# The power of the welcoming reminder

MANNERS MATTER • PART 1

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Doing the simple things well, and running the kind of service you yourself would like to visit, can transform treatment uptake and retention.

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**THE MANNERS MATTER** review is about how treatment services can encourage clients who make an initial contact to return and stay the course. Retention is a key policy target[7,8] because it is seen as the best indicator of the degree to which patients and society benefit from treatment.[1] Research broadly supports this link,[2,3,4,5,6] but retention is in turn just one indicator of 'engagement' – a sign that clients are actively 'working the programme', talking about the things that matter, forging therapeutic relationships, getting extra help if needed – the processes through which treatment makes a difference.[7,8,9,10]

Our focus is not so much on *what* services do, but *how* they do it, and how this can create a bond with the people who come to them for help. While which treatment 'technology' is delivered typically makes little difference, *how* it is done can transform the client's response. The principles are simple: the same human qualities which cement relationships outside treatment also do so within it. Part one of this review deals with some straightforward expressions of these qualities: responding quickly, keeping in touch, not too easily abandoning those who don't respond first time. Later parts deal with the client's relationships to their counsellor and to the agency. But the division is not (nor should it be) a sharp one; a reminder letter can be curt and off-putting, or warm and motivation-enhancing.

Or course, even if services know how to maximise retention, they may choose not to do so.[11] Waiting lists, deterrent intake procedures and early terminations can be used to manage workload and exclude less promising or more troublesome clients. Staff may also believe that initiating contact with clients who miss appointments erodes a necessary boundary between counsellor and client. Though acknowledging these barriers, the focus here is on what could be done with sufficient will and (usually little if any) extra resources.

## Waiting is de-motivating

Having to wait is less a test of motivation than its adversary. Apart from any direct impacts, responding quickly is a clear, early token of *responsiveness*, a quality which in various manifestations emerges as an important retention-enhancer.

Forced to wait too long, even seriously ill patients awaiting emergency care give up and go home.[12,13,14] In alcohol and drug treatment too, reducing the delay between initial contact and the first scheduled treatment session generally improves attendance at this session[15,16,17,18,19,20,21] without adversely affecting longer-term retention.[19,20,22,23,24,25,26,27] Neither is there any evidence that people who give up don't really need help.[15,24,27,28,29] Some studies find the reverse: those in greatest need are excluded by treatment access barriers.[16,25]

Asked by researchers (they rarely are), patients have testified to the impact of having to wait. In two studies, substance users who contacted services were asked why they did not go on to start treatment[16] and/or dropped out early.[20] In one, a fifth cited the waiting list and in the other, 16%, but in both many more cited factors which a waiting period can create space for: a change of heart; no longer feeling in need of help; forgetting the appointment; continued or resumed substance abuse; becoming ill; being arrested.

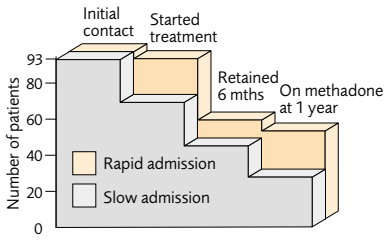
Other studies bear witness to these processes at one remove, in their effects on treatment uptake. Most simply observed intake processes, so cannot eliminate the possibility that what looks like a causal relationship between waiting time and treatment uptake is due to something else entirely – perhaps less motivated clients delay treatment entry and eventually avoid it altogether. More weight can be placed on studies which deliberately manipulate waiting times, stripping away confounding influences to reveal the effect on treatment uptake. These are the studies on which we focus.

### EVEN WHEN METHADONE IS THE INCENTIVE

Despite a powerful inducement, even prospective methadone patients are deterred by long waits. In this modality, rapid initiation must be balanced against the risks of injudicious prescribing and overdose. But within these limits, paring pre-treatment delays and 'hurdles' to the minimum increases treatment entry rates without adversely affecting retention or outcomes – exposing delays as simply a barrier to treatment, not a filter to exclude the unmotivated or unpromising.

One US service used extra funding to expand capacity, reduce the time from first contact to intake from 40 to 14 days, and to cut the intake

**Norman Rockwell's *The Waiting Room* captured the resignation anticipation and frustration of being in need but having to wait**




process from two weeks to two days.[25] Requests for intake appointments tripled from 35 to 100 per month yet the percentage actually kept rose from 33% to 54% without affecting longer term retention. Another effect was to open up the programme to more socially excluded and severely dependent clients, perhaps least able to hang on.

In Texas (*chart above*) a methadone programme randomly allocated 93 applicants each to its usual two-week assessment, or instead started patients on methadone within 24 hours.[28] Only 4% of these patients failed to make it to the first dose compared to 26% after extended assessment, yet over the next year just as many stayed in treatment, more (49 v 28) were still on methadone a year later,[i] and they did just as well in terms of drug use, HIV risk and social reintegration. Mexican-Americans were disproportionately represented in the pre-treatment drop-outs so benefited most from rapid admission.

The message is an old one. Over 30 years ago a methadone service in Philadelphia tried replacing its two-stage intake process (patients had to return the following day for a series of appointments) with a one-stop, walk-in procedure.[26] This completed initial assessment and the first methadone dose seamlessly on the same day. Two months after intake about 55% of one-stop patients remained in treatment but just 30% under the two-stage procedure, probably due to patients failing to return for the second stage.[ii] After this, the two sets of patients dropped out at roughly the same rate. The result was that at five months over twice as many one-stop patients were still in treatment. These gains were achieved through greater flexibility rather than greater resources.

The two previous studies are examples of 'triaged' assessment.[30] A rapid, brief assessment does enough to check whether the patient is at the right agency or should be referred on; comprehensive assessment is deferred until after treatment has started. Another approach is to establish a stripped-down methadone programme which can 'hold' applicants awaiting entry to the full programme. In New York this opened up access to treatment and reduced waiting times without adversely affecting retention.[27]

### IT'S GOOD TO TALK (SOON)

Arguments for rapidly starting non-drug based therapies are given added weight by the fact that these are the main treatments for cocaine/crack users,[31] and that engaging more of these users is now a national priority.[32]

Early clues came in the 1950s from Morris Chafetz's pioneering alcohol clinic in Massachusetts *Transformation stories 1,* p. 17. Among the measures trialed there was to initiate same-day social work contact in response to a (typically crisis) call from an alcoholic or their family, if necessary visiting their home.[33] Initial attendance tripled and over the next six months 27% of patients returned at least five times compared to none sent the usual appointment.

Equally striking results have been achieved with stimulant users, who also tend to call in a crisis. At a US community drug treatment service in Portland, 60% of phone callers randomly allocated to come as soon as possible (the same day if they wished) turned up compared to just 38% given appointments for on average 10 days later.[34] Two-thirds of those who completed admission primarily used stimulants.

**THE SAME HUMAN QUALITIES WHICH CEMENT RELATIONSHIPS OUTSIDE TREATMENT ALSO DO SO WITHIN IT**

To similar effect, a cocaine clinic in a poor urban area of New Jersey randomly allocated phone callers to the offer of an appointment the same day, the next day, three, or seven days later.[29] Callers who couldn't make it could reschedule. The criterion for successful attendance was turning up within a week of the first time offered. 72% offered a next-day appointment did so compared to around 40% offered a later slot. Taking other factors into account, next-day appointees were over four times more likely to attend.

One issue is whether the *offer* of a prompt appointment makes a difference, even if the client has to turn it down. An earlier study at the same clinic randomly allocated patients to same-day or normal (one to seven days) appointments.[35] Almost twice as many offered a same-day appointment attended for intake irrespective of whether they could actually come at the offered time.

### WAIT *less*, STAY *longer*?

Among patients who start treatment, those who had to wait less are sometimes found to stay longer. Some such studies have already been cited,[26 28 33] others are described below.

A short-term residential rehabilitation centre in England checked the records of all 2144 first admissions over 15 years.[23] About half had problems mainly with alcohol, half illicit drugs. On average those who went on to complete had waited four days less for entry. Slicing the figures another way, 56% waiting a week or less completed treatment but 44% who'd waited a month or more. Adjusting for other factors which might explain this relationship still left waiting time significantly related to completion.

Some studies have noted this trend but were unable to adjust for other factors. They add weight to the suggestion that shorter waits result in longer stays, but cannot exclude the possibility that the relationship is due to something else. Such studies have included one of a British outpatient drug and alcohol service whose caseload consisted mostly of problem drinkers,[24] an alcohol treatment unit in Manchester,[19] and a community drug team in south London.[36]

Even if shorter waits don't always result in longer stays, the reverse is rarely the case. An exception is an early study of a US alcoholism clinic.[21] Shorter delays (up to four days) between initial contact and intake appointment meant more people turned up for intake, but fewer of these returned for their first therapy session. The two effects roughly cancelled out, so that, regardless of intake delay, around a third of contacts attended their first therapy session. A possible explanation is that patients with the greatest problems (legal and employment) were fast-tracked to the intake phase but were also less able to follow through and start treatment. Another is that, for some, a rapidly arranged intake appointment was enough to quel the crisis which precipitated the original contact.

### *Take-home* GOLDEN BULLETS *messages*

- Rapid treatment intake after first contact means more clients turn up without jeopardising longer-term retention or outcomes.
- Consider using an initial rapid, brief assessment to decide whether callers are appropriate for your service and defer the rest until treatment has started.
- Attendance at initial and later treatment sessions is improved by reminders beforehand which make the client feel wanted and which are optimistic about the treatment they are embarking on.
- Personal approaches incorporating a motivational element work best, probably because they convey active caring rather than a bureaucratic reminder-mill.
- Reminders also encourage former patients to use aftercare services; 'How are you doing?' contacts can themselves help sustain the impact of the initial treatment.
- To reach former clients most likely to be in trouble, follow-up methods need to be relatively active, intensive and persistent.
- Services which under-invest in following up former clients jeopardise the gains made in the initial treatment and risk failing ex-patients in greatest need.

## Encouraging reminders improve retention …

When immediate entry cannot be arranged, measures can still be taken to increase treatment uptake. The simplest is the reminder, but its simplicity is deceptive; *how* it is done is as important as doing it. When silence or impersonal reminders are replaced by personal, motivation-enhancing, and welcoming contacts, the effect can be dramatic.[37]

In mental health services in general, reminder phone calls or letters improve attendance.[38] Especially when waits are long, the British NHS recommends a 'partial booking' system – giving the patient a rough indication, then contacting them nearer the time to agree a mutually convenient slot. Compared to fixed appointments, this reduces no-shows and cancellations on both sides.[39] The same strategy is being promoted by the English National Treatment Agency.[40] In England, the requirement to copy patients in to letters from hospital services to their GPs provides an opportunity to remind the patient of the importance of returning to the hospital or of attending aftercare.[41]

Within the substance misuse field, again Morris Chafetz's Massachusetts team were pioneers *Transformation stories 1,* p. 17.[33 37] After assessment, severely alcoholic patients who had to be sent off-site for inpatient detoxification rarely returned. A handwritten letter expressing personalised concern and desire that the individual would return increased nearly tenfold the numbers making a seamless transfer to outpatient care. A phone call had a similar impact.

Aware of Chafetz's work, in the late '60s social workers in New York tried to counter high early drop-out and erratic attendance among alcohol outpatients.[42] Letters like that in Massachusetts were sent immediately to patients who missed appointments, offering another date. The workers were persistent, continuing to send reminders until four appointments were missed, when the final letter still offered further help and expressed concern over how the patient was doing. Additionally, social workers saw any patient who made an unscheduled visit and offered crisis intervention if necessary.

The effect was to virtually halve early drop-out. In the seven weeks before these procedures, 51% of new patients dropped out within four visits, in the seven weeks after they had been established, 28%. Among patients as a whole, the proportion who missed two consecutive sessions fell from 57% to 22%. Among long-term patients, drop-out after a missed appointment fell from 33% to 8%. The letters were almost certainly the main factor, since the proportion of patients who made unscheduled crisis visits actually fell from 57% to 22%, indicative of improved stability.

### MAKE IT *personal* AND WELCOMING

A personal reminder works best was the implication of a series of randomised trials at an alcohol clinic in California.[43] The aim was to retrieve the many patients who dropped out within four weeks of starting treatment. Usually no attempt was made to recontact them. First the clinic tried sending a letter to a randomly selected half and repeated it each week they remained absent. It could have seemed cold and accusatory, asking why the patient had not come back, did they still want treatment, and if not, why not. It had no impact. Just 1 in 6 of the 60 patients in each group returned for treatment within four weeks of their first missed appointment.

Next a new set of drop-outs were sent the same letter or phoned by one of the researchers.[iii] She posed similar questions, but now 10 out of 25 patients returned compared to just 2 sent the letter. Moreover, she got valuable information on why most of the rest stayed away. Clearly a phone call provided the opportunity to be more personal and interactive. In a third study, the clinic tried to incorporate these qualities in a revised letter. It more clearly expressed an interest in the client and in checklist format sought feedback on their current treatment needs. It prompted over a third to return compared to just one of the 25 sent the old-style letter, and, again, helped find out why the remainder were not coming back.

In Florida similar efforts improved attendance at a clinic for substance abusing adolescents with severely antisocial behaviour.[38] Though about half were court-mandated to treatment, usually just 45% of families who contacted the clinic attended for intake. To improve on this, calls to the parent to agree an appointment were supplemented by a preset script. It consisted less of motivational encouragement than of bureaucratic information about procedures, legal penalties (less if they cooperated), attendance requirements, and the programme's effectiveness record.

For a randomly selected half of families, this was supplemented by a phone call to parent and child a few days before the first and second sessions. These *were* motivational, individualised and interactive. They named and praised the family's therapist who was "looking forward" to meeting them, empathically addressed concerns, stressed the programme's benefits, reiterated appointment details and (if applicable) relayed how impressed their therapist had been with their punctuality at the previous session.

The 'bureaucratic' calls were not *in*effective – they improved initial attendance to 60% – but adding the motivational calls doubled it to 89%. Overall attendance also improved to 57% and 83% respectively. Before this combination, most families had not turned up, now this was the exception. The researchers believe the most influential element was involving the young person themselves in scheduling the sessions.[44]

## … and aftercare attendance

Motivational reminders can also help keep former patients in contact with aftercare. This was one of the tactics which revolutionised aftercare attendance at the Salem Veterans Affairs Medical Centre, featured next issue as our *Transformation story*. Postal and phone reminders to attend and fulfil a previously signed aftercare contract improved aftercare initiation from 70% to 100%, doubled the number of sessions attended, and cut the need for hospital readmissions.[45] The letters and calls which transformed return to Morris Chafetz's alcohol clinic following off-site detoxification can be seen as another example[33] *Transformation stories 1,* p. 17.

Inspired by Chafetz, in the early '70s a short-term inpatient alcohol treatment unit in Buffalo used similar tactics to encourage use of its outpatient support services.[46] Randomly selected patients were either not contacted at all after they left or phoned six times over the next ten weeks. The calls expressed concern for the patient and successfully encouraged them to access more outpatient services, which in turn was associated with improved drinking outcomes and greater stability. Perhaps significantly, these

### OFFCUT 1

**Drug consumption rooms** are being seen as the next step up in harm reduction to counter overdose, improve infection control, connect heavy-end drug users to treatment, and to reduce the nuisance caused by open drug 'scenes'. Common in parts of mainland Europe, these are just a distant memory in Britain and represent a step too far many UK workers. A new report from the European Monitoring Centre for Drugs and Drug Addiction has surveyed European provision and collated the evidence on its effectiveness [1]. It suggests that all the expected benefits can be realised as long as services have adequate capacity, are easy to access, and are well managed in the context of political support for their role within a wider network of services. In practice, political support is most likely to be forthcoming when the public nuisance is both large and resistant to other options. Then such services start to seem an attractive way to restore local quality of life rather than a threat to it.

[1] Hedrich D. **European report on drug consumption rooms**. EMCDDA, 2004. Copies www.emcdda.eu.int.

## PROGRESS ON WAITING TIMES AND RETENTION

In England, recorded waiting times have fallen fast and some retention data (evidence is contradictory) also show big recent gains. Whether this has been achieved at the cost of quality is unclear. Similar data is not available for the rest of the UK.

### Recorded waiting times down

Figures from the National Treatment Agency (NTA) show dramatic reductions in average times from referral to treatment entry, from on average nine to just over three weeks between 2001 and 2003.[81] As yet there is no way to check the times reported by services, but neither is there any reason to doubt them, and proven initiatives such as those reviewed in this article are being introduced in a programme led jointly by the NTA and the National Institute for Mental Health.[40]

The NTA plans to use treatment retention and completion statistics to assess whether targets for increased capacity[76 77 79 80 97] and rapid intake[77] are being achieved at the cost of quality. These checks may not be enough. For example, one way methadone services can (and have[82]) cut waiting times is to divert resources from maintenance to detoxification. No warning bells need sound because this could simultaneously increase treatment completion rates – in this case, detoxification. Yet the typically high relapse rate following detoxification means that it could also sacrifice health improvements, crime reductions,[83] and even lives.[84 85]

Another way to cut waiting times without more resources is to establish a 'low threshold' methadone programme which, as well as streamlining entry, provides counselling only when the client asks for it.[86] The net effect could be beneficial, but such paring down risks increasing throughput by decreasing quality[87 88] in a way which might not show up in retention statistics. Conceivably, retention could actually 'improve' because fewer patients are helped to achieve a life where they no longer feel the need for daily methadone.

### Contradictory evidence on retention

The English National Treatment Outcomes Research Study (NTORS) of clients entering treatment in 1995 revealed considerable scope for improving retention. For residential services, it identified retention times associated with the greatest post-treatment gains. Most clients left before these times: 80% in inpatient programmes and 36% and 60% in short- and long-term rehabilitation.[5] For methadone maintenance, the key thing is *remaining* in treatment.[4 22 89 90] In NTORS, 38% of patients had left by one year and 58% by two years. At both points leavers had far worse outcomes.[6]

Whether things have improved since then is unclear. The NTA has said that it cannot assess retention trends until it has established a baseline for 2003/04,[78] yet also that there has been a "four-fold increase in the length of time clients stay in treatment from 57 days in September 2001, to 203 days in June 2003".[81]

This statement was based on a 15% sample of treatment services. However, routine returns from drug treatment services and GPs in England indicate that over roughly the same period, slightly *fewer* people starting treatment during a year were still there at the end.[91] Neither has England recorded the recent steep rises in the number of methadone prescriptions to be expected if services were expanding and improving retention; from 1998 to 2001, the increase levelled off to just 2–4% annually[92] and 8% from 2001 to 2002.[93] In contrast, Scotland has recently seen the expected steep increases.[94 95]

relatively light-touch procedures worked with a caseload most of whom were employed and had intact marriages.

A medical centre for ex-military veterans in California found reminders less successful.[47] However, the reminders appear to have been simply that rather than motivational in nature, and the caseload was so severely alcoholic that perhaps more was needed.

Typically patients were unemployed single men with a history of alcohol-related arrests and hospitalisations. Before inpatient detoxification they had been drinking heavily from the morning on, experiencing tremors and blackouts. On leaving, for a year they were offered at first weekly then fortnightly aftercare sessions taking a "problem-solving approach". To encourage attendance, for the first six months 96 patients were randomly allocated either to normal procedures (no active follow-up), to a phone reminder from their therapist a few days beforehand, or to instead be seen for aftercare at a place of their choosing, such as their home.

Reminders did little to increase the number of aftercare sessions attended, but did delay the point at which patients stopped coming altogether. For example, 15 weeks into the aftercare period, under 30% had dropped out compared to over 60% of normal-procedure patients. Taking aftercare to the patient had a much greater impact on its uptake, but neither reminders nor home visits improved drinking or social/emotional functioning outcomes. Possibly any such effect had been obscured by the fact that relatively few normal-procedure patients were followed up, filtering out those doing worst.[48 49 50] Possibly, too, the results raise a question mark over the appropriateness of the aftercare approach.

A face-to-face system was trialed in Chicago on people seeking treatment via a centralised intake unit.[51] This more hands-on approach may have been needed for patients who were typically dependent on crack, unemployed and with a history of homelessness and abuse. Three months later and then quarterly for two years, a randomly selected half were interviewed by unit staff who ran through a checklist to assess whether they should return to treatment. Those judged in need were transferred to another staff member to arrange the return, motivate the patient, and to give practical aid.

Over the two years, patients checked up on in this way typically returned to treatment within 376 days compared to 600 days for the remainder, 13% more returned at some stage, and they stayed longer in treatment. Perhaps as a result, by the end of the two years fewer (43% v. 56%) of the checked-up-on patients were assessed as still in need of treatment. However, the check-ups piggy-backed on visits being made anyway for research purposes. Without these how it is unclear how many of the patients would have attended.

## 'Hi, how are you doing?' – aftercare in itself?

'How are you doing?' contacts after patients have left do not just prompt aftercare attendance, but may themselves be therapeutic.

A recent trial used a recontact procedure similar to that in Buffalo[46] (*previous section*), but this time the benefits were not due to greater use of aftercare treatment. Two US day-hospital addiction services randomly allocated their patients to routine aftercare or to 'extended case monitoring'.[52] As in other studies where 'light-touch' interventions have worked, participants tended to have jobs, stable homes, and intact marriages.

'Case monitoring' involved specially trained staff who first met the client while they were in treatment. A week after they left the monitor initiated at first monthly phone calls, usually lasting 15 minutes. These continued for two years on a tapering schedule which could be ratcheted up in response to need. Attempts were also made to speak separately to the patient's 'significant other'. Calls adopted a motivational interviewing style, starting with a friendly enquiry about how the patient is doing and, if needed, advising further support or a return to treatment, but (unlike case management) the patient was left to take the required steps.

Interim results for the three years after discharge showed that the frequency of heavy drinking had been halved in case-monitored patients (12% v 24% of days) and that they had taken longer to resume sustained heavy drinking.[53] But this had not been achieved by encouraging a return to addiction treatment. In fact, it was the non-case monitored

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patients who tended to return. They also made many more visits to emergency departments. It seemed that the calls had reduced the need for further treatment by themselves helping to reduce drinking.

In Belfast, after six weeks' inpatient treatment alcohol patients were also routinely recontacted, but this time face-to-face during home visits by an experienced community psychiatric nurse.[54] Given the nature of the caseload, nothing less may have sufficed.

The nurse's role was to directly respond to 'slips' and to encourage attendance at AA and hospital meetings. Visits were made to 93 patients for 12 months at first weekly and then monthly, but could be increased if needed. For administrative reasons, another 54 patients were instead offered six-weekly review appointments at the clinic. In the event, these were poorly attended.

The two groups were practically identical: very heavy, highly dependent drinkers with a criminal background. Over the year of the visits and enduring for at least the next four, the nurse had a major positive impact; 36% of her patients sustained abstinence compared to 6% of the remainder and by year five two-thirds were virtually abstinent versus 40%. These results seemed due to the visits themselves rather than to these encouraging attendance at self-help groups or a return to treatment.[iv]

Outside the treatment arena there is some evidence of benefit from following up workers with substance misuse problems seen by a factory's medical/welfare service.[55] In parallel to their substance misuse treatment, a counsellor at the factory attempted to follow-up a randomly selected half of the 325 workers for a year, at first weekly then tapering to once every two months. The aim was to show concern and support, encourage their recovery, and to offer help if needed.

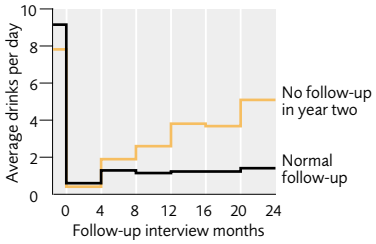
Though nearly two-thirds of the workers assigned to follow-up either refused it or dropped out, while it was in operation, company and insurance records indicated that it had reduced disability due to substance abuse and the need for substance abuse treatment. The other messages of the study lie in what went wrong: the need to gather good contact information beforehand, to integrate follow-up with the main intervention, and to create social incentives to make use of the services on offer.

### JUST RE-ASSESSING CAN BE THERAPEUTIC

Mechanisms which underlie the effectiveness of therapeutic follow-up contacts may also be at work when researchers re-interview clients. As Project MATCH found,[56] clients may make little distinction between a therapist asking them how they are doing, and a researcher doing the same. Just having to regularly review your drinking may itself be a moderating influence.

Usually any such effects are hidden because all research subjects experience the same follow-up procedures, but unforeseen complications in one alcohol treatment study meant that in the second follow-up year some did not receive the intended four-monthly research interviews.[57] They were interviewed, but only after a delay of 12 or 18 months. Compared to other subjects, they did just as well in the first follow-up year, but when contact was lost their drinking deteriorated ◤ *chart right*. By the end they were drinking heavily on a fifth of days compared to under 1 in 10 for other subjects, and consuming four times more alcohol.

The same kind of effect has been suspected in the Project MATCH study of alcohol




treatment,[58] in a study of injecting drug users' HIV risk behaviour,[59 60] and in one which recruited drinkers in a bar and simply asked them to regularly record their alcohol consumption for the next two years, using an automated phone system.[61]

## Benefits and costs of post-treatment follow up

Services considering whether and how much to invest in following up former clients will want to assess the benefits and the costs. Benefits can be addressed by asking what services stand to lose by *not* doing so. Evidence cited above shows that they will fail to retain patients in aftercare. Since greater access to and use of aftercare services is generally (but not always[62]) related to better outcomes,[63 64 65 66 67] they will also jeopardise progress made in the initial treatment.

Under-investing in follow-up also risks failing ex-patients in greatest need. Researchers conducting follow-up studies consistently find that former patients who are hardest to contact are the ones most likely to again be in trouble.[49 50 68 70 71 72 73] For example, in a US study primarily of crack users leaving residential rehabilitation, the harder someone was to recontact the more likely they were to have been arrested, to have resumed cocaine or crack use, and to be unemployed.[69]

### WHEN TO DRAW THE LINE

To contain costs a line has to be drawn beyond which further recontact attempts are not considered the best use of resources. Treatment services could learn much from researchers about where to draw this line and how to maximise success before crossing it.

A model tailored to addicted populations has been developed by US researchers and used to successfully recontact over 90% of 5000 research subjects in seven studies.[73] The model is based on thorough preparation while the patient is in the initial treatment to ensure that they expect and hopefully welcome follow-ups, and that they have given consent to contact their nominated associates and for those associates to disclose their whereabouts. Pre-follow-up verification ensures that associate information is up to date, and can be used to prepare them for later contacts. The researchers also ensure that letters and calls to (or which might be intercepted by) third parties do not disclose the nature of the patient's condition unless this is essential and the patient has previously given consent. Without this, follow-up risks causing embarrassment or worse.[74]

Treatment services and clinical researchers have used simpler methods to good effect. A study in Leeds showed that outcome information could cost-effectively be gathered on all but a few heroin or alcohol dependent patients three months after their initial assessment.[68] The procedure was to get consent for follow up during treatment and also to ask for the name and address of an associate who could help relocate the patient. Follow-up of patients not still being seen at the clinic was entirely through letters.

Similar preparations were made at the Hazelden Centre in Minnesota before mailing questionnaires to former patient three times during the 12 months after discharge.[50] Just around half were returned but phone calls netted most of the remainder, resulting in 70–80% follow-up. When phone calls had to be resorted to, patients were much more likely to be drinking.

In Liverpool researchers started cold in their attempts to relocate alcohol patients 11 months after they had been assessed for treatment; no prior consent or associate information had been obtained.[75] Nevertheless, a three-stage process involving two letters and (if these failed) a phone call recruited 75% of the former patients. Patients for whom treatment had failed tended not to respond until the final stage of the procedure; treatment successes usually responded at the first attempt.

### EFFICIENCY *and* THE HUMAN TOUCH

Though part 1 of this review has focused on relatively mundane procedures, already we can see that treating the patient as an individual, being welcoming, empathic, understanding, and demonstrating respect and active, persistent caring, are among the trademarks of services that hang on to clients.

We can also see that there is no conflict between these qualities and efficient admin-

## *Transformation stories* 1 THE MASSACHUSETTS ALCOHOL CLINIC

Much of what we know today was prefigured in a remarkable series of studies begun in the late 1950s at the alcohol clinic of Massachusetts General Hospital.[3337] It was run by Morris Chafetz, later to become founding director of the US National Institute on Alcohol Abuse and Alcoholism.

Dr Chafetz showed that not only can a service's performance be improved, it can be transformed by the simple application of empathy and organisation. He suspected that alcoholics' notoriously poor acceptance of and response to treatment reflected the negative attitudes of those around them, including clinical staff. If these attitudes were replaced with optimism and respect, then many more patients might embrace the help they needed – exactly what happened.

### Why won't they come?

Work started with the observation that virtually none of the alcoholics referred to the clinic from the hospital's emergency service actually attended. A micro-analysis of the referral process revealed that it entailed seeing perhaps a dozen individuals and numerous delays and opportunities to be baulked by the system. Staff attitudes did not engender determination to overcome the obstacles. Typically these 'Skid Row' alcoholics were in crisis (the reason for emergency admission), dirty, disturbed and disturbing, and often dragged in by the police. The effect was to evoke outright hostility and rejection on top of underlying moralistic and punitive attitudes.

Chafetz's team set out to create instead a welcoming and seamless procedure which established the emergency episode as the start of the rehabilitation process. It involved not just directly interfacing with the patient, but networking to gain the cooperation of other hospital staff and of outside welfare and housing services. Effectively Chafetz pioneered a 'case management' approach[96] intended to see that the alcoholic got coordinated, holistic and continuing care.

### Because *we* are doing the wrong things

In practice they established 'treatment catalyst' teams to reach out from the clinic, consisting of a psychiatrist on 24-hour call to immediately see patients in the emergency room and a social worker who worked with the patient, their family and outside services. By being welcoming, respectful and concerned, and by caring for the patient throughout, they sought to convey that they were the patient's own personal doctor and social worker. They also tried to avoid the patient being treated poorly by other staff. Rather than the insight-oriented psychotherapy then in vogue, they focused on taking action in response to the patient's expressed needs for practical help with things such as housing, money, a meal and a shave.

Alternate male alcoholic patients were assigned either to normal emergency procedures or additionally to one of the catalyst teams, 100 in each group. Nearly two-thirds (65%) of the treatment catalyst patients made an initial visit to the alcohol clinic compared to 5% of normal procedure patients. Forty-two of the patients seen by the teams made five or more visits compared to just one of the normal procedure patients – and he was a former clinic patient. The supposedly insoluble problem of engaging these "alienated men" was exposed as due not to their intractability, but to that of an inappropriate clinical response.[v]

### In a crisis, respond – *simple*

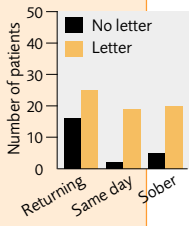
Another way the clinic came in contact with potential patients was through phone calls from the alcoholic or their family, usually during a domestic crisis. The response was typical of services then and perhaps of many now. A secretary noted basic details then mailed out an appointment for several weeks hence, by which time the moment and the motivation had passed. Instead Chafetz's team tried initiating same-day social work contact with the family, if necessary in person at the their home. After assessment, therapy and practical intervention were made immediately available. Throughout, the same social worker maintained contact.

On a quasi-random basis, callers were allocated to this approach or to normal procedures. Initial attendance tripled from 21% to 62% of patients and from 13% to 38% of their relatives. In nearly 30% of cases both came together compared to none under normal procedures. None of the usual-procedure patients returned at least five times over the next six months compared to 27% of the immediate-response patients.

### Keep them coming

Patients were now coming for intake but still many failed to return, particularly those (the most inebriated and debilitated) who after assessment had first to be sent to an inpatient unit to 'dry out'. The clinic's first attempt to retrieve them was a handwritten letter sent the day after their assessment. It expressed personalised concern ("*I* am concerned about *you*.") and equally personalised desire that the individual would return, when the service would be "glad to work with you". It was sent to 50 randomly selected patients; another 50 were handled as usual.

The impact was striking: 25 returned, all but 5 sober, and 19 the day they were discharged from the unit; without the letter, 16 returned, just 2 without delay and most after having resumed drinking ◤ *chart*. Replacing the letter with a phone call to the unit had a similar impact. Within a week of discharge, 22 of the 50 called patients returned for outpatient care but just 4 of the 50 who were not called.




### It's the way we say it

The next experiment was based on the belief that alcoholics are sensitised to hints of rejection in what a doctor says and how they say it. The doctors concerned were nine of the emergency physicians involved the year before in the studies. At issue was whether emotion betrayed months later in recordings of their responses to the question, "What has been your experience with alcoholics?" would correlate with how many of their patients had followed through on a referral to the alcohol clinic. Ratings were made of the unaltered recordings, of recordings filtered to obscure the words but leave emotional tone, and of transcripts.

As expected, ratings were related to referral success only when the treatment catalyst teams had not intervened to override the doctors' influence. Also not unexpectedly (all the patients had been men), the only significant relationships derived from male raters. The more anxious they felt the doctor sounded and (in filtered speech) the less angry, the more their referrals had been successful. The correlations were substantial and statistically significant. Just missing significance was a trend for more matter-of-fact and 'professional' sounding doctors to have a lower success rate. Assuming 'anxiety' was proxy for concern, it seemed that the more a doctor showed personal (rather than 'coldly professional') concern for a patient's welfare, and evidenced this in tone as well as words, the more likely the patient was to treat this as the start of a therapeutic relationship with which they wished to continue.

istrative procedures. To the contrary, such procedures are needed to give practical expression to the qualities and values which motivate them. Both are required. Another important lesson from the research is that there is nothing special about retention-enhancement or about how substance misuse patients react. Reflection on how we might react if we were in their shoes can predict much of what researchers have painstakingly set out to prove.

**NOTES**

**i** Includes readmissions. Not statistically significant.
**ii** The authors attribute the result to patients having effectively to decide twice whether to seek treatment since they did not see the initial contact as treatment.
**iii** Linda Sobell, already well known for her work on controlled drinking as a treatment objective.
**iv** Though more of her patients did attend hospital meetings.
**v** Later the alcoholic clinic's psychiatrists took on the screening role at the emergency service. The result was to identify and refer less socially isolated patients but they too attended far more often if the catalyst teams started the process in the emergency department: 62% made an initial visit versus 21%; 27% versus none made five or more visits.

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# Can we help?

MM2 MANNERS MATTER • PART 2

Around 'treatment' are the things services do to help patients get to treatment – or just to help, full stop. From the unglamorous periphery, *Manners Matter* places these centre stage.

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**THE MANNERS MATTER SERIES** is about how treatment services can encourage clients who make contact to return and stay the course, not by what type of therapy they offer, but by the manner in which they offer it. Part one dealt with some basic expressions of the 'good manners' which make for retention-enhancing treatment: responding quickly, sending reminders, keeping in touch. This part explores the impact of plain being helpful: offering a lift or to look after the children, convenient opening hours, realistic attendance requirements.[1]

As with reminders, aiding in these ways could serve several functions. First is the direct one of making treatment more accessible. Typical substance misuse caseloads live hand-to-mouth lives characterised by crises, instability, poverty, and poor housing. Without help, even the highly motivated may be unable to make and sustain contact.[1] Such help might also show that the service is being understanding, responsive and caring, strengthening the bonds at the heart of effective therapy. What a helping hand conveys about its owner could be as important as what it does for the recipient.

A related, much bigger agenda is particularly the province of case management: addressing the money problems, disrupted relationships, legal and housing difficulties which drive patients to attend treatment services.[1 2 3] Often these difficulties also obstruct access to treatment because people cannot afford transport or childcare, live such stressed lives that treatment drops down the list of priorities, or lives so disordered that keeping appointments is a challenge. While acknowledging this broader agenda, here we stick with the smaller task of overcoming some common, specific obstacles.

### WALK, NOT JUST TALK

For good reason, researchers have focused on practical, concrete help. People with sufficient resources and whose lives are sufficiently under their control could perhaps just be talked through access problems and left to implement the solutions. For many dependent substance users, this will not be enough.

Precisely this process was tried with randomly selected phone callers to a US service in Portland, who were also randomly allocated to come for intake as soon as possible the same day or given an appointment for on average 10 days later.[4] For these primarily stimulant users, rapid access did make a difference; discussing how to overcome whatever might stop the caller attending made none at all. In contrast, practical aid has usually been found to improve treatment uptake and often outcomes too. Helping to the client get to the service is an obvious first step.

## MM2 Could you do with a lift?

Studies commonly find that the further people have to travel for treatment, the less likely they are to do so. In these mainly US studies,[5 6 7 8] patients were typical of the deprived populations who access public treatment services: mostly black or Hispanic, single, unemployed, with no health insurance or only public insurance. Cars or taxis may be beyond their reach, they may be denied a driving licence, and live in areas poorly served by public transport.

**Some services find this their greatest asset in the drive to improve treatment uptake**

However, showing a link between transport obstacles and treatment attendance does not necessarily mean that helping overcome those obstacles would improve attendance and outcomes.[9] This is partly because some treatment populations[10] in some areas are in greater need of help than others. Los Angeles, infamous for its car-dependent transport system and congested streets,[7 4] is a prime example, and the site of several studies. As we'll see, results are also affected by how the aid is provided and whether it is used as a tool for individualised, holistic care.

A definitive test of the role of transport aid would involve randomly allocating some clients to receive this aid and others not, ensuring that this was the only difference between them. No such trial has been done, but the work reviewed next strongly suggests that providing transport really can help.

### TRANSPORT CRITICAL FOR METHADONE SERVICES

An analysis which takes us close to this conclusion comes from DATOS, the major national US drug treatment study. Understandably, the findings were

strongest in respect of methadone services, which in the USA demand daily attendance over long periods.

One of the DATOS sub-studies showed that clients stayed longer at outpatient services which provided transportation ◤ *chart*.[11] After taking caseload differences into account, methadone patients were three times more likely to stay for a year at clinics which offered drivers and vehicles than when no assistance was offered. At outpatient counselling services, the same was found for 90-day retention, but the link was much weaker. In contrast, no retention advantage was gained by reimbursing[ii] clients' transport costs – in fact, half as many clients stayed for 90 days at counselling services which met costs as at those which provided no help at all.

Several intriguing but speculative explanations were advanced for these findings. Perhaps reimbursing costs had opposing effects – helping with the money side, but adding the frustration of having to complete forms and wait for the refund, potential friction points between clinic and patients.[iii] Providing a driver plus vehicle entailed no such frustrations and supplied an escort to ensure that the journey was completed ◤ *Let me take you by the hand*, page 7. The driver's arrival would also have imposed structure on the patient's day. Perhaps, too, this degree of help signified a service which cared in other ways, encouraging patients to stay in contact.

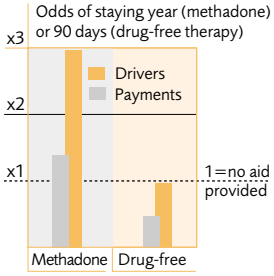
### FREE BUS TICKETS IMPROVE RETENTION

One of the Los Angeles studies suggested that if methadone services require impoverished clients to attend daily, they might also pay for them to get there – but through up-front vouchers rather than reimbursement.

The findings came from the Los Angeles Enhanced Methadone Maintenance Project.[12] It targeted HIV-infected injectors or those at high risk of infection including sex workers and the partners of injectors. Almost all the 500 subjects were unemployed, engaged in petty crime, prostitution or drug dealing and had criminal records. Nearly half were women.

They were randomly referred to the standard or to the enhanced programmes. Both required daily attendance, but among the enhancements were bus tokens for travel to the clinic. Tokens were handed to all patients in the first month and in months two and three to those who had attended at least three quarters of their appointments,[13] and they did seem[iv] to help patients avoid being thrown off the programme for failure to attend or otherwise comply with treatment. Largely as a result, at the enhanced clinics half as many patients exited treatment in the first three months.[14] Over the next nine months, the enhanced option's retention advantage eroded until it was no longer statistically significant.

There remains the conundrum of why




free transport worked at these methadone clinics but not in the DATOS study.[11] First possibility is the Los Angeles context. Second, the selection for the study of particularly disadvantaged drug users for whom fares might have been a significant disincentive. Third is the use of up-front vouchers rather than the reimbursement systems used by most of the methadone clinics in DATOS, removing the potential for friction with staff.

### TO GET ON TO METHADONE, I'LL GET THERE

Positive findings from the methadone studies cited above contrast with negative findings from Philadelphia – but this was a study of the *intake* process, not whether transport helped patients *keep* coming day after day, month after month.

The study sampled 102 parenting and/or pregnant women referred to a women's outpatient treatment service.[15] About 8 in 10 were primarily using heroin and most were offered methadone maintenance. They were randomly assigned to normal intake procedures or to these plus phone reminders, childcare, and a van to take them to and from intake appointments. Thirty of the 46 women offered these used the drivers,[v] yet the entire package resulted in only 8% more women (73% versus 65%) completing intake.

The high rate of intake completion in this study is attributed to the pulling power of methadone, especially in the rare context of a female-specific programme. With fares already paid for if the women wanted, the chance of a securing a place on a sympathetic methadone programme seemed incentive enough to make the few journeys required to complete admission, regardless of whether transport was provided.

### HELPS TOO AT COUNSELLING SERVICES

Though less so than at methadone services, transport aid has also encouraged Los Angeles' drug users to enrol and stick with counselling services.

Serving the city and surrounding county, a central unit referred applicants to publicly funded programmes. From this source, 145 people were included in the study; another 26 were referred from the street by researchers.[1] Stimulants, psychedelics, cannabis, and alcohol were the main substances involved, outpatient counselling the main response. Six months later, over a third of the 171 subjects had not started treatment. Rarely was transport cited as a reason for not even contacting a service, but of those who had made contact, about 1 in 7 indicated that transport problems contributed to their decision not to take it any further.

The study went on to investigate what made the two-thirds who had started treatment stick with it.[16] Transport was among the few relevant factors. Asked at treatment entry to rate the importance each of 30 services, most clients highlighted transport. Among them, clients who had *not* been helped stayed on average for less than three months compared to four if help had been provided. Helping with transport elevated retention to the same level as among clients for whom transport was not an issue.

Even after other potentially overlapping need-service matches had been taken into account, the effect of meeting transport needs remained statistically significant, but it

**GOLDEN BULLETS** Key points and practice implications

- Practical help to overcome access obstacles such as transport and childcare directly improves retention and also shows that the service is responsive and caring.
- Transport is most important among impoverished populations required to attend methadone services daily for supervised consumption.
- Direct help in the form of a driver and vehicle works best because it provides an escort and structures the patient's day. If this is not possible, provide pre-paid passes in preference to reimbursing costs.
- Transport augments efforts to link patients to external agencies such as housing and employment services.
- Childcare is essential if women are to be attracted and retained, especially in long-term residential care, but may not be used if it is unfamiliar or seems to threaten the mother's custody of the child.
- Flexible and realistic opening hours and attendance requirements mean patients with unpredictable lives are not set up to fail and allow others to maintain normal family and working lives.
- Especially in coerced criminal justice regimes, clients who do not have severe problems can be over-treated or over-supervised, with potentially detrimental effects on their abilities to return to or sustain a conventional lifestyle.

was not an overwhelming factor. Probable reasons were that the counselling services were more local than the methadone clinics and, unlike the clinics, most did not require daily attendance.[1]

### IT'S TRUE – WOMEN NETWORK BETTER

Also in Los Angeles, another study focused on outpatient counselling and therapy programmes.[17] Special funding had encouraged the provision of female-friendly services, so two-thirds of the 302 clients followed up eight months after treatment entry were women. Most clients were out of work and poor; crack, other stimulants, cannabis and alcohol were their main intoxicants. At the follow-up they were asked how useful they had found various services. Along with other variables, their replies were related to a composite measure of how long and how intensively (sessions attended per week) they had engaged with treatment.

The most striking overall finding was how much engagement depended on what services did and how this was perceived. One of the strongest links was with transport: clients who had both received transport services and found them useful had engaged far more deeply. The link was stronger for men but highly significant for both genders, of the same order as links with how useful patients had found treatment itself.

A further analysis attempted to identify which of the many factors were influential in themselves rather than because they overlapped with other factors. For men, transport remained the service most strongly linked to engagement. Among women it dropped out, but not necessarily because it was unimportant. At the start of treatment six in ten had friends and family prepared to help with issues such as transport, significantly more than the men.[18] Treatment agencies helped further by enabling female patients to share transport solutions, not noted among the men.[17] Also, factors which remained linked to women's retention (such as the usefulness of on-site medical services) themselves depended on being able to get to the agency. Lastly, providing transport could have contributed to the women's impression of how caring their counsellor had been, which was related to engagement.

### TRANSPORT LINKS TO EXTERNAL SERVICES

Siting medical and social services at the treatment centre is the surest way to get patients to use them,[19 20] but where this cannot be done, providing transport stops people falling through the gaps.

These were the clearest findings from a national survey of US outpatient drug treatment centres based on reports from their directors and staff.[19] Even after other relevant features had been taken into account (like referral arrangements and case management), patients made greater use of medical, employment, financial and housing services at centres which helped with transport.

Such findings make transport a potentially important way to link patients to sources of help with broader life problems, in Britain now starting to be given prominence in national policy.[21 22] But transport may not be enough unless coupled with a service which cares about those links and has an effective system for making them ◤ *Transport plus holistic care: more powerful than the parts?,* above.

**BEFORE A CLIENT COULD SERIOUSLY COMMIT TO TREATMENT, BASIC HUMAN NEEDS HAD TO BE MET AS WELL AS CHILD CARE TRANSPORTATION AND HOUSING**

### PRACTICAL AIDS BENEFIT MOST NEEDY

When studies have asked whether it helped when the agency as a whole offered transport, the answer has generally been positive. At the level of the individual, things can look quite different. Clients with the poorest prognoses due to social isolation and poverty tend to be the ones who take advantage of free transport (and other aids), the use of which then seems linked to a poor outcome. It takes a sophisticated analysis to identify whether these aids may in fact have make a bad situation somewhat better.

An example comes from Illinois, where the state provided childcare, transportation and "outreach" (presumably home visits) at selected outpatient centres for drug using mothers.[23] Compared to non-enhanced agencies, this was expected to improve access to the centres' services, which in turn would improve outcomes.

That's more or less how it turned out. Women who made use of the access enhancements also accessed more counselling, family, medical and social services. In turn, increased use of these services was associated with a greater likelihood of being abstinent from alcohol and drugs 14 months after entering treatment. Partly in these ways, enhancing the services also enhanced their outcomes.[vi] Because they were widely used, transport and outreach made the greatest contributions. As we'll see later, this was not the case for childcare.

But paradoxically, use of each of these services – transport most of all – was also statistically related to greater drug use at follow up. The explanation was that these aids were resorted to by women with the "most serious health, mental health, family and drug use problems". By giving these women access to the services they needed, the enhancements had helped more become abstinent. However, for many this was not enough to elevate their recovery to the level of less disadvantaged patients.

### TRANSPORT PLUS HOLISTIC CARE: MORE POWERFUL THAN THE PARTS?

Transport can be expected to have the greatest impact when it is used to get people to services they value and which actually do help. In turn this implies that the treatment agency is interested in, and capable of, making a broad assessment of need, and can appropriately direct clients to services. Programmes like these might, for example, not only actively refer patients to appropriate psychiatric services, but provide transport to see that patients get there. Hints of this effect can be seen in the Pennsylvania Wrap Around Services Impact Study.

The study analysed retention records and interviewed clients from nine publicly supported outpatient treatment centres.[40] Their patients were primarily unemployed alcohol or crack users involved with the criminal justice system. Though some of the centres required frequent attendance, in the first three months just 5% of patients were helped with transport, whether to the centre itself or to other sources of help. Overall, receiving transport aid was not linked to improved retention or outcomes; possibly its impact had been obscured because people with the greatest problems resorted to it.[23 xiv]

But there was one exception: a strong relationship between transport aid and improved mental health a year after starting treatment, *as long as* this aid had been provided by a service which also emphasised individualised treatment and access to a broad range of services. This might be dismissed as a statistical glitch, except that the same qualification applied to relationships between outcomes and aid with family and mental health problems or subsistence.

Individualised and holistic care are also key elements of case management, a role specifically designed to link patients to external services. But a national US study found that this was generally effective only when combined with transport aid.[19] The main findings of this survey of US outpatient drug treatment units have already been described: services which provided transport also had clients who made the greatest use of external services such as housing and employment ◤ *Transport links to external services*, below. In contrast, case management seemed relatively ineffective. But when case management was combined with transport, the combination *was* more strongly linked to service use (TB screening, medical examinations, and employment counselling) than either alone.

A tentative interpretation of these findings is that transport aid is targeted more effectively by programmes which carefully assess and try to meet the individual's broader needs. In turn, this aid helps ensure needs are met, creating the synergy seen in both studies.

## MM2 Let me take you by the hand

Sometimes providing an escort is the only way to ensure that clients don't stray (geographically or motivationally) in the transitions between referral and treatment or between treatment sites. In DATOS this could have been partly why providing drivers and vehicles was so strongly linked to retention in methadone programmes.[11] In Baltimore, it also seemed the overriding influence in a study of aftercare.

The study tried three levels of intervention in an attempt to secure the aftercare attendance of 166 patients (mainly black, male, single, unemployed, cocaine, heroin and alcohol users) following a three-day inpatient detoxification.[24] Some were randomly assigned to the basic level: an aftercare contract, bus pass to the aftercare centre, and instructions to attend the following day. Just 24% turned up and enrolled. Neither were patients swayed much by adding the incentive of $13 of bus or petrol tokens. This led 44% to enrol, not significantly more. But adding an escort from the detoxification unit to the aftercare centre did significantly increase enrolment to 76%. Altogether, the added measures had tripled the numbers at least starting aftercare.

### EXPERIENCE SHOWS ESCORTING WORKS

Also in Baltimore, researchers based at prenatal clinics struggled to engage pregnant drug users in four weekly motivational therapy sessions.[25] The women were overwhelmingly black, unmarried, unemployed, poorly educated, and generally had a history of cocaine or heroin dependence.

Reasoning that unmet basic needs were obstructing engagement, part way through the study the therapists tried starting each session by identifying those needs and referring the women to relevant social and welfare services. Despite this, and even after transport had been organised and funded, they found that escorting patients to the appointments was the only way to secure at least initial attendance. The result of accessing this broader provision was reduced drug use and improved welfare.

Escorting was also introduced in Chicago when initial attempts to bring relapsed former patients back in to treatment proved disappointing.[26] Every three months a randomly selected half of former patients were interviewed by staff from the central referral unit, who assessed whether they should return to treatment. Those judged in need were transferred to a 'linkage' worker to motivate the patient, arrange the return, and give practical aid.

After nine months, improved but still poor return rates prompted further enhancements including escorting and transportation. These did raise return rates (we don't know how much), but over the full two years of the study, just a third of patients encouraged to return to treatment did so. Overall, the study shows how 'hands-on' the effort had to be to re-engage these typically unemployed, crack dependent patients, many with a history of homelessness and sexual or physical abuse.

## MM2 Can we help with the children?

Transport and childcare commonly feature among the access obstacles which affect women more often or more sharply than men.[27,28] Their predicaments were described well in a report on a statewide effort to improve care of drug using mothers in California. Officials found that "before a client could seriously commit to treatment, basic human needs for shelter, food, and clothing had to be met first, as well as child care, transportation, and transitional housing".[29]

Why childcare might be important can readily be understood. Female substance misuse patients are typically young single mothers with dependent children, living alone or with other drug users, alienated or distant from relatives, isolated from the local community,[30] and unable to afford professional childcare. Their childcare options can be very limited.

It is, however, difficult to *prove* that providing childcare makes a difference. Agencies which have developed their own provision may be more attractive to women, but are probably also female-friendly in other ways. Only adding childcare to randomly selected agencies can prove that this is what improves retention. But these bolt-on, unfamiliar services may be rejected by mothers. Often, too, childcare is part of a more comprehensive package of special services.[31]

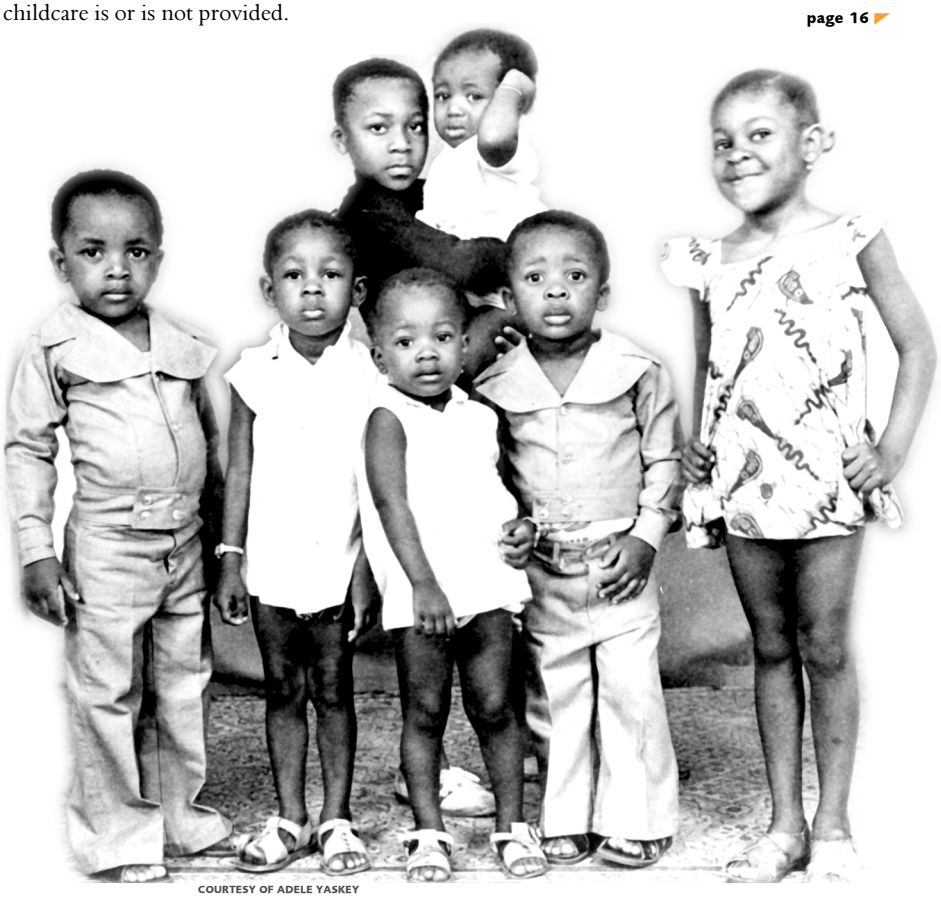
### CHILDCARE LINKED TO LONGER STAYS

Observations of attendance patterns when treatment is provided at home,[32,33,34] on an outpatient basis,[29,35] or in residential units (each step increasing childcare difficulties) are thought to reflect the importance for women of childcare.[36] Unless this is provided, it can be extremely difficult to attract women with dependent children,[37] especially if they are below school age.[38] This circumstantial and anecdotal evidence can be firmed up by looking at what happens when childcare is or is not provided.

### MODERATE LINK AT OUTPATIENT SERVICES

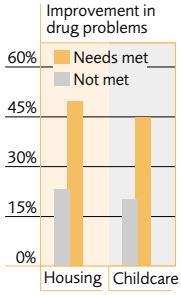
In the study of counselling services in Los Angeles which highlighted transport (*Helps too at counselling services*, page 5), nearly half the caseload were women[16] – probably why childcare was also prominent. When this was important to the client *and* provided by

page 16



COURTESY OF ADELE YASKEY

page 7




the service, retention exceeded five months, and six months after starting therapy drug problem severity had fallen by 45%. When it was important but *not* provided, clients left a month and a half sooner and problems fell by just 20%. Childcare was one of only two needs (housing was the other), the meeting of which was associated with better drug problem outcomes ◤ *chart*. It seems likely that childcare improved outcomes by improving retention.

Childcare was also considered important at the Pregnancy Substance Abuse Program in Ohio, which offered detoxification followed by intensive outpatient therapy.[39] From 1990, a revised regime including childcare became standard for drug using women under obstetric care. Nearly all were primarily using cocaine. After its introduction, 89% completed the inpatient phase compared to 61% beforehand, 83% referred to outpatient treatment started it compared to 46%, and completion of this demanding treatment more than doubled from 14% to 34%.

Some studies of outpatient services have found only a weak or no relationship between childcare and retention. This was the case for two of the studies cited in relation to transport, probably because in one childcare was almost universally on offer[17] while in the other there was virtually nil provision.[40] Still, in the latter study, 12 months after entering treatment the few, possibly atypical, women who had received childcare services demonstrated significantly greater reductions in alcohol and drug use.

### STRONG LINK AT RESIDENTIAL SERVICES

Having your child with you was strongly related to retention at a residential drug rehabilitation centre in Florida.[41] With their children, 55% of women completed therapy, without, just four out of 35. The former also stayed on average over eight months, nearly three times longer. What this means about childcare is unclear because mothers allowed to keep their children may have stayed longer for some other reason – perhaps they were more stable or committed to treatment. But the reactions of separated mothers did suggest that concern over their children – aggravated by inability to find out how they were – prompted some to leave early.

Similarly, improved retention after a residential centre introduced a female-oriented programme may have been due to features other than allowing children to stay, but this is likely to have been a significant influence.[31] From 42 days before the changes, once these had become embedded, women stayed for on average 158 days. Women with children at the centre stayed even longer. The presence of the children seems to have exerted a civilizing influence on all the residents including the men, whose retention also improved but not as much.

Importantly, there is no evidence that children suffer in these situations and we can expect them to benefit from the reduced drug involvement of their mothers.[42,43] However, the impact on the children is an under-researched area.

## DOES IT REALLY MAKE A DIFFERENCE?

All the studies cited so far simply observed relationships between childcare provision and retention or outcomes. Though the attempt was often made, such studies cannot eliminate other possible reasons for the findings. A few other studies have taken the further step of specially providing childcare to some women but not others to see if it really does make a difference. The record is patchy, partly it seems because these unfamiliar services may be distrusted by mothers who fear for the custody of their child.

### SERVICES MAY BE REJECTED

The transport element of the experiment in Illinois has already been reported ◤ *Practical aids benefit most needy*, page 6. Childcare was another strand. In the mid '90s, records had revealed that women with dependent children were unlikely to complete outpatient treatment.[44] Around the same time, the state's family and substance misuse departments combined to pilot improved provision for drug using mothers whose children were being monitored by the child welfare system.[23] As we've seen, compared to standard agencies, the offer of childcare, transportation and outreach improved drug use outcomes by enabling the women to access a broader range of services.

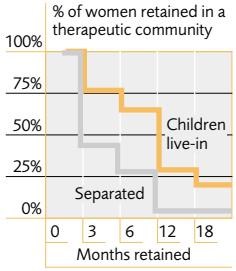
However, childcare made the smallest contribution, probably because in practice it was barely more widely used than at the standard sites. The only difference was in the uptake of home-based childcare, but still this was used by just seven of the 73 women at the enhanced agencies. It seems that on-site childcare already available at the agencies continued to be used but the new services were not. Some wariness was understandable; the services were, after all, being provided by state agencies which had the power to remove the women's children.

Something similar was certainly thought to have happened in the Philadelphia study of mainly heroin using mothers or mothers-to-be referred (generally for methadone maintenance) to a women's outpatient service.[15] A randomly selected half were offered extra services to help them complete the intake process, including childcare. Only three out of 46 took up childcare, primarily, staff thought, because these new clients did not yet trust the service. Most had not formally come to the attention of child welfare services and feared doing so.

### FAMILIES REHABILITATE TOGETHER

Being able to keep your children with you is likely to be particularly important in long-term residential care. Confirmation comes from Florida, where a family-friendly environment tripled the average stay at a residential therapeutic community.

The study selected over 50 newly admitted cocaine-dependent women with children under 11 years old who could legally live at the centre.[45] They were randomly assigned either to the standard dormitory regime (children could visit three times a week but not live in) or instead to shared houses where children lived with their mothers. On average these women stayed about ten months compared to just over three in the standard regime. Within three months, 23% had left the live-in regime but 55% the standard version ◤ *chart*. Previously women had stayed a far shorter time than men, now those living with their children stayed considerably longer.[vii]




### OFFCUT 1

Research on injectors in London indicates that **hepatitis C is spreading more rapidly** than was thought and that HIV is also on the increase. In 2001 researchers interviewed 428 injectors aged below 30 or who had been injecting for no more than six years and tested them for hepatitis C and HIV.❶ Over 90% were in London. A year later 70% were retested. At the first point about 44% were infected with hepatitis C and 4% with HIV. Over the following year those previously negative had about a 4 in 10 chance of becoming infected with hepatitis C and for HIV a 3–4 in 100 chance. These rates of fresh infection in new and younger injectors suggest that "drug policy is failing to maintain historical levels of protection from bloodborne viruses among this high risk group." Across England and Wales the proportion of new (up to three years) injectors already positive for hepatitis C has increased from 8–9% in the last years of the '90s to 14–17% in 2001–2003 and in 2003 nearly 1% were positive for HIV, the highest figure since 1990.❷

❶ Judd A. et al. *Incidence of hepatitis C virus and HIV among new injecting drug users in London: prospective cohort study*. British Medical Journal: 2005, 330, p. 24–25. Download from www.bmj.com.

❷ *Shooting up. Infections among injecting drug users in the United Kingdom 2003*. Health Protection Agency, 2004. Download from www.hpa.org.uk.

## *Transformation stories 2* AFTERCARE: TRY, TRY – AND TRY AGAIN

Through a series of inexpensive or cost-free steps each building on the other, researchers at the Salem Veterans' Affairs medical centre in Virginia transformed a poor aftercare attendance record into an excellent one. Both the initiatives and the methods used to assess them are well within the reach of many treatment agencies.

For its mainly alcohol-dependent, ex-military patients, the centre offers a 28-day residential or intensive non-residential rehabilitation programme run on cognitive-behavioural lines. To sustain sobriety, staff stressed the importance of attending weekly aftercare groups, but few patients did so and attendance was poor.

1 At first the centre tried randomly allocating 40 patients coming to the end of therapy either to normal procedures, or to a personalised introduction to the groups.[69] These patients could choose which aftercare group they wanted to attend and met the group leader, who explained why attendance was important, answered questions, and asked the patient to commit to at least eight meetings. The session ended with patients signing an 'aftercare contract' witnessed by the leader. Though non-attendance was an option, its wording was strongly weighted towards participation.[70] By signing it, patients acknowledged research indicating that aftercare tripled their chances of staying sober.

These procedures raised the proportion initiating aftercare from 40% to 70%, doubled the average number of sessions attended to three of the first eight, and meant that 35% versus 20% of patients were still in aftercare three months later.[71]

2 Next the service tried randomly allocating 41 patients to the innovations trialed at step 1, or to these plus reminders to attend and fulfil the aftercare contract.[70] The new procedures consisted of a mailed card to remind patients not just of the upcoming session (reinforced by an automated phone message) but of their attendance record and how far this lived up to the promises in their contract. Also, before the first session the group leader sent a handwritten letter saying they were pleased the client had joined them and that they looked forward to seeing them. Missed sessions were followed up with further letters and phone calls encouraging the client to return.

As a result, aftercare initiation increased from 70% to 100%, sessions attended doubled to over four out of eight, and 57% versus 35% patients were still in contact three months later.[71] The study also provided the first confirmation that improving aftercare attendance improved outcomes: over the five months after leaving the inpatient centre, the reminder group needed just five hospital readmissions, the control group 15, indicative of a significantly greater relapse rate.

Clients who'd received the reminders said these communicated the therapist's concern and engendered trust, while therapists found they provided an opportunity to help overcome any practical obstacles such as transport difficulties.

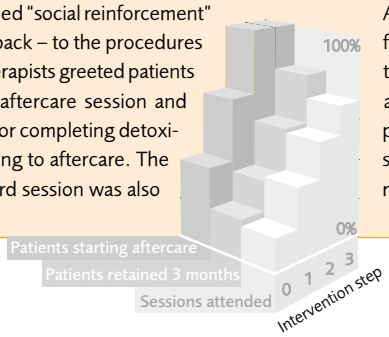
3 At 100%, initial attendance now could not be bettered, but still just half the first eight sessions were attended. To address this, the centre systematically added "social reinforcement" – public pats on the back – to the procedures trialed at step 2.[72] Therapists greeted patients attending their first aftercare session and congratulated them for completing detoxification and committing to aftercare. The milestone of their third session was also recognised as half way to the six which would earn them a certificate and a slot on a prominently displayed 'roll of honour'. Patients who attended all eight sessions were presented with a medallion.

Each milestone was recognised by presenting the individual to the group. This meant the reinforcers could not be applied to some individuals but not others, forcing the researchers to depart from a randomised research strategy. Instead they applied step 2 to 43 patients then after all these had finished aftercare, added social reinforcers for the next 38.

Social reinforcement patients attended on average nearly six of the first eight sessions compared to four without this public recognition, and 80% versus 40% remained in contact for at least three months.[71 72 73] Reinforcers were applied for eight weeks, but even after this attendance remained higher in the reinforced patients. For example, four to nine months later they attended four aftercare sessions versus one by other patients.[xi]

An attempt was made to follow up the first 20 patients from each of the groups six months after treatment had started to see if improved aftercare attendance had translated into improved outcomes.[73 xii] Compared to control patients, those whose attendance had been systematically reinforced recorded lower scores on a questionnaire measuring drinking and drink-related problems.[xiii] Additionally, 76% were abstinent from alcohol and drugs compared to 40% of the control group. They also tended to have fewer drug problems and, over the year after starting treatment, fewer hospital readmissions.

All these studies excluded participants who would have had difficulty getting to an aftercare centre due to distance, lack of transport or other commitments. Eliminating these practical barriers to attendance probably allowed the influence of what happens in treatment to show through so clearly. Because the centre served ex-military personnel there were also very few women




## MM2 We know you've got other things to do

For a service with set hours, whether people can get there during opening hours is clearly critical. If attendance requirements are both inflexible and demanding, unstable patients and those living crisis-ridden lives are set up to fail, while patients who are working, looking after their family, or otherwise productively occupied, are forced to choose between treatment and maintaining these important props to recovery.

### IMPOSSIBLE HOURS

These barriers seemed evident at an outpatient alcohol clinic in inner-city Chicago, where patients employed during its normal weekday opening hours were less likely to return after assessment than those who were employed in the evening or not at all.[6]

Unemployed clients also need time to deal with benefits claims, housing, family and other issues, why a New York day programme for crack using mothers found that flexibly adjusting attendance requirements improved retention without undermining the programme's effectiveness.[2]

Another US study randomly assigned unemployed methadone patients (most newly entering treatment) to a programme requiring attendance for therapy five hours a day, five days a week, or to one requiring attendance for just two hours a week.[46] After being told which they had been assigned to, 17 out of 307 patients did not return. All but one had been assigned to the more demanding programme.[47] This excess attrition was not compensated for by better outcomes in the more intensive programme.

In London a pilot methadone prescribing clinic recently opened at the Endell Street hostel for the homeless page 20 in this issue.[48] The clinic avoided unnecessary failures partly by allowing patients to pick up their prescriptions any time it was open, and partly by providing clinics at least every three days so that a missed session did not have to mean dropping out of treatment.

### DAILY TRIP TO DRINK METHADONE

Patients like those at Endell Street seem unlikely to consistently attend an outside clinic daily at a fixed time in order to consume their methadone, but very few studies have assessed the impact this requirement has on access and retention. Those which have suggest it is negative.[viii]

A snippet of UK evidence derives from the NTORS study of treatment services across England. In preparation for the study, 'structured' methadone maintenance clinics were established which required on-site consumption. Aversion to this requirement was said to have accounted for a higher drop-out rate in NTORS' maintenance as opposed to metha-

done reduction programmes,[49] reversing the normal advantage of maintenance regimes.

In South Australia, being able to get one's prescription dispensed at a local pharmacy was associated with a much lower drop-out rate (by a factor of five) at methadone clinics in the decade from 1981.[53] This may have been partly because take-homes were granted to more cooperative patients, but clinic policies were probably also a factor. Those which required daily attendance forced some patients to travel very long distances and to devote much of their lives to obtaining their medication.

US evidence is stronger, coming from a trial which randomly allocated patients to on-site consumption every weekday or just twice a week.[50] Within each set, patients were also randomly allocated to 50 or 80mg of methadone a day. Regardless of the attendance requirement, on the higher dose about 80% were still in treatment six months later. But at the lower dose, retention at 80% was twice as high when patients could visit just twice a week.

In Italy a clinic tried to prepare patients on take-home doses for the advent of a law prohibiting this practice, a rare 'natural experiment' in forcing on-site consumption.[51] During the six-month lead-up, the drop-out rate was 19% compared to 3% the year before. Rather, it seems, than have their take-homes withdrawn, another 23% (compared to 4% the year before) underwent a planned detoxification from methadone. Fifteen of the 49 detoxified patients could be traced three years later: ten were back in treatment, five had died.[ix] Clinic staff commented, "having medication at home means being allowed to organize the everyday routine of life on the basis of his or her needs (work, family, leisure, etc) ... lack of this opportunity can have repercussions on compliance with treatment".[52]

### SUPERVISED HEROIN HARD TO LIVE WITH

If attending daily for methadone can be a problem, having to do so two or three times a day to take heroin is even more onerous, counteracting the drug's attractions. The consequences have been documented in heroin prescribing trials in Switzerland and the Netherlands, both of which required on-site consumption.

The Swiss tempered the inconvenience by allowing patients to skip visits and take oral medication instead, an opportunity most took. Nevertheless, when the programme in Geneva was advertised in addiction treatment services, in seven months it attracted just 61 regular heroin users, suggesting a widespread preference for less demanding methadone regimes.[54] In the Swiss trials as a whole, retention was better than at methadone programmes, but still within a year of starting their treatment 30% of patients had left and within five years, two-thirds.[55,56] Despite successes in curbing illegal drug use and crime, not surprisingly, the heroin programmes did nothing to promote employment, if anything, the reverse.[57] As researchers commented, supervised consumption made "a complete reintegration into the workforce ... extremely difficult".

**WHAT A HELPING HAND CONVEYS ABOUT ITS OWNER COULD BE AS IMPORTANT AS WHAT IT DOES FOR THE RECIPIENT**

In the Netherlands, retention was actually slightly better among patients randomised to standard oral methadone regimes.[58] Many who left the heroin programme voluntarily or for medical reasons did so to return to methadone.[59]

## TOO MUCH ATTENTION

Offenders in particular may be forced into counter-productively inflexible and intrusive attendance requirements. This seems to have been the major reason for widespread failure to complete drug treatment and testing orders in England and Wales, whilst the more flexible regime in Scotland (where offenders are not failed simply for missing appointments) has a far better record.[60] Non-completion is strongly linked to later recidivism,[61,62] probably the main reason why the reconviction rate was lower in Scotland.

### TOO MANY HEARINGS IN DELAWARE

These issues have been most thoroughly explored at drug courts in Delaware.[63] In the first study, nearly 200 low-level offenders ordered into treatment were randomly assigned to mandatory fortnightly court hearings, or instead to be referred to the court when treatment staff thought this was necessary due to poor progress.[64]

The more rigid structure seemed to help problematic offenders (anti-social personalities or a history of drug treatment) comply with the court's requirements, but it did the opposite for the more conventional offenders. It did not curb their drug use as well as the flexible regime and unnecessarily blighted their futures by condemning more to fail and acquire a criminal record ◤ *charts*.[65] A suspected mechanism was the disruption it caused to employment and education.

Later these findings were partially replicated at two other Delaware drug courts in respect of relatively minor (misdemeanour) offenders[66] and more serious (felony) offenders.[67] In all these studies, the offenders were mainly young, employed men.

These findings came from offenders at least prepared to risk random allocation to fortnightly hearings. Even more revealing are the numbers (about half or more) who rejected this risk, perhaps rightly fearing that they would be more likely to fail than in the normal regime. Among those who did join the studies, 28% of the felony offenders assigned to fortnightly hearings dropped out. The researchers attributed this to the fact that the longer felony programme (at least six months and up to a year) interfered unacceptably with the offenders' abilities to maintain employment or education.

Similar findings emerged from a preliminary analysis of another US study where integrating intensive, long-term[x] group therapy in to the probation or parole supervision of high-risk, drug using offenders reduced re-arrest rates.[68] But moderate risk offenders did at least as well and possibly better left to follow through on treatment referrals in the usual way, even though this meant two-thirds did not enter treatment at all, and that those who did quickly left. MM2

## NOTES

**i** Other forms of practical help such as home visits and outreach instead relieve the load on the client to visit a service. Important as these are, this review largely lays them to one side to concentrate on what fixed-site services can do to encourage clients to attend.

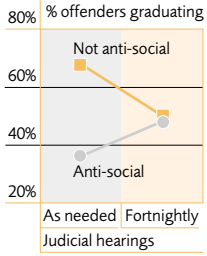
**ii** The main way of meeting transport costs at these services. Fewer provided vouchers.

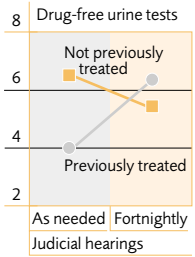
**iii** The apparently counterproductive effect of reimbursement at the drug-free clinics may also have been an artifact of which clinics offered to pay. DATOS's drug-free clinics ranged from intensive day programmes to weekly counselling services (Etheridge R.M. *et al*. "Treatment structure and program services in the Drug Abuse Treatment Outcome Study (DATOS)." *Psychology of Addictive Behaviors*: 1997, 11(4), p. 244–260). The most intensive were far less likely to retain patients for 90 days, perhaps because their programmes were shorter, or perhaps because of the greater burden they placed on patients. In an attempt to reduce the burden, these clinics may also have been the ones which offered to pay for transport. Such a mechanism would create a statistical link between paying and poor retention even though one did not cause the other.

**iv** Enhanced-programme patients were also given access to case management and extra therapy groups but partly due to resistance from patients and partly to resistance from external agencies, these were poorly implemented (◤ reference 13). This and the fact that the greatest impact was seen in the first three months suggest that transport was the main factor. The impact of making free transport contingent on good attendance is impossible to gauge, but in the context of other studies, it seems likely that much of the effect was due to simply providing the help.

**v** Twice as many as took up the offer (available to all the women) of vouchers for free transport.

**vi** How the state selected the enhanced centres is unclear and the researchers further selected the biggest centres to study, which also tended to be well established and of good repute. The result might be visible in the fact that women did better at these centres, regardless of whether they used




**In Delaware mandatory court hearings every two weeks helped anti-social offenders and those previously in treatment but were positively harmful to others.**

the access enhancements or even whether they used more of the centre's services. Whether less competent outfits would have made good use of the enhancements remains an open question.

**vii** These figures probably underestimated the impact of keeping the family together. While waiting for their children to be admitted, a few women left the live-in regime, something which could normally have been avoided. Up to two children under 11 years of age were allowed to stay, yet on average the women had three, meaning that many must have remained separated from some of their youngsters.

**viii** The safety and anti-diversion arguments for supervised consumption are acknowledged but are not the focus of this review.

**ix** It seems possible that only patients in either of these categories could be traced.

**x** Three times a week for six months.

**xi** A small part of these differences were due to slightly greater initial attendance so cannot be attributed to social reinforcement, but after discounting this there remained a substantial effect.

**xii** 32 of the 40 were reinterviewed. These patients were also the source for the longer term retention data.

**xiii** Alcohol was the primary concern for two-thirds of the patients.

**xiv** Given how few in Pennsylvania received this help, it seems likely that their needs were extreme.

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SECOND SIGHT

## A message from Albuquerque

*by* **Bill Miller**
Motivatonal interviewing's founder, University of New Mexico

I got interested in this field on an internship in Milwaukee. The psychologist-director, Bob Hall, enticed me to work on the alcoholism unit, even though (and because) I had learned nothing about alcoholism. Knowing nothing, I did what came naturally to me – Carl Rogers – and in essence asked patients to teach me about alcoholism and tell me about themselves: how they got to where they were, what they planned to do, etc. I mostly listened with accurate empathy.

There was an immediate chemistry – I loved talking to them, and they seemed to enjoy talking to me. Then I began reading about the alleged nature of alcoholics as lying, conniving, defensive, denying, slippery, and incapable of seeing reality. "Gee, these aren't the same patients I've been talking to," I thought. The experience of listening empathically to alcoholics stayed with me, and became the basis for motivational interviewing.

### Crash – and I wrote the manual!

To me our drug abuse study was a clear example of manuals failing to adapt to the patients ◤ study 13. I am now working on a paper which collapses the two 'poor outcome' groups (strugglers and discrepants) and the two 'good outcome' groups (changers and maintainers).[44] Their speech patterns are strikingly different.

Relative to good outcome patients, those who will have poor outcomes showed two substantial deviations. They backpedalled around the third decile [tenth of the session]. Commitment strength stopped climbing, and instead flattened out or fell. Then around the sixth decile it started picking up again, and actually reached the same point at decile 9 as the good outcome group. In decile 10, however, it fell abruptly back to zero.

"What were you doing to these people?" Paul Amrhein [language analyst] asked. The answer is that in deciles 1 and 2 we

**I BEGAN READING ABOUT ALCOHOLICS AS LYING AND DEFENSIVE. "GEE, THESE AREN'T THE SAME PATIENTS I'VE BEEN TALKING TO."**

were doing pure motivational interviewing. Around decile 3, we started assessment feedback. About 70% of patients went with it and showed the expected effect of increasing commitment to change, but the poor outcome group did not. They seemed to balk at or resist the feedback. I gave the therapists no choice in the manual but to continue with the feedback. Then around decile 6, the therapists went back to pure motivational interviewing.

Then the manual says to develop a change plan by the end of the interview. Again, the manual (which I wrote!) left no flexibility. The essential message was, develop a change plan whether or not the patient is ready. Crash. Any decent practitioner would know not to persist when patients start balking.

### Best for the ambivalent?

Your collection of studies suggesting an adverse effect with motivational interviewing for 'more-ready' clients is an important observation. The same direction is there in the anger match in Project MATCH. Low-anger clients showed somewhat worse outcomes with motivational therapy relative to the other two treatments. I can understand motivational interviewing having no effect with clients who are already ready for change, but the seeming adverse effect, now observed in several studies, seems surprising.

The clinical sense I can make of it is that when clients are ready to go, it is not time to be reflecting on whether they want to do so. Motivational interviewing was originally envisaged for working with people who are ambivalent or unclear about change, and perhaps that is the group for whom it will be most helpful.

Carl Rogers ◤ What happened when he let a troubled mother tell her own story convinced him that the therapist's task is to rely on the client for direction – the person-centred approach which inspired motivational interviewing.

**GET THE FULL STORY**

This analysis is distilled from an extended review available free on request from editor@drugandalcoholfindings.org.uk. Note that the aim is to investigate motivational interviewing as a preparation for patients seeking treatment without being legally coerced to do so, rather than as a treatment in its own right or a way of encouraging take-up of aftercare.

Toronto addiction treatment centre.[38] On alternate months each new alcohol patient was handed the *Alcohol and You* booklet at the end of their intake assessment. Written by Bill Miller,[4] this combined motivational elements and individualised assessment feedback comparing the drinker to national norms. It invited readers to reconsider their drinking but did *not* advocate return for treatment, an attempt to avoid its rejection by people who had decided not to come back.

Despite this, patients given the booklet were slightly *more* likely to return, but the biggest effect was to substantially reduce drinking over the next six months, especially among the minority who did not come back. These findings underline the twin arguments for motivational induction: not only may it promote engagement with treatment, but it also constitutes a potentially effective brief intervention for those who drop out.

## MM3 Beyond drinkers: pluses and minuses

For users of drugs including heroin, cocaine and cannabis, motivational interviewing has now been tried during the waiting period for treatment and the initial stages. Results have been mixed, perhaps because the patients themselves were mixed in the degree to which they needed a motivational boost or were at the stage where they could benefit from one.

### BRIEF RESPITE VERSUS INTENSIVE MARATHON

Two studies have trialed motivational interviewing to tide people over while waiting for treatment to start. Though really *pre*-induction, the results are relevant. In one there was no impact, in the other, long-lasting benefits. The difference may have been down to the degree to which motivation was the issue.

10 In Washington, the unsuccessful trial inserted measures including a manual-guided motivational interview between the time drug (mainly cocaine) abusing patients had been referred for treatment and their first appointment.[24] A relatively full-featured attempt to bridge this gap, it made no difference to how many patients started or completed treatment (a commendable 71% in both cases) or how well they did.

The 654 who joined the study typically suffered severe and multiple problems (including poor housing), and were overwhelmingly committed to the treatment on offer. For 85%, this was a short stay in hospital – conceivably an attractive respite from the streets, especially since most did not face opiate withdrawal. Those who nevertheless failed to turn up were probably less in need of a motivational boost than of intensive support.

11 A Spanish trial provides an instructive contrast. The marathon *Proyecto Hombre* rehabilitation programme attracted mainly heroin users living with their parents or in their own family home.[39 40] It started with roughly a year-long day programme during which the families came with the clients. Before this phase was half way through, four out of five had dropped out.

Seeking ways to stem the outflow, detoxified patients awaiting entry were randomly allocated to normal procedures or to a three-session motivational intervention, structured according to a broad outline rather than a detailed manual. Three months into treatment, the motivational group showed improved retention. The gap grew until by six months half were left compared to

just 1 in 5 after normal procedures.

These Spanish addicts had the home support lacking in Washington, potentially leaving their commitment to the programme as the main influence on whether they stayed. No respite from the streets, this was an extraordinarily extensive and intensive programme which would dominate their lives for nearly two years. Wavering commitment would have provided fertile ground for motivational interviewing.

### MIXED RECORD AS INDUCTION METHOD

The few direct tests of motivational induction for heroin or cocaine users confirm that it is most beneficial for those ambivalent about treatment and go further, showing that it can actually be counter-productive for more committed patients.

12 The first such study took place at an Australian methadone clinic.[41 42] There researchers had structured the motivational style into a one-hour 'bolt-on' module (plus a brief review session a week later) consisting of a seven-point agenda.

As adapted for heroin users, a brief examination of what they see as the good side of heroin use is intended to establish this as a chosen rather than an out-of-control behaviour. Then the focus is on eliciting and amplifying the client's account of the debit side of heroin use, featuring a balance sheet of the pros and cons completed at home for review at the follow-up session.

Compared with educational sessions on opiate use, on average motivational induction extended retention from about 18 to 22 weeks and delayed relapse to heroin use, consistent with an impact on outcomes via retention. However, improved retention may itself (as in study 5) have been due to the interviews helping patients rapidly curtail substance use.[iii]

How can we account for these findings, when adaptations of the same model for drinkers and cocaine users failed to improve on normal procedures ◤ studies 6 & 10? First, in contrast to these studies, many of the Australian patients were ambivalent about ending substance use. After all, patients starting *methadone* treatment clearly are not yet ready to see use of opiate-type drugs as an unambiguously bad thing.

Another key may have been the holding power of the intervention over the week between the sessions. Patients appreciated the chance to explore their experiences with a "highly skilled" therapist who rapidly established rapport. To return for 'closure' of this valued intervention, they had to stay on methadone for at least the first week after being stabilised, a vulnerable period. More did so than after the alternative induction, accounting for better long-term retention.

Underneath it all may have been the 'developer effect': the intervention was being trialed its creators, presumably enthusiastic exponents. Perhaps also, as its 'owners', the Australian team had the licence to adapt it. Where they stressed skilful flexibility, the other two papers suggest a more prescriptive implementation. The initial focus on the positives of substance use may need particular care unless, as with methadone patients, it simply acknowledges an undeniable and current reality for the client.

### "PUZZLING" FAILURE WITH DRUG USERS

13 A 'developer effect' was notably lacking when Bill Miller's team extended their work to drug users. The study took place in Albuquerque at his university's outpatient centre and at an inpatient detoxification unit.[43] For most of the 208 patients, cocaine (especially crack) was their primary problem, and for nearly one in three, heroin.

Half were randomly allocated to continue as normal and half to a motivational interview conducted by therapists trained and supervised to follow a manual. On practically every measure taken and no matter how the sample was divided up, the interview made no difference to motivation for change, retention, or drug and alcohol use outcomes over the next 12 months.

Among the possible explanations are that, according to paper-and-pen tests, nearly all the patients were in no need of a motivational boost, but an analysis of what they actually said in counselling sessions seems to belie this interpretation.[44] Several other explanations are feasible. For one, the same analysis provided empirical confirmation: the study's inflexible, manualised approach to motivational induction had left insufficient room for therapists to adjust and provoked counterproductive reactions when its instructions clashed with the client's state of mind ◤ *Care too with the unconvinced*, p. 38.

### DEPENDS ON INITIAL COMMITMENT

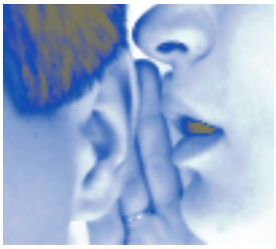
The next two studies found that motivational induction had no *overall* impact on retention, but also that this masked positive impacts among patients who saw themselves as still thinking about curbing drug use rather than having started the process. Less expected was a *negative* effect among the latter. These findings are explored later ◤ *More committed react badly*, p. 28.

### AMONG INDIGENT POOR

14 In Houston, 105 cocaine users started a ten-day outpatient 'detoxification'.[45] Most were black and unemployed and smoking crack. Patients who achieved abstinence could transfer to relapse prevention aftercare. The issue was whether starting detoxification with a motivational interview would improve transfer rates.

Patients were randomly allocated to normal procedures or additionally to a two-session motivational interview on days one and four, conducted by therapists trained and supervised to follow a detailed manual. There was no overall effect on transfer rates, but the interviews did help less motivated patients complete detoxification and transfer to aftercare. By doing so, they might have been expected to lead to a higher relapse rate during aftercare. The opposite occurred. More motivational patients started aftercare cocaine-free and over the next 12 weeks they continued in the same vein.

Drug use reductions seen in this study and the extra impact on less motivated patients were both absent in Albuquerque ◤ study 13. A possible reason is the way the patients entered treatment, in Albuquerque via normal routes, in Houston, via ads for the study. Judging from their motivational profiles, many in Houston would not have sought treatment unless prompted by the ads; motivational interviewing had something to bite on.



**Like a whisper in the ear, a motivational interview can have a dramatic impact, but just what that is depends on the relationship, the situation, what's said, and how it fits into what went before and what is yet to come.**

### AND EMPLOYED PRIVATE PATIENTS

15 A similar study which used a similar measure of motivation also found that this determined how patients would react.[46] The programme was a day-hospital regime in Rhode Island with an abstinence and 12-step orientation. Over 7 in 10 of the cocaine-dependent patients who joined the study smoked crack, but at this private facility they were not the poor minority caseload seen in Houston ◤ study 14.

Half were randomly allocated to a motivational interview planned for day two and half to meditation and relaxation. Therapists were trained and supervised and motivational sessions recorded to ensure they competently followed a manual. Though the emphasis could vary,[47] this prescribed an exploration of the pros and cons of cocaine use, how use or non-use fitted with the patient's goals, feedback of a prior assessment of their drug use and its consequences, and the formulation of a change plan.

At issue was whether this would improve on the inactive and it was thought ineffective relaxation approach. The answer was a surprising 'No'. Patients as a whole did well, but on none of the measures of retention or outcomes up to 12 months did the motivational interview further improve things. As in Houston, this was not because the interview itself was inactive, but because it had opposing impacts on different patients.

## MM3 Is it dangerous to follow the manual?

Manual-guided programmes have become seen as essential for any treatment which claims to be evidence-based.[48] The research rationale is to standardise 'inputs' so these can be related to outcomes, the clinical justification, that they enable clinicians to "replicate" proven treatments.[49]

An alternative view is that such detailed programming cramps client participation and clinical judgement[3] and focuses attention on techniques rather than ways of relating which cut across therapies.[2] If these are what matters, then the baby could be exiting with the bath water. Such prescriptiveness seems particularly risky for motivational interviewing, whose essence is to respond to clues from across the table, and whose mantra is that the "responsibility and capability for change lie within the client".[50]

Support for this view comes from a recent meta-analysis.[20] The studies it analysed differed in how they implemented motivational approaches. Of all the variations including duration, how many motivational-style principles and techniques were said to have been deployed, and therapist training and support, only one was related to outcomes – whether the therapist followed a manual: manualised therapy had *less* impact.

### MORE COMMITTED REACT BADLY

This result could have been due to differences between the studies other than whether they used a manual. But signs of the same effect can be seen *within* studies. In three, motivational induction helped 'low motivation' patients but retarded those more committed to action ◤ *charts*. Each time, therapists were supervised to ensure they adhered to a detailed manual which prescribed 'decisional balance' exercises, leading the patient to review the pros and cons of changing substance use or engaging in treatment or aftercare.

Two of the studies have already featured in this article. Both involved mainly cocaine users attending a short-term day detoxification programme, and divided patients into those typified more by 'taking action' to tackle their substance use as opposed to 'still thinking' about it.

In Houston (14), motivational induction improved completion rates among 'still thinking' patients, counterbalanced by the *opposite* effect in those who saw themselves as having already started this process – they did worse after the interviews. These effects were substantial and statistically significant.

In Rhode Island (15), consistently the interviews worsened cocaine use outcomes among 'taking action' patients while (to a lesser and non-significant extent) improving outcomes among those 'still thinking'. Seemingly no fluke, there was a similar pattern with drinking.

### ALSO IN AFTERCARE STUDY

19 The third study concerned alcohol patients admitted for on average five days of inpatient detoxification in Rhode Island.[51] It has not featured so far because the aim was to motivate take-up of aftercare.

After settling in for at least a day, randomly selected patient intakes were allocated to one of two types of induction. The first was five minutes of advice which comprehensively contravened motivational interviewing's code. Patients were told they had a significant drink problem, that abstinence was very important, and to get as involved as possible in AA aftercare groups.

The second type of session was a one-hour motivational interview. It also advised abstinence and AA, but not in the unambiguous manner of the more abrupt intervention. Instead, patients were led through exercises weighing the pros and cons of abstinence and AA and exploring how drinking conflicted with longer-term goals. Finally, they were asked to choose their own goals for attending AA groups or were informed of alternative sources of support.

> "THE PARADOX OF MANUALIZATION IS THAT THE PATIENT'S ACTIVE INVOLVEMENT IS LIKELY TO BE ESSENTIAL TO GOOD OUTCOME BUT DESTRUCTIVE OF EXPERIMENTAL CONTROL"[3]

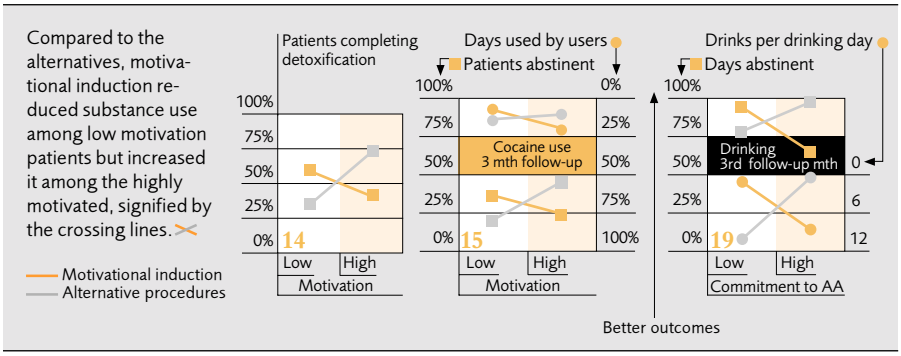
Among patients whose current plans and past records of attending AA/NA indicated less commitment to AA, the interviews had the expected effects. They abstained more often, and when they drank, drank less than patients given brief advice. But this was counterbalanced by an even greater *negative* effect on more committed patients.

Over a six-month follow-up, as long as patients *most* committed to AA had been directed to abstain and attend the groups, and those *least* committed had been through the motivational exercises, on average each sustained near 100% abstinence and drank little when they did. When this matching was reversed, outcomes were far worse.

### TWO STEPS BACK?

In all three studies, the puzzle is not why the least committed benefited (this is expected), but why the most committed reacted badly. It seems that motivational interviewing of this kind is as capable of knocking back more motivated patients as it is of helping those in need of convincing.

The explanation might be what to the patient could have seemed an undermining backward step to re-examine the pros and cons of whether they really did want to stop using drugs or commit to treatment and aftercare, when they had already decided to do so and started the process. Other unsuccessful induction trials might also be explained by the relatively high commitment of the clients allied with an insufficiently flexible approach ◤ studies 6, 10 & 13.




### CARE TOO WITH THE UNCONVINCED

One of these trials (13) uncovered another hazard of prescriptive therapy – failing to back off in the face of continuing ambivalence. Though the hazard is different, the study provides insights into how both sorts of mistakes can occur.

Despite considerable experience supplemented by 16 hours' training and feedback on their videoed performances from Bill Miller, who personally certified their competence, the study's motivational therapists failed to improve retention or outcomes.

In this study, so tightly was the interview programmed through a detailed manual, and so diligent, well trained and closely supervised were the therapists, that they introduced the same topics at roughly the same point with all their clients. It enabled what clients and therapists said to be matched to the topics addressed in each succeeding tenth of each session.[44 52]

Analysis of the videotapes suggested that it was not (as previously believed[20 53]) the frequency of 'change talk' which related to outcomes, but the strength of the client's determination to change versus to stay as they are. The difference between 'I hope to' and 'I *will*' (or similar) was more important than how many times either was said.

### WRONG MOVES AND PREMATURE CALLS

During the first five to ten minutes of each session clients were asked what had led them to seek treatment. Here the strength of their commitment to reduce drug use

simply reflected how far they had already done so. From then on, commitment strength started to respond to what the therapist was doing, and instead of reflecting where the client had come from, became a potent predictor of where they would end up in a year's time.

The first clue came around the middle of each session when clients had received feedback from an assessment of their drug use and related problems. As intended, about 70% expressed sustained or increased commitment to tackle these problems. Over the following year, they largely remained abstinent from their primary drug.

But faced with this almost unremittingly negative feedback, a minority retrenched towards a commitment to continued drug use, especially the ones who from the start had been less convinced that their drug use really had been all bad. Over the next year, they struggled to control their drug use.

The same patients tended to be among[iv] the ones who at the end of the interview backpedalled in their commitment to change. At this stage therapists tried to get their clients to tie up all the ends – no matter how loose – into a plan for tackling drug use, one concrete enough to have explicit criteria of success, and sufficiently well grounded to withstand the anticipated pressures of life beyond treatment.

Despite being tested in these ways, most sustained the strength of their commitment and went on to express this in reduced drug use. But a minority sharply backed down; 'I wills' or equivalent rapidly became 'I'm not sure'. The strength of this final, concrete, public and verifiable commitment was the single most reliable harbinger of whether clients would later control their drug use.[v]

Another significant juncture came about two-thirds through each session when therapists asked if the client was yet ready to change. Again, those who backtracked tended to do badly over the following year.

It seemed that some clients reacted badly to these attempts to push them forward. Instead of firming up their expressed commitment to curtailing drug use, they reversed, a setback followed by the predictable outcomes in terms of actual drug use. As far as could be determined, this was not just a case of people who had a poor prognosis anyhow reacting poorly to counselling.

The analysts cautioned that "a prescribed and less flexible approach to MI (as can occur with manual-guided interventions) could paradoxically yield worse outcomes among initially less motivated clients." Leading the client to review the good side of their drug use is, they thought, particularly risky; by fostering an 'It wasn't all bad' perception it might pave the way for resistant reactions to assessment feedback.

What caused these reversals was, for motivational interviewing, an atypical degree of directiveness by the therapist. If this can be seen in motivational therapy, it should also be apparent elsewhere.

This is territory to be covered later in the *Manners Matter* series. Here it's relevant to note the key finding: patients who like to feel in control of their lives, who react against being directed, and resist therapy, do best when therapists are less directive (as in true-to-type motivational interviewing), while those willing to accept direction do better when this is what they get.[29 31 32 33]

### ACCEPTANCE ELICITS HONESTY

Among these salutary lessons was a silver lining: the strength of the client's commitment to change at key junctures was so closely related to later drug use, that from this alone one could predict with remarkable precision (in 85% of cases) who would do well and who would struggle.

As required by motivational interviewing, the therapists had created a non-judgemental social space within which what the client said was a valid reflection of their state of mind and determination to change, rather than acting as a way to placate, save face, or terminate the encounter. The problem was that therapists were so constrained that they could not respond to these clues.

## MM3 Interchange; time to reflect

Still to come are the implications of these findings for training, research with legally coerced populations, and studies of linkage to aftercare. But in true motivational interviewing style, now is a good time to summarise and reflect.

First, clearly there is something here which works most of the time and more consistently and at less cost than the usual alternatives. What that 'something' is remains to be clearly defined. In every induction study in which motivational interviewing has apparently had a positive overall impact, this can be explained by 'non-specific' factors common to other therapies rather than the specific approach.

Most common, and potentially most powerful, is the enthusiasm and faith of the therapists, often newly trained and/or associated with the approach's developers ◤ studies 3, 4, 5, 8 & 12. Then there is extra assessment and/or feedback of assessment results (studies 3, 4, 5 & 8) and in some cases perhaps, simply spending time with a sympathetic listener ◤ studies 3, 4, 8 & 11. Finally, in two studies patients may have perceived the interviews as an earlier start to treatment ◤ studies 5 & 11.

Ironically, studies in which some patients did *worse* after a motivational interview show there is more to the approach than these non-specific influences; if these were all there was to it, we would expect every patient to benefit.

### SKILL AND SENSITIVITY NOT TRICKERY

Rather than some psychological trickery,[20] motivational interviewing's strength may be that it provides a platform for these generic, relationship-building behaviours: empathy, respect, optimism, enthusiasm, confidence. At a minimum, it seeks to avoid behaviours which erode these qualities; at best, discovering motivational interviewing helps to generate them. One of the approach's virtues is that it instills optimism and demands sustained respect even in the face what would otherwise be demoralising clients.[70]

Though trickery is not required, social skills and judgement are, because a 'one size fits all' programme risks negative interactions. The truer therapists stay to motivational interviewing's 'It's up to you' stance, the less they will provoke clients unwilling to accept direction. The problem with maintaining this stance regardless, is that it may also short-change clients ready and willing to follow the therapist's lead or who feel unable to self-initiate change.

Other hazards await therapists who forego sensitivity in favour of programmes which mandate a review of the good things about drug use, even if clients have moved beyond needing this as a way of establishing empathy, which land damningly negative assessments of drug use on people who may not be ready to see it that way, or seek commitment regardless of whether the ground has been firmed up sufficiently to support it. Done in this way, motivational interviewing is not always the safe, 'at least it can't hurt' option it once seemed.[6]

Managers also need to exercise judgement. Since these are what is researched, manualised programmes gather an evidence base around them and become seen as a therapeutic gold standard, while principle-based approaches reliant on the right spirit and social and clinical skills remain unsupported. Staff and commissioners under pressure[54] to base practice on evidence may then transfer over-prescriptive research programmes in to practice, valuing adherence to protocol above interpersonal skills.[3]

### BACK TO BASICS

No matter how well it is done, there is no universal answer to whether motivational interviewing is an effective induction approach and preferable to the alternatives.

In the first instance, it depends on the nature of the blockages to turning up and staying in treatment. Where these are primarily being unconvinced that you have a problem that needs treating or that treatment can help, motivational approaches

should have a role. Where they are to do with access-blocking administrative procedures, changing these is the first line of attack. Where they are to with the client's over-stretched life and inadequate resources, no feasible amount of motivational enhancement will provide all the answers.

When motivational interviewing does fit the bill, the research argues for a return to the modus operandi of the successful early studies, when absorbing principles took precedence over a set agenda, and to the client originally envisaged – not one already convinced they must change or determined on a way to get there, but unsure whether they want to. These are the conditions in which motivational interviewing has been most successful at improving retention and substance use outcomes. The effect is often to even out response to treatment by preventing initial low commitment becoming expressed in extremely poor outcomes ◤ studies 3, 4, 9, 14 & 15.

But even in the most conducive of circumstances, the approach requires sensitivity and social skills.[55] That perhaps understates it. True-to-type motivational interviewing *is* the application of sensitivity and social skills. The bad news is that this is not a packageable 'programme' to be lifted off the shelf – or is that the good news? MM3

## NOTES

**i** To preserve compatibility with the extended review some studies have been omitted without renumbering the rest.

**ii** Each unit is about 8gm or 10ml of pure alcohol.

**iii** Compared to control patients, over the first week motivational patients significantly hardened their intention to abstain from heroin or cut down.

**iv** The relationship was significant but not one-to-one: patients who had not reacted badly to feedback may still have backpedalled.

**v** Whether this would also be the case in normal practice may depend on the context. In this study, the motivational therapists were independent from the treatment programme – they had no power over the client. Second, from the client's point of view, it may well have seemed that their commitments were indeed subject to verification through research follow-ups and perhaps also through continuing contacts with the main treatment service.

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# THE Motivational hallo

MANNERS MATTER • PART 3

With its empathic style, motivational interviewing seems the ideal way to engage new clients in treatment, a psychological handshake which avoids gripping too tightly yet subtly steers the patient in the intended direction. And often it is, as long as we avoid deploying a mechanical arm.

*by* **Mike Ashton of** FINDINGS

**Thanks to Bill Miller, Jim McCambridge, Dwayne Simpson, Don Dansereau, Gerard Connors, and John Witton for their comments. Thanks also to Bill Miller, Janice Brown, Terri Moyers, Paul Amrhein, John Baer and Damaris Rohsenow for help with obtaining and interpreting their work. Though they have enriched it, none bear any responsibility for the final text.**

**THE MANNERS MATTER SERIES** is about how services can encourage clients to stay and do well by the manner in which they offer treatment. Parts one and two dealt with practical issues like reminders, transport and childcare. Even at this level, more is involved: respect; treating people as individuals; conveying concern and caring.

From here on, relationship issues take centre stage. Relegated by medicine to the 'bedside manners' which lubricate the interaction while technical treatments do the curing, in psychological therapies, bedside manners *are* the treatment, or a large part of it.[1 2 3] We start with how to 'say hello', and specifically with motivational interviewing's role in preparing clients for treatment ('induction'), the role for which Bill Miller created it.[4]

### MOTIVATION CAN BE MOVED

Induction strategies aim to prime the client for treatment by telling them what to expect, addressing concerns, enlisting support, and strengthening psychological resources. But most of all, the focus has been on reinforcing 'motivation', an amalgam of acknowledging a problem, wanting help, and resolving that treatment is the help you need.[5]

Once thought of as something the patient either did or did not have, motivation is now seen as a fluid state of mind susceptible to influence. Of the ways to exert this influence, motivational interviewing is by far the best known.[6] It qualifies for this review because it is more about *how* to relate to the client than *what* to say or do.[8]

We can see where it fits in through a model which encapsulates research on the processes underlying effective treatment and the points where these could be promoted by interventions ◤ *A model of treatment*, p. 24.[9] Motivational interviewing is among the "Readiness interventions" in the top left hand corner. Its importance is that the more motivated the patient is, the deeper their initial participation. This is linked to staying longer which in turn is linked to better outcomes.[10 11 12] Via this chain, if motivational interviewing does boost motivation, it should increase the effectiveness of subsequent treatment.

## MM3 Positive verdict from aggregated research

Before analysing individual studies (numbered from 1 to 19[i]), we'll take what we can from analyses which have amalgamated these studies. Conclusively, these tell us there is something here worth investigating. From diabetes to problem drinking, high blood pressure and poor diet, motivational approaches help patients adhere to treatment and change their lifestyles more effectively than usual clinical advice.[13] For drinking in particular, it has a better research record than practically any other treatment.[14 15 16]

But these omnibus verdicts conflate very different scenarios. For current purposes, the ideal analysis would focus on people seeking treatment rather than identified through screening, and then on induction studies rather than studies of motivational interviewing as a treatment in its own right. It would then assess whether treatment participation was productively deepened by motivational preparation. None precisely fit the bill, but some come close.

### STRONGEST RECORD IN INDUCTION STUDIES

Two analyses take us part way there.[14 17] Among drinkers known or presumed to be seeking treatment, these ranked motivational approaches eleventh and tenth in their league tables of evidence of effectiveness, outranking many treatments which take longer and cost more. Other analyses have confirmed this conclusion, and added that the benefits were significantly greater when motivational approaches were an induction to substance misuse treatment rather than a standalone therapy.[15 16 18 19]

A later analysis added two further observations.[20] First, that the gains from motivational induction are greater because they persist over at least the next 12 months while those from standalone therapies decay. Second, and contrary to expectations, therapists had *less* impact when they followed a manual. This finding's far-reaching implications are explored later ◤ *Is it dangerous to follow the manual?*, p. 28.

The final analysis focused on turning up for and sticking with treatment or aftercare.[21] Most of the studies it pooled were of substance misuse. On the basis that 12 found significant advantages for motivational interviewing, five that it was as effective as other approaches, and just four found no benefits, the authors declared themselves "cautiously optimistic". Though the weight of the evidence was positive, in three of the substance misuse studies (3, 6 & 10)

and in another not in the review,[25] motivational induction had no impact on starting or sticking with treatment. The reviewers argued that retention was already so good that there was little room for improvement, but in two studies (6 & 10) this does not seem to have been the case.

### LOOSE ENDS

Of the loose ends left by these analyses, loosest of all was whether some other induction approach would do as well or better, including feedback in another style. Then there were the negative studies and, for some, no convincing explanations why motivational interviewing failed in these but not in others. Finally, we have greater confidence that one thing causes another when we can see the levers connecting the two, yet the reviewers found little evidence that motivational interviewing actually did stimulate motivation more than alternative approaches,[19] or that it improved outcomes by enhancing engagement with treatment.

To get more of a grip on these loose ends, the individual studies in these analyses and several later studies were analysed in depth *Get the full story*, p. 26. What follows focuses on the patterns which emerged. Rather than definitive conclusions, the interpretations offered here are an attempt to make sense of these patterns and to reconcile seemingly inconsistent results

## MM3 Albuquerque air: the first studies of drinkers

The earliest trials of motivational interviewing were conducted by Bill Miller's team at Albuquerque in New Mexico. While therapists had the benefit of expert tuition and oversight from the approach's originator, as yet there was no manual for them to follow.

### PROMISING STANDALONE INTERVENTION

First it was tried as a standalone brief intervention combined with feedback from the Drinker's Check-up, a battery of tests of alcohol use and related physical and social problems. Though concerned enough to respond to ads for the check-up, participants were not the highly dependent 'alcoholics' normally seen at treatment services.

1 Comparing immediate against delayed motivational feedback suggested that this approach could motivate reduced drinking and treatment entry among this type of client.[27] The non-stigmatising offer of a check-up seemed to enable many to take a first (if often incomplete) step towards cutting down or seeking help, without violating their self-image as non-alcoholics.

2 The next study was similar, except that feedback was provided in one of two styles.[28] One was the empathic motivational style, the other the supposedly counter-productive style it aimed to improve on: explicitly directive, confrontational, and (when the cap fitted) dubbing patients 'alcoholics'. As expected, the empathic style did result in greater reductions in drinking, but the differences were small and fell short of statistical significance.

The reason may have been that in practice the therapists did not implement radically distinct approaches. Only when the focus was shifted to how they and their clients *actually* behaved did clear and significant relationships emerge. The more the therapist had confronted (arguing, showing disbelief, being negative about the client), the more the client drank a year later. The same was true of 'resistant' client behaviours like interrupting, arguing, or being negative about their need to or prospects for change.

These client and therapist behaviours were closely related. For motivational interviewing, the favoured interpretation is that when therapists departed from its non-confrontational style, clients were provoked in to hitting back or withdrawing. The pattern of results suggests this was at least part of what was happening. An alternative explanation is that resistant clients provoked *the therapists* into non-motivational responses related to poorer outcomes with this kind of client.[29] It certainly can happen,[30] but other studies with similar findings have been able to eliminate this possibility.[29 31 32 33]

Conceivably, both processes were in play. Whatever the truth, the study heightened the profile of the therapist's interpersonal style, seeming to confirm that the style mandated by motivational interviewing was preferable to confrontation. The stage was set for trials of the approach in its intended role – as a prelude to further treatment.

### STARTLING IMPACT IN INDUCTION STUDIES

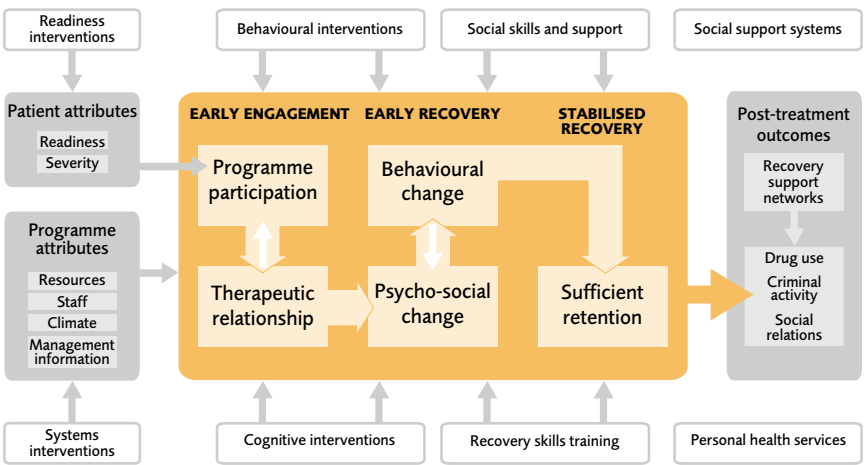
In 1993 results were published from the first trials of motivational interviewing as a prelude to respectively in- and out-patient treatment. In contrast to the check-up studies, patients had arrived for treatment via normal referral routes and were much heavier drinkers and more severely dependent.

In both trials, a non-directive, one-on-one motivational session preceded considerably more directive 12-step based group therapy.[21] There was a real chance one would undermine the other, but the opposite happened. Given that it was a brief prelude to more extended treatment, motivational feedback caused startlingly large reductions in post-treatment drinking.

3 The outpatient trial compared it with a typical 'You are an alcoholic and must return for treatment' induction.[22] During the succeeding months, the interview led to virtual 100% remission, perhaps partly because it avoided solidifying patients' identities as 'hopeless alcoholics'. Without it, a substantial minority of patients continued to drink at alcoholic levels, fulfilling the identity they had been given during induction and later treatment.

4 The inpatient trial was run on similar lines, except that the comparison group simply progressed through normal procedures.[26] From before treatment consuming about 20 UK units[ii] a day, the motivational patients cut down to on average four units; controls were still drinking 13 units a day. A new finding was that these benefits seemed to be due to motivational induction deepening engagement with the programme, an effect revealed by staff ratings of compliance with therapy. Here were some of the expected levers in action: motivational preparation leads to deepened engagement leads to less post-treatment drinking.

### A MODEL OF TREATMENT




**What goes on inside treatment (orange box) and how it might be influenced by interventions (white boxes).[9]**

## MM3 Leaving home: attempts to replicate early findings with drinkers

Attempts elsewhere to replicate the early induction findings had mixed results, perhaps partly for technical reasons (eg, which results were measured) and partly because the therapy, by now often hardened into manual form, failed to adapt to the patients.

### MORE IMPACT THAN ROLE INDUCTION

5 One uniquely important study not only tested whether motivational interviewing led to less drinking than normal procedures, but whether it led to less than 'role induction' – the most popular alternative induction method – and if it did, whether this was because it truly did deepen engagement with treatment.[34] On all counts, the answers seemed 'Yes', though effects were neither large nor could they be securely attributed to motivational induction.

Compared to other induction samples, the 126 alcohol abusers (no diagnosis of dependence was required) who joined the study at an outpatient unit in Buffalo drank less heavily and more had retained employment and intimate relationships. Those randomly assigned to the motivational interview went on to attend 12 out of 24 therapy sessions compared to eight for the controls. This partly accounted for the fact that during treatment and the 12-month follow-up, motivational patients drank heavily on fewer days and used other drugs less often – again, the elusive 'levers' in action. Retention itself may have been aided by the fact motivational induction helped patients quickly curb their drinking.

Important ingredients may have been an emphasis on motivational principles rather than a pre-set agenda, skilled and perhaps motivated exponents, and a caseload which embraced those with relatively moderate problems who could have needed some priming to commit to treatment. Together with earlier work, the study provides strong (but not incontrovertible) evidence that in these circumstances, assessment plus motivational feedback can aid treatment.

### SET AGENDA MANDATES WRONG FOCUS?

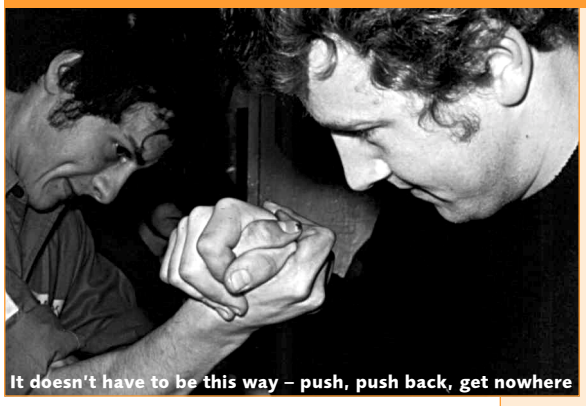
6 In contrast, a British study failed to confirm the promise of the early US work, possibly because for these patients its version of motivational interviewing mandated an inappropriate focus.[23]

Subjects were 60 dependent drinkers randomly allocated to one of two extra interventions when starting a day programme in Bournemouth. One was a pre-structured motivational intervention focused on eliciting from the patient the pros and cons of drinking and amplifying the salience of the cons. It was compared to education on the effects of drinking, using feedback of the client's answers to a "quiz".

Motivational induction had no impact on retention. This could have been because the patients already recognised their alcohol problems and said they were working hard to resolve them – and understandably so. Nearly all had lost whatever jobs they'd had, most had lost husbands or wives through divorce, each averaged over a decade of dependent drinking, and they had gone so far as to commit to and begin an intensive six-week programme.

For those who left early, the problem was unlikely to have been a failure to recognise the debit side of drinking. Given the stage they had reached, leading them to reflect on the *positives* of their drinking may also have seemed a disconcerting backward step.

### ROOTED IN RESISTANCE: THE ORIGINS OF MOTIVATIONAL INTERVIEWING



It doesn't have to be this way – push, push back, get nowhere

### DIFFERENT DRINKERS, DIFFERENT FORMAT

Remaining studies either involved special types of clients or departed from a mainstream motivational intervention.

#### DUAL DIAGNOSIS PATIENTS

8 One involved substance (mainly alcohol) abusing psychiatric patients with quite severe life problems starting a 12-week US day hospital programme.[35] Compared to a standard psychiatric induction, an initial motivational interview extended average retention from 22 to 31 days. Despite retaining people who would otherwise have left, it also improved their punctuality and halved the number of days of substance use while in treatment.

The interview incorporated feedback from prior assessments and a decisional balance exercise, but seemingly followed no set programme or manual.

#### HOW BRIEF CAN YOU CAN GET?

Among the loose ends left by the early US work was whether some other non-confrontational feedback approach might work as well. One possibility is simply providing new patients written materials – not as unlikely as it may seem.[36 37]

9 For induction purposes, the most relevant study was conducted at a

**RESISTANCE TO TREATMENT** is the central reality addressed by motivational induction.[56] In his first account of motivational interviewing,[57] Bill Miller noted that many clients resist because they reject stigmatisation through a process which entails being pigeon-holed as an 'addict' or 'alcoholic' no longer in control their lives.[58] Others may accept this yet be unconvinced that treatment will help.[59 60] Coerced patients may not think they have a problem at all and resent being forced to get 'it' treated. Others doubt the relevance of drug-focused treatment to what they see as their most urgent priorities.[61 62]

They encountered treatment services which demanded immediate abstinence, treated their patients as the embodiment of an addiction, and rarely offered effective help with the family, housing, employment, financial or other issues heading their list of concerns.[63 64] This mismatch can still be seen in British drug services.[65]

US researchers and clinicians observed the results: most dependent substance users avoided treatment or quickly left.[57] One interpretation of the genesis of motivational interviewing is that rather than realigning treatment, a way was found to get the patient to realign themselves via a roundabout route which gave them less to react against.[66] But the spirit of the approach demands that treatment too must adjust to the patient.

Swimming against the strong US disease-model tide, Dr Miller argued that the 'addict' should be treated (in both senses of the word) as someone who behaves just as 'we' might in a similar situation – someone whose self-perceptions and desires are to be respected as the valid expressions of a "responsible adult" capable of making their own decisions.[57 67] From this perspective, resistance is neither the manifestation of a character flaw nor a symptom of disease, but a product of interactions with therapists who impose their views of who/what the patient is and what they need, telling the client what they 'must' do, implying they are powerless, arguing, and confronting.

Dr Miller developed an approach which sidestepped these and other deterrent interactions.The result was motivational interviewing. One way to think of it is as a crystallisation of interpersonal styles which create a trusting, open and egalitarian relationship, and then use this as a communication medium across which influence can flow without disrupting the connection.[21 42] The 'crystallisation' consists of principles common to many therapies like 'expressing empathy', and specific tools like 'reflective listening'. Its main engine for change is the amplification of conflicts between the client's goals and values and their substance use.[67 68]

### Directive in intention if not in words

Even if the client envisaged by motivational interviewing is at least to some degree ambivalent about their goals, the therapist typically knows where they want to get to and systematically seeks to get there.[67] In this sense, like more up-front tactics, motivational interviewing *is* 'directive'; the difference is that it seeks to generate momentum by *not* being explicitly directive with the client.[15]

Ethical issues raised by this more covert approach have been addressed by Bill Miller,[69] who accepted that it could be used to pursue goals which were not those of the client,[57] departing from its client-centred ethos.[67] He argued for the client's goals to be respected – but from a position where the therapist had their own ideas of what their problem was and what would constitute "unwise" and what "healthful" paths forward. The aim was get the patient *themselves* to come to a matching conclusion.

SECOND SIGHT

## A message from Albuquerque

*by* **Bill Miller**
Motivatonal interviewing's founder, University of New Mexico

I got interested in this field on an internship in Milwaukee. The psychologist-director, Bob Hall, enticed me to work on the alcoholism unit, even though (and because) I had learned nothing about alcoholism. Knowing nothing, I did what came naturally to me – Carl Rogers – and in essence asked patients to teach me about alcoholism and tell me about themselves: how they got to where they were, what they planned to do, etc. I mostly listened with accurate empathy.

There was an immediate chemistry – I loved talking to them, and they seemed to enjoy talking to me. Then I began reading about the alleged nature of alcoholics as lying, conniving, defensive, denying, slippery, and incapable of seeing reality. "Gee, these aren't the same patients I've been talking to," I thought. The experience of listening empathically to alcoholics stayed with me, and became the basis for motivational interviewing.

### Crash – and I wrote the manual!

To me our drug abuse study was a clear example of manuals failing to adapt to the patients ◤ study 13. I am now working on a paper which collapses the two 'poor outcome' groups (strugglers and discrepants) and the two 'good outcome' groups (changers and maintainers).[44] Their speech patterns are strikingly different.

Relative to good outcome patients, those who will have poor outcomes showed two substantial deviations. They backpedalled around the third decile [tenth of the session]. Commitment strength stopped climbing, and instead flattened out or fell. Then around the sixth decile it started picking up again, and actually reached the same point at decile 9 as the good outcome group. In decile 10, however, it fell abruptly back to zero.

"What were you doing to these people?" Paul Amrhein [language analyst] asked. The answer is that in deciles 1 and 2 we

**I BEGAN READING ABOUT ALCOHOLICS AS LYING AND DEFENSIVE. "GEE, THESE AREN'T THE SAME PATIENTS I'VE BEEN TALKING TO."**

were doing pure motivational interviewing. Around decile 3, we started assessment feedback. About 70% of patients went with it and showed the expected effect of increasing commitment to change, but the poor outcome group did not. They seemed to balk at or resist the feedback. I gave the therapists no choice in the manual but to continue with the feedback. Then around decile 6, the therapists went back to pure motivational interviewing.

Then the manual says to develop a change plan by the end of the interview. Again, the manual (which I wrote!) left no flexibility. The essential message was, develop a change plan whether or not the patient is ready. Crash. Any decent practitioner would know not to persist when patients start balking.

### Best for the ambivalent?

Your collection of studies suggesting an adverse effect with motivational interviewing for 'more-ready' clients is an important observation. The same direction is there in the anger match in Project MATCH. Low-anger clients showed somewhat worse outcomes with motivational therapy relative to the other two treatments. I can understand motivational interviewing having no effect with clients who are already ready for change, but the seeming adverse effect, now observed in several studies, seems surprising.

The clinical sense I can make of it is that when clients are ready to go, it is not time to be reflecting on whether they want to do so. Motivational interviewing was originally envisaged for working with people who are ambivalent or unclear about change, and perhaps that is the group for whom it will be most helpful.

Carl Rogers ◤ What happened when he let a troubled mother tell her own story convinced him that the therapist's task is to rely on the client for direction – the person-centred approach which inspired motivational interviewing.

**GET THE FULL STORY**

This analysis is distilled from an extended review available free on request from editor@drugandalcoholfindings.org.uk. Note that the aim is to investigate motivational interviewing as a preparation for patients seeking treatment without being legally coerced to do so, rather than as a treatment in its own right or a way of encouraging take-up of aftercare.

Toronto addiction treatment centre.[38] On alternate months each new alcohol patient was handed the *Alcohol and You* booklet at the end of their intake assessment. Written by Bill Miller,[4] this combined motivational elements and individualised assessment feedback comparing the drinker to national norms. It invited readers to reconsider their drinking but did *not* advocate return for treatment, an attempt to avoid its rejection by people who had decided not to come back.

Despite this, patients given the booklet were slightly *more* likely to return, but the biggest effect was to substantially reduce drinking over the next six months, especially among the minority who did not come back. These findings underline the twin arguments for motivational induction: not only may it promote engagement with treatment, but it also constitutes a potentially effective brief intervention for those who drop out.

## MM3 Beyond drinkers: pluses and minuses

For users of drugs including heroin, cocaine and cannabis, motivational interviewing has now been tried during the waiting period for treatment and the initial stages. Results have been mixed, perhaps because the patients themselves were mixed in the degree to which they needed a motivational boost or were at the stage where they could benefit from one.

### BRIEF RESPITE VERSUS INTENSIVE MARATHON

Two studies have trialed motivational interviewing to tide people over while waiting for treatment to start. Though really *pre*-induction, the results are relevant. In one there was no impact, in the other, long-lasting benefits. The difference may have been down to the degree to which motivation was the issue.

10 In Washington, the unsuccessful trial inserted measures including a manual-guided motivational interview between the time drug (mainly cocaine) abusing patients had been referred for treatment and their first appointment.[24] A relatively full-featured attempt to bridge this gap, it made no difference to how many patients started or completed treatment (a commendable 71% in both cases) or how well they did.

The 654 who joined the study typically suffered severe and multiple problems (including poor housing), and were overwhelmingly committed to the treatment on offer. For 85%, this was a short stay in hospital – conceivably an attractive respite from the streets, especially since most did not face opiate withdrawal. Those who nevertheless failed to turn up were probably less in need of a motivational boost than of intensive support.

11 A Spanish trial provides an instructive contrast. The marathon *Proyecto Hombre* rehabilitation programme attracted mainly heroin users living with their parents or in their own family home.[39 40] It started with roughly a year-long day programme during which the families came with the clients. Before this phase was half way through, four out of five had dropped out.

Seeking ways to stem the outflow, detoxified patients awaiting entry were randomly allocated to normal procedures or to a three-session motivational intervention, structured according to a broad outline rather than a detailed manual. Three months into treatment, the motivational group showed improved retention. The gap grew until by six months half were left compared to

just 1 in 5 after normal procedures.

These Spanish addicts had the home support lacking in Washington, potentially leaving their commitment to the programme as the main influence on whether they stayed. No respite from the streets, this was an extraordinarily extensive and intensive programme which would dominate their lives for nearly two years. Wavering commitment would have provided fertile ground for motivational interviewing.

### MIXED RECORD AS INDUCTION METHOD

The few direct tests of motivational induction for heroin or cocaine users confirm that it is most beneficial for those ambivalent about treatment and go further, showing that it can actually be counter-productive for more committed patients.

12 The first such study took place at an Australian methadone clinic.[41 42] There researchers had structured the motivational style into a one-hour 'bolt-on' module (plus a brief review session a week later) consisting of a seven-point agenda.

As adapted for heroin users, a brief examination of what they see as the good side of heroin use is intended to establish this as a chosen rather than an out-of-control behaviour. Then the focus is on eliciting and amplifying the client's account of the debit side of heroin use, featuring a balance sheet of the pros and cons completed at home for review at the follow-up session.

Compared with educational sessions on opiate use, on average motivational induction extended retention from about 18 to 22 weeks and delayed relapse to heroin use, consistent with an impact on outcomes via retention. However, improved retention may itself (as in study 5) have been due to the interviews helping patients rapidly curtail substance use.[iii]

How can we account for these findings, when adaptations of the same model for drinkers and cocaine users failed to improve on normal procedures ◤ studies 6 & 10? First, in contrast to these studies, many of the Australian patients were ambivalent about ending substance use. After all, patients starting *methadone* treatment clearly are not yet ready to see use of opiate-type drugs as an unambiguously bad thing.

Another key may have been the holding power of the intervention over the week between the sessions. Patients appreciated the chance to explore their experiences with a "highly skilled" therapist who rapidly established rapport. To return for 'closure' of this valued intervention, they had to stay on methadone for at least the first week after being stabilised, a vulnerable period. More did so than after the alternative induction, accounting for better long-term retention.

Underneath it all may have been the 'developer effect': the intervention was being trialed its creators, presumably enthusiastic exponents. Perhaps also, as its 'owners', the Australian team had the licence to adapt it. Where they stressed skilful flexibility, the other two papers suggest a more prescriptive implementation. The initial focus on the positives of substance use may need particular care unless, as with methadone patients, it simply acknowledges an undeniable and current reality for the client.

### "PUZZLING" FAILURE WITH DRUG USERS

13 A 'developer effect' was notably lacking when Bill Miller's team extended their work to drug users. The study took place in Albuquerque at his university's outpatient centre and at an inpatient detoxification unit.[43] For most of the 208 patients, cocaine (especially crack) was their primary problem, and for nearly one in three, heroin.

Half were randomly allocated to continue as normal and half to a motivational interview conducted by therapists trained and supervised to follow a manual. On practically every measure taken and no matter how the sample was divided up, the interview made no difference to motivation for change, retention, or drug and alcohol use outcomes over the next 12 months.

Among the possible explanations are that, according to paper-and-pen tests, nearly all the patients were in no need of a motivational boost, but an analysis of what they actually said in counselling sessions seems to belie this interpretation.[44] Several other explanations are feasible. For one, the same analysis provided empirical confirmation: the study's inflexible, manualised approach to motivational induction had left insufficient room for therapists to adjust and provoked counterproductive reactions when its instructions clashed with the client's state of mind ◤ *Care too with the unconvinced*, p. 38.

### DEPENDS ON INITIAL COMMITMENT

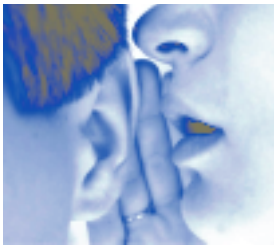
The next two studies found that motivational induction had no *overall* impact on retention, but also that this masked positive impacts among patients who saw themselves as still thinking about curbing drug use rather than having started the process. Less expected was a *negative* effect among the latter. These findings are explored later ◤ *More committed react badly*, p. 28.

### AMONG INDIGENT POOR

14 In Houston, 105 cocaine users started a ten-day outpatient 'detoxification'.[45] Most were black and unemployed and smoking crack. Patients who achieved abstinence could transfer to relapse prevention aftercare. The issue was whether starting detoxification with a motivational interview would improve transfer rates.

Patients were randomly allocated to normal procedures or additionally to a two-session motivational interview on days one and four, conducted by therapists trained and supervised to follow a detailed manual. There was no overall effect on transfer rates, but the interviews did help less motivated patients complete detoxification and transfer to aftercare. By doing so, they might have been expected to lead to a higher relapse rate during aftercare. The opposite occurred. More motivational patients started aftercare cocaine-free and over the next 12 weeks they continued in the same vein.

Drug use reductions seen in this study and the extra impact on less motivated patients were both absent in Albuquerque ◤ study 13. A possible reason is the way the patients entered treatment, in Albuquerque via normal routes, in Houston, via ads for the study. Judging from their motivational profiles, many in Houston would not have sought treatment unless prompted by the ads; motivational interviewing had something to bite on.



**Like a whisper in the ear, a motivational interview can have a dramatic impact, but just what that is depends on the relationship, the situation, what's said, and how it fits into what went before and what is yet to come.**

### AND EMPLOYED PRIVATE PATIENTS

15 A similar study which used a similar measure of motivation also found that this determined how patients would react.[46] The programme was a day-hospital regime in Rhode Island with an abstinence and 12-step orientation. Over 7 in 10 of the cocaine-dependent patients who joined the study smoked crack, but at this private facility they were not the poor minority caseload seen in Houston ◤ study 14.

Half were randomly allocated to a motivational interview planned for day two and half to meditation and relaxation. Therapists were trained and supervised and motivational sessions recorded to ensure they competently followed a manual. Though the emphasis could vary,[47] this prescribed an exploration of the pros and cons of cocaine use, how use or non-use fitted with the patient's goals, feedback of a prior assessment of their drug use and its consequences, and the formulation of a change plan.

At issue was whether this would improve on the inactive and it was thought ineffective relaxation approach. The answer was a surprising 'No'. Patients as a whole did well, but on none of the measures of retention or outcomes up to 12 months did the motivational interview further improve things. As in Houston, this was not because the interview itself was inactive, but because it had opposing impacts on different patients.

## MM3 Is it dangerous to follow the manual?

Manual-guided programmes have become seen as essential for any treatment which claims to be evidence-based.[48] The research rationale is to standardise 'inputs' so these can be related to outcomes, the clinical justification, that they enable clinicians to "replicate" proven treatments.[49]

An alternative view is that such detailed programming cramps client participation and clinical judgement[3] and focuses attention on techniques rather than ways of relating which cut across therapies.[2] If these are what matters, then the baby could be exiting with the bath water. Such prescriptiveness seems particularly risky for motivational interviewing, whose essence is to respond to clues from across the table, and whose mantra is that the "responsibility and capability for change lie within the client".[50]

Support for this view comes from a recent meta-analysis.[20] The studies it analysed differed in how they implemented motivational approaches. Of all the variations including duration, how many motivational-style principles and techniques were said to have been deployed, and therapist training and support, only one was related to outcomes – whether the therapist followed a manual: manualised therapy had *less* impact.

### MORE COMMITTED REACT BADLY

This result could have been due to differences between the studies other than whether they used a manual. But signs of the same effect can be seen *within* studies. In three, motivational induction helped 'low motivation' patients but retarded those more committed to action ◤ *charts*. Each time, therapists were supervised to ensure they adhered to a detailed manual which prescribed 'decisional balance' exercises, leading the patient to review the pros and cons of changing substance use or engaging in treatment or aftercare.

Two of the studies have already featured in this article. Both involved mainly cocaine users attending a short-term day detoxification programme, and divided patients into those typified more by 'taking action' to tackle their substance use as opposed to 'still thinking' about it.

In Houston (14), motivational induction improved completion rates among 'still thinking' patients, counterbalanced by the *opposite* effect in those who saw themselves as having already started this process – they did worse after the interviews. These effects were substantial and statistically significant.

In Rhode Island (15), consistently the interviews worsened cocaine use outcomes among 'taking action' patients while (to a lesser and non-significant extent) improving outcomes among those 'still thinking'. Seemingly no fluke, there was a similar pattern with drinking.

### ALSO IN AFTERCARE STUDY

19 The third study concerned alcohol patients admitted for on average five days of inpatient detoxification in Rhode Island.[51] It has not featured so far because the aim was to motivate take-up of aftercare.

After settling in for at least a day, randomly selected patient intakes were allocated to one of two types of induction. The first was five minutes of advice which comprehensively contravened motivational interviewing's code. Patients were told they had a significant drink problem, that abstinence was very important, and to get as involved as possible in AA aftercare groups.

The second type of session was a one-hour motivational interview. It also advised abstinence and AA, but not in the unambiguous manner of the more abrupt intervention. Instead, patients were led through exercises weighing the pros and cons of abstinence and AA and exploring how drinking conflicted with longer-term goals. Finally, they were asked to choose their own goals for attending AA groups or were informed of alternative sources of support.

> "THE PARADOX OF MANUALIZATION IS THAT THE PATIENT'S ACTIVE INVOLVEMENT IS LIKELY TO BE ESSENTIAL TO GOOD OUTCOME BUT DESTRUCTIVE OF EXPERIMENTAL CONTROL"[3]

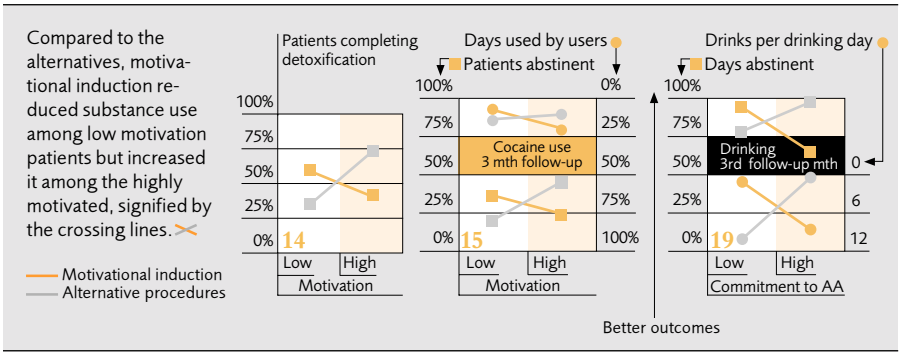
Among patients whose current plans and past records of attending AA/NA indicated less commitment to AA, the interviews had the expected effects. They abstained more often, and when they drank, drank less than patients given brief advice. But this was counterbalanced by an even greater *negative* effect on more committed patients.

Over a six-month follow-up, as long as patients *most* committed to AA had been directed to abstain and attend the groups, and those *least* committed had been through the motivational exercises, on average each sustained near 100% abstinence and drank little when they did. When this matching was reversed, outcomes were far worse.

### TWO STEPS BACK?

In all three studies, the puzzle is not why the least committed benefited (this is expected), but why the most committed reacted badly. It seems that motivational interviewing of this kind is as capable of knocking back more motivated patients as it is of helping those in need of convincing.

The explanation might be what to the patient could have seemed an undermining backward step to re-examine the pros and cons of whether they really did want to stop using drugs or commit to treatment and aftercare, when they had already decided to do so and started the process. Other unsuccessful induction trials might also be explained by the relatively high commitment of the clients allied with an insufficiently flexible approach ◤ studies 6, 10 & 13.




### CARE TOO WITH THE UNCONVINCED

One of these trials (13) uncovered another hazard of prescriptive therapy – failing to back off in the face of continuing ambivalence. Though the hazard is different, the study provides insights into how both sorts of mistakes can occur.

Despite considerable experience supplemented by 16 hours' training and feedback on their videoed performances from Bill Miller, who personally certified their competence, the study's motivational therapists failed to improve retention or outcomes.

In this study, so tightly was the interview programmed through a detailed manual, and so diligent, well trained and closely supervised were the therapists, that they introduced the same topics at roughly the same point with all their clients. It enabled what clients and therapists said to be matched to the topics addressed in each succeeding tenth of each session.[44 52]

Analysis of the videotapes suggested that it was not (as previously believed[20 53]) the frequency of 'change talk' which related to outcomes, but the strength of the client's determination to change versus to stay as they are. The difference between 'I hope to' and 'I *will*' (or similar) was more important than how many times either was said.

### WRONG MOVES AND PREMATURE CALLS

During the first five to ten minutes of each session clients were asked what had led them to seek treatment. Here the strength of their commitment to reduce drug use

simply reflected how far they had already done so. From then on, commitment strength started to respond to what the therapist was doing, and instead of reflecting where the client had come from, became a potent predictor of where they would end up in a year's time.

The first clue came around the middle of each session when clients had received feedback from an assessment of their drug use and related problems. As intended, about 70% expressed sustained or increased commitment to tackle these problems. Over the following year, they largely remained abstinent from their primary drug.

But faced with this almost unremittingly negative feedback, a minority retrenched towards a commitment to continued drug use, especially the ones who from the start had been less convinced that their drug use really had been all bad. Over the next year, they struggled to control their drug use.

The same patients tended to be among[iv] the ones who at the end of the interview backpedalled in their commitment to change. At this stage therapists tried to get their clients to tie up all the ends – no matter how loose – into a plan for tackling drug use, one concrete enough to have explicit criteria of success, and sufficiently well grounded to withstand the anticipated pressures of life beyond treatment.

Despite being tested in these ways, most sustained the strength of their commitment and went on to express this in reduced drug use. But a minority sharply backed down; 'I wills' or equivalent rapidly became 'I'm not sure'. The strength of this final, concrete, public and verifiable commitment was the single most reliable harbinger of whether clients would later control their drug use.[v]

Another significant juncture came about two-thirds through each session when therapists asked if the client was yet ready to change. Again, those who backtracked tended to do badly over the following year.

It seemed that some clients reacted badly to these attempts to push them forward. Instead of firming up their expressed commitment to curtailing drug use, they reversed, a setback followed by the predictable outcomes in terms of actual drug use. As far as could be determined, this was not just a case of people who had a poor prognosis anyhow reacting poorly to counselling.

The analysts cautioned that "a prescribed and less flexible approach to MI (as can occur with manual-guided interventions) could paradoxically yield worse outcomes among initially less motivated clients." Leading the client to review the good side of their drug use is, they thought, particularly risky; by fostering an 'It wasn't all bad' perception it might pave the way for resistant reactions to assessment feedback.

What caused these reversals was, for motivational interviewing, an atypical degree of directiveness by the therapist. If this can be seen in motivational therapy, it should also be apparent elsewhere.

This is territory to be covered later in the *Manners Matter* series. Here it's relevant to note the key finding: patients who like to feel in control of their lives, who react against being directed, and resist therapy, do best when therapists are less directive (as in true-to-type motivational interviewing), while those willing to accept direction do better when this is what they get.[29 31 32 33]

### ACCEPTANCE ELICITS HONESTY

Among these salutary lessons was a silver lining: the strength of the client's commitment to change at key junctures was so closely related to later drug use, that from this alone one could predict with remarkable precision (in 85% of cases) who would do well and who would struggle.

As required by motivational interviewing, the therapists had created a non-judgemental social space within which what the client said was a valid reflection of their state of mind and determination to change, rather than acting as a way to placate, save face, or terminate the encounter. The problem was that therapists were so constrained that they could not respond to these clues.

## MM3 Interchange; time to reflect

Still to come are the implications of these findings for training, research with legally coerced populations, and studies of linkage to aftercare. But in true motivational interviewing style, now is a good time to summarise and reflect.

First, clearly there is something here which works most of the time and more consistently and at less cost than the usual alternatives. What that 'something' is remains to be clearly defined. In every induction study in which motivational interviewing has apparently had a positive overall impact, this can be explained by 'non-specific' factors common to other therapies rather than the specific approach.

Most common, and potentially most powerful, is the enthusiasm and faith of the therapists, often newly trained and/or associated with the approach's developers ◤ studies 3, 4, 5, 8 & 12. Then there is extra assessment and/or feedback of assessment results (studies 3, 4, 5 & 8) and in some cases perhaps, simply spending time with a sympathetic listener ◤ studies 3, 4, 8 & 11. Finally, in two studies patients may have perceived the interviews as an earlier start to treatment ◤ studies 5 & 11.

Ironically, studies in which some patients did *worse* after a motivational interview show there is more to the approach than these non-specific influences; if these were all there was to it, we would expect every patient to benefit.

### SKILL AND SENSITIVITY NOT TRICKERY

Rather than some psychological trickery,[20] motivational interviewing's strength may be that it provides a platform for these generic, relationship-building behaviours: empathy, respect, optimism, enthusiasm, confidence. At a minimum, it seeks to avoid behaviours which erode these qualities; at best, discovering motivational interviewing helps to generate them. One of the approach's virtues is that it instills optimism and demands sustained respect even in the face what would otherwise be demoralising clients.[70]

Though trickery is not required, social skills and judgement are, because a 'one size fits all' programme risks negative interactions. The truer therapists stay to motivational interviewing's 'It's up to you' stance, the less they will provoke clients unwilling to accept direction. The problem with maintaining this stance regardless, is that it may also short-change clients ready and willing to follow the therapist's lead or who feel unable to self-initiate change.

Other hazards await therapists who forego sensitivity in favour of programmes which mandate a review of the good things about drug use, even if clients have moved beyond needing this as a way of establishing empathy, which land damningly negative assessments of drug use on people who may not be ready to see it that way, or seek commitment regardless of whether the ground has been firmed up sufficiently to support it. Done in this way, motivational interviewing is not always the safe, 'at least it can't hurt' option it once seemed.[6]

Managers also need to exercise judgement. Since these are what is researched, manualised programmes gather an evidence base around them and become seen as a therapeutic gold standard, while principle-based approaches reliant on the right spirit and social and clinical skills remain unsupported. Staff and commissioners under pressure[54] to base practice on evidence may then transfer over-prescriptive research programmes in to practice, valuing adherence to protocol above interpersonal skills.[3]

### BACK TO BASICS

No matter how well it is done, there is no universal answer to whether motivational interviewing is an effective induction approach and preferable to the alternatives.

In the first instance, it depends on the nature of the blockages to turning up and staying in treatment. Where these are primarily being unconvinced that you have a problem that needs treating or that treatment can help, motivational approaches

should have a role. Where they are to do with access-blocking administrative procedures, changing these is the first line of attack. Where they are to with the client's over-stretched life and inadequate resources, no feasible amount of motivational enhancement will provide all the answers.

When motivational interviewing does fit the bill, the research argues for a return to the modus operandi of the successful early studies, when absorbing principles took precedence over a set agenda, and to the client originally envisaged – not one already convinced they must change or determined on a way to get there, but unsure whether they want to. These are the conditions in which motivational interviewing has been most successful at improving retention and substance use outcomes. The effect is often to even out response to treatment by preventing initial low commitment becoming expressed in extremely poor outcomes ◤ studies 3, 4, 9, 14 & 15.

But even in the most conducive of circumstances, the approach requires sensitivity and social skills.[55] That perhaps understates it. True-to-type motivational interviewing *is* the application of sensitivity and social skills. The bad news is that this is not a packageable 'programme' to be lifted off the shelf – or is that the good news? MM3

## NOTES

**i** To preserve compatibility with the extended review some studies have been omitted without renumbering the rest.

**ii** Each unit is about 8gm or 10ml of pure alcohol.

**iii** Compared to control patients, over the first week motivational patients significantly hardened their intention to abstain from heroin or cut down.

**iv** The relationship was significant but not one-to-one: patients who had not reacted badly to feedback may still have backpedalled.

**v** Whether this would also be the case in normal practice may depend on the context. In this study, the motivational therapists were independent from the treatment programme – they had no power over the client. Second, from the client's point of view, it may well have seemed that their commitments were indeed subject to verification through research follow-ups and perhaps also through continuing contacts with the main treatment service.

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# Motivational arm twisting

## MANNERS MATTER • PART 4 Contradiction in terms?

Motivational interviewing would seem the ideal way to defuse resentment, deflect the resistance, and improve the engagement of offenders ordered in to treatment. And it can be, if the counter-productive context and distrust of the clients can be overcome.

*by* **Mike Ashton** *of* FINDINGS

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**IN THE PREVIOUS ISSUE** we explored motivational interviewing as a preparation for people voluntarily[i] entering treatment. Its mixed record seemed partly due to whether patients were in need of a motivational boost to begin with. When they were, the approach had something to 'bite on' and generally improved retention and/or substance use outcomes. Given this record, and its origins in overcoming resistance, motivational induction ought to have a special role in boosting the motivation and deflecting the anger and resentment of people coerced into treatment by the criminal justice system or other authorities.[1] Whether starting their treatment the motivational way really does help is the main question addressed in this review.

### COMPATIBLE WITH CRIMINAL JUSTICE?

What hampers this endeavour most is a surprising lack of studies. Relevant research has been almost entirely limited to drink-drivers, young offenders, and mothers involved with child protection agencies. There are no controlled studies of the many thousands of adult offenders ordered in to treatment by courts because their revenue-raising offending is thought to have been motivated by addiction.

This may be the first clue to an incompatibility between motivational interviewing and the criminal justice system.[2] 'It's up to you what you do about your substance use' is arguably an inappropriate stance when your role is to control that substance use to prevent crime and/or safeguard children or the public. It may also be one the offender will find hard to credit as genuine, undermining the therapeutic relationship.

At a more practical level, there is a conflict between the requirements of the courts to know that certain things are going to be done to an offender, and motivational interviewing's insistence that it starts from where the client is at and that the client participates in the process, which cannot therefore be predetermined. Some clients may not have a serious substance use problem at all, yet this may be the focus mandated for the intervention.

Criminal justice clients are also especially likely to lack the resources – psychological, intellectual, physical, economic, and social – needed to implement change or even to get to grips with motivational interviewing's discussion-based rationality. These are some of the reasons for creating new approaches which incorporate motivational elements but are tailored for criminal justice populations ◤ *Making it more concrete*, p 16.

All these issues emerge in the studies, yet when the clients and the circumstances have been conducive, and therapists have been able to implement key elements of the motivational style, it has fulfilled its promise and made big differences to engagement with treatment.

### MM4 DEPRESSED DRINK DRIVERS RESPOND (BUT NOT THE REST)

Of the three relevant studies of drink-drivers, only a study in Mississippi could assess whether motivational interviewing was a useful supplement to normal programmes. It was, but only for drinkers who also suffered from depressed mood. Promising results elsewhere are compromised by the lack of a comparison group

**Each major study is numbered. Some included in the extended review behind this article have been omitted. To maintain consistency with that review, the remainder have not been renumbered.**

1 At the time Mississippi's programme for first time drink-driving offenders consisted of four weekly classes of two and a half hours each. During the first offenders completed assessment instruments, the results of which were fed back during the last session in a computer-generated report. In between were class discussions and exercises and other educational activities.

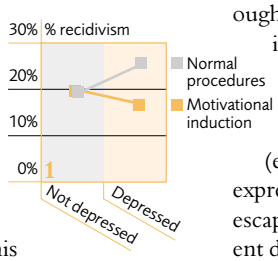
Over 4000 offenders agreed to participate in a study which for a random selection replaced class time with two 20-minute individual counselling sessions from counsellors trained in motivational interviewing.[3] The first was used to advance feedback to the second week. Since this was also the week of the first class, it occupied an induction slot in the overall programme. As well as seeking to boost motivation, where appropriate counsellors offered referral to services. The second individual session took place during time allotted to the last of the four classes. Offenders were also offered a further session four to six months later, which about half attended. Guidance for therapists stipulated neither a set objective nor a set end point to the sessions, asking only that "For those who are ready ... develop plans and alternatives for change".[4]

Over typically the next three years, drink-driving offence records revealed that the modified programme had significantly improved on the classes –

**Unwilling offenders seem ideal candidates for motivational interviewing, yet at the same time the criminal justice context imposes constraints likely to undermine implementation and hamper effectiveness. Issues include the degree to which motivational interviewing can (or can credibly) stick to its person-centred, non-directive ethos, and whether it can (even whether it should) persuade offenders to open up, when the system within which it is operating is explicitly oppressive, directive, and intended to limit rather than enhance the 'client's' autonomy. These issues have recently been debated at length by motivational therapists, some uneasy at the contradictions, others convinced that despite the environment, the problems can be worked round and offenders can be helped ◤ reference 2.**


**Additional issues arise in respect of young offenders. Foremost is an inability to focus on the long-term pros and cons of continued drug use, partly because for many the cons have yet to be too pressing.[8] There is also a question over whether it is realistic to expect adolescents to be given, or to take, full responsibility for their lives and choices. No matter how keen to do so, youngsters lack the resources and the autonomy needed to self-initiate important changes in their lives.**

but only among the quarter of offenders who had felt most depressed or sad on entering the programme; without the individual sessions, 26% were reconvicted, with them, 17%, a 35% reduction in recidivism. Among the bulk of offenders not feeling so down, results from the enhanced and standard programmes were virtually identical – about 20% were reconvicted ◤ *chart*.




The effect was to counteract (in fact, to reverse) the poor prognosis of the more depressed offenders. This result did not seem to be due to attending the follow-up sessions, and generally held regardless of which site the classes had been held in, when they had been held, and the participants' race, gender, age, education, offending history, or severity of drink problems. Of all these variables, only depressed mood predicted who would react well to the motivational sessions.

Unfortunately, this clear-cut result does not have an equally clear-cut explanation. One possibility is that offenders whose drinking was tied up with feelings of worthlessness and depression needed individual treatment and referral to services, while those whose drinking was primarily social did just as well with group education classes.

2 A study in New York state recorded good results from an approach which included motivational induction, but without a comparison group who did not have this induction, it is impossible to say whether it was the key factor.[5] The study involved 25 drink/drug offenders referred by the courts for assessment at an outpatient substance abuse clinic. All received motivational-style feedback of the severity of their substance misuse problems and the reasons for their heavy drinking.

Eight of the offenders were diagnosed as having a drink problem; before they could resume driving they were required to attend treatment, which all completed. Though not legally required to do so, 14 of the remaining 17 chose to attend risk-reduction sessions. Only among the three who refused were there any drink/drug driving re-arrests (one only) over on average the next two years. The clinicians saw these results as an encouraging indicator that motivational interviewing could improve engagement with treatment, highlighting the way clients became more willing to disclose and discuss their drink problems.

Promising treatment engagement results were also found after motivational feedback to US repeat drink-driving offenders in prison but, again, lack of a control group precludes conclusions about whether this was the active ingredient.[6]

## MM4 SUBSTANCE USE MAY BE WRONG FOCUS FOR TROUBLED YOUNG OFFENDERS

Teenagers typically enter treatment having been directed by families, courts, schools or welfare services[7 8] and retention and outcomes are usually poor.[9] These unwilling, often angry and uncooperative youngsters ought to be fertile ground for motivational interviewing, but there are reasons why this approach might fail to find purchase.[8] Their lack of autonomy and resources limit the degree to which (even if it is boosted) motivation can be expressed in action and outcomes. With escape routes constricted, the non-dependent drug use or under-age drinking which typically brings them into trouble with the law may seem a valued way of coping with severe problems in the rest of their lives.

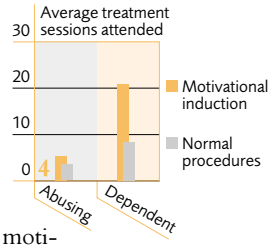
How these forces pan out in practice is largely unknown because there are very few relevant studies. The most positive findings came from a study whose subjects truly did seem to have significant substance use problems, whose therapists seemed able to practice (more or less) true-to-type motivational interviewing, and whose clients felt able to open up in response.

4 This study is available only as a dissertation from one of Bill Miller's students[10] though further information can be gleaned from reviews.[1 11 12 13 14 15] It took place at the adolescent outpatient programme of Dr Miller's New Mexico centre. The centre's clients suffer "overwhelming" problems not just with drugs but with the law, their schools, and their families. Typically they resent being told to 'say no' to drugs and half did not return after initial contact.

To find a way to stem the outflow, 77 youngsters aged 14-20 were recruited into the study. Mainly Hispanic, about a third were primarily diagnosed as dependent on alcohol and 4 in 10 as dependent on the use of several substances. There seems little doubt that most had real and multiple problems including patently excessive substance use. At intake they were randomly assigned to normal procedures (the control group) or additionally to a motivational interview lasting up to an hour.

The two motivational therapists were clinically supervised by Bill Miller and one (the study's author) seems to have been particularly well versed in the approach. Despite a commitment to motivational principles, they did not altogether avoid telling the youngsters what was good for them. There was "clear advice to reduce consumption" (reinforced by a comparison of assessment scores against national norms) and encouragement to engage with the centre's programme. Given the youngsters' problems, such advice may have seemed a warranted expression of concern rather than unwelcome arm-twisting. In a caring context, directiveness does not necessarily generate counter-productive resistance.[16]

The clearest effect was dramatically enhanced engagement with treatment. Records showed that 72% of the control group went on to meet their counsellors, itself an improvement on past performance, but the motivational interview further raised this to 95%. Moreover, these youngsters stayed for an average of 17 sessions compared to six after regular intake. Gains were most marked among those with dependence problems who stayed for 20 sessions versus eight ◤ *chart*. On discharge, unit staff rated motivational clients as having achieved significantly more of their goals.




Reductions in substance use in the three months after the motivational interview were also substantial, but confidence in these findings is eroded by the fact that only half the youngsters could be re-assessed. Among these, motivational clients were using illicit drugs or alcohol much less than at intake[ii] while the controls' substance use was relatively unchanged. Heavy use (excessive drinking or drug use three or more times in a day) was particularly clearly affected, among motivational clients falling from 81% of days at intake to 24% at follow-up, versus 65% and 73% among the controls. Motivational clients had used illicit drugs on half the days (26%

## CAN BE ADAPTED FOR GROUPS

In criminal justice settings treatment is typically delivered to groups and especially in residential or prison-based programmes, therapeutic communities are often the core treatment modality. For motivational interviewing to play a role, ways must be found to adapt an individualised, one-on-one intervention to a group format. Only in New Jersey has a such a programme been evaluated with legally coerced patients.

11 There a non-residential substance misuse service found that legally coerced referrals who could see no point to their treatment (as they saw it, they didn't have a problem to work on or a goal to work towards) failed to benefit and tended to leave early.[34]

For these 'no-goal' clients, a group run on motivational lines was established as an introduction to the centre's abstinence-based treatment. It met six times led by therapists trained in motivational interviewing. The set programme included decisional balance exercises and, in the fourth session, a discussion of the written feedback each member

versus 59%) of normally admitted patients, and there was a similar gap for alcohol use.

What produced these effects? These young people were encountering an approach almost entirely at variance with their customary interactions with adult authority figures. Instead of the expected resistance, they appeared "open to exploring their substance use [with] a respectful and empathic counsellor working in a collaborative manner". In this study, too, the motivational interview was well integrated in to the surrounding treatment context yet seemingly unlinked to legal or parental authorities. It built on an extended assessment conducted by the same therapists and clients were encouraged to engage with "our" treatment programme, and to take into that what they had learned in the interview.

Apart from low follow-up, question marks over this study include the fact that only a fifth of the unit's prima facia eligible adolescent intake were included in the study, whether the motivational clients reported less substance use at follow up because they wanted to please the therapists (they did the follow-up interviews), how far therapists adhered to motivational interviewing principles, and, if they did, whether they might have had a similar impact using a non-motivational approach.[15]

5 The latter possibility is suggested by a study in Baltimore.[17 18] Instead of being pitted against normal procedures, motivational interviewing was compared with a different induction interview, equalising the degree of extra, sympathetic attention.

At issue was how best to prepare youngsters for 19 weekly group therapy sessions focused on relapse prevention skills, a programme developed for 14–18-year-olds with at worst moderate substance use problems, generally referred by the juvenile justice service after a substance-related arrest.[19]

On average the 194 youngsters in the study had used substances (mainly cannabis) on one day out of three. Apart from run-ins with the law, few reported major drug-related problems and generally they saw little need for treatment. Though their drug problems were relatively minor, the same cannot be said of the rest of the lives. Most of the clinics in the study served delinquents from poor areas whose drug use was one of a number of risky and criminal activities.

Over about an hour and a quarter, the motivational induction aimed to elicit a "formal commitment to discontinue substance use". A decisional balance (pros and cons of continued drug use versus stopping) exercise was followed by the development of a "change plan". In contrast, the comparison session focused on the treatment to come – what the youngster expected, their concerns, and what would happen and why – a form of 'role induction' seen as a "minimal" input against which to profile the benefits of motivational interviewing.

This was not the outcome. Typically the teenagers stayed in treatment for 14 out of the scheduled 20 weeks, but they left *earlier* after the motivational interview. This was the case at all five clinics in the study[20] and, across all five, was statistically significant, but how to interpret it is unclear. Stays beyond 20 weeks were permitted in case of poor progress or problems which required extra time to resolve, and this seemed to account for the findings.[20]

In any event, which induction session the youngsters had received made no difference to outcomes up to 12 months later. Drinking and criminal activity remained roughly at pre-treatment levels, though the frequency of cannabis use had fallen.

How can we account for the apparent ineffectiveness of the motivational interview in this study when in study 4 the effects were so dramatic? Possibly in both studies, extra individual attention was the active ingredient rather than a motivational approach, but there were other differences. In Baltimore, the motivational interview may have been undermined by having to promote a sole acceptable objective (abstinence), making it more like the responses the youngsters were used to rather than a novel and empowering interaction. And given their (in comparison with study 4) mild substance use, insisting that the interview focus on this rather than greater troubles elsewhere was probably a mistake. It may have been why the therapists were usually unable to elicit commitment to a change plan, perhaps the key way motivational interviews generate change.[21]

6 A study of young adult cannabis users is covered here because of the parallels with studies of younger users. Once again, it attests to the limitations of motivational (and other) substance-focused therapies for multiply problematic young cannabis users.

The subjects were 18–25-year-olds referred to an outpatient clinic by probation services in New Haven Connecticut, patients the clinic had found to be poorly motivated for treatment and poorly retained.[22] The 65 who joined the study averaged 20 years of age and were referred either to three sessions of motivational enhancement therapy or to this plus vouchers for attending these sessions and doing so promptly. In accordance with the manual, during the sessions patients were encouraged to prepare a "quit contract" for giving up cannabis at a set date, to develop a change plan to do so, and to continue outpatient treatment.

Yet just 14 patients took up the offer of further treatment. Even among those who attended all three motivational sessions, these on their own were associated with only a small reduction in cannabis use, from 10 days a month before treatment to eight the month after it had ended.

As in Baltimore (study 5), these young adults were multiply delinquent. They averaged five previous arrests and nine or ten months in prison. Most had failed to

had received after an assessment of their drinking and drink problems compared to national norms.

Four out of every ten clients admitted to the service were eligible for the group. Mainly because of limited spaces, not all joined. The study compared the progress of 75 who did against 92 who did not. Overwhelmingly they were single male problem drinkers and despite their attitudes to treatment, over 60% had problems sufficiently severe to warrant a diagnosis of dependence.

Treatment completion was the main outcome, defined as attending the final treatment session with a period of abstinence from drugs or alcohol behind one and satisfactory progress in other problem areas. On this stringent criterion, 56% of motivational patients completed against 32% not admitted to the group, and they had also attended more of their treatment sessions (83% versus 76%).

However, more of the motivational patients were employed and fewer diagnosed as dependent. When these variables were taken into account, there remained significant but now only slight retention gains after the motivational sessions, gains which could have been be due to other, unmeasured differences between the samples. They may also have been due simply to the extra group therapy time given to the motivational patients. Arguing against this are their distinctive reactions to the approach: surprise at not being confronted with "alcoholic" labels and at not being told "what was good for us"; resultant deflection of resistance and anger leading to an improved atmosphere, greater openness, and less conflict; and the salutary impact of learning how far one's drinking exceeded national norms. The relief of staff as well as patients is palpable in the research report.

One of this study's achievements is to show that motivational interviewing can be adapted for groups. Another particularly thoughtful adaptation has been used as an induction for voluntary patients, with promising initial signs of improved motivation.[35]

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## MAKING IT MORE CONCRETE

Though the best known, motivational interviewing is not the only way to boost the motivation of offenders ordered in to treatment. Alternative methods have been devised tailored to criminal justice settings where group formats and set programmes are the norm and the 'clients' are often poorly educated offenders unused to the abstract, verbal explorations of motivational interviewing.

The most persistent and systematic attempt to engineer such interventions has been undertaken by the Cognitive Enhancements for the Treatment of Probationers (CETOP) project based at the Texas Christian University, now also helping England's National Treatment Agency trial similar enhancements.[37] The aim is to lead participants to construct their *own* reasons for engaging in treatment, and then to bolster the knowledge and resources needed to make the most of it.

Though informed by motivational principles, CETOP's "readiness training" interventions attempt to enhance readiness for treatment more broadly, seen as consisting of knowledge of what it takes to change, the personal and external resources needed to do so, self-confidence in the ability to change, and willingness to accept and even welcome the process and its consequences.

In terms of delivery methods, the emphasis is on engaging, hands-on, practical exercises and 'games' requiring only basic reading and verbal skills. These must be capable of being conducted in group formats and easily integrated in to existing programmes – one reason for development of detailed manuals and ready-made or easily reproduced materials, and for the creation of a set of compatible but self-contained intervention modules which services can 'plug in' without disrupting the main programme.

### RESEARCH FINDS IMPROVED ENGAGEMENT

To date research on these interventions has found gains in indices of engagement with treatment and expectations of post-treatment success, but no study has yet extended far enough to evaluate whether these expectations were fulfilled. Impacts have been modest, but so too has the investment; in the major studies, the training occupied at most eight out of about 720 hours of programming. Importantly, there were indications that, as expected, it particularly helped less well educated offenders and those who find it difficult to think things through without concrete supports.

In an early study, offenders on probation who were being treated in a residential programme were required to complete a task listing the negative consequences of drug use and the positives of abstinence.[38] As long as this was done after they'd had time to come to terms with the new regime (a month rather than ten days), the result was to heighten indices of motivation.

Under the CETOP banner, the main test bed has been a substance misuse therapeutic community at a community prison in Mansfield, Texas. Under court orders, residents live at the centre in communities of 30–40 for four months of intensive therapy, training, and education, followed by non-residential support.

### HELPS LESS INTELLECTUAL OFFENDERS

The first CETOP study involved 500 offenders admitted to 16 communities in 1996 and 1997.[39 40 41] Though typically with a history drug-related offending, as a whole their drug use before treatment was less severe than among people seeking treatment voluntarily.

A randomly selected eight of the communities continued with normal procedures while the other eight supplemented these with four, two-hour readiness training sessions conducted in the fourth and fifth weeks of the programme.

In the first, residents completed the *Tower of Strengths* and *Weekly Planner* exercises. In the second, they played the *Downward Spiral* board game and drew 'maps' of the personal changes they had already made or wished to make ◤ *Serious games*. During the third session they constructed a *Personal Action List* intended to foster a positive view of treatment and to identify important actions to make the most of their stay. The final session addressed skill deficits which might impede treatment, providing techniques for improving memory and performance on cognitive or physical tasks.

Eight weeks in to the programme (so two or three weeks after completing readiness training), residents in the communities which had undergone the training were more likely to see themselves and their co-residents as actively engaged in treatment, to be positive about their communities, to see their counsellors as helpful, caring and effective, and to value community meetings about substance use. As expected, the concrete exercises had been most

◤ page 7

complete a basic education. In this context, their use of cannabis one day out of three could have been an inappropriate focus for intervention.

7 The same seems true of many of the youngsters in the Cannabis Youth Treatment Study, whose basic treatment option incorporated motivational enhancement sessions as a lead-in to cognitive-behavioural treatment.[23 24] Again, the motivational sessions were meant to lead to a pre-ordained conclusion – ceasing to use cannabis.

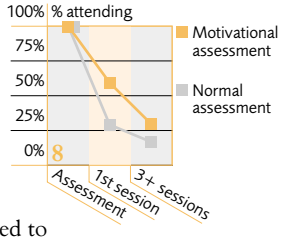
At best partly encouraging post-treatment outcomes[25 26 27 28] may be related to the fact that before treatment, 80% of the youngsters did not feel their cannabis use was a problem and, more importantly, many may have been right. The caseload was a mix of youngsters who probably did not need treatment at all, others with multiple severe problems which demanded a more holistic, intensive and persistent response than any of the treatments on offer,[29] and others who seemed the victims of how America criminalises young, black males from deprived backgrounds.

## MM4 PARENTS BENEFIT WHEN MOTIVATION IS THE ISSUE

Especially in the US context, drug using parents and or parents-to-be are commonly directed in to treatment by child welfare services. As with unwilling youngsters, motivational interviewing ought to have a role in defusing defensiveness and anger, but conceivably with more success. As adults and parents, these referrals may be more inclined to look to the future, and therapists should find more leverage in their decisional balance exercises – clear potential downsides to drug use in the form of the effects on the child or on the parent's prospects of being allowed to keep them. However, results have been mixed.

8 Services in Connecticut faced the challenge of motivating substance using parents referred for outpatient treatment by child welfare services.[30 31] Often angry and resistant to treatment, most did not re-attend after assessment. At one of the provider units, the standard assessment was replaced by one which gathered the same information over the same time, but using a motivational interviewing style. The unit's own staff conducted the assessments after just a day's training in motivational interviewing, but had access to continuing problem-solving support.

Sixty parents (of the 75 asked) joined the study and were randomly allocated to normal or motivationally enhanced assessment. The enhanced version doubled the proportion who went on to attend their first treatment sessions from 29% to 59%, a statistically significant difference. But from then on about half attended no more than one further session, deterred (the researchers speculated) by encountering different therapists and a more confrontational approach ◤ *chart*.




Participants were typically white and employed and substance use was confined to occasional drinking and cannabis use and very occasional cocaine use. To them, referral to treatment may have seemed unwelcome and unwarranted. Nevertheless,

## MOTIVATIONAL INTERVENTIONS TAILORED TO OFFENDERS

helpful for the least well educated offenders. Divided into those who had or had not exceeded tenth grade at school, only the latter had reacted more positively to the training than to normal procedures.[v]

Unexpectedly, measures reflecting the degree to which residents experienced each other as supportive and trustworthy and a positive influence were unaffected, and the training was no more effective for the residents who were presumably most in need of it – the ones who at the start were least committed to treatment.

### WHOLE COMMUNITY TRAINING WORKS BEST

In these early studies training was applied to entire communities which retained the same residents across the four months, maximising the chances of influencing the therapeutic environment. By the time of the second study (of residents admitted in 2000–2001) each of the centre's six communities took in batches of four or five offenders a month, and it was these batches who were randomly allocated to readiness training rather than an entire community.

Perhaps as a result, and perhaps too because the sample (at most 210 residents) was smaller than before, significant overall impacts from the training were few. Towards the end of the residential phase (but not in the middle or during aftercare) they were apparent in higher ratings of how far each resident felt their motivation to get involved in treatment, resist drug use, and reduce infection risk, had increased since entering the programme.[42]

This report was restricted to the 146 participants still in aftercare at the time the last measures were taken. Another report[43] taking in all 210 residents found no overall benefits from the training, not even for the roughly half of the residents who had not graduated from their high schools, failing to duplicate the benefits for poorly educated offenders seen in the first study.

However, significant (if modest) gains did emerge when the residents were split into those who saw thinking things through and learning new ways as a chore, versus those who professed to welcome these challenges. The training had significantly helped the former, presumably because its engaging, concrete activities provided the supports they needed to get to grips with their situation and with treatment. Improvements were seen in their perceptions of how involved they were in treatment, whether they were disruptive or a bad influence, how much they cared for their fellow residents, and their expectations of success on leaving.

When the Mansfield facility converted to an outpatient programme, the study transferred to Wilmer in Texas, where a centre provides six months of residential treatment to offenders on probation. As yet unpublished findings indicate that the same interventions improved residents' ratings of their counsellors and of the programme.[44]

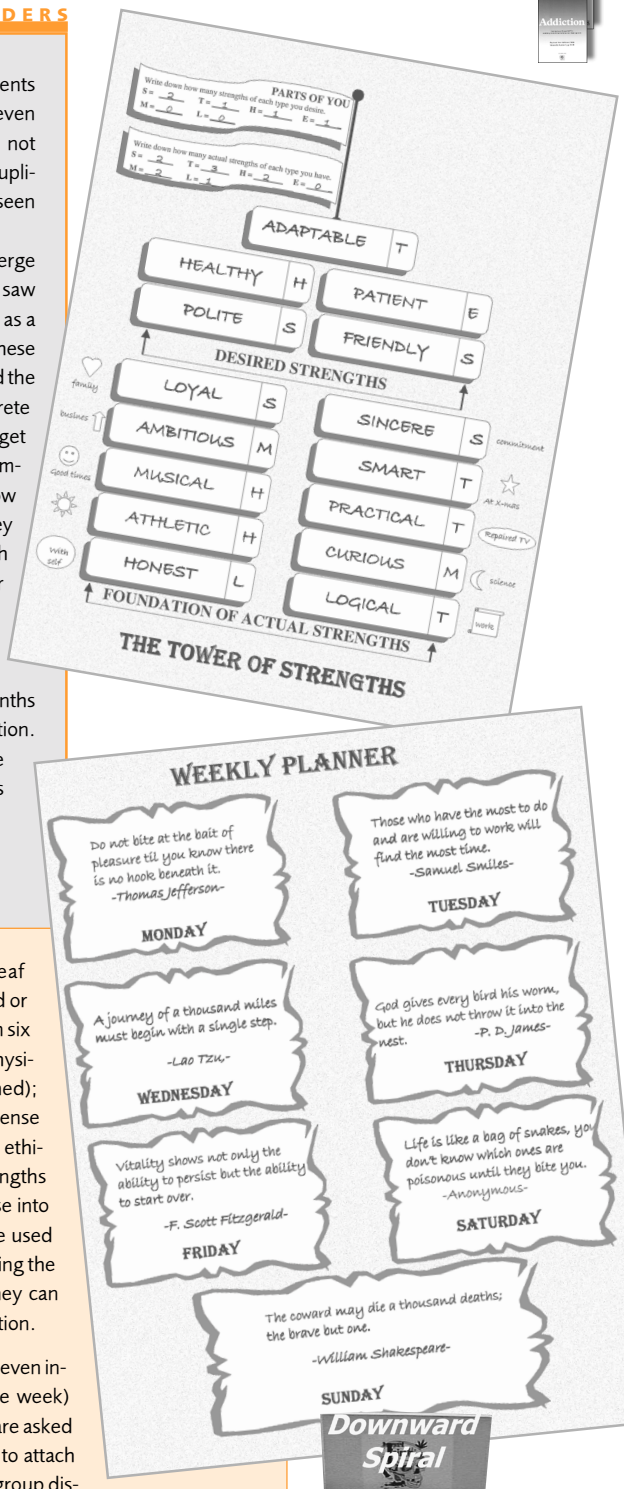
pervading the initial contact with responses which demonstrated caring and understanding, and which acknowledged their autonomy ("What you decide to do about your substance use is up to") persuaded most to at least give it a try. The impact may have been augmented by the staff's enthusiasm for a prestigious research project and for an approach which promised to resolve a major source of disappointment – 'rejection' by 7 in 10 clients.

After the study the centre expanded its commitment to motivational approaches, suggesting that patients had responded positively. As one of the clinicians put it: "[Clients] felt threatened about coming in and doing the [assessment]. I think having someone use the [motivational] approach, rather than a confrontational approach, was good for them. We were more able to engage them in treatment."

9 Positive findings in Connecticut contrast with nil effect from a motivational intervention in Oklahoma,[32] but these new mothers had every reason to clam up despite motivational probings.

The 71 in the study had attended an

## SERIOUS GAMES




**TOWER OF STRENGTHS** Participants leaf through a pack of 60 cards each with a word or phrase designating a personal strength from six domains: social (eg, friendly); behavioral/physical (eg, musical); motivational (eg, determined); cognitive (eg, organised); emotional (eg, sense of humour); and spiritual/philosophical (eg, ethical).[45] Each chooses ten of their existing strengths and five they'd like to have and inserts these into the *Tower of Strengths* diagram. These are used to structure a small group discussion exploring the importance of these attributes and how they can used and developed to improve one's situation.

**WEEKLY PLANNER** Each individual selects seven inspirational quotes (one for each day of the week) from a pack of 87 quote cards. Participants are asked to select quotes relevant to their goals and to attach these to particularly relevant days before a group discussion of what the quotes mean and how they can help. Offenders enter the quotes on to their personal weekly planner to be referred to at the start of the day, providing a motivating reminder of the way forward.

**DOWNWARD SPIRAL** is a board game intended to motivate players by facing them with the potential consequences of continued substance abuse without being directly confrontational.[46] Five or six players take on the roles of people committed to a life of substance use. Mimicking the real-life consequences of such a decision, players throw dice to move across a board whose squares represent potential downfalls related to family, health, friendships, finances, self-esteem, and the law, each described on cards the players collect. The aim is to be the last player alive, but due to their substance use, throughout the game players lose social support, health, money, and their sense of self-value. Just staying alive becomes more challenging the longer the player stays in the game.

**More information and downloads from www.ibr.tcu.edu**

intake session for a year-long programme for women who used drugs while pregnant. Over 8 in 10 had been referred by child welfare services after having their newborn child removed when a test revealed illicit drug use. The consequences of continuing to test positive could include being denied visits to their children. Despite this, over the first two months only half the scheduled therapy sessions were attended and half the urine tests were either missed or positive.

To improve retention and outcomes, a motivational interview was incorporated in the intake session and two further interviews were scheduled for a week and two months later. Women were randomly allocated to this procedure or to educational videos at times corresponding to the first two interviews, and at the two-month stage to an extra home visit. On average the trained motivational therapists faithfully adhered to motivational interviewing principles. Yet they did not significantly improve attendance either at their own follow-up sessions or at the main treatment sessions, half of which were missed. Urine test results too were unaffected; again, about half were missed or positive for drugs or alcohol.

Instead of prescriptive or manualised guidance, therapists were given complete freedom to follow the client's lead. The problem was that clients rarely gave much of a lead. At risk of perpetuating the loss of their child (the treatment service reported each client's progress to the authorities), few owned up to any substance use problems or to any ambivalence about a drug-free life, depriving therapists of essential grist to the motivational interview. That their confidence was false or misplaced was indicated by urine test results, by a history of attempts to stop using drugs with no lasting success, and by a relatively severe drug use profile.

Another possibility is that the educational videos (portraying loss of a child due to parental drug use and their subsequent return) had an impact rivalling that of the motivational interviews. Important too may have been the nature of the client group – poor, single, unemployed and under-educated mothers on welfare with a history of psychiatric symptoms, criminal convictions and domestic violence. Despite considerable attempts to bolster their resources and overcome barriers to service use,[47] perhaps what they lacked was not motivation to regain their newborn children, but the ability to put this in to effect.

10 This seems to have been the case among a similar population studied in Baltimore.[33] The caseload was pregnant women attending for their first prenatal care visit at one of three obstetric clinics. Overwhelmingly black, unmarried, unemployed, poorly educated, and with multiple unmet basic needs, 90 of the 120 women who agreed to enter the study had used heroin, cocaine or cannabis in the past month, about half each had a history of dependence on cocaine and major depression, and over a quarter were diagnosed as suffering from trauma-induced stress disorder.

They were offered four weekly motivational counselling sessions aimed at reducing drug use, plus financial incentives for drug-free urines. But by the third session, over half were skipping their appointments and drug-free urines were a rarity.

The motivational sessions had tried to mobilise the "patient's inner resources", but both these and the women's practical resources were severely depleted. Appreciating these difficulties, part way through the study the researchers began each session by identifying unmet basic needs and referring the women to relevant social and welfare services, later supplemented by providing escorted transport to appointments.

Following this enhancement, at least the first two counselling sessions were better attended, after which it seems many of the women had got the help they needed to sort out their housing (however inadequately), transport and mental health needs. Women offered this extra help also cut down their drug use to a greater degree (eg, over a third had two consecutive drug-free urines compared to just 6% of the other patients) though still over half did not produce a single drug-free urine.

## MM4 BENEFITS DEPEND ON CLIENTS, APPROACH, AND CIRCUMSTANCES

As with voluntary clients,[36] with coerced samples there is no universal answer to whether motivational interviewing works. For each of the major client categories, motivational induction has had some successes, but has also failed to improve on normal or alternative procedures.

**MOTIVATIONAL INTERVIEWING HELPS THERAPISTS AVOID REPLICATING THE OPPRESSIVE NATURE OF THE SURROUNDING CONTEXT**

The one study of drink-driving offenders capable of addressing this issue (1) found recidivism reductions only for the minority of offenders suffering depressed mood at intake, possibly because these were the subset in need of treatment as opposed to the usual educational response.

With young people, enhanced engagement and substance use reductions were found in one study (4) but not in another (5). In the successful trial, motivational interviewing was probably true to its principles, eliciting the typical positive reactions, and the caseload seemed in need of substance-focused help. In the unsuccessful trial, the interview's aims differed little from familiar 'Don't do it' injunctions, and though the clients' problems were multiple and severe, substance use was not high among them. In other studies too (6 7), motivational interviewing may have been undermined by an insistence on one acceptable outcome (abstinence) and an inappropriate focus on substance use in the face of multiple severe problems.

Similar factors may account for mixed fortunes with parents ordered by child protection authorities for assessment or treatment. When stressed and under-resourced lives were the main features of the caseload, motivational interviewing was unable to make much of a difference (9 10). When these were less pressing and motivation more the issue, improved engagement with treatment was the result (8).

Last is the one controlled study (11) of group motivational interviewing. Among this mixed bag of offenders, the result was slight improvements in engagement with treatment for those unable to see a point to the treatment they were being forced in to.

Across these caseloads, substance-focused motivational interviewing was ineffective or only marginally effective when substance use was not the major problem in the offenders' lives (5 6 10). Even when substance use problems were relatively severe, patients would not open up to a therapist whose reports back to legal authorities might have severe consequences for themselves and their families (9).

### SIX ROUNDS, FOUR HITS, NO KNOCKOUT

Among these studies, motivational interviewing was tested most adequately in the six which compared it with normal or alternative procedures. Four of these recorded positive effects for some subgroups (1 11) or for the sample as a whole (4 8). However, on their own, none was conclusive.

In two (1 4) it is impossible to say whether motivational interviewing made the difference, or the sympathetic, individualised attention which came with it.[iii] Yet even if this were true, it is not an argument *against* motivational interviewing, but *for* the quality of the relationships it fosters. One of the most important virtues of the approach may be that it clears the way for standardised, dehumanising responses to be replaced by re-humanising ones such as empathy, validation, respect and optimism.

Of the remaining two positive studies, one (8) seems a convincing demonstration that staff enthused by motivational interviewing can make a big difference to initial treatment uptake when this approach is incorporated in to assessment procedures. The second found engagement benefits from a group format adaptation (11), but these may have been due to extra group therapy time rather than the approach taken, or to differences between the non-randomly allocated offenders.

Another reason for caution is that in all the positive studies, we cannot be sure motivational interviewing really was the intervention being evaluated. In one (11) it certainly was not (because of adaptations to a group format) and the remainder neither record continuing supervision of therapists nor checks on whether they stayed true to motivational principles.[iv]

## SUFFICIENT WIDTH AND DEPTH

Despite the caveats, this accretion of positive outcomes is enough to suggest that the approach *can* work – given that substance use is an appropriate focus, that the patients have the resources to make positive changes, that therapists can remain reasonably true to motivational principles, and that the patients feel safe about opening up to their therapist. Unfortunately, in legally coerced populations, elements are often missing from this virtuous constellation.

Whether the motivational approach itself accounts for these findings is harder to

**QUESTIONS FOR SERVICES**

? **Does the client really have a substance use problem requiring treatment or are other issues more pressing?**

? **Is lack of motivation the main thing holding clients back from engaging with treatment, or is it practical obstacles or over-stressed and under-resourced lives?**

? **Are motivational therapists insulated from reporting-back obligations to legal authorities, and are patients reassured that this is the case?**

divine – other factors almost certainly played a part. But the reactions of the clients suggest that motivational principles really were an active ingredient. When the population and circumstances have been conducive, and therapists have been able to implement key elements of the motivational style, they have been rewarded by the typical positive reactions from patients relieved of denigrating labels and injunctions about what they must do (2 4 11 and possibly 8).

For services, the implications seem to be to assess whether there really is a substance use problem requiring treatment, and whether motivation is the main issue holding their legally coerced clients back from engaging with it, or whether instead it is practical obstacles or over-stressed and under-resourced lives. If a motivational approach seems indicated, therapists should be insulated from reporting-back obligations to legal authorities, and patients should be reassured that this is the case.

Motivational interviewing is not the only way to enhance the engagement of people coerced in to treatment. In settings where dehumanisation and standardised group approaches are the norm, sympathetic, individualised attention to the offender's needs and goals may pay dividends, regardless of the particular approach taken. What motivational interviewing offers is a systematic way to do this which helps therapists avoid replicating the oppressive nature of the surrounding context and which is capable of enthusing jaundiced staff.

## NOTES

**i** The limitations of designating patients as coerced, pressured or voluntary are acknowledged. Many legally coerced patients welcome treatment, many who appear to have chosen to enter treatment have in fact been pressured by families, employers or other third parties.

**ii** However, the comparison seems to have been between the full intake sample and the follow-up sample rather than confined to the youngsters who could be followed up.

**iii** Another study (5) which equalised this factor found motivational interviewing conferred no extra benefits.

**iv** The same can be said of one of the two studies (5) which found no benefits though not of the other (9). The latter was the only one to check (and find) that its therapists stayed true to motivational principles.

**v** Asked to compare how they felt two or three weeks after the training to how they felt on entering the centre, they saw themselves as now more motivated to engage in treatment, confident that they would do so and get something out of it, and more motivated and confident that they could resist relapse to drinking or drug use.

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MM5
MANNERS MATTER • PART 5

# My way or yours?

How directive the therapist is in the face of client resistance is emerging as one of the strongest and most consistent influences on the outcomes of therapy. There is no one right answer – it all depends on the client, in particular on how much they perceive and react against threats to their autonomy.

*by* **Mike Ashton** *of* FINDINGS

**Much of the work on substance use reviewed here derives from Mitchell Karno and colleagues at the University of California in Los Angeles, who are thanked for this and for their generosity in sending papers. We would also like to thank Mitchell Karno, Larry Beutler of the Pacific Graduate School of Psychology, William Miller of University of New Mexico's Center on Alcoholism Substance Abuse and Addiction, Christopher Kahler of Brown University's Center for Alcohol and Addiction Studies, Petra Meier of Manchester Metropolitan University, and Rosemary Kent of the Kent Institute of Medicine and Health Sciences, for their comments on this article in draft and in several cases for sending research papers and reviews. Though these commentators have enriched it, they bear no responsibility for the final text.**

**HOW DO YOU FEEL** when a companion takes the lead, leaving you no option but to tag along or object? Maybe not bothered, perhaps even relieved that someone else is taking the decisions when you lack confidence, energy or impetus. If they are the guide on this excursion, you might simply expect it. Or maybe you react against it – this is your trip too, and even if they are the guide, their role is to lead to where *you* want to go. You might be annoyed enough to subvert their plans, insist on another direction, or just decide against continuing the journey in tandem.

What if instead your companion answers every question about where you should be going with, 'What do you think?' – a welcome acknowledgement of your autonomy, or maddening buckpassing? It may help ensure things stay on track, or be a recipe for stagnation if you really don't have much idea where to go or how to get there.

Common and difficult enough in everyday life, during therapy such relationship issues are writ large, leading to correspondingly substantial consequences. This happens partly because *as a matter of design*, some therapeutic philosophies consistently demand conformity to a set world view and a way of tackling addiction, while others just as doggedly insist that the therapist takes a back seat and stays there. Both attitudes preclude the adjustments which could avoid counter-productive interactions.

As in life outside the consulting room, neither back seat nor driving seat is invariably the preferred position – it all depends. Any given mixture of taking versus ceding the lead will be right for some companions at some times, wrong for others. Get it right, and the client wants to stay (retention) and joins with you in progressing to a mutually desired destination (outcomes); get it wrong, and they find more amenable companions, abandon the journey, or even go in the opposite direction.

Generally termed 'directiveness', across a variety of psychological complaints and psychotherapeutic approaches, this dimension of the therapist's interpersonal style is an important determinant of how clients react. One recent review found that in 16 out of 20 studies where this was investigated, outcomes improved when therapist directiveness matched the degree to which clients tended to 'resist orders'.[1] Highly resistant clients benefited more from self-control methods which left them in charge and from minimal therapist directiveness, while clients with low resistance benefited more from therapist directiveness and explicit guidance.

The exceptions to this rule were the few studies in which the tendency of highly 'reactive' clients to ricochet against direction was exploited not by being *non*-directive, but by directing them in the *wrong* direction, encouraging a continuation of their problems.[i] Setting these studies to one side (none concerned substance misuse treatment), the resistance–directiveness match is unusually consistent – if one is high, the other should be low.

The same pattern is now clearly emerging in addiction therapy. FINDINGS readers will already have come across it in the context of our review of motivational interviewing, but the principles extend to other major therapeutic approaches. This review pulls together the relevant data and asks how far it can guide therapists about when to set the agenda, and when to leave this to the client.

Inescapably, this is a complex issue because human interactions are themselves complex. Simplification is bound to lead to errors, and has demonstrably done so in studies where one-size-fits-all interventions have failed clients who actually do *not* fit. To help get a grip on the data, it is essential first to clarify the concepts involved, for which readers are referred to the panel *Directiveness and resistance* on page 25.

## Pre-structured motivational induction; helps the unsure, confuses the committed

Readers who've followed the *Manners Matter* series will already appreciate the risks of over-directive therapy, one theme in our analysis of an initial motivational interview as an induction intended to promote engagement with treatment or aftercare ▸ *The motivational hallo*, issue 13.[2]

The relevant findings came from four studies during which motivational therapists, mandated by a manual and held to it by supervision, directed their clients to address certain issues in a predetermined sequence and at more or less predetermined stages of therapy.[3 4 5 6 7] Paradoxically, this tightly controlled structure was intended to ensure that therapists remained *non*-directive about what the client should think and do about their substance use. Indeed, clients were led to reconsider decisions and judge-

ments they may already have made, even if these promoted recovery.

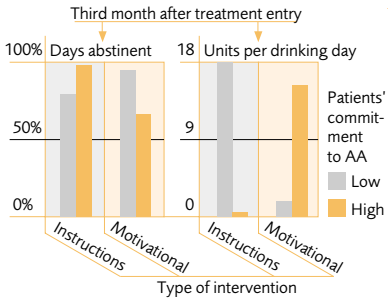
All the studies assessed (though in different ways) how ready clients were to tackle their drug problems and found that this influenced how they reacted. Across all four, if we can read the 'unready' clients as being 'resistant', what we have is resistant clients reacting well when this type of intervention non-directively accepts and explores their ambivalence about their drug use, badly when interventions directively constrict how this should be seen and tackled. Conversely, the more ready, presumably non-resistant clients, reacted badly to opening up the options and did better when left to more directive normal or alternative procedures.

### 'JUST DO IT' OR 'LET'S THINK AGAIN'?

One of the studies was particularly instructive, because it directly contrasted motivational interviewing with an intervention not only highly directive in structure, but also in content.[5]

The alcohol-dependent patients were undergoing inpatient detoxification in a unit whose programme featured daily AA meetings. Additionally, they were randomly allocated to one of two interventions aimed at encouraging engagement in aftercare and continued sobriety. The first was simple – explicit, abrupt instructions to abstain and join AA – the second, a motivational interview which invited patients to weigh the pros and cons of drinking and of AA or other approaches. Abstinence and AA engagement remained the aim, but the interview opened up other options and left the conclusions to be drawn by the client.

To judge by their later drinking, those eager and ready for AA found that the more abrupt intervention matched and maybe reinforced their commitment, while the 'Let's think again about this' approach was an undermining step backward. But for others – in the context of the unit's programme, the 'resistant' clients less committed to AA – instructions to abstain and join AA seem to have pushed them down a route they were not ready to take, prematurely closing off other options. In any event, they drank far more after this short intervention than after the motivational approach. The effects were visible both in terms of days abstinent and the amount drunk on each drinking day *chart*.




**Instructed to join AA, patients already committed to that course were virtually abstinent after detoxification. Ambivalent patients benefited more from a less directive, motivational intervention.**

Within this nutshell of a study, an approach which comprehensively contravened motivational interviewing's core principles nevertheless worked better for some clients, whilst its more modern, science-based tactics backfired. They key was how resistant/committed the clients were to the 12-step-based detoxification and aftercare

**CONTRAVENING MOTIVATIONAL INTERVIEWING'S CORE PRINCIPLES WORKED BETTER FOR SOME CLIENTS** regime on which the interventions were superimposed. If they were at least somewhat unsure or resistant, a motivational interview which acknowledged and explored their ambivalence helped sustain their sobriety. If they were pretty well fully committed, a more directive approach consonant with this commitment worked best.

### CORNERED CLIENTS STRIKE BACK

Another of the studies, this time of drug users entering treatment, illustrated that while directively addressing set topics may be fine, there can still be resistance when the client is implicitly directed to reach predained conclusions on those topics.[6,7]

The therapists' agenda included getting the client to weigh the pros and cons of their substance use based on feedback from a prior assessment, then to formulate a plan to change this, and finally to anticipate and prepare for potentially derailing influences.

For the more 'ready' clients, it worked fine. The problem was with 'resistant' clients who did not see their former drug use as all bad. It cropped up first when they were landed with what in the event was almost uniformly negative assessment feedback. Linguistic analysis revealed the classic counter-reaction *against* curbing their substance use. Counter-productive reactions also occurred when later they were prematurely asked to commit to change and then to defend their change plan, seemingly before its motivational underpinnings had been secured. In each case, the effect was to weaken their commitment to curtailing drug use, followed by the predictable outcomes in terms of actual drug use.

## Inside Project MATCH: anger, reaction and confrontation

Despite the interventions being merely brief preludes to more extended treatment, in the four studies reviewed so far, the impact of (mis)matching directiveness to resistance emerged strongly. What of studies in which the entire treatment adopted a more or less directive stance?

Because it involved a version of motivational interviewing, closest to the studies reviewed so far is the multi-million dollar US Project MATCH study of alcohol dependent patients. It compared motivational enhancement therapy to two therapies which more explicitly imposed a set programme and a set view of addiction.[8] One was 12-step facilitation, an approach based on the disease model of alcoholism and on AA tenets; the other was cognitive-behavioural therapy, which sees addiction as a learnt behaviour and aims to develop new learning in the form of skills and strategies to maintain sobriety.

One of the clearest findings was that patients prone to react angrily did best in motivational therapy, at least in the 'outpatient' arm of the study where the MATCH therapies were the primary treatments.[9,10] They drank on fewer days and less on each of those days than after the other therapies, an effect which remained strongly significant even three years later. This much was expected; deflecting anger and resentment is supposed to be motivational interviewing's

**GOLDEN BULLETS** Key points and practice implications

- Non-directive styles generally suit clients characterised by anger or resistance; directive approaches profit clients who welcome a lead.
- The ability to assess which style is likely to work best, and to adjust accordingly, could be one way in which empathy and social skills improve outcomes.
- Key therapist behaviours are how often and how forcefully they offer interpretations, confront resistance, and initiate topics rather than allowing clients to set the agenda.
- Which 'brand' of psychosocial therapy is offered does matter, but largely because it influences the style of the therapist.
- Ideally, initial assessments of the client and/or their reactions early in therapy which indicate how far they resist direction would be integrated with other considerations to decide which therapists or therapies were most likely to get the best results.
- Before changing therapeutic style, consider first whether it is the direction the client is being led in which needs to be changed rather than the degree of directiveness.


**Directiveness can work. Lord Kitchener's famous injunction, underlined by handlebar moustache, steely gaze and pointing finger, helped recruit over three million volunteers in the first two years of World War I.**

strength. But unexpectedly, the reverse was also the case – the least angry patients did *worse* when allocated to motivational therapy.

How this happened has been investigated across the five outpatient clinics.[10] Compared to the more directive alternatives, motivational therapy excelled at handling high client resistance to treatment, preventing this from expressing itself in continued drinking, presumably a benefit of the motivational therapists' drilling in 'rolling with resistance' and avoiding provocation. Conversely, it seemed that clients ready and willing to be directed were somewhat let down by the hands-off, 'It's up to you' stance of the motivational therapists.

This picture was pieced together from paper and pencil tests which only indirectly measured client resistance and without any measures of how directive therapists had actually been. Work done at one of the MATCH clinics in Providence enables us to probe deeper. There, videos of counselling sessions afforded a direct, observational measure of how clients and therapists responded to each other.

### BEST NOT PROVOKE THE PROVOKABLE

Though in the other arm of the MATCH study,[ii] at this clinic too, motivational therapy was generally most effective for patients prone to react with anger, least effective for the less fiery.[11] The videos revealed the underlying reason. Motivational therapists had been significantly less directive than those implementing cognitive-behavioural therapy, and it was this which accounted for the differences in how patients reacted. True, motivational therapy promoted a less directive style, cognitive-behavioural a more directive, but still, style rather than therapeutic 'brand' was decisive.

The upshot was that, whatever the therapy, clients with a medium to high tendency to react angrily remained virtually abstinent after seeing therapists who had avoided being directive. For calmer clients, it was the opposite; they remained virtually abstinent when the therapist had given a lead. Reverse this matching, and both types of patients were more likely to drink.

But there was a remaining puzzle. As expected, for angry patients motivational therapy had worked better than cognitive-behavioural, but the same was not true of 12-step therapy. Yet on the face of it, this programme based on an approach which insists on a fixed notion of addiction and how to recover from it, should have counter-productively lit their fuses. The explanation was simple: confounding expectations, 12-step therapists had actually been no more directive than the motivational therapists. Presumably as a result, these therapies had similar impacts on angry patients.

The question then becomes, why weren't the 12-step therapists more directive? Possibly for two reasons. First, in the US context,

**THE MORE DIRECTIVE THERAPISTS HAD BEEN, THE MORE HIGHLY REACTIVE PATIENTS DRANK**

12-step approaches are accepted wisdom and familiar to patients – 'second nature'. There would be little need to direct and teach, even more so in the arm of the MATCH study which Providence hosted. Here, nearly all the patients had just emerged from detoxification and they were heavier drinkers, more treatment-aware, and more involved with AA, than patients in the other arm of the study.[12 13]

Second, the 12-step therapy manual was far less prescriptive and detailed than the cognitive-behavioural version. Both influences would have promoted a more directive style for cognitive-behavioural than for 12-step therapy, sharpening the contrast with the non-directive motivational style.

The (tentative) lesson is that whilst some therapies seem to lend themselves to a directive style, whether this is actually the case will depend partly on the patients and on the cultural context.

### RISKY TO CONFRONT THOSE WHO HIT BACK

Digging yet deeper in to what was happening in Providence, another report drew on observations not just of the therapists, but of the clients.

From videos of the first therapy session, raters assessed the degree to which clients seemed reluctant to relinquish control and reacted against direction.[14] Though based on actual responses in therapy, the raters' mission was to assess the client's *predisposition* to behave in these ways rather than to record responses to the particular situation. In this it appears they largely succeeded *Directiveness and resistance* page 25.

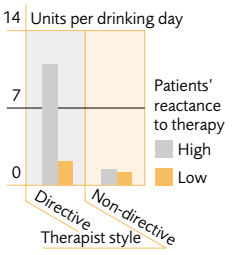
Importantly, their assessments of the patients 'reactance' were unrelated to how directive the therapist had been during that and subsequent sessions. It seemed that patients who started treatment in reactive mode were not responding to the therapist; it was simply how they were. Therapists too were more or less directive, regardless of how the patients behaved. Had each been echoing the other, it would have muddied the causal waters, making it difficult to know what was cause and what effect.

In the event, the waters seemed remarkably clear. Whether the outcome was the number of drinking days or the amount drunk on each of those days, the more directive therapists had been, the more the highly reactive patients drank in the year after therapy ended *chart below*.

Paired with a directive therapist, on average they drank on around a quarter of days and then fairly heavily, about 11 UK units. Paired with a non-directive therapist, the same type of patients went on to drink rarely and on average just one or two units. Given a non-directive style, despite their tendency to obstruct and resist, these patients did just as well as the more cooperative patients. It seemed that their potential to ricochet in the wrong direction had been defused by the absence of a hard therapeutic direction to ricochet against.

A more detailed analysis explored whether the effect of directiveness–reactance matching applied in each of the three therapies. With respect to drinking days, it did, but the effect was much more apparent after motivational interviewing, perhaps because tactics such as confrontation or

**Clients who react against therapist direction do better when the therapist gives them little to react against.**




interpreting the client's resistance rather than 'rolling with it' violate its essence in a way they do not for the other therapies.

Overall, in this clinic and with these patients, it was safer to be non-directive. On average, no type of client suffered as a result, and it avoided poorer outcomes among reactive patients. In other MATCH clinics and in other studies, this hasn't always been the case – sometimes the calmer and less resistant patients do lose out if therapists take too much of a back seat.

### IS ANGER THE SAME AS REACTANCE?

With outcomes related both to how anger-prone patients were and how reactive they were, the next step was to check whether these were simply the same characteristics measured differently. This new analysis first

## DIRECTIVENESS AND RESISTANCE

To make sense of the data we need first to clarify what directiveness is and what it is not, and similarly for resistance. These seemingly simple concepts are in fact complex, partly because it is perfectly possible at one level to be directive or resistant, yet simultaneously, at another to be the opposite.

### Directiveness – content and style

Therapists can be *directive* in the sense of directing the client to do or talk about certain things, or limiting their freedom of action, yet still be *flexible* about which things, when, and with whom, and *sensitive* enough to deploy that flexibility in ways which adapt to the client.

In theory then, mistakes can arise in several ways. First, a directive style *as such* may be the problem: no matter how sensitive or flexible the therapist, some clients may react badly to being led. Alternatively, the style may not be the problem, but the *content*: the client may be ready and willing to be directed, but is led along a counterproductive trajectory due to insufficient flexibility or sensitivity.

Important as they are, these distinctions are not as sharp as they seem. At a deeper level, sticking to an explicitly directive style when that is just going to provoke, is itself to be insufficiently flexible or sensitive. And a directive style provides more opportunities to be inflexible or insensitive by directing the client in ways which clash with their own priorities or motivational state.

So in practice, these dimensions are often conflated. The therapist is at the same time directive in style, relatively inflexible in content, and limited in the extent to which they sensitively adapt content and style to the client. In research settings, this often happens because they have themselves been directed to follow a set procedure, often in manual form. Commonly this prescribes both the style and the content of the interaction.

The content imposed by a directive therapist can itself occupy at least three different levels. First is being directive about the *structure* of the session – mandating that certain topics are addressed, when they are addressed, and/or in what sequence. Second is being directive about the *conclusions* of those discussions – for example, the implicit or explicit indication that drug use must allways be bad, that only certain goals are acceptable, or that addiction always has similar roots and manifestations.

At a further level up, neither structure nor conclusions may be imposed, but still the therapist is directive in the sense of knowing where they want the interaction to go, and seeking to subtly nudge the client in to adopting that direction too – the classic motivational strategy.

### Resistant by nature, or just a raw nerve?

On the client's side, the key distinction is between being generally *predisposed* to resist direction from other people, versus in a given situation, reacting as anyone might to uncomfortable topics or unpalatable threats to one's autonomy. These are hard to disentangle and measures intended to reflect one may be contaminated by the other,[29] but in clinical terms, the distinction is crucial.

Awareness of the client's predisposition should influence the overall therapeutic style, typically contraindicating explicitly directive approaches for resistant clients. On the other hand, 'normal' signs of resistance evoked during therapy can be handled by micro-managing the encounter rather than a wholesale change in style.[1]

**AT THE CORE OF THESE REACTIONS IS A RESISTANCE TO BEING DENIED CHOICE OR HAVING ONE'S AUTONOMY UNDERMINED**

So if the task is to match therapeutic style to the patient, gauging predispositions is the important issue. In the MATCH Providence studies, observers were asked to infer these predispositions from how patients *actually* behaved early in therapy ◤ *Risky to confront those who hit back* page 24.[14] On the face of it, there was a risk that raters would mistakenly see uncooperative behaviour as characteristic of a stubbornly resistant streak, rather than as a normal reaction to what was happening then and there.

In fact, their assessments of the patients' predispositions were only weakly related to whether the patient actually exhibited resistant behaviour.[30] And on the key issue of how patients responded to directive versus non-directive therapy, resistant behaviour was unrelated, whilst the measure intended to reflect enduring predispositions did affect outcomes. The raters seem to have successfully divined the patients' predispositions and it was these rather than in-session resistance which interacted with therapeutic style.

There is also a distinction between more passive forms of resistance, such as diversion and dragging one's feet, and outright opposition. This latter manifestation is closely associated with traits such as anger, defensiveness, dominance and need for autonomy[29] – important, because often these are what is measured rather than resistance as such.

At the core of these reactions is a resistance to being denied choice or having one's autonomy undermined in other ways. Some philosophies see this as part of the pathology being treated, an avoidance of painful insights or repressed feelings and impulses. Others say it's simply human nature to counter threats to what you see as your legitimate freedom to act. Sometimes called 'reactance', different people express this to different degrees and in different ways, partly in response to the seriousness and nature of the threat, but partly also in accordance with their own predisposition to perceive such threats.[1]

Mirroring the levels of therapist directiveness, clients may resist structure as such, resist a particular structure, or accept the order and timing of topics yet resist being led to reach certain conclusions about those topics. An example is the study in which it was thought some clients reacted not against being led to consider the pros and cons of their drug use, but against the conclusion being imposed on them that it was unremittingly negative ◤ *Cornered clients strike back* page 23.

established that in fact, the two dimensions were only loosely related; someone could score high on anger yet not react against direction, and vice versa.[15]

So while 'angry' and 'reactive' patients overlapped somewhat, they were distinct groups. Still, it was possible that these two groups would respond similarly to directive therapists. To test this, the researchers decomposed directiveness into what turned out to be two quite different components.

First was the prototypical confrontational style, characterised not just by confrontation, but also by interpreting the meaning of the patient's own behaviour or experiences. No matter how diffidently, such interventions impose on the client the therapist's view of who they are and why they behave as they do. Second were activities less to do with imposing content than with imposing structure – initiating a focus on certain topics, providing information, and asking closed-end questions. These sub-styles too were only loosely related: therapists might be directive in one way but not the other. At issue was whether the consequences for the patient might also differ.

**LACKING A SPARK OF THEIR OWN, CALMER PATIENTS NEEDED SOME INCENDIARY FROM THE THERAPIST TO MAXIMISE CHANGE**

In the event, whether the measure was drinking as such or heavy drinking, highly reactive patients reacted badly to both forms of direction, yet with non-directive therapy, they did about as well as other patients. The exception was simply providing information, a relatively neutral form of directiveness which did not provoke much of a backlash, even among reactive patients.[14]

Less consistently relevant was whether clients were prone to anger. Here, only the confrontation sub-style mattered, and then only with respect to abstinence. In the year after treatment, anger-prone patients drank on fewer days if therapists had avoided confrontation, on more if the therapist had confronted.[iii]

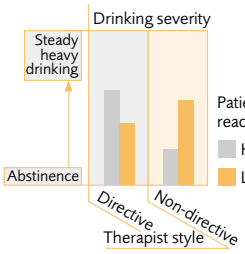
This much was the predictable result of provoking the provokable. Less expected was the finding that after seeing a non-

confrontational therapist, calmer patients drank on *more* days than they did after being confronted. In fact, they ended up drinking more than their angry peers – as if lacking a spark of their own, they needed some incendiary from the therapist to maximise change.

Persuasive as these findings are, it is important to remember the context – the MATCH study, in which therapists were highly selected, trained and supervised.[16] In this context, such 'confrontation' as there was is unlikely to have been extreme, persistent or abusive. A further caution – that not too much should be made of results from a single set of clients at a single clinic participating in a tightly controlled study – would be worth emphasising more if these were isolated findings. In fact, they exemplify a pattern seen elsewhere in very different circumstances.

## Similar view beyond motivational interviewing

By now a fairly clear picture is emerging. Across several common types of therapies, if the therapist is directive they risk a backlash from patients with a short fuse or who resist other people's attempts to lead the interaction. Conversely, calmer patients or those who welcome direction thrive when given more of a lead.




**Patients prone to react against attempts to influence them drank least when therapists had been non-directive. For patients willing to embrace influence and direction, the reverse was the case.**

From studies of motivational interviewing, we also know that when direction is pre-structured and inflexibly applied, there is a risk of fouling things up both with those most and those least committed to tackling their drug use, when the programme's mandate fails to match their state of mind.

So far this picture has emerged from studies which have included adaptations of motivational interviewing. We'll see now that the landscape remains familiar when widened to studies which have not explicitly involved a motivational approach.

### SOME WANT TO LEAD, OTHERS TO BE LED

First is an analysis of alcohol patients engaged in two sorts of outpatient couples therapy, one cognitive-behavioural, the other family-focused.[17] Both were intended to span five or six months, of which the last three or four were a 'maintenance' phase designed to sustain the gains made earlier. The outcome was how far drinking severity (assessed by clinician-observers using all the available data) during this phase had changed compared to pre-treatment drinking levels.

The degree to which outcomes were affected by the therapist was assessed through ratings made from sessions videoed in the first phase of treatment. Directiveness was measured using the scale used in the Providence MATCH studies, except that the raters assessed not just how directive therapists had been (eg, asking closed-ended questions), but also how far they had actively been the opposite – for example, asking open-ended questions and allowing patients to select the topics to be discussed.

Regardless of which type of therapy they'd been in, patients prone to defensively resist attempts to influence them[iv] drank least when their therapists had been non-directive, most when therapists had tried to take the lead. For patients willing to embrace influence and direction, the reverse was the case. They drank least when the therapist took the lead, most when they avoided being directive and/or were actively non-directive ◤ *chart left*.

As in the MATCH clinic in Providence, how the therapists behaved was largely independent of their patients' predispositions, strengthening the implication that the therapist's style truly was an active ingredient in producing the drinking outcomes.

**THE CLASH BETWEEN DIRECTIVE THERAPISTS AND REACTIVE PATIENTS LED TO POORER OUTCOMES AMONG RETAINED PATIENTS; OTHERS JUST LEFT**

These findings are compromised somewhat by an inability to re-assess 27 of the 75 patients who started the study. But had these been followed up, the results might have been even more clear cut, because they tended to be the patients prone to react defensively and those who had seen the most directive therapists. If (as it probably did) retention in the study reflects retention in therapy, it seems that the clash between directive therapists and reactive patients might not only have led to poorer outcomes among retained patients, but also led others to leave early.

### STRUCTURE SUITS THE 'HELPLESS'

A similar picture emerges from a study of a very different set of patients, not mainly white, employed drinkers, but poor, black, single unemployed men seeking outpatient treatment at an inner-city clinic in Philadelphia, where cocaine was the dominant drug problem.

How far they resisted direction was not directly assessed, but a similar variable was. People characterised by 'learned helplessness' feel unable to control their lives, in particular that it is futile for them to try to initiate positive changes. They seem like the people who in other studies would welcome direction from others. At the other end of learned helplessness are people confident in their abilities to initiate positive change, the ones who seem most likely to react against the therapist doing the initiating.

Patients were randomly allocated to 12 weekly sessions of two kinds of therapies, designed in some ways to be at opposite poles. In one the counsellor structured the therapy, leaving little room for the client to take the lead. They directed the client to

OFFCUT 1

Steep recent increases in **liver cirrhosis deaths** appear to expose the failure of British alcohol policy to curb consumption and related medical harm. The analysis by researchers from the London School of Hygiene and Tropical Medicine and the National Addiction Centre found that Scotland led the way with a doubling between 1987–1991 and 1997–2001 in deaths in men and a 63% increase among women. ❶ In England and Wales, the corresponding increases were 67% and 35%. These rises were the steepest in western Europe. Across the rest of the region, on average mortality rates fell over the same period. From in the late '50s being at or near the bottom of the European cirrhosis mortality league, rates in Scotland are now among the highest in western Europe and in England and Wales have climbed to match the average.

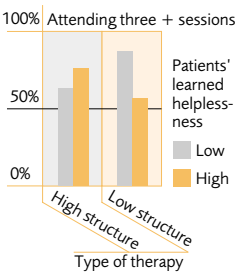
Declines elsewhere have the researchers argued been driven mainly by falling alcohol consumption in the wine-drinking countries of southern Europe, while in the UK consumption per head has doubled over the past 40 years. "There is no doubt", said a linked editorial, that this played "a primary role" in the trend in deaths, yet UK policy has not targeted across-the-board drinking reductions and avoided measures capable of achieving such reductions. ❷ Those with the greatest research backing include the politically unpalatable options of increasing the price of alcohol through taxation and restricting its availability. ❸ ❹ Instead the British health service has focused on research on tackling "alcohol misuse" rather than drinking as such. ❺

❶ Leon D.A. *et al*. "Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data." *Lancet*: 2006, 367, p. 52–56, and corrections in *Lancet*: 2006, 367, p. 645.
❷ Room R. "British livers and British alcohol policy." *Lancet*: 2006, 367, p. 10–11.
❸ Babor T. *et al*. *Alcohol: no ordinary commodity*. Oxford University Press, 2003.
❹ Chisholm D. *et al*. "Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis." *Journal of Studies on Alcohol*: 2004, 65(6), p. 782–793.
❺ Mulvihill C. *et al*. *Prevention and reduction of alcohol misuse*.Health Development Agency, 2005.

identify concrete behavioural goals, taught cognitive-behavioural strategies for reaching those goals, and reviewed progress. In the less structured therapy, counsellors instead provided a sounding board for exploration of feelings and the development of the client's awareness and understanding. Though the same counsellors delivered both versions, video-based ratings by observers and feedback from clients confirmed that the therapies differed in the intended ways.

At the time of an earlier report,[18] 80 patients had been randomised; later, 120 and post-treatment follow-up data was available.[19] Both reports found neither therapy preferable overall, but that this masked different impacts on different types of clients. Those characterised by learned helplessness did better when the therapy required the counsellor to take the lead, while clients who felt more in control of their lives did better when the less structured therapy allowed them to set the agenda.

**Given directive, structured therapy, patients who like to feel in control (low learned helplessness) tended to leave early while their less confident peers stayed longer.**




During treatment, the effect was seen in patient and therapist ratings of benefit, retention (*chart*), and numbers of drug-free urines. In the six months after treatment, it was apparent in measures of drug, family, social and (to an extent) psychiatric problems, though none of these reached conventional levels of statistical significance.

More depressed clients also did best in the more structured therapy and worst when required to take the initiative, again, potentially related to their tolerance for direction: depressed clients seem unlikely to be prone to angry defensiveness. However, depression did not account for the earlier findings: when it was statistically 'evened out', learned helplessness remained just as or even more significant.

By the time of a third report,[20] 143 clients had been recruited to the study but the results seen earlier held up.[21] The main reservation over this study is a low follow-up rate, just 85 of the 120 patients in the most relevant of the reports,[19] a shortfall attributed to the indigent caseload.

## Principles and probabilities but no universal recipes

What might all this mean for practice? At best it identifies some general patterns in how people who differ on one particular dimension of personality respond to therapeutic styles also narrowly characterised as differing on one particular dimension.

Partly because there is much more to people and much more to therapy, such research cannot be used to determine which therapeutic style should be adopted for any particular individual. The reasons for this caution are not just easily dismissed nitpicking, but integral to the nature of research and to the nature of the human interactions which constitute psychosocial therapies.

### BEWARE GENERALISATIONS

First is the fact that many more dimensions are involved than directiveness, and they interact. For example, in one of the studies reviewed above, the biggest influence on drinking outcomes was not directiveness, but whether therapists addressed the emotional states of highly distressed patients.[17] Had they failed to do so for fear of being over-directive, they might have done more harm than good.

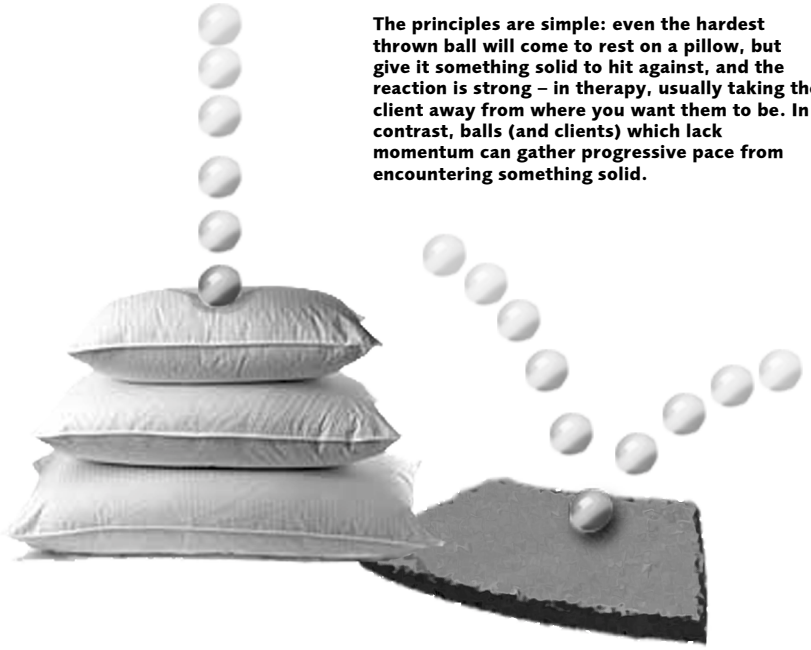
Complicating things further is the possibility that adopting one style or the other, when it does not come naturally or fit the circumstances, will violate another tenet of effective therapy – being and seeming genuinely caring. An 'It's up to you' stance from a probation officer to an offender can seem less than genuine, even to the officer,[22] as can biting one's tongue when it would have been natural and caring to be direct about the risks the client faces.[23]

There is also the concern that what in short-term evaluations seems an effective approach with some patients, may in the longer term prove less so, or vice versa.[v] This phenomenon of shifting outcomes has been seen with skills-based therapies[24,25] and with motivational interviewing,[26] generally seen as at opposite ends of the directiveness dimension. In Project MATCH, the most substantial client-therapy match seen in the study did not become apparent until three years after the therapies had ended.[27]

The results for directiveness and resistance, and all the other dimensions on which therapists and patients may differ, are averages over many clients and several therapists. Typically, the extent to which knowing these variables helps predict individual outcomes is quite limited. Even with a comprehensive score sheet from both sides of the table, for any given therapist-client pairing, it is impossible to categorically recommend one approach above another.

### SUBSTANCE USE IS NOT THE ONLY OUTCOME

While this is the outcome focused on in the research, substance use as such is rarely why patients seek treatment, rather, it is the problems to which their use gives rise in the context of that individual's life circumstances and social reactions. It is entirely conceivable that some angry patients who get confronted by therapists, and end up drinking slightly more than they might have, nevertheless benefit psychologically from being challenged, whilst the calmer types driven to abstinence by a directive therapist may suffer in other ways, perhaps by having their subservience confirmed.



**The principles are simple: even the hardest thrown ball will come to rest on a pillow, but give it something solid to hit against, and the reaction is strong – in therapy, usually taking the client away from where you want them to be. In contrast, balls (and clients) which lack momentum can gather progressive pace from encountering something solid.**

So even if we knew for certain (which we cannot) that a certain approach would maximally reduce substance use for this particular individual, whether that is what matters most to them, and whether globally they end up functioning and feeling better, are separate issues and arguably a more appropriate focus for person-centred therapy.

Even assuming, once again, an implausibly well stocked set of measures characterising both patient and therapist, how these will relate to outcomes does not necessarily stay invariant across different cultures or different settings. We got a hint of this in the surprising fact that in one of the US studies,[11] 12-step therapists were no more directive than motivational therapists, possibly a function of the way in that culture, and especially for these treatment-hardened patients, 12-step approaches are second nature.

Last and most fundamentally, the most the research can show is that *generally* certain types of clients respond best to certain therapeutic styles, but it also shows that doing *anything* 'generally' risks counter-productive reactions among some clients.

### 'YOUR WAY OR MINE' – IT DOES MATTER

What we can say is that the research offers some useful and unusually robust findings for therapists to incorporate in their thinking as an aid to clinical expertise and individualised treatment, not as a substitute.[28]

Part of this grist to the mill is that non-directive styles generally (in terms of substance use) work best for clients characterised by anger, defensiveness, or resistance, or who like to take control, while more structured and directive approaches may profit calmer clients, those who welcome a lead, and those already committed to the course of action being directed.

But before making a wholesale change in style or therapist, first the possibility should be considered that it is not directiveness (or its opposite) as such which is rubbing the client up the wrong way, but being directed along an unsuitable trajectory. This can include leading clients to commit to certain courses of action before they are ready, but can also take the form of leading clients to reconsider commitments and judgements already decided on.

**DOING ANYTHING 'GENERALLY' RISKS COUNTER-PRODUCTIVE REACTIONS AMONG SOME CLIENTS**

When therapists encounter this choppy water, experience from general psychotherapy suggests negotiating a different direction, acknowledging and exploring the nature of the resistance, or explicitly focusing on the therapeutic relationship, the aim in all cases being to defuse the situation by returning a sense of control to the client.[1]

### CLUES TO SUITABLE STYLES

The ability to assess (either explicitly or 'instinctively') whether a change of style is needed, and which style is likely to work best, could be one way in which therapist empathy and social skills improve outcomes. Some therapists can (or can be trained) to deploy approaches at opposite poles of the directiveness dimension. In other cases, it may be best to match the therapist's style to that of the client.

More formally, initial assessments of the client could probe how far they resist or welcome direction and allocate them to the therapists or therapies likely to get the best outcomes. Standard psychological tests can be used and/or such tendencies may be evident from the patient's history, especially how they have typically responded to authority figures.[1]

Patient behaviour early in therapy is also a powerful clue, and one immediately available to the observant therapist. Remember that at the Providence MATCH clinic, a tendency to resist direction, assessed from behaviour in the first therapy session, was a better indicator than a pre-treatment measure of anger.[15] If the observers could gauge this tendency from session videos, then in theory, so too could the therapists, paving the way for adjustments to be made to ease up on confrontation or agenda-setting or to inject a little directional impetus if the patient lacks momentum.

Feedback from early counselling sessions through recordings assessed by supervisors or peers, or through short 'de-briefing' surveys given to the clients, could also be used to assess whether there is a mismatch between therapist and client interactional styles. If there is, clinical supervision can be used to encourage a more suitable therapeutic style or to revise client allocation.

Among the therapist behaviours particularly to look out for are how often and how forcefully they offer interpretations, confront resistance, and initiate topics rather than allowing clients to raise the issues most important to them. These seem particularly potent ways to prompt counter-productive reactions from predisposed clients. However, they are neither 'good' nor 'bad' in themselves, but good or bad for different kinds of clients.

Finally, which brand of psychosocial therapy is offered does matter, but within the limited range studied so far, this is largely because the therapy influences the style of the therapist. To a degree, style can be changed even while the therapy remains cognitive-behavioural, motivational, or of some other ilk, but it might be more effective and easier to choose therapies which promote the required style. For example, the teaching stance of cognitive-behavioural therapy lends itself to directiveness in content as well as structure, while true-to-type, non-standardised motivational interviewing lends itself to the opposite.

But how far therapists *need* to direct clients in any particular therapy will depend partly on how familiar and comfortable the client is with it. At this level too, there are no hard and fast recipes for success, rather multiple influences whose complex interactions change with the context.

OFFCUT 2

Gaps in Britain's harm reduction defences of the kind previously highlighted in FINDINGS ❶ are permitting a minor **resurgence in HIV infection**. The most compelling findings were reported by researchers from the Health Protection Agency and the Centre for Research on Drugs and Health Behaviour. ❷ To model HIV spread from 1990 to 2003 they combined the results of HIV tests on injectors attending drug services in England and Wales with tests on injectors recruited on the street and in non-treatment locations. The proportion infected with HIV bottomed out at 0.5% in 1999 but then more than doubled in the first years of the new millennium, reaching over 1.5%. In each year of the 2000s injectors were two to three times more likely to be infected than in the mid '90s. Though numbers were very small, there was an increase in the proportion of new (under three years) injectors who had become infected. The rate at which injectors became seropositive was greatest among new injectors in London, where it had increased since the late '90s to around 3% in the first year of injecting. In UK terms (modest compared to other nations), the figures were consistent with an upsurge in new infections since 1999 focused on London. Other reports indicate that most of the newly diagnosed infections in the capital involved injectors from mainland Europe.

Though this report was reassuring about trends outside London, later tests on injectors attending drug services revealed that outside the capital there had been a six-fold increase in HIV prevalence from 0.2% in 2002 to 1.2% in 2005. ❸ Though the numbers were small, nationally over the same period the proportion of new (last three years) injectors infected had increased from 0.3% to 1.3%, consistent with a recently increased rate of spread.

❶ Ashton M. "Hepatitis C and needle exchange: part 3 • the British record." *Drug and Alcohol Findings*: 2004, 10, p. 22–29.

❷ Hope V.D. *et al*. "HIV prevalence among injecting drug users in England and Wales 1990 to 2003: evidence for increased transmission in recent years." *AIDS*: 2005, 19(11), p. 1207–1214.

❸ Health Protection Agency. "Evidence of a continuing increase in the HIV prevalence among injecting drug users in England and Wales." *CDR Weekly*: 16 March 2006, 16(11).

## NOTES

**i** I am grateful to Larry Beutler for for pointing this out.
**ii** In which patients had all just left intensive treatment, usually inpatient detoxification.
**iii** This was the case relative to less angry patients and also within the group of more angry patients.
**iv** Assessed before treatment using questionnaires intended to measure this concept.
**v** I am grateful to Petra Meier for pointing this out.

## OFFCUT 3

Rapid change on entry to treatment is well documented and with respect to cocaine addiction, cutting back in the run up to treatment is the best predictor of longer term success. The rapidity and timing of such changes precludes treatment as a major factor, at least in their initiation. The US alcohol treatment trial Project MATCH provides an example. Patients who did not return for therapy did almost as well as those who went through all 12 sessions of the two most extensive therapies. Across the study, nearly all the improvement there was going to be in drinking had occurred by week one.❶ In another US study of heavy drinkers who responded to ads offering help to cut back, most of the drinking reductions occurred after they had responded to the ads, but before receipt of any of the project's assessment or self-help materials.❷ In both cases, change was on average well sustained after treatment.

Such findings focus attention on the **processes associated with deciding to cut back** or stop using. When these processes are intentional – weighing up the pros and cons and taking an explicit decision – Prochaska and DiClemente's 'stages of change' model offers a detailed description. But this is not the only nor it seems the most robust way people change. In a national UK survey, half of all attempts to stop smoking were unplanned – often smokers did not even finish the pack.❸ These resolutions were twice as likely to 'stick' as planned attempts. Similarly in California, a survey of problem drinkers found that weighing the pros and cons as a reason for cutting down was much less likely to lead to lasting remission than 'conversion' experiences like hitting rock bottom, a traumatic event, or experiencing a spiritual awakening. ❹ In these situations too, half finished bottles can be poured down the sink.

The authors of the UK paper relate their findings to "an alternative model to the stages of change … based on 'catastrophe theory' [which] deals with the way in which tensions develop in systems so that even small triggers can lead to sudden 'catastrophic' changes." They argue that the build up to such events creates a state of "motivational tension" in which "even quite small 'triggers' can lead to a renunciation of smoking." A catastrophe model has also been developed in the USA for the opposite process – relapse to dependent drinking.❺

❶ Cutler R.B. *et al*. "Are alcoholism treatments effective? The Project MATCH data." *BMC Public Health*: 2005, 5:75.

❷ Sobell L. *et al*. "Responding to an advertisement. A critical event in promoting self-change of drinking behavior." Presented at the Association for the Advancement of Behavior Therapy, 2003.

❸ West R. *et al*. "'Catastrophic' pathways to smoking cessation: findings from national survey." *British Medical Journal*: 2006, doi:10.1136/bmj.38723.573866.AE. For more see www.primetheory.com.

❹ Matzger H. "Reasons for drinking less and their relationship to sustained remission from problem drinking." *Addiction*: 2005, 100, p. 1637–1646.

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**30** Personal communication from Mitchell Karno, April 2006.



**Many of the young recruits who followed Kitchener's lead were soon killed in gruesome battles, such as that of the Somme. Being reactive and oppositional may not always be bad.**

LINKS Nuggets **14.1 12.5 9.3** *The motivational hallo*, issue 13