

Adults With COD

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

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

Having any mental disorder increases the risk of substance misuse. As indicated in TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (SAMHSA, 2013), clients with mental illness or COD may find it harder to engage and remain in treatment. **Motivational interventions that engage and retain clients in treatment, increase motivation to adhere to treatment interventions, and reduce substance use are a good fit for these clients.** A meta-analysis of randomized controlled treatment studies of people with SMI and substance misuse found that, although MI was not any more effective, in general, than other psychosocial treatments, clients who participated in an MI group reported to their first aftercare appointment significantly more often than clients in other treatment interventions and these clients had greater alcohol abstinence rates (Hunt et al., 2013). Another meta-analysis

adherence to treatment significantly improved adherence and psychiatric symptoms (Wong-Anuchit, Chantamit-O-Pas, Schneider, & Mills, 2018). Dual Diagnosis MI (DDMI), a modified version of MI for adults with CODs, can effectively increase task-specific motivation and adherence to cognitive training interventions (Fiszdon, Kurtz, Choi, Bell, & Martino, 2015).

COUNSELOR NOTE: DUAL DIAGNOSIS MOTIVATIONAL INTERVIEWING

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

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

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

EXPERT COMMENT: MI FOR ADULTS WITH COD

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

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

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

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

Brief Motivational Interventions

A growing trend worldwide is to view substance misuse in a much broader context than diagnosable SUDs. The recognition that people who misuse substances make up a much larger group—and pose a serious and costly public health threat—than the smaller number of people needing specialized addiction treatment is not always reflected in the organization and availability

of treatment services. As part of a movement toward early identification of alcohol misuse and the development of effective and low-cost methods to ameliorate this widespread problem, BI strategies, which include motivational components, are widely disseminated in the United States and other countries (Joseph & Basu, 2016).

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

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

BI is a structured, person-centered counseling approach that can be delivered by trained health and behavioral health professionals in one to

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

EXPERT COMMENT: BI IN THE EMERGENCY DEPARTMENT

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

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

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

Ed Bernstein, M.D., Consensus Panel Member

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

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

Screening, Brief Intervention, and Referral to Treatment

A specific BI called SBIRT, which adds screening and referral components, has been implemented widely in the United States in diverse settings, including EDs, primary care offices, and community-based health clinics, through a SAMHSA multisite initiative (Babor et al., 2017). It is the largest SBIRT dissemination effort in the United States (Aldridge, Linford, & Bray, 2017). SBIRT was specifically developed for nonspecialized treatment settings. It has demonstrated effectiveness in primary care offices, EDs, and general inpatient medical units in reducing substance use and misuse among adolescents, young adults, and adults, as well as in increasing participation in follow-up care

(Barata et al., 2017; DiClemente et al., 2017; Kohler & Hoffman, 2015; McQueen, Howe, Allan, Mains, & Hardy, 2015; Merchant, Romanoff, Zhang, Liu, & Baird, 2017; Timko, Kong, Vittorio, & Cucciare, 2016; Woolard et al., 2013).

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

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

Conclusion

Motivational interventions can be used in BI, in BT, and throughout the SOC process. Some strategies, like screening and FRAMES, are more applicable to BI methods whereas others, like developing discrepancy and decisional balancing, are more useful in specialized addiction counseling settings

where clients receive longer and more intensive treatment. What is common in all motivational interventions, no matter the treatment setting or the client population, is the focus on engaging clients, building trust through empathetic listening, and demonstrating respect for clients' autonomy and cultural customs and perspectives.