Chapter 2 -- Motivation and Intervention

Using the transtheoretical perspective...seeks to assist clients in moving from the early stages of change...to determination or action. It uses stage-specific strategies to foster a commitment to take action for change...[and it] assists clients to convince themselves that change is necessary. Noonan and Moyers, 1997

Motivational intervention is broadly defined as any clinical strategy designed to enhance client motivation for change. It can include counseling, client assessment, multiple sessions, or a 30-minute brief intervention. This chapter examines the elements of effective motivational approaches and supporting research. Motivational strategies are then correlated with the stages-of-change model (a framework that is discussed in Chapter 1 and elaborated on in later chapters) to highlight approaches that are appropriate to specific stages. Recommendations are presented for providing motivational interventions that are responsive and sensitive to differing cultural and diagnostic needs, as well as to different settings and formats. This chapter concludes with a description of an increasingly accepted type of intervention known as a brief intervention, which is useful outside of traditional substance abuse treatment settings. For a broader discussion of brief interventions and therapies, refer to the forthcoming TIP, Brief Interventions and Brief Therapies for Substance Abuse (CSAT, in press [a]).

Elements of Effective Motivational Interventions

To understand what prompts a person to reduce or eliminate substance use, investigators have searched for the critical components--the most important and common elements that inspire positive change--of effective interventions. The following are important elements of current motivational approaches:

- The FRAMES approach
- Decisional balance exercises
- Discrepancies between personal goals and current behavior
- Flexible pacing
- Personal contact with clients not in treatment

These elements are described in the following subsections.

FRAMES Approach

Six elements have been identified that were present in brief clinical trials, and the acronym FRAMES was coined to summarize them (Miller and Sanchez, 1994). These elements are defined as the following:
• **Feedback** regarding personal risk or impairment is given to the client following assessment of substance use patterns and associated problems.

• **Responsibility** for change is placed squarely and explicitly on the client (and with respect for the client's right to make choices for himself).

• **Advice** about changing--reducing or stopping--substance use is clearly given to the client by the clinician in a nonjudgmental manner.

• **Menus** of self-directed change options and treatment alternatives are offered to the client.

• **Empathic** counseling--showing warmth, respect, and understanding--is emphasized.

• **Self-efficacy** or optimistic empowerment is engendered in the client to encourage change.

Figure 2-1 lists 32 trials and their FRAME components, as reviewed by Bien and colleagues (Bien et al., 1993b). Since the FRAMES construct was developed, further clinical research and experience have expanded on and refined elements of this motivational model. These components have been combined in different ways and tested in diverse settings and cultural contexts. Consequently, additional building blocks or tools are now available that can be tailored to meet your clients' needs.

**Feedback**

The literature describing successful motivational interventions confirms the persuasiveness of personal, individualized feedback (Bien et al., 1993b; Edwards et al., 1977; Kristenson et al., 1983). Providing constructive, nonconfrontational feedback about a client's degree and type of impairment based on information from structured and objective assessments is particularly valuable (Miller et al., 1988). This type of feedback usually compares a client's scores or ratings on standard tests or instruments with normative data from a general population or from groups in treatment (for examples, see Figures 4-1 and 4-2). Assessments may include measures related to substance consumption patterns, substance-related problems, physical health, risk factors including a family history of substance use or affective disorders, and various medical tests (Miller et al., 1995c). (Assessments and feedback are described in more detail in Chapter 4.) A respectful manner when delivering feedback to your client is crucial. A confrontational or judgmental approach may leave the client unreceptive.

Do not present feedback as evidence that can be used against the client. Rather, offer the information in a straightforward, respectful way, using easy-to-understand and culturally appropriate language. The point is to present information in a manner that helps the client recognize the existence of a substance use problem and the need for change. Reflective listening and an empathic style help the client understand the feedback, interpret the meaning, gain a new perspective about the personal impact of substance use, express concern, and begin to consider change.

Not all clients respond in the same way to feedback. One person may be alarmed to find that she drinks much more in a given week than comparable peers but be unconcerned about potential health risks. Another may be concerned about potential health risks at this level of drinking. Still another may not be impressed by such aspects of substance use as the amount of money spent on substances, possible impotence, or
the level of impairment—especially with regard to driving ability—caused by even low blood alcohol concentrations (BACs). Personalized feedback can be applied to other lifestyle issues as well, and can be used throughout treatment. Feedback about improvements is especially valuable as a method of reinforcing progress.

Responsibility

Individuals have the choice of continuing their behavior or changing. A motivational approach allows clients to be active rather than passive by insisting that they choose their treatment and take responsibility for changing. Do not impose views or goals on clients; instead, ask clients for permission to talk about substance use and invite them to consider information. If clients are free to choose, they feel less need to resist or dismiss your ideas. Some clinicians begin an intervention by stating clearly that they will not ask the client to do anything he is unwilling to do but will try nevertheless to negotiate a common agenda in regard to treatment goals. When clients realize they are responsible for the change process, they feel empowered and more invested in it. This results in better outcomes (Deci, 1975, 1980). When clients make their own choices, you will be less frustrated and more satisfied because the client is doing the work. Indeed, clients are the best experts about their own needs.

Advice

A Realistic Model of Change: Advice to Clients

Throughout the treatment process, it is important to give clients permission to talk about their problems with substance use. During these kinds of dialogs, I often point out some of the realities of the recovery process:

- Most change does not occur overnight.
- Change is best viewed as a gradual process with occasional setbacks, much like hiking up a bumpy hill.
- Difficulties and setbacks can be reframed as learning experiences, not failures.

Linda C. Sobell, Consensus Panel Member

The simple act of giving gentle advice can promote positive behavioral change. As already discussed, research shows that short sessions in which you offer suggestions can be effective in changing behaviors such as smoking, drinking alcohol, and other substance use (Drummond et al., 1990; Edwards et al., 1977; Miller and Taylor, 1980; Sannibale, 1988; Wallace et al., 1988). As with feedback, the manner in which you advise clients determines how the advice will be used. It is better not to tell people what to do--suggesting yields better results. A motivational approach to offering advice may be either directive (making a suggestion) or educational (explaining information). Educational advice is based on credible scientific evidence supported in the literature. Facts that relate to the client's conditions, such as BAC levels at the time of an accident or safe drinking limits recommended by the National Institute on Alcohol Abuse and
Alcoholism, can be presented in a nonthreatening way. Thoughtfully address the client's behavior by saying, "Can I tell you what I've seen in the past in these situations?" or, "Let me explain something to you about tolerance."

Such questions provide a nondirective opportunity to share your knowledge about substance use in a gentle and respectful manner. If the client requests direction, redirect her questions in order to clarify what is wanted rather than giving advice immediately. Any advice you give should be simple, not overwhelming, and matched to the client's level of understanding and readiness, the urgency of the situation, and her culture. (In some cultures, a more directive approach is required to adequately convey the importance of the advice or situation; in other cultures, a directive style is considered rude and intrusive.) This style of giving advice requires patience. The timing of any advice is also important, relying on your ability to "hear"—in the broad sense—what the client is requesting and willing to receive.

### The PIES Approach

In World War I, military psychiatrists first realized that motivational interventions, done at the right time, could return a great number of dysfunctionally stressed soldiers to duty. The method could be put into an easily remembered acronym: PIES.

- **Proximity:** Provide treatment near the place of duty; don't evacuate to a hospital.
- **Immediacy:** Intervene and treat as soon as the problem is noticed.
- **Expectancy:** Expect the intervention to be successful and return the person to duty.
- **Simplicity:** Simply listening, showing empathy, and demonstrating understanding works best.

Highlight the fact the person is normal while the situation is abnormal and that the person will recover with rest and nourishment. No prolonged or complex therapy was needed for the great majority of cases. Evacuation to higher echelons of care was reserved for the low percentage of individuals who did not respond to this straightforward approach.

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**Kenneth J. Hoffman, Field Reviewer**

### Options

Compliance with change strategies is enhanced when clients choose—or perceive that they can choose—from a menu of options. Thus, motivation for participating in treatment is heightened by giving clients choices regarding treatment goals and types of services needed. Offering a menu of options helps decrease dropout rates and resistance to treatment and increases overall treatment effectiveness (Costello, 1975; Parker et al., 1979). As you describe alternative approaches to treatment or change that are appropriate for your clients, provide accurate information about each option and a best guess about the implications of choosing one particular path. Elicit from your clients what they think is effective or what has worked for them in the past. Providing a menu of options is consistent with the motivational principle that clients must choose and take responsibility for their choices. Your role is to enhance your clients' ability to make
informed choices. When clients make independent decisions, they are likely to be more committed to them. This concept is further discussed in Chapter 6.

Empathic counseling

Empathy is not specific to motivational interventions but rather applies to many types of therapies (Rogers, 1959; Truax and Carkhuff, 1967). Empathy during counseling has been interpreted in terms of such therapist characteristics as warmth, respect, caring, commitment, and active interest (Miller and Rollnick, 1991). Empathy usually entails reflective listening--listening attentively to each client statement and reflecting it back in different words so that the client knows you understand the meaning.

The client does most of the talking when a clinician uses an empathic style. It is your responsibility to create a safe environment that encourages a free flow of information from the client. Your implied message to the client is "I see where you are, and I'm not judgmental. Where would you like to go from here?" The assumption is that, with empathic support, a client will naturally move in a healthy direction. Let this process unfold, rather than direct or interrupt it. Although an empathic style appears easy to adopt, it actually requires careful training and significant effort on your part. This style can be particularly effective with clients who seem angry, resistant, or defensive.

Self-efficacy

To succeed in changing, clients must believe they are capable of undertaking specific tasks and must have the necessary skills and confidence (Bandura, 1989; Marlatt and Gordon, 1985). One of your most important roles is to foster hope and optimism by reinforcing your clients' beliefs in their own capacities and capabilities (Yahne and Miller, 1999). This role is more likely to be successful if you believe in your client's ability to change (Leake and King, 1977). You can help clients identify how they have successfully coped with problems in the past by asking, "How did you get from where you were to where you are now?" Once you identify strengths, you can help clients build on past successes. It is important to affirm the small steps that are taken and reinforce any positive changes. The importance of self-efficacy is discussed again in Chapters 3 and 5.

Decisional Balance Exercises

The concept of exploring the pros and cons--or benefits and disadvantages--of change is not new and is well documented in the literature (Colten and Janis, 1982; Janis and Mann, 1977). Individuals naturally explore the pros and cons of any major life choices such as changing jobs or getting married. In the context of recovery from substance use, the client weighs the pros and cons of changing versus not changing substance-using behavior. You assist this process by asking your client to articulate the good and less good aspects of using substances and then list them on a sheet of paper. This process is usually called decisional balancing and is further described in Chapters 5 and
8. The purpose of exploring the pros and cons of a substance use problem is to tip the scales toward a decision for positive change.

The actual number of reasons a client lists on each side of a decisional balance sheet is not as important as the weight--or personal value--of each one. For example, a 20-year-old smoker might not put as much weight on getting lung cancer as an older man, but he might be very concerned that his diminished lung capacity interferes with playing tennis or basketball.

**Discrepancies Between Goals and Current Behavior**

One way to enhance motivation for change is to help clients recognize a *discrepancy* or gap between their future goals and their current behavior. You might clarify this discrepancy by asking, "How does your drinking fit in with having a happy family and a stable job?" When an individual sees that present actions conflict with important personal goals such as health, success, or family happiness, change is more likely to occur (Miller and Rollnick, 1991). This concept is expanded in Chapters 3 and 5.

**Flexible Pacing**

Every client moves through the stages of change at her own pace. Some will cycle back and forth numerous times between, for example, contemplating change and making a commitment to do so. Others seem stuck in an ambivalent state for a long time. A few are ready to get started and take action immediately. Therefore, assess your client's readiness for change. By determining where the individual has been and is now within the stages of change, you can better facilitate the change process.

The concept of pacing requires that you meet your clients at their levels and use as much or as little time as is necessary with the essential tasks of each stage of change. For example, with some clients, you may have to schedule frequent sessions at the beginning of treatment and fewer later. In other cases, you might suggest a "therapeutic vacation" for a client who has to take a break before continuing a particularly difficult aspect of recovery. If you push clients at a faster pace than they are ready to take, the therapeutic alliance may break down.

**Personal Contact With Clients Not In Treatment**

Motivational interventions can include simple activities designed to enhance continuity of contact between you and your client and strengthen your relationship. Such activities can include personal handwritten letters or telephone calls from you to your client. Research has shown that these simple motivation-enhancing interventions are effective for encouraging clients to return for another clinical consultation, to return to treatment following a missed appointment, to stay involved in treatment, and to increase adherence (Intagliata, 1976; Koumans and Muller, 1965; Nirenberg et al., 1980; Panepinto and Higgins, 1969). This concept is discussed in Chapter 7.
Motivational Intervention And the Stages of Change

Clients need and use different kinds of motivational support according to which stage of change they are in and into what stage they are moving. If you try to use strategies appropriate to a stage other than the one the client is in, the result could be treatment resistance or noncompliance. For example, if your client is at the contemplation stage, weighing the pros and cons of change versus continued substance use, and you pursue change strategies appropriate to the action stage, your client will predictably resist. The simple reason for this reaction is that you have taken the positive (change) side of the argument, leaving the client to argue the other (no change) side; this results in a standoff.

To consider change, individuals at the precontemplation stage must have their awareness raised. To resolve their ambivalence, clients in the contemplation stage require help choosing positive change over their current situation. Clients in the preparation stage need help identifying potential change strategies and choosing the most appropriate one for their circumstances. Clients in the action stage (the stage at which most formal treatment occurs) need help to carry out and comply with the change strategies. During the maintenance stage, clients may have to develop new skills for maintaining recovery and a lifestyle without substance use. Moreover, if clients resume their substance use, they can be assisted to recover as quickly as possible to resume the change process.

Figure 2-2 provides examples of appropriate motivational strategies you can use at each stage of change. Of course, these are not the only ways to enhance motivation for beneficial change. Chapter 3 describes some of the fundamental principles of motivational interviewing that apply to all stages. Chapters 4 through 7 describe in more detail the motivational strategies that are most appropriate for encouraging progression to each new change stage. Chapters 4 and 8 present some tools to help you recognize clients' readiness to change in terms of their current stage.

Catalysts for Change

In the search for common processes--integrative models--of personal growth and change across psychotherapies and behavioral approaches, Prochaska (Prochaska, 1979) initially isolated the core approaches of many therapeutic systems and further developed these in a factor analytic study (Davidson, 1994; Prochaska and DiClemente, 1983). These fundamental processes represent cognitive, affective, behavioral, and environmental factors influencing change as they appear in major systems of therapy (DiClemente and Scott, 1997). These change catalysts are derived from studies examining smoking cessation, alcohol abstinence, general psychotherapeutic problems, weight loss, and exercise adoption (Prochaska et al., 1992b). For each of the 10 catalysts, several different interventions can be used to encourage change. Figure 2-3 describes these catalysts for change and illustrates a few interventions often used for each.
Typically, cognitive-experiential processes are used early in the cycle (i.e., contemplation, preparation), and behavioral processes are critical for the later stages (i.e., action, maintenance) (Prochaska and Goldstein, 1991).

Figure 2-4 suggests which catalysts are most appropriate for each change stage. To avoid confusion for both the client and clinician, only those catalysts that are best supported or most logical are recommended for a particular stage; this does not imply, however, that the other catalysts are irrelevant.

**Special Applications of Motivational Interventions**

The principles underlying motivational enhancement have been applied across cultures, to different types of problems, in various treatment settings, and with many different populations. The research literature suggests that motivational interventions are associated with a variety of successful outcomes, including facilitation of referrals for treatment, reduction or termination of substance use, and increased participation in and compliance with specialized treatment (Bien et al., 1993b; Noonan and Moyers, 1997). Motivational interventions have been tested in at least 15 countries, including Canada, England, Scotland, Wales, the Netherlands, Australia, Sweden, Bulgaria, Costa Rica, Kenya, Zimbabwe, Mexico, Norway, the former Soviet Union, and the United States (Bien et al., 1993; Miller and Rollnick, 1991). Motivational strategies have been used primarily with problem alcohol drinkers and cigarette smokers, but also have yielded encouraging results in marijuana and opiate users with serious substance-related problems (Bernstein et al., 1997a; Miller and Rollnick, 1991; Noonan and Moyers, 1997; Sobell et al., 1995).

Special applications of motivational approaches have been or are currently being explored with diabetic patients, for pain management, in coronary heart disease rehabilitation, for HIV risk reduction, with sex offenders, with pregnant alcohol drinkers, with severely alcohol-impaired veterans, with persons who have eating disorders, and with individuals with coexisting substance use and psychiatric disorders (Carey, 1996; Noonan and Moyers, 1997; Ziedonis and Fisher, 1996). Populations that have been responsive to motivational interventions include persons arrested for driving under the influence and other nonviolent offenders, adolescents (Colby et al., 1998), older adults, employees, married couples, opioid-dependent clients receiving methadone maintenance, and victims and perpetrators of domestic violence (Bernstein et al., 1997a; Miller and Rollnick, 1991; Noonan and Moyers, 1997). The literature also describes successful use of these motivational techniques in primary care facilities (Daley et al., 1998), hospital emergency departments (Bernstein et al., 1997a; D’Onofrio et al., 1998), traditional inpatient and outpatient substance abuse treatment environments, drug courts, and community prevention efforts. These interventions have been used with individuals, couples, groups, and in face-to-face sessions or through mailed materials (Miller and Rollnick, 1991; Sobell and Sobell, 1998). The simplicity and universality of the concepts underlying motivational interventions permit broad application and offer great potential to reach clients with many types of problems and in many different cultures or settings.
In my practice with persons who have different world views, I've made a number of observations on the ways in which culture influences the change process. I try to pay attention to cultural effects on a person's style of receiving and processing information, making decisions, pacing, and being ready to act. The more clients are assimilated into the surrounding culture, the more likely they are to process information, respond, and make choices that are congruent with mainstream beliefs and styles. The responsibility for being aware of different cultural value systems lies with the practitioner, not the client being treated.

More specifically, the manner in which a person communicates, verbally and nonverbally, is often directly related to culture. One young Native American stated on initial contact that he "might not be able to come back because his shoes were too tight." This was his way of saying he had no money.

However, ethnicity doesn't always determine the culture or values one chooses to live by. For example, white Americans may adopt Eastern world views and value systems. Further, an advanced education doesn't necessarily indicate the degree of assimilation or acculturation. Asian-Americans or African-Americans who are well educated may choose to live according to their traditional cultural value system and process information for change accordingly.

Culture is a powerful contributor to defining one's identity. Not having a healthy ethnic sense of self affects all stages of the change process. As Maslow wrote, to have a strong sense of self, you have to be powerful in the areas of being, knowing, doing, and having. Ethnic Americans who have been raised in environments that isolate them from their own cultures may not have accurate information about their ethnicity and may not develop a healthy ethnic sense of self.

I believe clinicians who use motivational enhancement therapy need to know different cultural value systems and be culturally sensitive. If in doubt of the client's beliefs, explore them with the client. Acknowledging and honoring differing cultural world views greatly influence both motivational style and therapeutic outcome.

Rosalyn Harris-Offutt, Consensus Panel Member

Responding to Differing Needs

Clients in treatment for substance abuse differ in ethnic and racial backgrounds, socioeconomic status, education, gender, age, sexual orientation, type and severity of substance use problems, and psychological health. As noted above, research and experience suggest that the change process is the same or similar across different populations. Thus, the principles and mechanisms of enhancing motivation to change seem to be broadly applicable. Nonetheless, there may be important differences among populations and cultural contexts regarding the expression of motivation for change and the importance of critical life events. Hence, be familiar with the populations with whom you expect to establish therapeutic relationships and use your clients as teachers regarding their own culture.
Because motivational strategies emphasize the client's responsibility to voice personal goals and values as well as to select among options for change, a sensitive clinician will understand and, ideally, respond in a nonjudgmental way to cultural differences. Cultural differences might be reflected in the value of health, the meaning of time, the stigma of heavy drinking, or responsibilities to community and family. Try to understand the client's perspective rather than impose mainstream values or make quick judgments. This requires knowledge of the influences that promote or sustain substance use among different populations. Motivation-enhancing strategies should be congruent with clients' cultural and social principles, standards, and expectations. For example, older adults often struggle with loss of status and personal identity when they retire, and they may not know how to occupy their leisure time. Help such retired clients understand their need for new activities and how their use of substances is a coping mechanism. Similarly, when you try to enhance motivation for change in adolescents, consider how peers influence their behaviors and values and how families may limit their emerging autonomy.

In addition to understanding and using a special population's values to encourage change, identify how those values may present potential barriers to change. Some clients will identify strongly with cultural or religious traditions and work diligently to gain the respect of elders or other group leaders; others find membership or participation in groups of this type an anathema. Some populations are willing to involve family members in counseling; others find this disrespectful, if not disgraceful. The label "alcoholic" is proudly and voluntarily adopted by members of AA but viewed as dehumanizing by others. The message is simple: Know and be sensitive to the concerns and values of your clients.

Another sensitive area is matching the client with the clinician. Although the literature suggests that warmth, empathy, and genuine respect are more important in building a therapeutic partnership than professional training or experience (Najavits and Weiss, 1994), nevertheless, programs can identify those clinicians who may be optimally suited because of cultural identification, language, or other similarities of background, to work with clients from specific populations. Programs will find it useful to develop a network of bilingual clinicians or interpreters who can communicate with non--English-speaking clients.

Finally, know what personal and material resources are available to your clients and be sensitive to issues of poverty, social isolation, and recent losses. In particular, recognize that access to financial and social resources is an important part of the motivation for and process of change. Prolonged poverty and lack of resources make change more difficult, both because many alternatives are not possible and because despair can be pervasive. It is a challenge to affirm self-efficacy and stimulate hope and optimism in clients who lack material resources and have suffered the effects of discrimination. The facts of the situation should be firmly acknowledged. Nevertheless, clients' capacity for endurance and personal growth in the face of dire circumstances can be respected and affirmed and then drawn on as a strength in attempting positive change.
Brief Interventions

Over the last two decades, there has been a growing trend worldwide to view substance-related problems in a much broader context than diagnosable abuse and dependence syndromes. The recognition that persons with substance-related problems compose a much larger group—and pose a serious and costly public health threat—than the smaller number of persons needing traditional, specialized treatment is not always reflected in the organization and availability of treatment services. As part of a movement toward early identification of hazardous drinking patterns and the development of effective and low-cost methods to ameliorate this widespread problem, brief interventions have been initiated and evaluated, primarily in the United Kingdom (Institute of Medicine, 1990a) and Canada but also in many other nations. (For a greater discussion of brief intervention and brief therapy, refer to the forthcoming TIP, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT, in press (a)].) They have been tried in the United States and elsewhere with great success, although they have not been widely adopted outside research settings (Drummond, 1997; Kahan et al., 1995). The impetus to expand the use of this shorter form of treatment is a response to

- The need for a broader base of treatment and prevention components to serve all segments of the population who have minimal to severe substance-related problems and consumption patterns
- The need for cost-effective interventions that will not further deplete public coffers and will also satisfy cost-containment policies in an era of managed health care (although research indicates that intensive treatment for nicotine dependence is more cost effective [Agency for Health Care Policy and Research, 1996])
- A growing body of research findings that consistently demonstrate the efficacy of brief interventions relative to no intervention

### Brief Intervention in the Emergency Department

When I apply a motivational interviewing style in my practice of emergency medicine, I experience considerable professional satisfaction. Honestly, it's a struggle to let go of the need to be the expert in charge. It helps to recognize that the person I'm talking with in these medical encounters is also an expert—an expert in her own lifestyle, needs, and choices.

After learning about the FRAMES principles in 1987, I tried them once or twice, and they worked, so I tried them again and again. This is not to say that I don't fall back to old ways and sometimes ask someone, "Do you want to go to detox?" But more often than not, I try to ask permission to discuss each individual's substance use. I ask patients to help me to understand what they enjoy about using substances, and then what they enjoy less about it. Patients often tell me they like to get high because it helps them relax and forget their problems and it's a part of their social life. But they say they don't like getting sick from drugs. They don't like their family avoiding them or having car accidents or having chest pains after using crack. I listen attentively and reflect back what I understood each person to have said, summarize, and ask, "Where does this leave you?" I also inquire about how ready they are to change their substance use on a scale of 1 to 10. If someone is low on the scale, I inquire about what it will take to move forward. If
someone is high on the scale, indicating readiness to change, I ask what this person thinks would work for him to change his substance use.

If a patient expresses an interest in treatment, I explore the pros and cons of different choices. An emergency department specialist in substance use disorders then works with the person to find placement in a program and, if needed, provides a transportation voucher. This systematic approach, which incorporates motivational interviewing principles, is helpful to me in our hectic practice setting. It's not only ethically sound, based as it is on respect for the individual's autonomy, but it's less time consuming and frustrating. Each person does the work for him- or herself by naming the problem and identifying possible solutions. My role is to facilitate that process.

Ed Bernstein, Consensus Panel Member

**Uses of Brief Interventions**

Brief interventions for substance-using individuals are applied most often outside traditional treatment settings (in what are often referred to as *opportunistic* settings), where clients are not seeking help for a substance abuse disorder but have come, for example, to seek medical attention, to pick up a welfare check, or to respond to a court summons. These settings provide an opportunity to meet and engage with individuals with substance abuse disorders "where they are at." In these situations, persons seeking services may be routinely screened for substance-related problems or asked about their consumption patterns. (For more on how this can work in one such setting, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* [CSAT, 1997].) Those found to have risky or excessive patterns of substance use or related problems receive a brief intervention of one or more sessions, each lasting a few minutes to an hour. Urgent care may involve just one brief encounter, with possible referral to other services. These brief interventions are usually conducted by professionals from the service area where the person seeks services, not by substance abuse treatment specialists. The purpose of a brief intervention is usually to counsel individuals about hazardous substance use patterns and to advise them to limit or stop their consumption altogether, depending on the circumstances. If the initial intervention does not result in substantial improvement, the professional can make a referral for additional specialized substance abuse treatment. A brief intervention also can explore the pros and cons of entering treatment and present a menu of options for treatment, as well as facilitate contact with the treatment system.

Brief interventions have been used effectively within substance abuse treatment settings with persons seeking assistance but placed on waiting lists, as a motivational prelude to engagement and participation in more intensive treatment, and as a first attempt to facilitate behavior change with little additional clinical attention. A series of brief interventions can constitute brief therapy, a treatment strategy that applies therapeutic techniques specifically oriented toward a limited length of treatment, making it particularly useful for certain populations (e.g., older adults, adolescents).