Motivational Enhancement for Dually Diagnosed Consumers

A guideline developed for the Behavioral Health Recovery Management project

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Overview

Dually diagnosed consumers face a host of challenges unique to living with both a psychiatric illness and a co-occurring substance use disorder. Data from the Epidemiologic Catchment Area (ECA) Study (Regier, Farmer, Rae, Locke, Keith, Judd, & Goodwin, 1990), showed that substance abuse disorders are far more prevalent among persons with psychiatric illness (22.3 percent have alcohol disorders, 14.7 percent have drug abuse disorders) than in the general population (13.5 percent for alcohol, 6.1 percent for drug abuse). Furthermore, those with chronic psychiatric conditions demonstrate particularly elevated rates of co-occurring substance use. According to the ECA study, approximately 50 percent of individuals with schizophrenia meet criteria for a substance abuse or dependence diagnosis. Estimates are even higher for individuals with bipolar disorder, and are widely supported by other estimates (Sonne, Brady, & Morton, 1994; Brady & Lydiard, 1992; Hasin, Endicott, & Lewis, 1985; Mueser, Bellack, & Blanchard, 1992).

Due to complex clinical presentations and a host of special needs, dually diagnosed consumers have long suffered from a lack of coherent treatment practices designed to address their unique circumstances. Unfortunately, the traditional practice of treating dual disorders as separate conditions has proven to be largely ineffective, regardless of whether treatment is inpatient or outpatient (Drake, Mercer-Mcfadden, Mueser, McHugo, & Bond, 1998). However, recent work with dually diagnosed consumers over the past decade has led to the development of comprehensive integrated treatment programs that appear to offer tremendous promise (Drake, Yovetich, Bebout, Harris, & McHugo, 1997; Drake et al., 1998), especially when treatment delivery is for 18 months or longer, and is

managed by a single provider or unified treatment team (Drake et al., 1998). Building on the assumption that psychiatric symptoms and substance abuse are intimately related, integrated programs offer an array of clinical services including assertive outreach, intensive case management, medication management, skills training, stage-sensitive (or stage-wise) substance abuse counseling, and motivational enhancement. In short, integrated treatments employ a comprehensive, unified approach to the treatment of multiple, inter-related, problem areas for consumers with complex clinical presentations. The primary challenge now facing the health care community involves the process of integrating what we have learned from research into clinical practice (Drake, Essock, Shaner, Carey, Minkoff, Kola, Lynde, Osher, Clark, & Rickards, 2001).

The purpose of this guideline is to introduce clinicians to the use of Motivational Enhancement Therapy (MET) with dually diagnosed consumers as one component of an integrated treatment program. Because substance abuse significantly interferes with the assessment, treatment, and management of psychiatric symptoms (Dixon, Haas, Weiden, Sweeney, & Frances, 1991; Mueser, et al., 1992; Ananth, Vandewater, Kamal, Brodsky, Gamal, & Miller, 1989), it is important that consumers reduce their recreational use of alcohol or drugs. Motivational enhancement refers to a style of clinical interaction designed to engage ambivalent or resistant consumers in the treatment process. Within an integrated treatment program, the job of the ME therapist is to prepare unmotivated consumers for a course of treatment by encouraging change talk, and decreasing resistance to the notion of reducing the use of alcohol or drugs.

Once you complete your review of this guideline, you can expect to be better prepared to work with dually diagnosed consumers for three reasons. First, by having read this far, you already know that integrated outpatient treatment programs have shown to be the

most effective long-term treatments for dually diagnosed consumers to date. Second, by gaining an introductory understanding of MET, you will be better equipped to assist the ambivalent or resistance consumer. Third, by following the three-session treatment guideline provided, you will have a clinical strategy by which to structure a brief intervention with consumers who are abusing alcohol or drugs. Lastly, we hope that the resource section included at the end of this guideline will serve as a useful reference in your effort to become more knowledgeable of, and efficient with, the practice of motivational enhancement.

Background for Motivational Enhancement Techniques

Typically, clinical interventions for both addictive behaviors and chronic psychiatric illness have relied heavily on approaches rooted in a medical, or disease model whereby health care professionals are regarded as "experts" in possession of knowledge that can remediate of a variety of clinical ailments. In fact, over the past 20 years a growing body of evidence has emerged to suggest that a non-collaborative style of interaction serves to not only alienate the consumer from the process of treatment, but may often result in poorer outcomes as well (Eisenthal, Emery, Lazare, & Udin, 1978; Miller and Rollnick, 1991; in press). Additionally, given the ambivalent nature of many persons living with schizophrenia (Meehl, 1962) and other psychiatric conditions, such a style of interaction may be especially detrimental with regard to treatment outcomes.

Motivational Interviewing

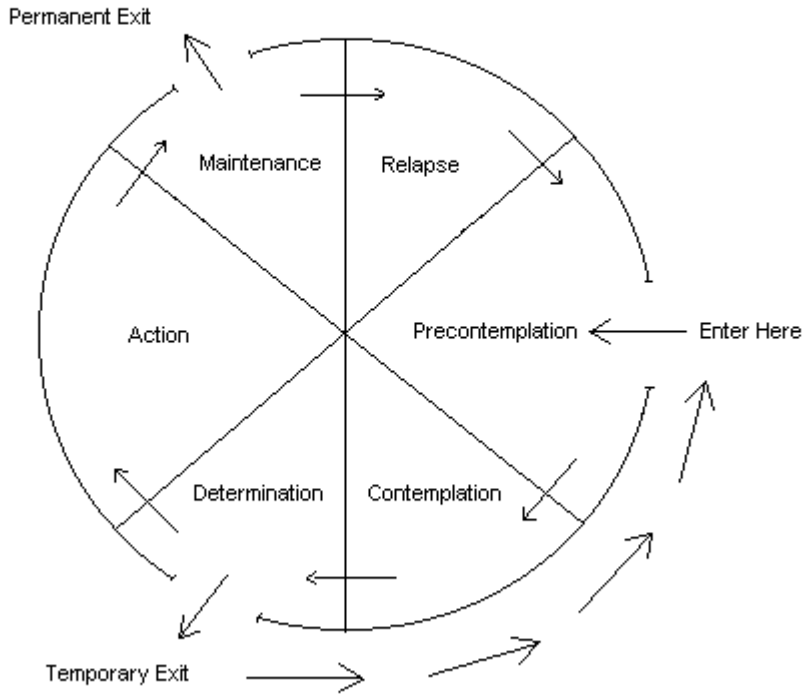
A relatively recent advancement in the field of treating addictions (primarily alcohol-related) is a client-centered approach called Motivational Interviewing (MI) (Miller & Rollnick, 1991, in press). Motivational Interviewing espouses principles that are directive,

but explicitly egalitarian in principle. Motivational Interviewing incorporates a collaborative relationship between the health care provider and consumer by emphasizing directional flexibility, consumer choice, self-efficacy, and the overall responsibility of the consumer to determine his or her own life goals, including those related to substance use and medication compliance.

Motivational Interviewing is firmly rooted in the transtheoretical model of change proposed by Prochaska and DiClemente (1982, 1984, 1985, 1986). In the transtheoretical model individuals vary with regard to change "readiness" by moving though 6 distinct stages including pre-contemplation, contemplation, determination (or preparation), action, maintenance, and relapse. For example, an individual in the pre-contemplation stage would be described as not considering change. On the other hand, a person in the "action" stage would be actively employed in an effort to reduce his or her drinking or drug use. Importantly, this is the foundation by which there is often treatment incongruence between providers and consumers. Health care providers are frequently in an "action-oriented" state of mind while consumers entering treatment are frequently contemplating change, or worse, in pre-contemplation. The result of such incongruence is reflected in the all-too-common scenario where the health care provider is pushing the consumer to change as though he or she were in an action phase when, in fact, the consumer may have substantial ambivalence to do so. As Miller and Rollnick (1991, in press) point out, such a "persuading" on the part of the treatment provider for change will frequently result in the consumer becoming defensive and possibly more ambivalent. Obviously, such an outcome is counter-productive to the therapeutic process, and frustrating to all involved. Figure 1 below offers an illustration of the stages of change model.

Figure 1. A Stage Model of the Process of Change

Prochaska and DiClemente



In contrast to an incongruent relationship between the treatment provider and consumer, motivational interviewing is based on four primary principles designed to foster a more open therapeutic exchange (Miller and Rollnick, in press). The four principles of MI are: 1) Express empathy, 2) Develop discrepancy, 3) Roll with resistance, and 4) Support self-efficacy. MI is conceptualized as a therapist response to ambivalence in the crucial stages of contemplation and determination and may also be useful if ambivalence recurs further along in the change process. By relating to the consumer in a way that is both respectful and empathic, the provider facilitates an environment of mutual trust. By adopting a collaborative, stage-sensitive style, the provider is less likely to elicit resistance from the consumer and more likely to stimulate open, honest communication. Importantly, variations within client gender, ethnicity, and socioeconomic status do not appear to affect

(or predict) outcomes in studies of MI (Brown & Miller, 1993; Miller, Sovereign, & Krege, 1988; Miller, Benefield, & Tonigan, 1993; Smith, Heckemeyer, Kratt, & Mason, 1997). This finding indicates that MI can be utilized as an appropriate clinical intervention for most people.

Despite the current need for large randomized clinical trials of MI in dually diagnosed populations, there are a handful of preliminary studies that support the utility of MI with this population (Daley, Salloum, Zuckoff, Kirisci, & Thase, 1998; Martino, Carroll, O'Malley, & Rounsaville, 2000; Swanson, Pantalon, & Cohen, 1999; Zeidonis & Fisher, 1996; Zeidonis & Trudeau, 1997). In a recent study by Swanson et al. (1999), the authors examined treatment adherence among psychiatric and dually diagnosed patients. The study compared groups that were randomly assigned to standard treatment (including pharmacological interventions) or standard treatment plus a one-hour motivational interview with an additional 15 minutes of personalized feedback regarding the consumer's drinking habits. Over twice as many (42%) of the dually diagnosed patients who received the additional component of MI plus feedback attended their first outpatient appointment as compared to only 16% of those in the standard treatment condition. These results are widely supported by other studies that report improved attendance for a variety of treatment programs related to the use of MI (Daley et al., 1998; Martino et al., 2000; Zeidonis & Fisher 1996; Zeidonis & Trudeau, 1997).

Motivational Enhancement Therapy

If MI is a style of clinical interaction, then its derivative, Motivational Enhancement Therapy (MET) (Miller, Zweben, DiClemente, and Rychtarik, 1995), provides the topic(s) of conversation. MET is a brief (3-5 sessions) structured clinical intervention focused heavily on the on the second principle of MI-the development of discrepancy. Helping the

consumer to develop discrepancy between the perceived (if any) and actual costs associated with substance abuse is a powerful tool in the process of eliciting self-motivational statements for change. Comprised of three components including, feedback, decisional balance exercises, and the creation of a change plan, MET serves to facilitate and support the consumer's evaluation of two essential areas (Miller et al., 1995). First, by using feedback procedures based on data obtained during an intake assessment, the degree to which substance abuse is affecting the consumer's life, both positively and negatively, and with regard to established normative data is examined. Second, by attending to the costs and benefits associated with change and how that change will impact daily life, the consumer is able to make decisions about their continued use of alcohol or drugs.

Given the previously mentioned dearth of research on motivational procedures in dually diagnosed populations, there are few clear guidelines for the use of MET within the context of a larger integrated treatment program. While there is evidence to suggest that a brief course of MET (4 sessions) is an effective stand-alone treatment for alcohol use disorders in the general population (Project MATCH Research Group, 1997; Project MATCH Research Group, 1998), MET as a stand-alone treatment for dually diagnosed consumers is unlikely to be sufficient given the need for longer-term, intensive services. This is not to say, however, that motivational enhancement is not a valuable component of treatment for these individuals (Miller & Rollnick, in press). Given the added weight of psychiatric symptoms that may serve to complicate an already difficult recovery process from substance abuse, motivational enhancement may be an especially important component for dually diagnosed consumers.

Ideally, MET should occur toward the beginning of treatment following an intake assessment period (Center for Substance Abuse Treatment, 1999; Miller & Rollnick, 1991; Miller et al., 1995; Miller & Rollnick, in press). There are many benefits to starting an integrated treatment program with MET. First, given its client-centered approach, MET can help to facilitate the development of a positive relationship between the treatment provider and consumer. Based on the sheer weight of evidence to support the importance of the therapeutic relationship with regard to treatment outcomes, this point cannot be over-emphasized. Second, because substance abuse often interferes with a host of other abilities, and functions to impede the effectiveness of treatments for other symptoms, it is advantageous to make it a primary focus of intervention. Lastly, given the typically iterative process of substance abuse treatment, the earlier the topic is introduced into an integrated treatment program, the more time can be devoted to issues of sobriety maintenance, or relapse should they occur.

At the Albuquerque Veteran's Administration Hospital in New Mexico, researchers recently conducted a small trial of MET with dually diagnosed consumers in which aspects of the intervention were modified to offer greater specificity to the presenting needs of both inpatient and outpatient consumers diagnosed with schizophrenia. Preliminary evaluation of data from this study show that consumer's who received MET significantly reduced their number of drinking days and experienced substantial reductions in average blood alcohol concentrations and total standard drinks consumed. These findings are even more impressive when consideration is given to the fact that MET was the only treatment given prior to the 4 and 8-week follow up periods.

Designed with the three primary components of MET in mind, the study utilized four focal areas that we are recommending for use in this guideline. They include: 1)

Feedback, 2a) Values clarification specific to consumers with schizophrenia, or other psychiatric conditions, 2b) Decisional balance exercises designed to weigh the pros and cons of change, and 3) Creation of a change plan.

Clinical Guidelines

Once the decision is made to incorporate MET into an integrated treatment protocol, there are, at minimum, three specific sessions that are recommended (keeping in mind that more than three appointments may be necessary to complete the content).

Feedback (Session 1)

During the first session, the consumer is presented with feedback about his or her drinking or drug use behavior. This feedback is based on information that should be gathered during a separate intake assessment prior to the first session. While the scope of assessment may vary widely, there are several categories commonly targeted for the feedback session. These may include: 1) Information about the consumer's substance use including amount typically consumed in a given week, and the consumer's level of use relative to all same sex American adults, 2) Level of intoxication including peak blood alcohol concentrations (BACs) (for alcohol) for a typical week and heavier drinking or drug use, 3) A variety of risk factors including level of tolerance, other drug use, familial risk (based on heritability), and age of onset, 4) Negative consequences, and 5) Physiological measures such as SGOT, GGTP, SGPT, Uric Acid, and Billirubin. References for a number of assessment options related to these categories are listed in the resource section at the end of this guideline.

At the end of the initial intake assessment appointment, two things should be emphasized to the consumer. First, if the consumer has a significant other (SO) such as a

spouse or family member that is supportive of their treatment efforts, it is advantageous to have the SO attend as many sessions as possible with the consumer (**). Numerous studies have shown that the supportive presence of a significant other can dramatically increase the efficacy of treatment. Second, also explain to the consumer that he or she must not be under the influence of alcohol or other substances during sessions. In many cases, sobriety can be verified by a breath alcohol test, or by simply asking in the case of suspicion for alcohol or other drug use.

During the feedback session, results from the consumer's assessments are presented. Receiving feedback can often be difficult for the consumer. Frequently, some results are unexpected. In the case of alcohol, for instance, a consumer may find out that he or she is drinking more than 98% of other adults and will report that this is "hard to believe," since they seem to have less trouble with alcohol than many of their friends. Alternatively, consumers may have difficulty believing that a relatively low level of consumption can cause such serious problems for them. By employing the principles of MI, the therapist will have a variety of ways in which to respond to such a statement. For example, rolling with resistance (third principle of MI) by using a simple reflection such as, "This number seems awfully high to you," will often serve to facilitate a more open dialogue with the consumer than a comment like, "Well, this information is based on accurate data." Keep in mind that a primary goal of the feedback session is to increase the consumer's awareness of the degree to which substance abuse is affecting their lives. When faced with resistance, the provider should utilize reflections frequently and "roll" with resistance in an effort to facilitate a more open exchange.

Toward the end of the first session when the feedback has been presented to the consumer, it is often helpful to summarize what has been covered. This is an especially

important step for dually diagnosed consumers with cognitive deficits. After the summary, ask the consumer if there is any change that he or she can think of that they might like to make in their use before the next session. If the consumer appears willing to make some commitment to change between the first and second sessions, do not hesitate to set a reasonable goal that can be agreed upon. Lastly, after the first session is complete, write a follow-up note to the consumer. In the note, reflect upon the fact that you were happy to see the consumer (and the consumer's SO, if applicable) in treatment. Additionally, the note should emphasize affirmations of the consumer's strengths, reflect the seriousness of the problem, reiterate highlights of the session, state that you have optimism or hope with regard to the outcome of treatment, and remind the consumer of his or her next session. An example of such a note is as follows:

> Dear, Mr. Carter,
>
> I just wanted to let you know that I enjoyed seeing you and your brother today. I think it's really terrific that you have made the decision to address the serious concerns that you have about your drinking. You are obviously aware of some changes that you can already be working on. I look forward to our work together, and am confident that we will be able to find some solutions to these problems. Your next appointment is this coming Wednesday the 8th at 4pm. See you then.

Values Clarification and Decisional Balance (Session 2)

When the consumer returns for the second session, you'll want to start by spending a few moments summarizing major points from the first session. After this is done, introduce the topic of values clarification to the consumer. Values clarification for dually diagnosed individuals is an important step. The point to this exercise is to have the consumer list, *in as concrete of terms as possible*, things that he or she values in daily life. It is extremely important that this not be done in an esoteric manner. Consumers presenting with cognitive deficits such as those often present in individuals with schizophrenia, will greatly

benefit from values clarification that relates to concrete daily goals. An example would be, “It is important to me that I don’t embarrass myself in public,” or, “It is important to me that I am able to go to work every day that I am supposed to.” A helpful guide for such an exercise can be found in the form of a values “card sort.” Even if you don’t have a set of cards, it is easy to make them. If you’re looking for ideas of what to include, simply ask your clients what kinds of (concrete) things they value in their daily lives, or use examples that seem relevant based on your work with similar consumers. Examples used in the Graeber, Moyers, Griffith, Guajardo & Tonigan study included 1) having my own apartment or living space 2) managing my money without external assistance 3) having a loving relationship with another person 4) helping others who have problems like mine. Once the consumer has generated an acceptable list of values, or sorted the cards in order of importance (at least three), spend some time discussing why they are important, and how substance use influences these important values.

After the values clarification is completed, transition into a decisional balance exercise in which the consumer will evaluate the pros and cons of drinking or drug use. The purpose of a decisional balance is to have the consumer openly compare the costs versus benefits of use. It is important that the treatment provider begin the decisional balance exercise by focusing on the pros of use first. By discussing the pros of use, the provider is more likely to elicit cons *from the client*. As a result, it is now the client who is in the position of arguing against use instead of the other way around. During the exercise, write down items from both categories in a side-by-side fashion so that you can offer a visual comparison to the consumer when they have finished.

Often, consumers will generate a list containing more cons than pros and this is a useful time to elicit self-motivational statements from the consumer in favor of change. If

it's the case that the list favors the pros of use, and/or the consumer seems unable to come up with their own discrepancies about using and how it may be interfering with other important goals, this is a good time for the ME therapist to use what they have learned about the consumer's values in an attempt to develop discrepancies. For example, one of the values that a given consumer may have selected would be the importance of making it in to work on time each morning. In contrast, however, the same client may also say that he enjoys staying up until 3 AM drinking or smoking marijuana with friends because it's fun. In such a case, the therapist might make use of a double-sided reflection by saying, "On the one hand it's important to you that you get enough sleep to make it into work on time, but on the other hand you really enjoy staying up late drinking and smoking with your friends." Such a statement will gently direct the consumer to address the obvious conflict that arises from these clearly discrepant activities.

Recapitulation and Change Plan (Session 3)

Once the consumer has completed the content from the first two sessions (remembering that it may take more than two sessions), they should next work on creating a change plan. This can be helpful for dually diagnosed consumers as it offers a concrete illustration of what action the consumer has decided to take and clearly specifies a series of steps by which they can mark their own progress. The change plan should include six general areas developed by Miller et al. (1995) including; 1) The changes I want to make are…, 2) The most important reasons I want to make these changes are…, 3) The steps I plan to take in changing are…, 4) The ways other people can help me are…, 5) I will know that my plan is working if…, and 6) Some things that could interfere with my plan are…

Before proceeding with the change plan, however, it is useful to recapitulate the reasons by which the consumer has arrived at this point. Using as many of the

consumer's own self-motivational statements and including his or her stated values and reasons for change, give the consumer a summary of what has been covered during the course of treatment thus far. Once you have done this and completed the change plan, one step remains. Simply ask the consumer for a commitment to change as it has been specified in the change plan. By seeking a commitment and asking them to sign the change plan worksheet, the consumer agrees that plan they have developed is something that they are willing to try. Make a copy of the change plan and give one to the consumer.

Considerations and Limitations

As noted previously, research on motivational techniques with dually diagnosed consumers is in its infancy. As such, our knowledge of what works and what doesn't for this population is only beginning to emerge. As a result, the creation of treatment guidelines with respect to such techniques is currently overly reliant on methods that have been validated in populations other than those that are the target of this guideline. While motivational techniques including Motivational Interviewing and Motivational Enhancement Therapy have demonstrated impressive effectiveness in non-psychiatric populations, there are several important theoretical questions that remain to be addressed regarding the use of these techniques with dually diagnosed individuals. We will now address some of these concerns.

Given the dependence of motivational enhancement techniques upon some level of cognitive ability, there may be limits to the efficacy of motivational enhancement techniques for those consumers who suffer from severe cognitive deficits or who are in need of psychiatric stabilization. To date, we are not aware of any research that has addressed the limitations of cognitive ability with regard to motivational techniques. For

instance, it may be the case that the efficacy of motivational enhancement is inversely related to cognitive deficit such that while useful and effective for mild to moderately disordered individuals, ME may be less so for those with acute symptomatology. Clearly, this is a question of central importance to the use of motivational techniques within a subset of the dually diagnosed population.

Another area of concern with regard to the use of motivational techniques involves the ability to isolate effects. By this we refer to the idea that within an integrated treatment approach, it is difficult to isolate and measure which effects are due to which interventions. Because the best treatment for this population includes the integration of several treatment approaches, most of which are quite intensive over long periods of time, the question arises as to the identification of factors most responsible for favorable outcomes when decisions must be made with regard to which services to include. This is not an easy question to answer, and may not be as important for this population given their need for more comprehensive treatment in the first place. However, for purposes of treatment engagement, research with dually diagnosed consumers clearly shows that motivational techniques do, in fact, increase the number of treatment appointments attended. Regardless of other potential benefits, this finding alone offers tremendous promise for the use of motivational techniques. Ultimately, if consumers don't attend therapy to begin with, even the most effective treatments are rendered irrelevant.

Lastly, given the relatively spartan amount of research with MI and MET in dually diagnosed consumers, little is know about what modifications are optimal to tailor the intervention to specific groups of consumers. For example, while it may be advantageous to use clear, concrete language for goals and other aspects for individuals with

schizophrenia, would this also be the case for consumers who present with a diagnosis of bipolar disorder? Research is needed to clarify such questions.

In addition to these issues, this guideline has been created in the interest of introducing treatment providers to a general overview of the use of motivational techniques. As such, it provides a very basic introduction to an area of much greater complexity. The acquisition of adequate motivational interviewing skills will likely require most health care professionals to conduct a more effortful review of the literature and we would highly recommend formal training via sources such as videotaped training sessions, live training seminars, and/or supervision from a qualified source. References for some of these resources are provided in the resource section.

Summary

Having now considered some of the limitations and concerns surrounding the use of motivational enhancement with dually diagnosed consumers, we'd like to close with an emphasis on three specific principles that we think are important to keep in mind.

First, it is important to evaluate the underlying assumptions of blended, or integrated, treatments. As mentioned earlier, it is unlikely to be the case that motivational interventions alone will prove to be sufficient in the treatment of substance abuse in dually diagnosed consumers. However, while research is limited at this point, preliminary studies have indicated that motivational enhancement is, indeed, helpful in engaging consumers in outpatient care to a far greater extent than otherwise observed.

Second, it is of crucial importance when implementing MET with dually diagnosed consumers that tasks be tailored to the population of interest. As discussed earlier, when treating substance abuse within schizophrenia, it is important to make goals and general

discussion relate to specifically concrete terms given the general cognitive limitations of these consumers. MET is, by no means, a “one sizes fits all” paradigm, and customization is especially necessary when other psychiatric symptoms are present.

Lastly, it is important to utilize the spectrum of resources available to consumers through an integrated treatment program when developing and implementing a change plan. Integrated treatment that addresses both substance use and psychiatric symptomatology as related problems has been shown to be more successful than any other treatments currently available for dually diagnosed individuals. As such, it is essential that the treatment provider utilize as many of the available resources as possible when developing the change plan. For instance, if the consumer has access to skills training, he or she can focus on refusal skills to help them avoid drinking or using drugs when this behavior conflicts with other goals based on values resulting from the clarification exercise. Additionally, if the consumer has access to intensive case management, they can utilize the expertise of their case manager in areas such as job finding, or securing other domestic services that are of tremendous importance in creating a more supportive environment that can facilitate a healthier, more rewarding lifestyle.

Resources

Recommended Reading

Drake, R.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G.J., & Bond, G.R. Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin* 24: 589-608, 1998.

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Miller, W.R., and Rollnick, S. *Motivational Interviewing* (2nd ed.). New York: Guilford Press, in press.
Zeidonis, D.M., & Trudeau, K. Motivation to quit using substances among individuals with schizophrenia: Implications for a motivation-based treatment model. *Schizophrenia Bulletin* 23: 229-238, 1997.

Recommended Assessment and Treatment Manuals

Center for Substance Abuse Treatment. *Enhancing Motivation for Change in Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, Number 35. DHHS Pub. No. (SMA) 99-3354. Washington, DC: U.S. Government Printing Office, 1999.
Miller, W.R.; Zweben, A.; DiClemente, C.C.; and Rychtarik, R.G. *Motivational Enhancement Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence*. Project MATCH Monograph Series, Vol. 2. NIH Pub. No.94-3723. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1995.
National Institute on Alcohol Abuse and Alcoholism. *Assessing Alcohol Problems*. Treatment Handbook Series 4. J.P. Allen, & M.Columbus (eds.). NIH Pub. No. 95-3745. Rockville MD: National Institute on Alcohol Abuse and Alcoholism, 1995.

Demonstration Videotapes

Miller, W.R. *Motivational Interviewing*. Albuquerque, NM: University of New Mexico, 1989. Available from William R. Miller, Ph.D., Department of Psychology, University of New Mexico, Albuquerque, NM, USA 87131-1161. European format videotape available from the National Drug and Alcohol Research Centre, P.O. Box 1, University of New South Wales, Kensington, NSW 2033, Australia.
Motivation and Change. Set of two training videotapes available from the Addiction Research Foundation, 33 Russell Street, Toronto M5S 2S1, Ontario, Canada.
Rollnick, S. *I Want It But I Don't Want It: An Introduction to Motivational Interviewing*. Mind's Eye Video, 1989. European format only. Available from the Department of Psychology, Whitchurch Hospital, Cardiff, Wales, United Kingdom, CF4 7XB.

Internet-Based Resources

The two websites listed below offer a rich source of information regarding the assessment and treatment of addictive behaviors. Many assessment instruments can be downloaded free of charge from the UNM CASAA website, and you can also order training materials and view the locations for upcoming training sessions.

If you are looking for assessment instruments, or information on a variety of other related topics, you can find them on the University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions (CASAA) website at http://casaa.unm.edu.

For information about motivational interviewing, please consult the official MI website at www.motivationalinterview.org.

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Dixon, L., Haas, G., Weiden, P.J., Sweeney, J., & Frances, A.J. (1991). Drug abuse in schizophrenic patients: Clinical correlates and reasons for use. American Journal of Psychiatry, 148, 224-230.

Drake, R.E., Essock, S.M., Shaner, A, Carey, K.B., Minkoff, K., Kola, L., Lynde, D., Osher, F.C., Clark, R.E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services, 52, 469-476.

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