The Forum

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On Co-Occurring Mental Health and Substance Abuse Disorders

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Recovery as a Journey Through The Stages of Change

By M. Lynn Smith, M.A., LCADC

During the last decades, the psychological treatment based on Trans-theoretical Model of Change (Prochaska & DiClemente, 1984) has been the cornerstone in the field of addictive behaviors. This model is also the foundation of Motivational Enhancement Therapy or Motivational Interviewing. These principles have been recognized as Best Practices in the treatment of substance abuse & mental health Co-Occurring Disorders (COD).

The basic principle in the Stages of Change Theory is that change occurs in increments and migrates from one-level of "readiness" to another-level as a result of motivating factors. This theory also readily accounts for the relapse factor often associated with substance abuse behaviors.

Conceptually speaking, the stages of change begin with some *pre-contemplation,* and then proceeds towards *contemplation*, *preparation*, *action* and *maintenance*. A person begins the process of changing behavior by considering the possibility of change. Only after "admitting" that a specific problem exists can a person be ready to make plans.

The therapist plays a crucial role in assisting the person to come to a new way of thinking about him/herself. Empathy and validation are key therapeutic interventions in addition to reflective listening. However, the client must take "ownership" for any plan-for-change.

Once a specific plan is determined, the client can begin to take steps towards developing a new behavioral repertoire. New behaviors call for ongoing therapeutic support, advice and feedback. A necessary part of this advice-giving interaction is the development of a maintenance or relapse prevention plan.

Recidivism is a typical and very normal human response to the discomforts of adaptation and initiation into new behaviors. Therefore, the realities of relapse must be met with encouragement in adopting new behaviors and the recognition of the difficulty in achieving meaningful change. For example, "reframing' any drug consumption as an unfortunate learning experience is a positive way of handling an incident of drug relapse.

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Clinical Supervision Of Motivational Interviewing

By Denise Hall, LPC, NCC

It is essential to plan for staff training opportunities by choosing state-of-the-art practices with skill development goals. Training should result in measurable and meaningful improvements in staff skills that are relevant to client needs and result in enhanced clinical services.

Effective clinical supervision is the lynchpin to providing quality clinical services. This is especially true when implementing an evidence-based practice. However, the supervision of motivational interviewing (MI) techniques in an integrated treatment setting presents many challenges. This is especially true during the early acquisition of motivational interviewing skills.

Hettema, Steel, and Miller (2005) note that the treatment outcome literature for MI is growing and has spread well beyond addictive behaviors. However, there are valid concerns for the effective use and application of MI techniques in diverse clinical settings. This requires that clinicians use MI proficiently and adhere to clinical protocol.

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This is critically important in order to maintain the integrity of the quality of clinical services.

While introductory and skill-based training on MI is readily available, a method for the supervision of MI has been more difficult to employ in community treatment programs. Miller and Mount (2001) note that one-time training workshops show little difference in clinician practice when measured four months later. Further, clinical proficiency in MI is not readily acquired through readings, viewing videotapes, or attending a clinical workshop.

When MI training is practiced and monitored through supervisory feedback and coaching, outcome data suggests significant clinical improvements in the skill-levels of clinicians and clients. Many evidence-based adoption-studies have shown that clinicians tend to regress to their pre-training comfort zones unless effective supervision is readily available. Therefore, ongoing supervision becomes a key ingredient in maximizing skill training.

One very useful resource developed explicitly to maximize the retention of skills learned during MI training is the Motivational Interviewing Assessment: Supervisor Tools for Enhancing Proficiency (MIA: STEP). This supervisory package was developed through the cooperative efforts of the National Institutes on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The MIA:STEP package (2006) focuses on the MI assessment process and several supervisory tools including a modified "tape-rating guide".

The tape rating guide details a system of ways for clinicians to identify counseling strategies that are consistent with MI. As such, the tape-rating guide establishes proficiency and adherence to MI guidelines. This package offers the supervisory tools necessary to facilitate in the acquisition and mastery of MI skills. To locate this package see website: (www.midattc.org) sponsored by the Mid-Atlantic Addiction Technology Transfer Center..

The MIA:STEP system helps supervisors monitor and evaluate the work of clinicians and adherence to well-designed MI interventions by demonstrating MI consistent responses. Key to the use of this Tape Rating System is that the supervisor must have previous MI training and experience as a clinical supervisor. The assumption that anyone can supervise MI is a misnomer of MI's deceptively simple principles.

It is imperative that supervisors are also trained and effective practitioners of MI in order to promote effective skill building in supervisees.

Otherwise, organizations spend money and staff time sending staff to skills-based training on MI without realizing any real long-term adoption or enhancement of their clinical services. Simply put, 'a MI workshop teaches you about motivational interviewing and clients teach you how to use it.' (Miller, personal communication).

At some agencies, MI trainees are provided advanced copies of the TIP 35 manual entitled "Enhancing Motivation For Change in Substance Abuse Treatment" for reading and reference (see page 4 for free copy). The reading material can be processed in a group format in a systematic fashion prior to beginning the actual skills training. These training events can be coordinated so that supervisors provide ongoing supervision to trainees at the initial training event and during a subsequent 3-6 months period of time. In this way, the supervisors act as trainer assistant during the initial practice role-playing sessions. Subsequently, meetings for these paired staff are scheduled as a formal practicum and enhance the initial training benefits.

In various clinics, there are many particular problems that clients have in common and are readily approached with a motivational intervention. For example, with COD clients, prescription drug medication compliance should always be monitored and often requires clinical encouragement to maintain the taking of medication. Other specific behavioral problems could be identified prior to training in order to identify standard problems areas in need of individual motivational interventions. After mastering basic, problem-specific motivational statements, each counselor is able to develop and begin to incorporate these techniques into their personal and professional counseling services.

In summary, the research and literature on the utility of MI in treating co-occurring disorders is overwhelmingly positive. The above resources can assist supervisors and agencies in utilizing MI training initiatives and other integrated treatment models. Although the supervision of MI presents its own unique challenges, it also offers opportunities to develop the current workforce into purveyors of proficient MI practice. By utilizing an organizational framework that emphasizes clinical supervision, an infrastructure can be built to augment the adoption and sustainability of MI practice.

References

Hettema et al. Motivational Interviewing: Meta-analysis. Annual Review of Clinical Psychology, Vol. 1: 91-111, 2005.
Miller and Mount. Training in motivational interviewing. Behavioral and Cognitive Psychotherapy, 29: 457-471. Cambridge University Press, 2001.

A Change In My Life

By Steve B.*

We all know for a fact that as time passes, our mental and medical health can become more complicated and compromised. I'm not blaming time for my complications because I choose a drug abuse lifestyle. At age 33, I feel I have lived a very long time and it's been a difficult road less traveled.

As a child I wasn't abused, we weren't poor and I didn't grow up in the worst neighborhoods; but my father was a chain-smoker and an alcoholic. Research shows that when parents consume alcohol/drugs, there is a much greater chance that their children will also indulge in similar consumption.

As a young kid I experimented with every single drug that came my way. By age 14, I was smoking cigarettes and marijuana and drinking beer and rum with my school buddies. Around age 17, I began doing cocaine and then all kinds of prescription drugs like Valium and Xanax, which I liked very much. However I lost interest in all drugs except tobacco when I began using heroin at age 27. Without much notice, I was being pulled into a scary dark culture and fell into a hell of pain that spread throughout my family, social and personal life.

Before my eyes I lost everything and everyone in my life, and metaphorically, part of my soul. I blamed everything on my drug abuse, but there was more to it, beginning I guess early, especially the experiences of my childhood.

In retrospect, I realize that I was a moody child, at times angry and violent or sleepy and depressed. I was too ignorant to realize that my problems were mental.

At age 26, I had nothing materially and no family support. I had problems with the law and there are no words to explain the pain of being in jail. While incarcerated my father died, a brother died of AIDS, and my mother had open-heart surgery. Self-pity just wasn't working anymore and with nowhere to run, I continued my drug abuse in jail.

When I was finally released from jail I believed I could change and took control of my life. However, six months late I lost what little I had gained and was burning down bridges that I had worked so hard to build. I couldn't understand how it happened so quickly. I became emotionally unstable, suicidal and was hospitalized with a diagnosis of a bipolar disorder. Slowly I began to understand all my behaviors from the past.

I realized that maybe this mental diagnosis was the real trigger and need for the drugs, but I needed to know more. I knew I could be such a liar but now wanted to know the truth, become honest and open about my need for support and professional help. I had a serious problem, and needed to take the first step into recovery.

I walked into a Health Clinic feeling worse than ever, suicidal and confused. A counselor said that they needed to stabilize my mental health with medication before we could work on my drug abuse problems. I thought he must be crazy, but also realized that I had to allow professionals to help me and be committed to their decisions and the process that followed.

Each interview is unique and I have learned to approach one problem at a time. It's important to be 100% honest with yourself and your counselor, also with your family. You must share your experiences and what you learn in order to foster and maintain the support you need.

Today, I am stable on medications and have followed my doctors' recommendations and take my medications regularly. I don't miss counseling sessions and focus on seeing things different and more clearly now.

As I continue to learn about my drug abuse and bipolar disorder, I simply have to keep up with the work for my physical and mental health. A significant part of maintaining my "motivation-to-change" is hearing others say that I am looking better than ever. I feel so proud of myself, and all that surrounds me.

I would like to motivate others to do the same. I think that if you are capable of making a commitment and show the courage necessary to walk through an opened door to face an initial interview with a professional, I assure you that life can change for the better. We all need help at some time in our lives.

**The author's name has been changed to protect his privacy.*

Enhancing Motivation For Change In Substance Abuse Treatment
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Treatment Improvement Protocol TIP 35
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Call (800) 729-6686
For a free copy
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Substance Abuse Treatment For Persons With Co-Occurring Disorders
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Treatment Improvement Protocol TIP 42
****
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FALL 2006 TRAINING

Friday, October 27, 2006, 9:00 a.m. to 4:00 p.m.
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Confounding Variables:
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The idea that change is an ongoing and oscillating process that occurs in stages is not revolutionary. Unfortunately, this simple fact is often overlooked in the treatment of individuals with COD. This is especially true when the behaviors involved are life-threatening as is often the case when a client is in crisis or suffers from of a series of incidents associated with substance abuse and mental illness. With regard to drug relapse, the client may not be aware that substance abuse exacerbates symptoms of mental illness. From the perspective of the COD client, such drug consumption may seem to be helping.

Miller & Rollnick (2002) offer four-principles of motivational interviewing. Their first principle of "therapeutic empathy" is fundamental. That is, therapeutic acceptance facilitates behavioral change and therapeutic ambivalence is normal. This principle recommends that therapeutic empathy is best expressed through reflective listening.

The second principle recommends that the client become able to articulate the discrepancies between their present behavior and their future personal goals. The client must decide on and state the reasons for changing. The third principle requires that the therapist understand the client's ambivalence towards change is normal. When faced with resistance, it is best to avoid argumentation and direct confrontation. The final principle of self efficacy emphasizes the importance of a belief in the possibility of change on the part of the client and the therapist.

These outlined principles can graphically be achieved through skillful reflective listening and thoughtful feedback. The accomplished motivational therapist will elicit responses that strengthen the clients desire to move forward. Open-ended questions that target client strengths and positive intentions help the client put into words the ideas and beliefs that will strengthen their resolves. Therapeutically summarizing the client's ambivalences and arguments both for and against a particular course of action helps expand and clarify the complex elements involved in any situation. In William Miller's words, "Motivational Interviewing is a therapeutic attitude that is attentive, respectful and empathic."

Counselors can make use of specific tools to support the client in the change process. Working with a "Decision Balance Scale" is often helpful during the *contemplation stage*. The counselor asks the client to weigh "good things" against "not so good things."

Conversely, the client is asked to weigh "good things" about *not changing*. In this way, the client, not the counselor, puts into words their reasons for change.

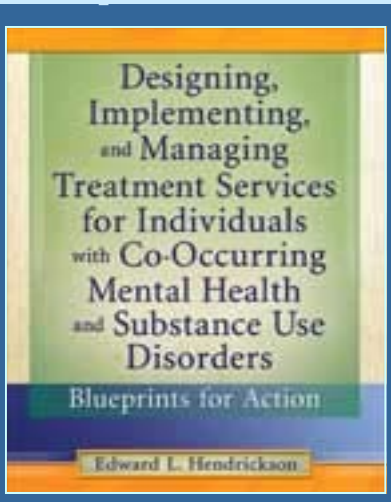
Another facilitative tool is a "Change Plan Worksheet." The counselor works with the client to complete a worksheet that lists answers to questions such as about the obstacles to change and recovery. A sample Change Plan Worksheet can be found in the book, *Motivational Interviewing*, or SAMHSA (TIP 35) entitled: *Enhancing Motivation for Change in Substance Abuse Treatment* (see page 4 for free copy). The counselor's clinical and diagnostic abilities of to assess the client's actual stages of change is crucial to delivering the appropriate, tailored intervention.

Working within the framework of stages of change avoids frustration and results in fewer stressful encounters. These stages of treatment and levels of programming that complement the stages of change are considered cutting-edge and best-practices in the treatment of Co-Occurring Disorders.

References

Prochaska and DiClemente. The Transtheoretical Approach. Dow Jones-Irwin, 1984.
Miller and Rollnick. Motivational Interviewing: Preparing People to Change . Guilford Press, 1991.
Motivational Interviewing website at http://www.motivationalinterviewing.org/

A New Comprehensive Publication



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For more information, visit
www.HaworthPress.com

This book, by the founding Chair of the Co-Occurring Disorders Committee, describes how to provide effective treatment services for individuals with dual diagnosis substance abuse and mental health disorders. It explores the issues in creating a new program or expanding an existing one, as well as the mechanics of day-to-day management.

This book also:

- **Gives you the tools you need to develop an effective program specific to co-occurring treatment.**
- **Discusses staff training and the clinical supervision of treatment staff.**

"Mr. Hendrickson's work… offers a wealth of down-to-earth, concrete, practical suggestions."
Kenneth Minkoff, M.D., Harvard University

The Forum is published twice yearly by the Metropolitan Washington Council of Governments Co-Occurring Disorders Committee.
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The Forum

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