes with my functioning at home or/and at work.	1	2	3	4	5
9. Drug use makes me more of a fun person.	1	2	3	4	5
10. Some people close to me are disappointed in me because of my drug use.	1	2	3	4	5
11. Drug use helps me to loosen up and express myself.	1	2	3	4	5
12. I seem to get myself into trouble when I use drugs.	1	2	3	4	5
13. I could accidentally hurt someone because of my drug use.	1	2	3	4	5
14. Not using drugs at a social gathering would make me feel too different.	1	2	3	4	5
15. I am losing the trust and respect of my coworkers and/or spouse because of my drug use.	1	2	3	4	5
16. My drug use helps give me energy and keeps me going.	1	2	3	4	5
17. I am more sure of myself when I am using drugs.	1	2	3	4	5
18. I am setting a bad example for others with my drug use.	1	2	3	4	5
19. Without drugs, my life would be dull and boring.	1	2	3	4	5
20. People seem to like me better when I use drugs.	1	2	3	4	5

Scoring:

Pros of Using Drugs	Cons of Using Drugs
2, 4, 7, 9, 11, 14, 16, 17, 19, 20	1, 3, 5, 6, 8, 10, 12, 13, 15, 18

To get the average number of Pros endorsed, add up the total number of points from the items and divide by 10. Pros of drug use (2+4+7+9+11+14+16+17+19+20) / (10 possible items for using drugs)= Sum of items

To get the average number of Cons endorsed, add up the total number of points from the items and divide by 10. Cons of drug use (1+3+5+6+8+10+12+13+15+18) / (10 possible items for not using drugs) = Sum of items

To calculate the difference score, subtract the Cons from the Pros. If the number is positive, the individual is endorsing more Pros than Cons for using drugs. If the number is negative, the individual is endorsing more Cons then Pros for using drugs.

Source: Prochaska et al., 1994. Reprinted from material in the public domain. Available online at no cost (https://habitslab.umbc.edu/files/2014/07/Drug-Decisional-Balance-scale20item.pdf).

12. Brief Situational Confidence Questionnaire (BSCQ)

Name: ________________________________ Date:_________________________

Instructions: Listed below are eight types of situations in which some people experience an alcohol or drug problem. Imagine yourself as you are right now in each of the following types of situations. Indicate on the scale provided how confident you are right now that you will be able to resist drinking heavily or resist the urge to use your primary drug in each situation by placing an "X" along the line, from 0% "Not at all confident" to 100% "Totally confident."

Right now I would be able to resist the urge to drink heavily or use my primary drug in situations involving…

1. UNPLEASANT EMOTIONS (e.g., if I were depressed about things in general; if everything were going badly for me).

I feel… |————————————————————|

0% Not at all confident — 100% Totally confident

2. PHYSICAL DISCOMFORT (e.g., if I were to have trouble sleeping; if I felt jumpy and physically tense).

I feel… |————————————————————|

0% Not at all confident — 100% Totally confident

3. PLEASANT EMOTIONS (e.g., if something good happened and I felt like celebrating; if everything were going well).

I feel… |————————————————————|

0% Not at all confident — 100% Totally confident

Right now I would be able to resist the urge to drink heavily or use my primary drug in situations involving…

4. TESTING CONTROL OVER MY USE OF ALCOHOL OR DRUGS (e.g., if I were to start to believe that alcohol or drugs were no longer a problem for me; if I felt confident that I could handle drugs or several drinks).

I feel… |————————————————————|

0% Not at all confident — 100% Totally confident

5. URGES AND TEMPTATIONS (e.g., if I suddenly had an urge to drink or use drugs; if I were in a situation where I had often used drugs or drank heavily).

I feel… |————————————————————|

0% Not at all confident — 100% Totally confident

6. CONFLICT WITH OTHERS (e.g., if I had an argument with a friend; if I were not getting along well with others at work).

I feel… |————————————————————|

0% Not at all confident — 100% Totally confident

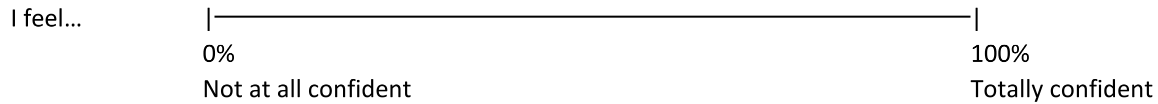
7. SOCIAL PRESSURE TO USE (e.g., if someone were to pressure me to "be a good sport" and drink or use drugs with him; if I were invited to someone's home and he offered me a drink or drugs).

I feel… |————————————————————|

0% — 100%

Not at all confident Totally confident

8. PLEASANT TIMES WITH OTHERS (e.g., if I wanted to celebrate with a friend; if I were enjoying myself at a party and wanted to feel even better).



Scoring: Each of the 8 scales produces a score from 0% to 100 %. Identify 1 to 3 situations where the client has the lowest confidence rating for further discussion.

Instructions for presenting findings to clients are available online (www.nova.edu/gsc/forms/BSCQ%20Instructions.pdf).

A blank self-confidence profile chart is available online (www.nova.edu/gsc/forms/BSCQ%20blank.pdf).

Source: Bresslin, Sobell, & Sobell, 2000. Adapted from material in the public domain.

13. Alcohol Abstinence Self-Efficacy Scale (AASES)

Name: ______________________________________ Date: __ __ / __ __ / __ __ __ __

Instructions: Listed below are a number of situations that lead some people to use alcohol. We would like to know how confident you are that you would not drink alcohol in each situation.

Circle the number that best describes your feelings of confidence not to drink alcohol in each situation during the past week according to the following scale:

1 = Not at all confident
2 = Not very confident
3 = Moderately confident
4 = Very confident
5 = Extremely confident

Situation	Confident not to drink alcohol				
	Not at all	Not very	Moderately	Very	Extremely
1) When I am in agony because of stopping or withdrawing from alcohol use.	1	2	3	4	5
2) When I have a headache.	1	2	3	4	5
3) When I am feeling depressed.	1	2	3	4	5
4) When I am on vacation and want to relax.	1	2	3	4	5
5) When I am concerned about someone.	1	2	3	4	5
6) When I am worried.	1	2	3	4	5
7) When I have the urge to try just one drink to see what happens.	1	2	3	4	5
8) When I am being offered a drink in a social situation.	1	2	3	4	5
9) When I dream about taking a drink.	1	2	3	4	5
10) When I want to test my will power over drinking.	1	2	3	4	5

11) When I am feeling a physical need or craving for alcohol.	1	2	3	4	5
12) When I am physically tired.	1	2	3	4	5
13) When I am experiencing some physical pain or injury.	1	2	3	4	5
14) When I feel like blowing up because of frustration.	1	2	3	4	5
15) When I see others drinking at a bar or a party.	1	2	3	4	5
16) When I sense everything is going wrong for me.	1	2	3	4	5
17) When people I used to drink with encourage me to drink.	1	2	3	4	5
18) When I am feeling angry inside.	1	2	3	4	5
19) When I experience an urge or impulse to take a drink that catches me unprepared.	1	2	3	4	5
20) When I am excited or celebrating with others.	1	2	3	4	5

Scoring:

Subscale	**Item Number**
Negative Affect	1,3,9
Social/Positive	10,11,12
Physical and Other Concerns	2,7,8
Cravings and Urges	4,5,6

To obtain a mean overall Abstinence Self-Efficacy or Temptation score, sum scores from all items and divide by 12.

To obtain mean scores for individual subscales, sum item scores for each subscale and divide by the number of items (3).

Source: DiClemente, Carbonari, Montgomery, & Hughes, 1994. Adapted from material in the public domain.

AASES available online at no cost (*https://habitslab.umbc.edu/files/2014/07/Alcohol-Abstinence-Self-efficacy-Scale-20item.pdf).*

Drug Abstinence Self-Efficacy Scale (adapted version of AASES) available online at no cost (*https://habitslab.umbc.edu/files/2014/07/Drug-Abstinence-Self-efficacy-scale.pdf*).

14. Motivational Interviewing Knowledge Test

Instructions: Choose the best answer for each of the following questions. Each question has only one correct answer.

1. Which of the following is NOT consistent with the MI approach to counseling?
a) rolling with resistance
b) avoiding argumentation
c) confronting denial
d) supporting self-efficacy

2. Within the MI framework, advice may be given by a therapist to a client
a) at any time
b) when the client requests it
c) after the therapist receives permission to give it
d) never
e) both a and b
f) both b and c

3. According to Miller and Rollnick (1991), when a therapist argues that a client's behavior needs to change, the client often responds by
a) accepting the need for change
b) arguing against change
c) asking for advice
d) moving to the next stage in the process of change
e) all of the above

4. Two strategies which are usually effective for avoiding the confrontation-denial trap are
a) giving advice and reflective listening
b) reflective listening and eliciting self-motivational statements
c) skills training and warning
d) aversive conditioning and supporting self-efficacy

5. The MI approach is
a) completely non-directive
b) highly authoritarian
c) directive but client-centered
d) primarily educational
e) all of the above

6. To develop discrepancy, therapists using the MI approach
a) inform clients about the harmful effects of their behavior
b) direct clients to stop the problem behavior
c) warn clients about the future consequences of their behavior
d) point out differences between the client's own stated goals and current behavior
e) none of the above

7. According to Miller & Rollnick (1991), resistance is best seen as
a) a trait of difficult clients
b) a healthy assertion of independence
c) a function of a mismatch between the client's stage of change and the therapist's strategies
d) an indicator of poor prognosis which, if persistent, indicates that the client should be dropped from counseling
e) none of the above

8. Within the MI framework, ambivalence about change on the part of the client is seen as

a) normal and useful
b) a major roadblock to change
c) pathological
d) irrelevant

9. Which of the following therapist behaviors is NOT a roadblock to a client's self-expression
a) interpreting or analyzing
b) warning
c) reflecting
d) reassuring, sympathizing, or consoling

10. Within the MI framework, individual client assessment is seen as
a) a stumbling block to change
b) an unnecessary distraction since the only effective treatment is already known
c) a vital part of determining a client's needs
d) a dehumanizing and authoritarian exercise

11. Which of the following is NOT an MI-consistent strategy for handling resistance?
a) simple reflection
b) amplified reflection
c) argument
d) reframe
e) emphasizing personal control

Please read this exchange between counselor and client and answer the questions that follow:

1-C: I know I messed up. I ruined my family, my wife hates me, I got fired from my job, and now I just feel so hopeless. I'm sad all the time, and it's like I can't do anything about it.
2-T: Where did you work?
3-C: Joe's Auto. I just felt lost there all day, like I didn't want to be there.
4-T: Did your boss know you were drinking?
5-C: Yeah, when he fired me, he told me he could smell the alcohol. God, he must really think I'm a loser.
6-T: What you are is an addict.
7-C: I'm not addicted, OK. I just need a few beers after work to calm down.
8-T: No, you are an addict. You have to admit you are powerless over it before you can better.

12. Therapist statement #2 represents
a) a failure to express empathy
b) a failure to develop discrepancy
c) a failure to explore ambivalence
d) all of the above
e) none of the above

13. Therapist statements #2 and #4 indicate which MI trap?
a) labeling trap
b) Q-A trap
c) expert trap
d) premature focus trap
e) blaming trap

14. Therapist statement #6 reflects which MI trap?
a) labeling trap
b) Q-A trap
c) expert trap
d) premature focus trap
e) blaming trap

15. Therapist statement #8 represents
a) a confrontation of denial
b) an accurate reflection
c) a failure to roll with resistance
d) both a and b
e) both a and c

For the following exchange between client and therapist, answer the questions below:

1-T: What would you like to discuss today?
2-C: Look, the judge said I gotta come here, but I don't think I need to be here, so don't expect me to cooperate with you.
3-T: You feel that things are fine.
4-C: I'm not saying that everything is perfect, but I'm not a dope fiend.
5-T: Do you feel that others see you that way?
6-C: Yeah! People at work are always on my case about it, saying I'm gonna die someday from it. They just need to mind their business.
7-T: Sounds like they're concerned.
8-C: Yeah, well, I guess.

16. Therapist statement #3 is a demonstration of
a) the MI trap of labeling
b) the MI trap of premature focus
c) the MI principle of rolling with resistance
d) the MI principle of expressing empathy
e) both c and d

17. This therapist is using which opening strategy?
a) listen reflectively
b) affirm
c) summarize
d) all of the above

18. A therapist who responds to a client's reluctance to accept the label of alcoholic by saying, "I've been in this business for 15 years and I know an alcoholic when I see one" has fallen into
a) the reflection trap
b) the authenticity mode
c) the expert trap
d) the motivational interviewing mode

19. The importance and confidence rulers are
a) a means of assessing client readiness
b) an intervention that is inconsistent with MI
c) used only with clients who are in the action stage of change
d) a way of rolling with resistance

20. According to Miller and Rollnick (2002), a therapist should respond to client change talk in all of the following ways, except by
a) elaborating on the change talk with an open question
b) reflecting the client's change talk
c) asking the client to commit to a treatment plan
d) summarizing the client's language

21. The purpose of querying extreme consequences of maintaining behavior is
a) to elicit the cons of behavior change (counter change talk)
b) to warn the client about negative consequences of their behavior
c) to elicit the pros of behavior change (self-motivating statements)

d) to scare the client straight

22. What would be the best therapist response to elicit change talk in the following situation?
T: "How confident are you on a scale of 0 to 10 that you can make this change?"
C: "About a 4."
a) So, you're about a 4.
b) Why are you a 4 and not a 0?
c) You've got some confidence, but not a lot.
d) Why are you not a 10?

Motivational Interviewing Knowledge Test Answer Key

1. c) confronting denial
2. f) both b and c
3. b) arguing against change
4. b) reflective listening and eliciting self-motivational statements
5. c) directive but client-centered
6. d) point out differences between the client's own stated goals and current behavior
7. c) a function of a mismatch between the client's stage of change and the therapist's strategies
8. a) normal and useful
9. c) reflecting
10. c) a vital part of determining a client's needs
11. c) argument
12. d) all of the above
13. b) Q-A trap
14. a) labeling trap
15. e) both a and c
16. e) both c and d
17. a) listen reflectively
18. c) the expert trap
19. a) a means of assessing client readiness
20. c) asking the client to commit to a treatment plan
21. c) to elicit the pros of behavior change (self-motivating statements)
22. b) Why are you a 4 and not a 0?

Source: Moyers, Martin, & Christopher, 2005. Reprinted from material in the public domain. Available online at no cost (https://casaa.unm.edu/download/ELICIT/MI%20Knowledge%20Test.pdf).

Appendix C—Resources

Motivational Interviewing and Motivational Enhancement Therapy

Motivational Interviewing Network of Trainers (MINT) (www.motivationalinterviewing.org). This website includes links to publications, motivational interviewing (MI) assessment and coding resources, and training resources and events.

Motivational Enhancement Therapy Manual (https://casaa.unm.edu/download/met.pdf). This manual describes the history of motivational enhancement therapy (MET) and its use in Project MATCH. It provides an overview of MET, its relationship to the stages of change, the structure of MET sessions, and a thorough review of the assessment and personalized feedback process used in MET.

Institute for Research, Education & Training in Addictions Motivational Interviewing Toolkit (https://ireta.org/resources/motivational-interviewing-toolkit). This website provides educational materials about MI and links to no-cost MI resources.

Stages of Change

Health and Addictive Behaviors: Investigating Transtheoretical Solutions Lab at the University of Maryland, Baltimore County (https://habitslab.umbc.edu). This website provides an overview of the Transtheoretical Model of behavior change, printable assessments and scoring information, related publications, and learning tools.

Training and Supervision

Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency Manual (www.motivationalinterviewing.org/sites/default/files/mia-step.pdf). This collection of tools is for mentoring counselors in MI skills used in the engagement and assessment stage of counseling people with substance use disorders (SUDs). It includes teaching tools, counselor self-assessment skill summaries, MI rating guides and forms, transcripts and ratings of sample MI interviews, and trainer instructions.

Center on Alcoholism, Substance Abuse, and Addictions (https://casaa.unm.edu). This multidisciplinary research center at the University of New Mexico provides links to alcohol and drug assessment tools, MI coding tools and therapist manuals, and audio files and uncoded transcripts of counselor role plays that can be used for training.

Motivational Interviewing Resources (https://motivationalinterviewing.org/motivational-interviewing-resources). This MINT webpage provides links to downloadable coding manuals for assessing counselor fidelity to the MI spirit and practice skills including the ***Manual for the Motivational Interviewing Skill Code (MISC)*** (https://casaa.unm.edu/download/misc.pdf), the ***MISC 2.5*** (https://casaa.unm.edu/download/misc25.pdf), the ***Motivational Interviewing Treatment Integrity Coding Manual 4.2.1*** (https://motivationalinterviewing.org/sites/default/files/miti4_2.pdf), and the ***Assessment of Motivational Interviewing Groups—Observer Scale (AMIGOS–v 1.2)*** (https://motivationalinterviewing.org/sites/default/files/amigos_rating_form_v1.2.pdf)

Substance Abuse and Mental Health Services Administration

Screening, Brief Intervention, and Referral to Treatment (SBIRT) (www.samhsa.gov/sbirt). This website has information on dissemination and implementation of SBIRT and additional resources.

Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration Center for Integrated Health Solutions (www.integration.samhsa.gov). The Center for Integrated Health Solutions promotes development of integrated primary and behavioral health services to better address the needs of people with mental disorders and SUDs, whether they are seen in specialty behavioral health or primary care settings. This website provides information and resources on screening tools (www.integration.samhsa.gov/clinical-practice/screening-tools), motivational interviewing (www.integration.samhsa.gov/clinical-practice/motivational-interviewing), and tobacco cessation (www.integration.samhsa.gov/health-wellness/wellness-strategies/tobacco-cessation-2).

Treatment Improvement Protocol (TIP) 63: *Medications for Opioid Use Disorder* (https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC). This TIP reviews the use of the three Food and Drug Administration-approved medications used to treat opioid use disorder—methadone, naltrexone, and buprenorphine—and other strategies and services to support recovery.

TIP 60: *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (https://store.samhsa.gov/product/TIP-60-Using-Technology-Based-Therapeutic-Tools-in-Behavioral-Health-Services/SMA15-4924). This TIP provides information on implementing technology-assisted care. It discusses the importance of technology in reducing access to treatment and highlights the importance of using technology-based assessments and interventions in behavioral health services.

TIP 59: *Improving Cultural Competence* (https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849). This TIP helps providers and administrators understand the role of culture in the delivery of mental health and substance use services. It describes cultural competence and discusses racial, ethnic, and cultural considerations.

TIP 57: *Trauma-Informed Care in Behavioral Health Services* (https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816). This TIP helps behavioral health professionals understand the impact of trauma on clients. It discusses patient assessment and treatment planning strategies. These strategies support recovery and building a trauma-informed care workforce.

TIP 52: *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (https://store.samhsa.gov/product/TIP-52-Clinical-Supervision-and-Professional-Development-of-the-Substance-Abuse-Counselor/SMA14-4435.html). This TIP presents guidelines for clinical supervision in SUD treatment. It covers supervision methods and models, cultural competence, ethical and legal issues, performance monitoring, and an implementation guide for program administrators.

TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992). This TIP gives SUD providers information on co-occurring mental and substance use disorders. It discusses terminology, assessment, and treatment strategies and models.

TIP 39: *Substance Abuse Treatment and Family Therapy* (https://store.samhsa.gov/product/TIP-39-Substance-Abuse-Treatment-and-Family-Therapy/SMA15-4219). This TIP describes the integration of family counseling approaches into SUD treatment. It also discusses cultural competency, considerations for specific populations, policy and program issues, and guidelines for assessing violence.

SAMHSA Publication No. PEP19-02-01-003
Published 2019

Substance Abuse and Mental Health Services Administration
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