FACTsheet

Intramural Motivation Centre [1]

Intramural Motivation Centres (IMCs)reach a target group that can hardly be connected with traditional addiction care. IMCs contribute to a decrease of the nuisance caused by the life style of addicts. This manual gives a large overview of the backgrounds, objectives, set-up, ways of working and the results of IMCs. It clarifies the characteristics of the client population, what view there is on the provision of help, care chain, and what knowledge and skills staff should have. The manual is based on evaluation research.

Background

In 1994 the Dutch government initiated the establishment of experimental IMCs. Their main aim was to reduce the trouble caused by addicts. Traditional care appeared to reach problematic addicts insufficiently. The support offered in an IMC was thought to reduce the chance of breaking off the treatment prematurely. It was hoped that IMCs would push back the trouble and would motivate judicial clients to change their use of substances.

IMCs were expected to give support in social functioning, to pay attention to resocialisation and carry out a wide assessment at intake. The admission to the programme was estimated at three months.

Target group and orientation

An IMC is aimed at long-term problematic addicts that cause nuisance and have little motivation and intrinsic possibilities to cut down on their substance use quickly and completely. This affects both drugs and alcohol clients, as well as judicial and non-judicial clients. Part of this target group are also care dodgers and addicts with unsuccessful treatments in the past.

Within the care chain, an IMC functions as a link with various forms of care. An IMC is positioned at the start of a care chain, at the end of a treatment chain, or as part of rehabilitation within social addiction care. Assigning someone to a route manager is aimed for if external help has not yet been organised thoroughly. This function can be fulfilled by various disciplines with the field of care.

Inflow

An IMC is meant for clients with the minimum intention of changing their use of substances. Clients with multiple problems which give rise to nuisance situations belong to the target group. The intake procedure is low-threshold by nature: limited in length and characterised by short “hierarchical lines”. The client is not required to have a permanent change in behaviour concerning the use of substances. In order to be admitted, clients do not need to have a particular question for help.

Counter-indications for inflow are the following:

- 17 years of age or younger;
- acute psychosis;
- severe cerebral disorders;
- necessity of intensive treatment in bed / nursing care;
- severe mental defectiveness;
- referral on the basis of article 43 to addiction treatment;
- simple set of problems, comparatively short period of addiction, the lack of long-term care dodging or treatment history, social integration.

An IMC may function well without an indication committee on the doorstep. Preconditions are: direct medical-somatic and medical-psychiatric screening (fast referral, if possible), careful screening and, if possible, further diagnostics at a later stage.

Flow-through and outflow

The flow-through of clients is individualised and is not fixed at the moment of inflow. The following four levels of outflow are distinguished:

Level 1: the client is geared to medication, has recovered physically, and has shown a number of minimum skills within the structure of the treatment service.
Level 2: the client has learned a number of minimum skills, and is able to retain them during a certain period after being admitted.

1 A. Diepraam (2003). *Intramuraal Motivatie Centrum. Een handboek.* Project Resultaten Scoren, uitgave GGZ Nederland.

The 'Intramural Motivation Centre' bookcover.

Level 3: the client has taken a decision about the follow-up route, which is aimed at objectives concerning accommodation, work, way of spending the day, and substance use, if any.
Level 4: the client has taken a decision in favour of addiction treatment, which is aimed at abstinence and/or drastic change of his/her addiction behaviour and life style.

If a client flows out at one of the levels mentioned above, an IMC will have reached its objective for this particular client. The manual gives concrete indications concerning the way in which the transfer to an external care provider should take place (in connection with the level of flowing out), and what should be paid attention to during a follow-up treatment.

Characteristics of care

Clients are not obliged to kick the habit completely; the use of methadone is allowed, and there is no obligation to follow therapy. A crucial factor for the atmosphere is the importance that is attached to rehabilitation. Central issues are the reinforcement of the autonomy and support in various living areas. An IMC offers the client extensive possibilities to find ways of spending the day.

Clients are taken to account for their own behaviour. After all, they are capable of influencing it. The way in which they are treated is non-moralising, accepting and respectful.

The providers of care show a sincere interest in the clients themselves, and work on building a relationship of trust.

The provision of help is further characterised by the following:

- The individual set of problems and the question for help are central issues for the tailoring of help.
- The focus is on the problems and behaviour in the current situation and circumstances.
- Specific support is put in per problem area (accommodation, social problems, substance use, support from the client's environment).
- The approach is aimed at the client's behaviour.
- The interventions are tailored to the stage of change that the client is in.

Objectives

In order to be able to serve the particular target groups of an IMC, a number of main targets have been set. It is determined per client which targets are applicable and in which stage these are aimed at. The primary objective is that the relationship with the care provider(s) has been established and/or improved. The secondary objectives are as follows:

- Objective 1: Physical improvement (rest, rhythm, food, external care).
- Objective 2: Medical/psychiatric screening and adjusting to medication (e.g. methadone).
- Objective 3: Learning basic skills in terms of staying and living somewhere.
- Objective 4: Psychiatric diagnostics, if it is a question of psychiatric problems.
- Objective 5: Gaining insight into the nature and function of the patient's substance use (insight into patterns of problematic substance use; reducing the use; self-control).
- Objective 6: Improving basic social skills.
- Objective 7: Improving social functioning; starting to integrate into society, if so required.
- Objective 8: Improving relationships with the system of non-users.

In order to reach the primary target, every client is assigned a mentor, who is responsible for individual guidance, communication with the client's environment, and support at drawing up the follow-up stage. The manual gives concrete descriptions of the way of working of an IMC in trying to reach the eight objectives mentioned above.

FURTHER INFORMATION

The publication, including an overview of the literature consulted, can be downloaded from the knowledge net of GGZ Nederland: www.ggzkennisnet.nl (› informatieservice zorginhoud › Resultaten Scoren › Handboek Intramuraal Motivatie Centrum).

COLOFON

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