

Structured Motivational Interventions in Methadone Maintenance Treatment

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Summary

Improving the quality of services and increasing treatment effectiveness is quite a challenge in addiction treatment, including methadone maintenance. Besides adequate methadone dosing and length of treatment, there is an area that is fundamental but that does not yet seem to have been fully explored. It lies in the nature of the staff-client interaction and style used in meeting with clients. It is these factors that create a programme atmosphere and communicate deeper programme values

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Introduction

Improving the quality of services and increasing treatment effectiveness is quite a challenge in addiction treatment, including methadone maintenance. Besides adequate methadone dosing and length of treatment, there is an area that is fundamental but that does not yet seem to have been fully explored. It lies in the nature of the staff-client interaction and style used in meeting with clients. It is these factors that create a programme atmosphere and communicate deeper programme values (trust, care, helping

relationships, positive change, and so on).

One way of enhancing programme functioning by exploring the available resources in that direction could be that of structuring team-client interactions at all levels around the basic principles and strategies of motivational approaches that have proved to be effective and that promise future progress in the field of addictions and behaviour change, namely Motivational Interviewing and its adaptations, Motivational Enhancement Therapy and brief motivational interventions.

This paper presents a structured set of motivational interventions developed as a stepwise model for dealing with everyday contacts with clients, routine problems, tough or conflictual situations, and difficult clients in methadone maintenance programmes.

Approaching problems through this model provides an opportunity to reframe client misdeeds in a positive way and use them as therapeutic opportunities for focusing on behaviour change instead of administrative sanctioning and termination, which are often practised under the “umbrella” and philosophy of strictly sticking to programme rules and “clients’ free choice”.

This style can give practical expression to the team’s willingness to actively work with and enhance behaviour change in clients by overcoming their difficulties in following the treatment plan and sticking to programme requirements and regulations; it can contribute a great deal to creating and maintaining an atmosphere of trust, positive attitudes and helping relationships as the backbone of programme functioning.

The role of counselling and psychosocial services in MMT

The answer to the question “Is counselling necessary, and what kind of ancillary services are most appropriate in MMT?” has been unclear for some time.

Commenting on the need for counselling in MMT, some have argued that considering ancillary services as the main component of effective methadone maintenance treatment reveals a reluctance to acknowledge methadone’s capacity to bring about the changes that have been associated with maintenance therapy¹⁸. Based on the same philosophy and due to the lower costs involved, low-threshold programmes with minimal counselling and other ancillary services have been widely advocated as a way of making methadone maintenance available to more people¹².

Nevertheless, methadone alone is no substitute for care, advice, support and concern³. Many authors have, in fact, suggested that counselling is important in determining treatment outcome⁶.

The best treatment retention and outcomes, as witnessed by improved social functioning, were those seen in the earliest methadone clinical trials⁷ in programmes characterized by careful client screening, adequate dosing policies and extensive adjunctive services. Longwell and colleagues¹¹ found that counselling had a positive effect on illicit drug use – in their study, patients who received no counselling had significantly more opiate-positive urinalysis results compared with those who did have counselling.

The extent to which counselling is an important part of MMT was also explored

by Ball and Ross ² in their correlational study. They note that both staff and patients viewed counselling as the most important component of the rehabilitative aspect of methadone treatment. Their results provide evidence that programmes with a high level of treatment services for patients were associated with less heroin use, less cocaine use, less injecting drug use and less criminal behaviour among their patients, and strongly suggest that MMPs which delivered more counselling tended to have better outcomes compared with programmes that focus on administrative functioning, while programmes with an empathetic and supportive approach do better than programmes that aim to control and administrate.

Similarly, Zweben ²⁴ concluded that programmes should do without a punitive or confrontational style of therapeutic relationship.

The findings of Joe et al. ⁹ suggest that more intense counselling services lead to a better outcome – involving less drug use, injecting, and crime – and to higher retention in methadone maintenance treatment.

Condelli ⁴ studied strategies devised to increase retention in methadone programmes, and found that when psychosocial services provided during the first month after admission were evaluated by patients in terms of high quality, they were considered to have substantially raised the chances of one-year retention in treatment.

The highly positive effect of psychosocial services was clearly confirmed by McLellan et al. ¹³, using a random assignment to one of three treatment groups for a 6-month clinical trial. Patients in group 1 (methadone alone, at least 60mg/day, with no other services) reduced their opiate use, but showed less improvement than patients in group 2 (same dose of methadone plus counselling) and than patients in group 3 (same dose of methadone plus counselling, and on-site medical-psychiatric, employment, and family therapy); group 3 patients did better than those in group 2. The authors concluded that methadone alone may only be effective for a minority of patients, and argued that the addition of counselling, medical, and psychosocial services dramatically raised the efficacy attained by methadone alone.

Interestingly, other studies that review the relative value of standard and enhanced services have found reluctance among clients to participate in the enhanced mode and few advantages for enhanced services ¹. Another study ²² again found little benefit in the provision of enhanced services over standard counselling.

Conversely, Ball and Ross ² emphasized the importance of “brief contact” – a term that refers to the brief communication between counsellor and client when they meet in the hallway, or when a client drops in to ask a question.

Although no specific study on the effectiveness of brief motivational counselling in MMT was found in a search through the literature, a number of studies do support the effectiveness of brief motivational interventions for substance abuse ⁸.

Reflecting developments in the substance abuse and alcohol dependence treatment field, new psychological interventions have recently been applied to methadone maintenance patients. Specifically, motivational interviewing has become the object of study. Saunders and his colleagues ^{20,21} have compared the effects of a two-session

motivational interviewing intervention with a two-session educational intervention at the beginning of methadone maintenance. They found that the motivational interviewing of subjects was more conducive to treatment and led to fewer relapses than in the control group. The most important contribution to methadone maintenance treatment made by motivational interviewing may be that of improving the general relationship between patients and unit staff and between patients and counsellors ¹².

Therapist effects

Most psychotherapy and counselling research has, until recently, compared the relative effectiveness of different types of interventions but, in so doing, has assumed that one therapist is equivalent to another. Crits-Christoph and colleagues ⁵ discuss in detail the implications of therapist effects for psychotherapy and counselling research and argue that therapists are often treated in statistical analyses as if they were a fixed form of treatment, like a therapeutic drug. They found therapist effects in most of the studies; the largest therapist effect for any outcome measured in these studies attributed 55% of the variability in outcome seen in the patients to differences between therapists, while one in every two studies showing one intervention to be superior to another would be misleading if differences between therapists were not investigated, and evaluated statistically where found.

The implication of these findings extend to studies of methadone maintenance treatment. Ball and Ross ² have found that methadone maintenance units differ in their effectiveness. This suggests that methadone maintenance units should be treated as random factors in treatment outcome studies comparing different modalities, unless it can be demonstrated that the variation in unit effect is zero.

In any case, for the purposes of treatment practice, the most important implication of these findings is that an examination of therapist characteristics and their relationship with client improvement may lead to more effective therapies in general ¹².

Style of effective interventions

Counsellor style may be one of the most important and most often ignored variables for predicting client response to an intervention, accounting for more of the variance than client characteristics ^{14,15}. In a review of the literature on counsellor characteristics associated with treatment effectiveness for substance abuse, two main findings emerge:

Confrontational approaches, which have been widely used for many years in addiction treatment programmes, increase defensiveness and resistance and “are among the least effective treatment methods” ¹⁵.

Setting up a cooperative alliance through good interpersonal skills is more important than professional training and experience, and the most effective methods are those that imply empathy, non-possessive warmth, genuineness, respect and affirmation ¹⁷.

To an even greater extent this applies to the style of a methadone programme as

a whole.

Theoretical basis for motivational interventions

The proposed model of structured motivational interventions largely derives from the Concept of Motivation, as defined by Miller and Rollnick in their basic work in 1991¹⁶, the Transtheoretical Approach and the Stages of Change Model of Prochaska and DiClemente¹⁹, the FRAMES Model of brief motivational counselling, and the strategies of Motivational Enhancement Therapy, together with the principles and strategies of Motivational Interviewing¹⁶, which was hailed as the most important advance in the treatment of addiction “in more than a decade” when it first appeared¹⁰.

There is no doubt that for the patients in MMT the intake of an adequate dose of methadone is of dominant importance, but it is also clear that the success of methadone programmes is closely related to strictly following programme rules, therapeutic regimen and the application of a range of psychosocial interventions. The participation of patients in these activities is based on their level of motivation to do so²³.

Motivation plays an important role in people’s decision to change their behaviour and substance use. It has been defined as “the probability that a person will enter into, continue, and adhere to a specific change strategy”¹⁶. Motivation is therefore a state of readiness for change which can be influenced by focused clinical interventions. Patients are motivated to different degrees, and their state of motivation flows with time and circumstance. Most importantly, Miller and Rollnick¹⁶ argue that a person’s motivation can be affected by how he or she is treated by clinical staff.

The process of methadone maintenance treatment is a dynamic interaction between patients’ efforts to overcome their addiction and the programme’s ability to raise, support and facilitate their motivation, readiness and ability to change.

The motivational approach begins with the assumption that the responsibility and capacity for change lies with the client. The counsellor aims to create a set of conditions that will increase the client’s motivation for and commitment to change. In fact, increasing client motivation is seen as a central part of the clinician’s task. The counsellor works to elicit the client’s own concerns. When the client (rather than the counsellor) expresses the reasons for change, the client’s internal motivation is harnessed and he or she is more ready to change. Most of this work involves an exploration of the client’s ambivalence about change, matching interventions to his or her current level of readiness for change, and employing motivational strategies to mobilize the client’s own resources for change.

Model description

After examining the work carried out by clinical staff in MMPs, Ball and Ross² concluded that most of it can best be described as casework rather than counselling; it is work dealing with day-to-day issues, mostly of a practical nature. How these

interactions are conducted, especially the attitude of staff members, is probably the second most important determinant of treatment effectiveness after an adequate dose of methadone¹².

Consistently with that, the proposed model of interventions is focused on practical clinical work. A structured spectrum of brief motivational interventions is developed, and tailored to common situations in the daily work of an MMP, which vary in complexity, intensity and duration. These range from simple reflections at the moment of methadone delivery, through 5-15 minute interventions by the case manager, to motivational sessions by an experienced counsellor, motivational interventions by the whole programme team and group motivational interventions in various group settings.

The Model is designed as a stepwise scheme, with 5 levels of progressively greater interventions:

The first, most brief and simplest intervention is the **Simple Reflection**, performed by the nurse at methadone delivery. It is very brief and may take the form of a Rogerian reflection, a simple reflection or a double-sided reflection.

The second intervention is the **Brief Motivational Intervention**, delivered for 3-5 min by the case-manager. It is based on reflective listening, reframing, giving advice to the client, providing the client with a menu of choices, giving the client responsibility for change and choice, and supporting his or her self-efficacy and optimism in being able to successfully change.

These 2 interventions are routinely practised in everyday contacts with clients and they form the dominating style of staff communication with clients, when they come to receive their methadone every day, or every second, third, fifth or sixth day.

The 3rd level is the **Brief Motivational Session**, which is highly structured, and delivered by the case-manager for 10-20 min. It is based on the same techniques as the previous one, but includes greater reflection, which is needed to drive the client from the level of emotions to the level of cognitions, more rolling with resistance and helping the client to accept the change needed in his or her beliefs, understanding and behaviour.

The 4th level of intervention is the **Full Motivational Session**, which takes 30-60 min and is delivered by an experienced counsellor trained in motivational techniques. It implies the principles and strategies of Motivational Interviewing, mainly developed by Miller and Rollnick, but with a strong focus on affirmation and validation of the client, confrontation with reality to allow the problem to be defined and accepted, involvement with the client's resistance, expressing care in an empathetic and supportive way ("confrontation with love and care"), raising awareness, supporting self-efficacy and the optimism of the client that he or she will be successful in changing behaviour, and eliciting self-motivational statements from the client.

The last, 5th level, is the **Motivational Encounter with the Team**. It is applied with the most difficult clients – those who break programme rules in a rough way, and are aggressive and impulsive; these are the people who create serious problems, and are the most difficult to deal with. This encounter is structured in a non-judgmental,

supportive, caring and empathetic way. This intervention provides a different context, more closely related to these individual dimensions. It provides a different, more institutionalized setting. This is not a person-to-person intervention, as on the previous levels; it is a person-to-institution encounter, as the client meets the whole team. It provides a different message that is related to and concerns basic values – personal ones and those that are part of the programme, addressing not simply changes in behaviour, but mainly acceptance/or refusal of the programme rules and the programme as a whole, and a different level of responsibility for the client – to accept and stay in the programme or leave it.

The techniques used here are basically the same as in 3 & 4, but are more concise, focused, brief and directive, and, in the self-motivational statements of the client, acceptance of the programme and programme rules as a whole only at a basic level is expected, and the client is given more space and time to make a decision and take on his or her responsibility.

Style, strategies and principles of the interventions

The style and strategies of the interventions are based on the use of empathy and warmth, not authority and power, developing non-judgmental and collaborative therapeutic interactions, making treatment individualized and client-centered, avoiding argument and direct confrontation, shifting control away from the clinician and giving it back to the client. Change is viewed as the responsibility of the client and the counsellor's role is to elicit and enhance motivation.

The main principles for implementing the model imply the routine implementation of less intensive interventions, whereas more experienced counsellors are assigned and more intensive and specific interventions are structured, in the case of more difficult and complex problems. Interventions are matched with the specific problems, situations and individual characteristics of clients.

Discussion

Even in a comprehensive, well-structured methadone maintenance programme, with adequate rules, dosing policy and psychotherapeutic frame, an effective tool is needed to meet everyday problems and situations in a therapeutic way, substituting an administrative, authoritative or paternalistic style with a therapeutic one.

This paper argues for a motivational communication style for working with clients, based on advanced technologies already developed in the field of psychosocial addiction treatment and the enhancement of motivation and behaviour change, specifically designed to match the clinical needs of an MMP. It was developed and tested in the highly-structured 300-patient MMP of the National Centre for Addictions in Sofia, Bulgaria.

The practical implementation of the model resulted in improved client compliance

with programme rules, a more successful resolution of situations of conflict, a better client-staff relationship and level of trust, a lower level of staff burn-out, a more supportive and user-friendly atmosphere in the programme as a whole and a therapeutic context able to enhance other psychosocial modalities and interventions.

The proposed model draws heavily on the principles and strategies of effective motivational approaches and is specifically tailored to the everyday functioning, problems and situations of methadone maintenance programmes. It creates a programme spirit and therapeutic context which turn every contact with clients into a coherent part of the overall flow of interventions, whose aim are better psychosocial adjustment and positive behaviour change.

This approach has several components that have major implication for MMPs – it provides as a style for meetings with clients, a tool for dealing with situations of conflict and difficult clients, offers active guidance on behaviour change, supplies an organizing structure for team-client interactions, offers an integrative framework for understanding and intervening in behaviour change, and puts strong emphasis on creating a therapeutic atmosphere of acceptance, partnership, warmth and understanding, and positive and supporting relationships.

In conclusion

There is a broad consensus that motivation is a key issue in addressing addictive behaviour. It could be argued that motivation lies at the very heart of the problem.

The implementation of effective motivational approaches in MMT is a powerful tool, giving effective leverage for building better therapeutic relationships, programme cohesiveness, and atmosphere. These approaches could be used to substantially enhance the quality of services, programme administration patterns, management style and treatment effectiveness as a whole.

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