Questions from Audience during *Blending Solutions: Integrating Motivational Interviewing with Pharmacotherapy* presented on September 8, 2007 in Nashville, Tennessee

1.) Are there any non-prescription over-the-counter medications, vitamins or herbal remedies that may work for alcohol dependence instead of prescribed medications?

Dr. Carlo DiClemente: If you mean are there any medications that can work to cut craving or support abstinence like the approved medications discussed in this program, I am not aware of any that have any substantive research support. As you know there are a number of other alternative products that have made claims for this, but at this point, there is not sufficient evidence for any of these claims. However, as you may know, some of the detrimental effects of excessive drinking are from depletion of vitamins and other nutrients since alcoholic drinks often represent empty calories and some of the consequences of alcohol dependence are related to nutritional deficiencies. Therefore, vitamins can be helpful.

2.) Can therapists bypass psychiatric medical staff and refer clients to PCP for medications? Is that good practice?

Dr. Carlo DiClemente: Any doctor can prescribe these medications and often are doing so. The response depends on the setting where the therapist is working and what relationships he or she has with any physicians including psychiatrists. Clearly in a clinic setting where there is a treatment team, it would be inappropriate to bypass the psychiatric staff of the clinic or treatment program and go outside for prescribing. However, many settings have consulting doctors who perform the physicals and could be brought in to consult on medications. If the therapist can talk with the client's primary care physician and that doctor is comfortable giving the medication that could also work for the client as long as there is clear communication between providers. The long acting medication, Vivitrol, requires an injection. Often psychiatrists are not comfortable giving these injections so there is a need to refer to another primary care or specialty doctor, physician assistant or nurse to give this type of medication.

3.) In areas where certification is the only requirement to become an addictions counselor, do you honestly believe that medical doctors will work with these individuals on an "equal" level, especially concerning the different education levels of an MD and a certificate?

Dr. Carlo DiClemente: Collaboration does not mean that providers have to be equal in education or training. This is the essence of a team approach to treatment where different providers have different types of expertise. I know many doctors who have counselors on their staffs. The key is creating an ongoing relationship of mutual respect and being able to discuss differences of opinion.

4.) Could you speak to how some core principles of Motivational Enhancement and Stages of Change are inherent in the 12 steps of AA?

Dr. Carlo DiClemente: The short answer is that there are many of the principles and practices of AA that can be motivational and promote movement through the Stages of Change. An article I wrote for a monograph on research in AA, edited by Barbara McCrady and Bill Miller, detailed how the various AA principles and practices like making a moral inventory, taking a desire chip, having a sponsor and realizing a sense of powerlessness could contribute to movement from one Stage to the next and could increase important coping processes of change. It is too complicated to go into in depth here, but there are certainly important parallels between AA's 12 steps and the principles of Motivational Enhancement and the Stages of Change.

5.) Could you explain how Motivational Interviewing can be implemented in a group setting?

Dr. Carlo DiClemente: Although more difficult because MI is so focused on individual client perspectives, there are a number of professionals who are using these techniques in group settings. The key principles and practices of empathy, reflective listening, supporting self-efficacy, dealing with ambivalence and offering advice and summaries of what the person seems to be saying can work in the group. You do have to teach the group some of these principles as ways that they should interact with one another in group. Mary Velasquez and several colleagues, including me, have created a manual for substance abuse treatment based on the stages of change and using motivational interviewing style and strategies. It seems to be working well in several settings where it is being tested.

6.) How soon is it recommended that we suggest a client to engage in a medication and what Stage of Change would the introduction of medication be more effective?

Dr. Carlo DiClemente: Discussing medication can be important in any Stage of Change for different reasons. Clearly discussing medication during the preparation stage when doing the planning for action would be an ideal time to discuss in depth how medication could or could not fit into the client's plan for action. However, knowing that there may be a medication that could help could be a way to engage someone in precontemplation or contemplation. A recent article in *Addiction Professional* magazine discussed the pros and cons of introducing medication in the various Stages of Change.

7.) In the treatment of depression, more than one antidepressant medication may be needed to relieve symptoms. Are multiple medications being used in decreasing cravings, etc. and if so, when?

Dr. Carlo DiClemente: Interesting questions and this was the idea behind the recently completed COMBINE study that combined both acamprosate and naltrexone in one of the cells of the trial.

This study did not find any increased benefit of combining these medications. However, there are other trials ongoing, and there is some belief that because alcohol affects different areas of the brain, medications that affect different parts of the brain may one day be found to be helpful in combination because of the possible synergistic effect.

8.) I have encountered many addiction professionals who, in spite of the current research and evidence, continue to reject and/or oppose the use of medication-assisted recovery, specifically those medications used for opioid dependence. How can NAADAC/SAMHSA do more to change these out-dated attitudes and beliefs of addiction professionals?

Dr. Carlo DiClemente: I think that some of the testimonials of the clients that were shown in this program and the experience of clients who have benefited are the best ways to change attitudes. Medication, like many of the tools in our toolboxes, can be used in ways that are good and not so good. We need to be careful not to throw out an entire set of options for our clients in reaction to some perceived problems with one type of medication or medication usage. That would be like throwing out the option of going to AA after one has gone to one group that did not function well or did not seem to meet a particular client's needs.

9.) If the client is not contemplating change, how would you get them to take medications before you moved them to the contemplation stage?

Dr. Carlo DiClemente: You would not want to just give medication to a person not concerned about their drinking or in precontemplation. Actually, someone not contemplating change might be interested in medication as a miracle cure of the problem without having to make a change, but this is not a good use of medication. However, I might tell a precontemplator who is very discouraged about the possibility of changing, and thus has given up on trying, that there are some new medications around that might be able to help him or her achieve or sustain sobriety and that we could discuss these once they have decided that they would like to make a change in their drinking. For the discouraged person in precontemplation, medication could be something that might help convince them to begin considering making an attempt at change.

10.) Is motivation intrinsic or extrinsic? How do we utilize extrinsic motivation to the benefit of clients until they become (or begin to move forward) intrinsic motivation? We cannot discount the importance and value of extrinsic motivations, after all, that's how most of our client's get to treatment.

Dr. Carlo DiClemente: Well said. Motivation can be both intrinsic (coming form inside considerations) and extrinsic (encouraged by consideration and pressures for outside). None of our motivations are probably purely either, all one or the other. However, if the primary reason I am in treatment or am not drinking at the moment is simply to get my driver's license back (mostly extrinsic), the prospects of change once I get it back are less than if I did this and then

saw that my life is better because I am not drinking so then I begin to see it as in my best interest to stay sober (intrinsic). People can do many things based on extrinsic motivation so it is an important motivator. There are some couples, for example, who stay together for years for the good of the children and not because the marriage seems to be intrinsically satisfying. However, my bias is that engaging intrinsic motivators is very important for long term success in changing addictions.

11.) How do these medications work with mental health medications and with polysubstance abusers?

Dr. Carlo DiClemente: Good question. Obviously, a physician would have to evaluate drug interactions and advise the client about using two medications together or using this medication while using cocaine or heroin or cannabis. That would be part of the prescribing protocol. It would depend on the medication or drug being used. There may be come crossover benefits for some drugs since some of the medications for alcohol, e.g. naltrexone, could have an effect on decreasing the effect of other drugs of abuse.

12.) How helpful would it be for the precontemplative offender in need of treatment to engage in a cognitive-based program in order to increase treatment readiness?

Dr. Carlo DiClemente: There are several studies that have indicated that preparing clients for treatment and giving a brief motivational engagement session or sessions prior to treatment could increase readiness for treatment. It would be helpful to engage this offender with some strategies prior to expending the energy to give a cognitive based intervention that required the participation of the offender.

13.) How do you help someone envision the possibility of change when the needs are overwhelming and resources scarce?

Dr. Carlo DiClemente: Another great question! For someone who is so overwhelmed and under-resourced, there should be some support system set up to help that person regain basic self-regulation capacity before you can really get them engaged in change. That supportive environment could be a shelter or some other residential option or a focus on the most overwhelming need to be able to resolve some of the problems that are barriers to change. The reason that many treatment systems are promoting “housing first” is precisely because it is difficult to get some changes going without getting a stable living environment.

14.) Is there a simple resource for helping educate clients on the principles of MI and Stages of Change? How much is too much or too little information for a client?

Dr. Carlo DiClemente: There is a self help book titled *Changing for Good* that was written by Jim Prochaska, John Norcross and I that used the Stages of Change and taught individuals how to evaluate where they are and what to do about it. There may be some materials for clients on MI, but most of the written materials are for the providers since it is a style and set of strategies for providers to use.

15.) How can the medically indigent clients obtain free or reasonably priced medications and how can nonprofit residential programs find resources for pharmacotherapies?

Dr. Carlo DiClemente: There may be some assistance from agencies that have funding for substance abuse programs that can be used for some clients. Sometimes Medicaid will reimburse for certain medications if they are on the approved formulary. There are also some pharmaceutical companies that have some special programs to provide medication to some need clients at reduced or no cost.

16.) What is one of the best interventions for getting the client to argue for change?

Dr. Carlo DiClemente: Listening and reflecting in ways that allow the client to find their own motivation and reasons for change seem to be the best ways to get the client to present the argument for change.

17.) How do you use the Readiness Rulers and how frequently do you use them with clients?

Dr. Carlo DiClemente: Rulers are helpful as you are doing assessments or trying to get the client to make concrete some of the discussion that has been going on. There is really no rule about using them. I use them mostly in the beginning of treatment but they could be useful are various points along the course of treatment to note that there may be some change either forward or backward in terms of motivation.

18.) Reportedly, Bill Miller is moving away from blending MI with Stages of Change. Any thoughts/comments on this?

Dr. Carlo DiClemente: The first MI book had Stages as a more central part of the introduction. Some folks are using the Stages as labels and boxes to put people into. That is problematic for me and for the MI folks since Stages represent tasks that need to be engaged in and completed, and individuals can move from one to the next in a single session. I think there has been some reaction to that use of Stages.

19.) Clinical use of MI is undermined by organizational demands to increase units of service, have clients enter groups ASAP and be abstinent while in treatment - economic reality undermining effective treatment. Any examples of programs successfully getting past this hurdle?

Dr. Carlo DiClemente: There are a number of programs and treatment agencies that have made a commitment to use motivational approaches as they work with clients. Some programs have developed orientation groups that allow people to learn about treatment and where they are and what they need from treatment. Policies about what the client needs to do to stay in treatment are helpful if they are used as incentives and less useful if used as punishment.

20.) How does a counselor work with a client who has mental health issues? How do you get the client to be motivated?

Dr. Carlo DiClemente: This is a complicated question and a complicated problem. These clients require a focus on both the substance abuse problem and the mental health problem so that the counselor can see where the client motivation is focused at the present moment. If the mental illness is serious and seriously compromising cognitive functioning, medication may be needed to get some stability and space to work on the substance abuse problem. Integrated treatment seems to be an important part of the needed approach.

21.) What about the safety of the client while engaged in the process leading to change?

Dr. Carlo DiClemente: If you have serous concerns about the safety of the client, then you need to take steps to keep the client from harm and may not be able to be as reflective and non directive in your approach as suggested by the MI approach. However, if the client is outclient and you are using another approach with this client, there is no reason to think that this approach would be more dangerous than other approaches that you would use. In Project MATCH, we did not find any differential harmful effects on outcomes when we compared a motivational enhancement treatment of 4 sessions with both Twelve Step Facilitation and CBT treatments that had 12 sessions over 12 weeks.

22.) In the 1960s, therapy was about affect feelings. In the 1970s, it was about cognition and CBT was born. In the 1980s, it was about the dysfunctional family. In the 1990s, it was about brain chemistry. Today, it is about MI and pharmacotherapy. What’s next? Is it possible MI works/is effective because it establishes rapport, demonstrates a relationship, and shows empathy? So MI is a great method among others to build relationships and the method without caring for the client is only a tool. Maybe, when all our data/research is in we will find counseling is about the relationship and any method (CBT, MI, pharmacotherapy, family counseling) that builds empathy is useful.

Dr. Carlo DiClemente: Clearly, the relationship between the counselor and the client is at the heart of what we call talk therapy and is the foundation of any approach that is used. MI and pharmacotherapy should be seen as part of what we can do with clients and not as usurping all the others.