Youth Treatment in Practice: A Community & Motivational Approach

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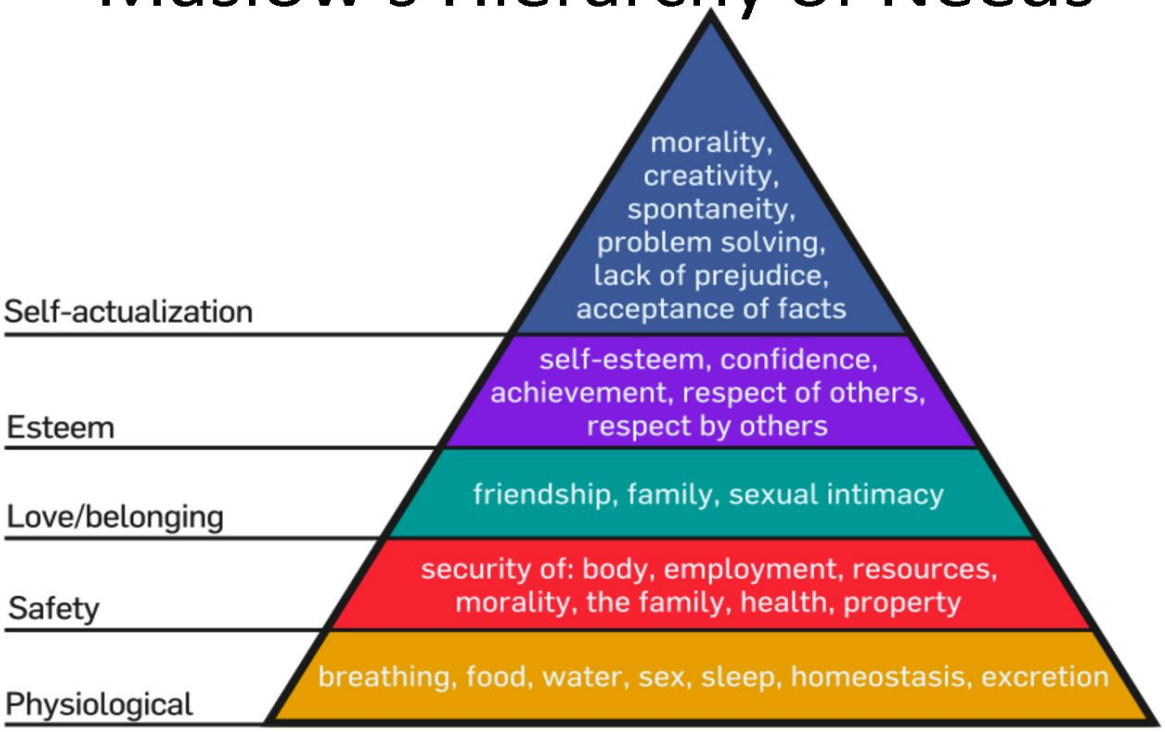
Training/Framework Goals

- Enhance your competence to work with youth who struggle with substance use
- Increase recognition of youth developmental stages and how the social environment impacts youth
- Increase use of youth-centric approaches and tools (offer highly individualized treatment)
- Increase youth treatment access, engagement, & retention.

The Role of the Counselor

- *Do no harm*
- *Meet clients where they are at*
- *Don't make assumptions*
- *Don't take things personally*
- *Don't work harder than the client (adolescents may be an exception))*

Remember Maslow



Source: http://en.wikipedia.org/wiki/File:Maslow's_Hierarchy_of_Needs.svg

Adolescents

Challenges	Opportunities
• Engagement; adolescent mistrust of authority • Less capacity for cognitive control (e.g. impulse control) • More hypersensitivity to rewards related to substance use; dopaminergic system is very active! • May not be questioning or assessing the appropriateness of decisions.	• Adolescents tend to care deeply about what others think-seeking attention & approval • Can be quite reflective regarding life's challenges-what lies ahead • Are generally considered more open-minded than adults • Are very capable at learning new skills

Why Use Substances?

While there are certainly risks for most individuals, there are also rewards. Whether sexual promiscuity, substance use, etc.:

- Feels good, relaxation; 'self-medication hypothesis'
- A social lubricant; meets a social need
- Quick and fast results; instant gratification
- Creates a sense of identity
- Alleviates boredom
- Addiction (food model)

What else?

Other Therapist Challenges

- Can I provide enough resource & support?
- Balancing openness with humor
- Time limitations; can increase anxiety in therapist & adolescent
- Deciding what level of parental notification is appropriate/required.

Self-Assessment

- Complete pages 2 & 3 of Workbook.

Therapeutic Alliance

40% - client internal factors, strengths, social support, etc.

30% - a positive therapeutic alliance

15% - hope, expectancy, placebo

15% - therapeutic technique

(Project Match)

Therapeutic Alliance

- Must begin work with adolescents by explicitly stating, "My *role is not to tell you what to do.*"

- In your head, try to reframe the maladaptive behavior (e.g. substance misuse) as a strategy to get needs met.

Clinical Vignette: Engagement

- See pages 6-7 in Workbook

Informed Consent Process

- Need to let youth/parent(s) know you will not give specifics of the adolescent's use, but will share diagnosis, recommendations, and general level of concern about substance use.

- Doing this in front of adolescent may help increase the adolescent's degree of trust in the therapist. Can also ask (in front of the adolescent) the parents' level of concern.

- Craft sample informed consent statement.

Informed Consent Exercise

- Complete page 4 in Workbook

Addiction 101

Prevention Overview

NIDA's Definition

Addiction is defined as:

"A chronic, relapsing brain disease characterized by compulsive drug seeking and use, despite harmful consequences.

It is considered a brain disease because drugs change the brain, its structure, and how it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who misuse drugs.

Risk and Protective Factors

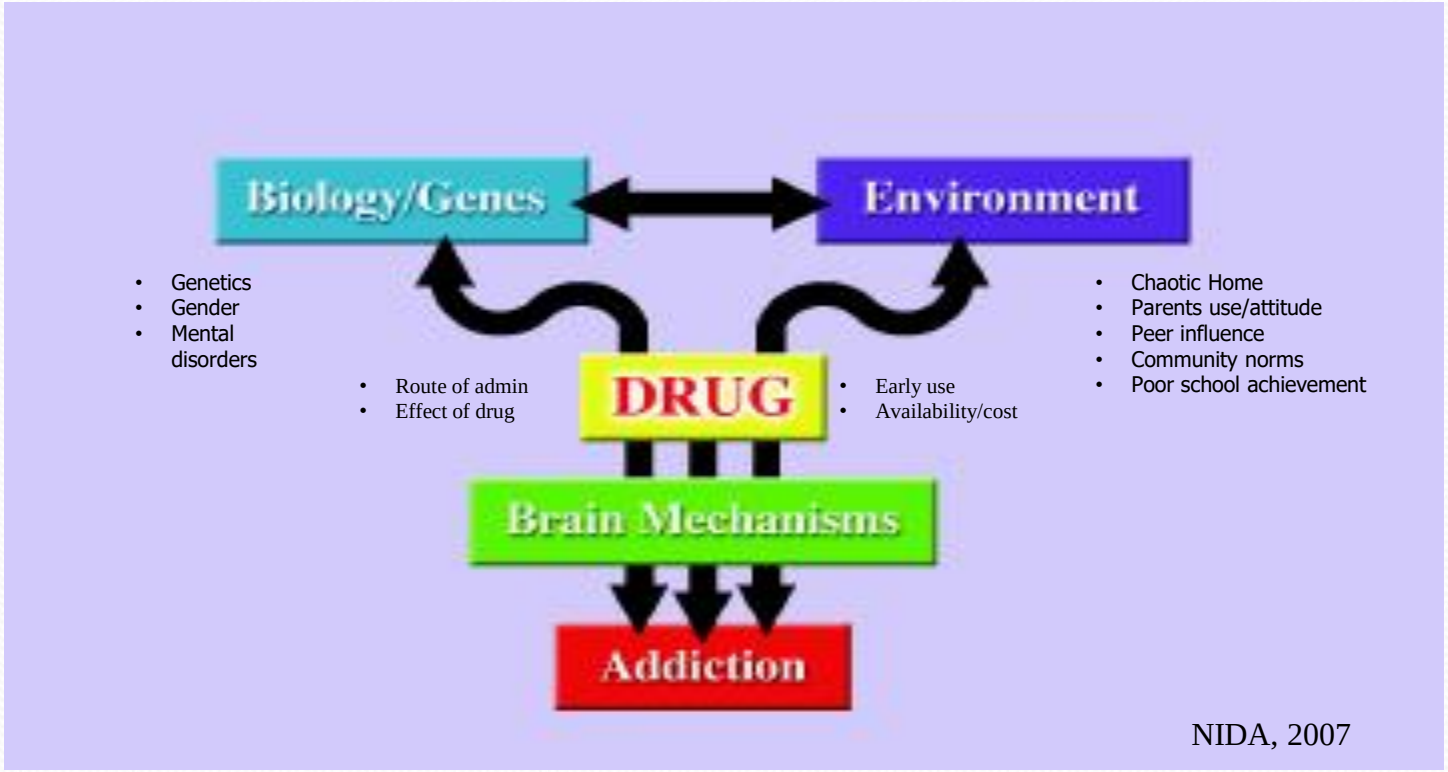
RISK:

- Early aggressiveness
- Poor social skills
- Lack of parental supervision
- Drug availability
- Substance using peers
- Poverty
- Trauma History
- Genetics

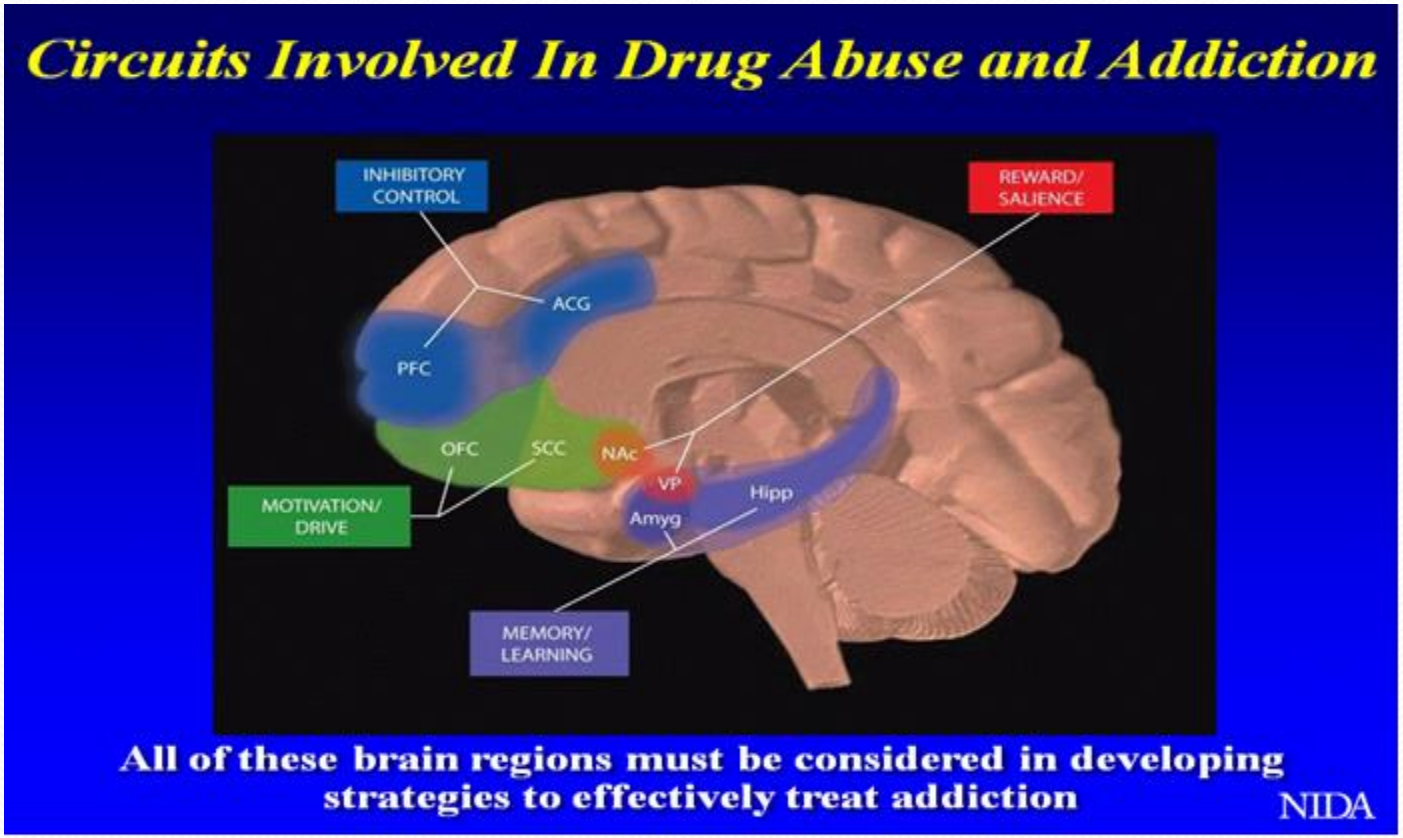
PROTECTIVE:

- Self-control
- Positive relationships
- Parental monitoring
- Anti-drug use policies
- Hobbies
- Academic Competence
- Religion/Spirituality

Addiction is Complex!



The Brain's Reward Pathway

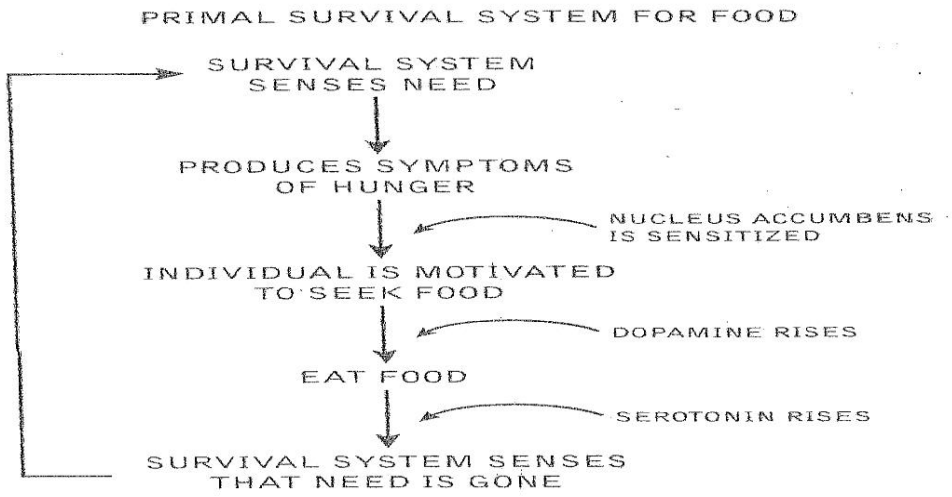


Dopaminergic System (Dopamine Release)

- 2-10x more powerful than natural reinforcers (exercise, sex, novel experience, music, helping/altruistic acts, beginning a new relationship)

- Anticipation of reward

Food Model



The survival system for food senses a need. Transmitters send the message to the limbic system, which produces feelings of hunger and causes stress. This increases the sensitivity of the nucleus accumbens. The seeking of food raises dopamine and the eating raises serotonin. The survival system senses that the need is satisfied and removes the pain of hunger, which reduces the sensitivity of the nucleus accumbens. The ability of food to motivate action is gone.

Epidemiology

- 1 in 4 adolescents nationally report use of substances (slightly higher in the Northeast)
- Substance use almost always begins in adolescence
- Delaying use until age 25 makes person highly unlikely to develop a problem

Epidemiology

- For adolescents, marijuana is overwhelmingly the "drug of choice," often combined with alcohol
- 1 in 10 high school seniors report non-medical use of prescription painkillers (Vicodin & OxyContin)
- Use of opiate analgesics is the only drug that is "on the rise"

Cannabis facts

Dispelling Myths about Marijuana:	
It's not addictive	Marijuana can be addictive. Drugs do not need to be physically addictive be problematic. There were over 320,000 treatment admissions for marijuana nationally in 2008 (Treatment Admission Data Set., 2010).
It's the least harmful drug	This is false; depends on the frequency and amount of use. Marijuana has long been known to impair memory and learning and often increases anxiety in new users.
Everybody is doing it	Most youth do not smoke marijuana! Perception of harm has been decreasing since 2007, despite additional findings that marijuana has multiple harmful effects.

Physical signs & symptoms

- Fatigue
- Smell of alcohol or smoke
- Excessive use of breath mints
- Repeated health complaints
- Frequent flu-like episodes or chronic cough
- Red and glazed eyes
- Impaired short-term memory
- Change in health or grooming

Emotional signs & symptoms

- Sudden mood changes
- Irritability, anger, hostility
- Irresponsible behavior
- Low self-esteem
- Poor judgment
- Appearance of loneliness, paranoia, or depression
- Apathy or general lack of interest

School related signs & symptoms

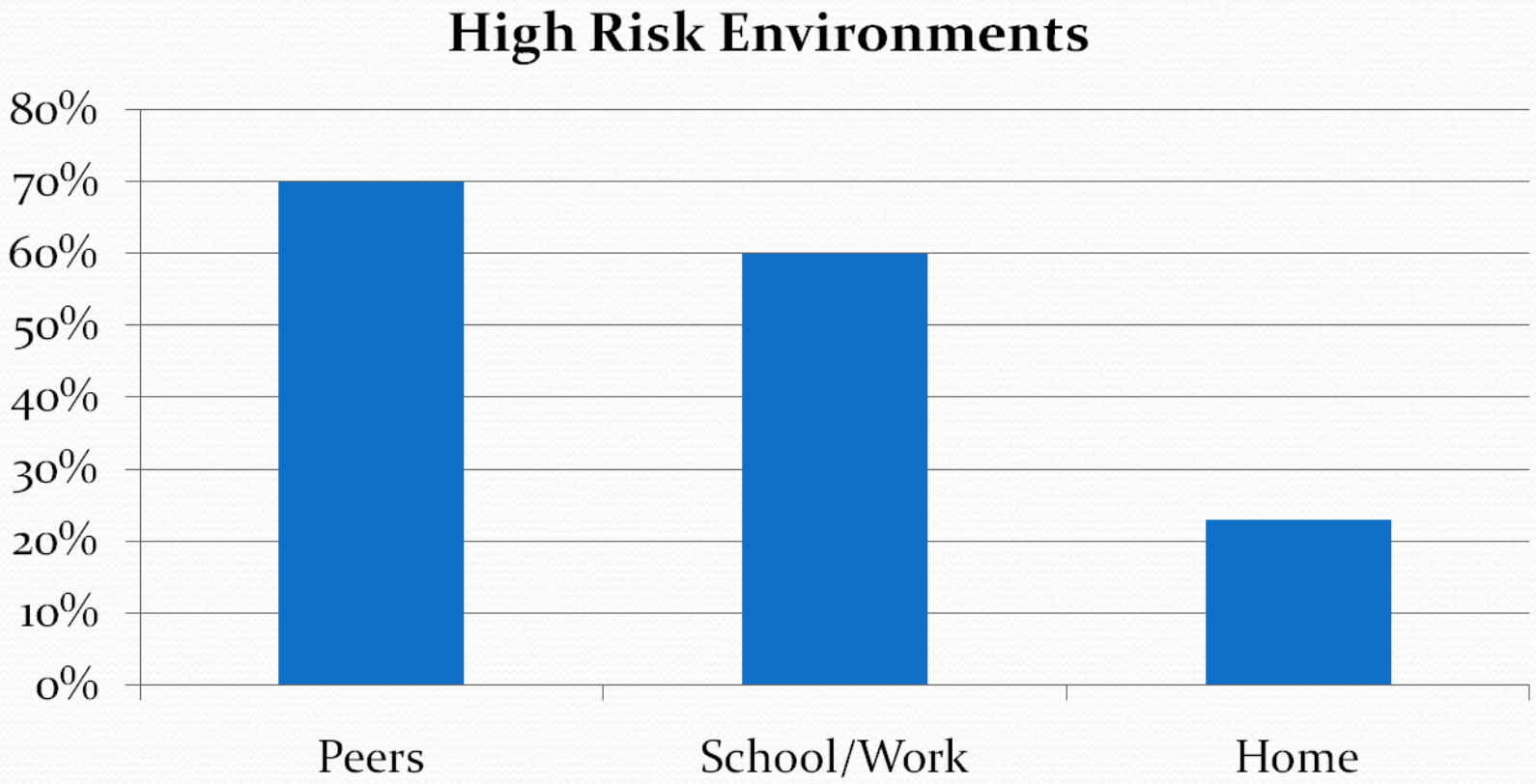
- Decreased interest
- Negative attitude or acting out behaviors
- Unexplained drop in grades
- Irregular school attendance or truancy
- Discussion of partying or parties
- Frequently seen passing objects (suspiciously) to others
- Not returning home after school

Peer related signs and symptoms

- Dropping old friends
- New group of friends
- Not bringing friends home
- New friends who make poor decisions and are not interested in school
- Changes to a different style in dress and music
- Attending parties with no parental supervision

* Note patterns in behavior change(s)

Exposure



Source: Adapted from Dennis, 2007

What to Do?

- Always find an opportunity to reinforce good choices!
- High/moderate risk youth: refer to guidance counselor, alert parents, and/or refer for treatment
- Low risk youth: consider parent notification

Important to Stress:

- Most adolescents do make healthy choices by not engaging in drugs or other risky behaviors!

Protective factors we can help bolster

- Close adult monitoring, e.g. after school & weekends
- Encouraging kids to get involved in extracurricular activities
- Helping kids achieve academic and social competence
- Helping youth access supports

Target Major Risk Factors

- Poor social skills- through a positive approach and role playing refusal skills and effective communication
- Substance using peers- through encouraging youth to participate in sports, clubs, etc.

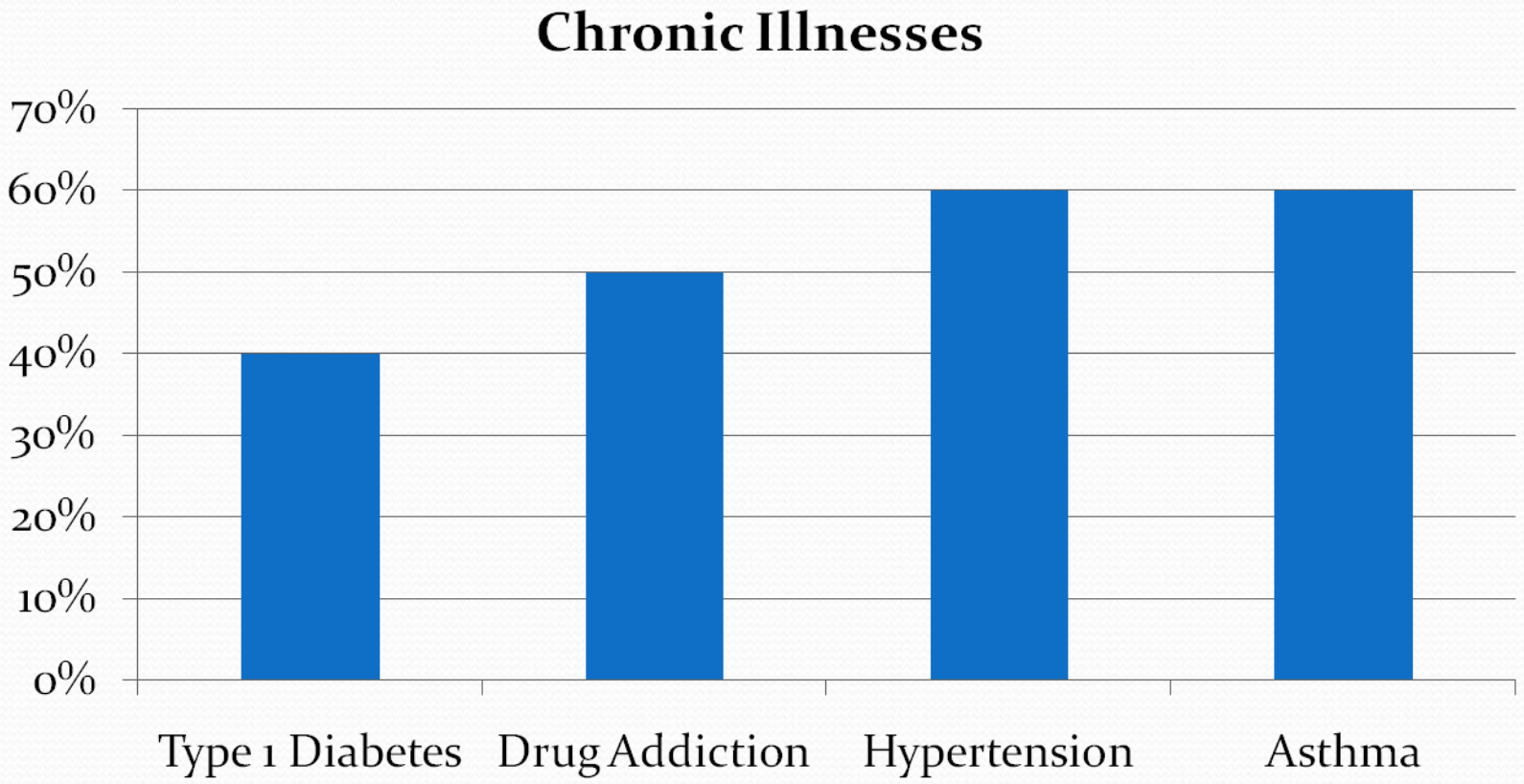
Youth already struggling with addiction

- Youth in substance use treatment settings tend to be at the far end of the spectrum in terms of the seriousness of their substance use and other challenges

- Most began using drugs/alcohol around age 12 and have a range of challenges in addition to substance use

- Progress may take time. In general relapse in common and 3-5 treatment attempts are necessary before a sustained period of abstinence is achieved.

Relapse is the Norm



Source: NIDA, 2007

Typical profile of youth with severe substance use issues

- Use of multiple substances
- Multiple stressors
- Weak support system/chaotic home life
- Poor communication skills
- Academic difficulty
- Other mental health issues

Providing prevention programming in schools…a major challenge

- 1 in 4 educators who teach prevention in the classroom have limited or no training
- 50% of schools incorporate substance education into health classes (often inconsistently)
- Only 1 in 3 educators rate their prevention programs as effective
- Research shows that >10 hours per year of prevention programming is needed to be effective
- Schools pressure to focus on academic testing standards (i.e. lack of time)
- General drug education and distribution of printed materials yields little effect

- Schools that are serious about prevention programs should adopt proven, research-based prevention programs and curricula for use in after-school and extracurricular activities (see *National Registry of Evidence-Based Practices and Principles* website)

Adapted from "Prevention Education in America's Schools: Findings and Recommendations from a Survey of Educators" (2007)
Study design involved surveying 3500 educators and administrators in schools nationwide.

Important classroom messages: must be tailored to what is important to youth

- Most youth make good choices (i.e. don't get involved with substances)

Youth who do use substances risk a lot:

- Health effects
- Arrest (background checks can keep from getting the job you want)
- Poorer grades
- Limited acceptance among peer groups
- Less attractive to others
- No money to do what you really want

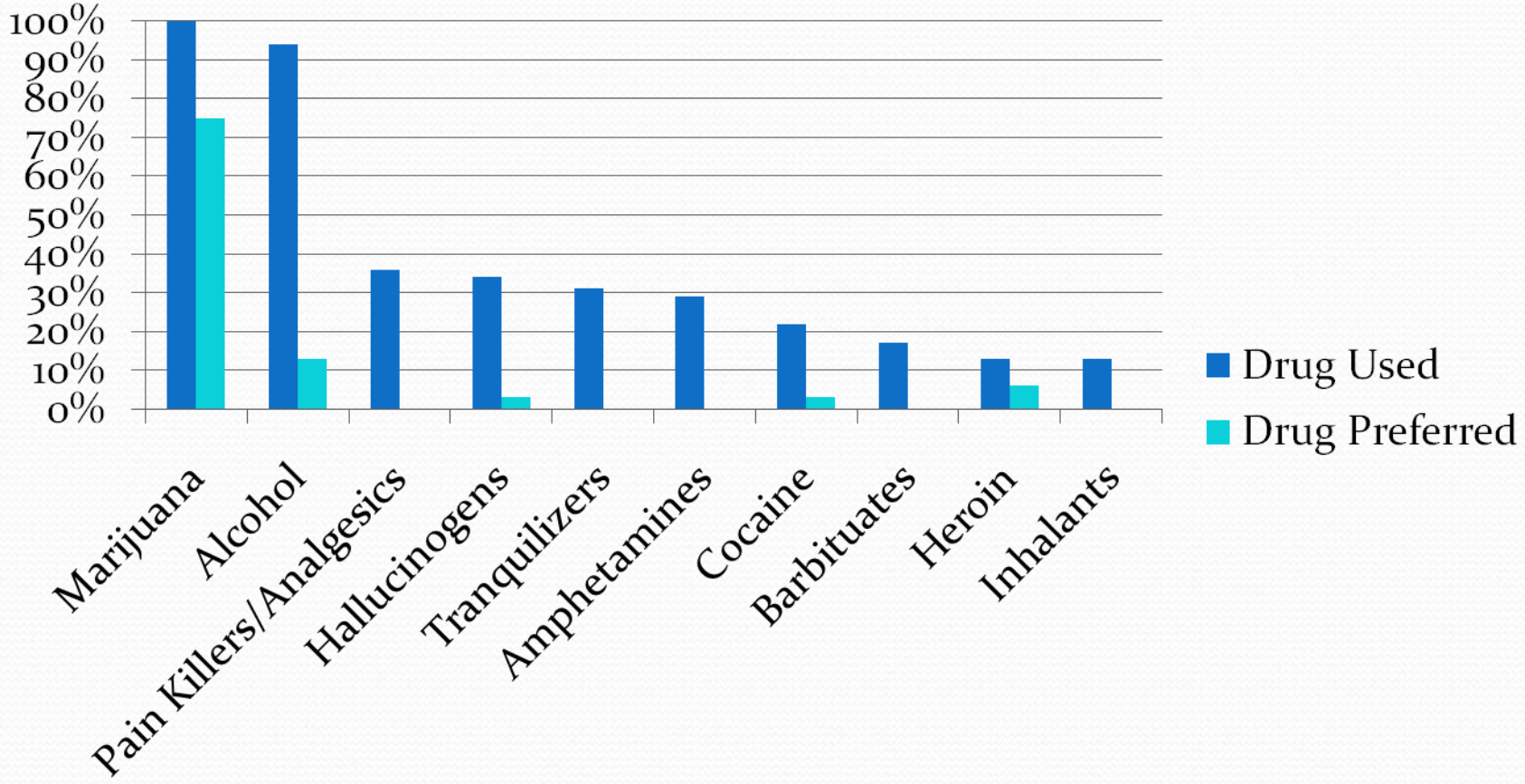
Talking with teens

- Visualize what they are saying…appreciate the emotion in what they are relating
- Don't make assumptions…withhold advice giving
- Use active listening…validate…paraphrase…reflect
- Stay positive…never state anything about their "attitude"…and don't develop one yourself
- Don't push or probe for information…unless there is a serious safety concern
- Let them know you care
- Don't make statements such as "what were you thinking" or ask "why?"
- Use simple language
- Don't try to act "cool" or fit in too much
- Don't make promises you can't keep
- Ask "Want do you think makes sense?", "What do you want to do?" (or some variation of this)
- Is _____ (behavior) going to get you what you want?
- Ask if they have someone they can talk openly to.

Youth Substance Use

Preferences & ‘Designer’ Drugs

Substances of Use & Preference



New “Designer Drugs”

- Products with psychoactive properties, manufactured with synthetic chemicals to produce a high when used similar to illegal drugs such as marijuana, cocaine, methamphetamine, ecstasy, etc.

“Legal Highs”

- Marketed as “*innocent*” products such as **incense** or **bath salts** and labeled as “**not for human consumption**” – although they are most often sold in head shops – avoiding laws on both illegal drugs and food additives.

Concerns

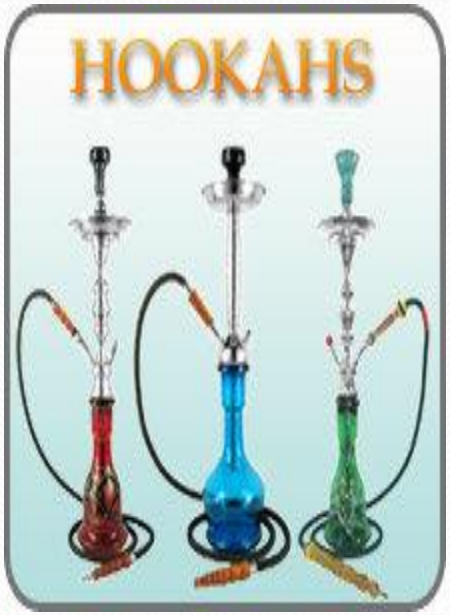
“Designer Drugs/Legal high” products (synthetic marijuana, synthetic cocaine, high-alcohol, high-caffeine drinks) have been associated with emergency room visits, hospital admissions, injuries and even deaths among users.

Synthetic Marijuana

- It looks like marijuana.
- It gives a high like marijuana.
- Recently became regulated.

- “K2” or “Spice”, as it is commonly known, falls under the category of synthetic cannabinoids, chemically engineered substances that are similar to THC (the active ingredient in marijuana) in both appearance and composition.

Synthetic Marijuana



- American Association of Poison Control Centers began receiving calls in 2009 related to synthetic marijuana (112 calls from 15 states).
- By 2010, the number of calls increased to over 2,700 from 49 states.

Potential Health Risks

- Agitation
- Anxiety
- Nausea
- Vomiting
- Tachycardia (fast, racing heartbeat)
- Elevated blood pressure
- Tremors
- Seizures
- Hallucinations
- Paranoid behavior
- Non-responsiveness

Synthetic Cocaine

Ivory Wave, a synthetic product that contains hallucinogenic, mind-altering chemicals similar in structure to those also found in cocaine and ecstasy.

Sold as a bath salt, or plant food in order to by-pass FDA regulations - not sold as food or drug product.

A white, tan or brown odorless, powdery substance.

Synthetic Cocaine

Also sold under the names:

- Vanilla Sky
- Snow
- Charge
- Purple Wave
- Magic

To name several…

Synthetic Cocaine

- Effects are similar to cocaine, methamphetamine, or MDMA.
- Sometimes called “fake” cocaine or “fake” meth
- Can be snorted, injected, or eaten.

Salvia Divinorum

- Salvia divinorum is a psychoactive mint, used in traditional spiritual practices by the Mazatec people of Mexico
- Is legal in both Mexico and the United States
- However, some states (3) have banned it, making its possession, like that of heroin or cocaine a felony
- Can cause hallucinations when smoked — rivaling the potency of the synthetic hallucinogens like LSD.

What does Salvia look like?

Green plant leaves or a liquid extract

It can be ingested (liquid form) or smoked (powder form)

Salvia Effects

- Depending on dosage, a user's reaction can vary from a subtle (just-off-baseline state) to a full-blown psychedelic experience
- Can induce an intense hallucinatory experience (particularly when smoked) which typically persists from several minutes to an hour
- Described by some as a "20-minute acid trip."

Vodka “Eyeballing”

- Pouring vodka into the eye “induces feelings of drunkenness at break-neck speeds” by passing through the mucous membranes and into the bloodstream
- Users say that “pain is part of the competitiveness”
- Can cause burning, inflammation, and scarring of the cornea and sclera."

Purple Drank

- A concoction of the prescription cough syrup Promethazine with Codeine, typically mixed with a soda, like 7-Up or Sprite, or with an alcohol like gin or vodka

- This leaves the drink a pink-purple color
- When taken in sufficiently high doses can lead to sleepiness, altered thoughts, impaired motor functions (i.e. shuffling pace or “lean” to one's walk)
- Also known as Rainbow Colors, Lean, Sip-Sip, Sizzurp, Syrup, to name several.

Dextromethorphan (DXM)… *Triple Cs, Skittles*

- Recreational use of DXM is sometimes referred to as "robo-tripping"
- Can have a powerful 'dissociative' effect (out-of-body sensations and hallucinations)

- About half of regular users report experience of withdrawal, including fatigue, flashbacks, constipation; in rarer cases panic attacks and tremors
- Combining with stimulants can cause a dangerous rise in blood pressure and heart rate resulting in seizure or death.

Molly

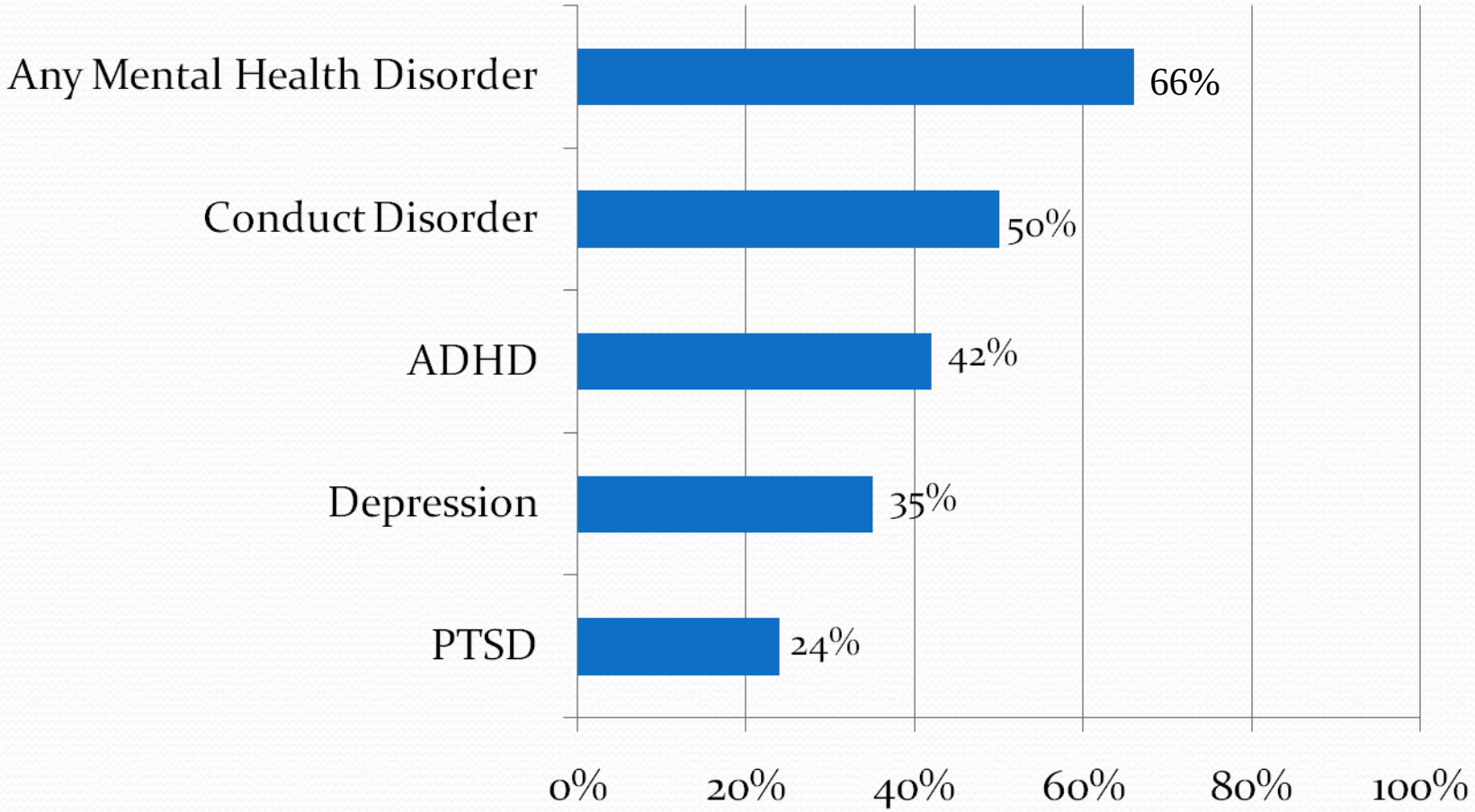
- Powder or crystal form of MDMA, the chemical used in Ecstasy
- Popular drug at music festivals
- Users tend to be ages 16 to 24
- Can cause confusion, anxiety, depression, paranoia, sleep problems
- High doses can result in sharp increase in body temperature (hyperthermia), leading to liver/kidney/cardiovascular failure

Mental Health

And Other Co-Occurring Conditions

Mental health and other problems almost always accompany substance abuse disorders

Co-Occurring Disorders:



Source: Adapted from Dennis, 2007

Substance Use and Mental Health among Youth

Major Depression:

- Youth 12-17 who use alcohol or illicit substances of any kind are 2x more likely to have an episode of major depression as compared with youth who do not use substances (4% for alcohol users and 36% for illicit drug users).

Suicide:

- Youth who abuse or are dependent on substances have almost 4x the amount of *serious* suicidal thoughts as compared with youth who do not abuse substances (11% vs. 3%).

Psychosis:

- New research is pointing to chronic, daily marijuana use as a risk factor for psychosis.

Substance Use and Mental Health among Youth

Schizophrenia:

- For people with a genetic vulnerability to schizophrenia, marijuana may trigger onset.

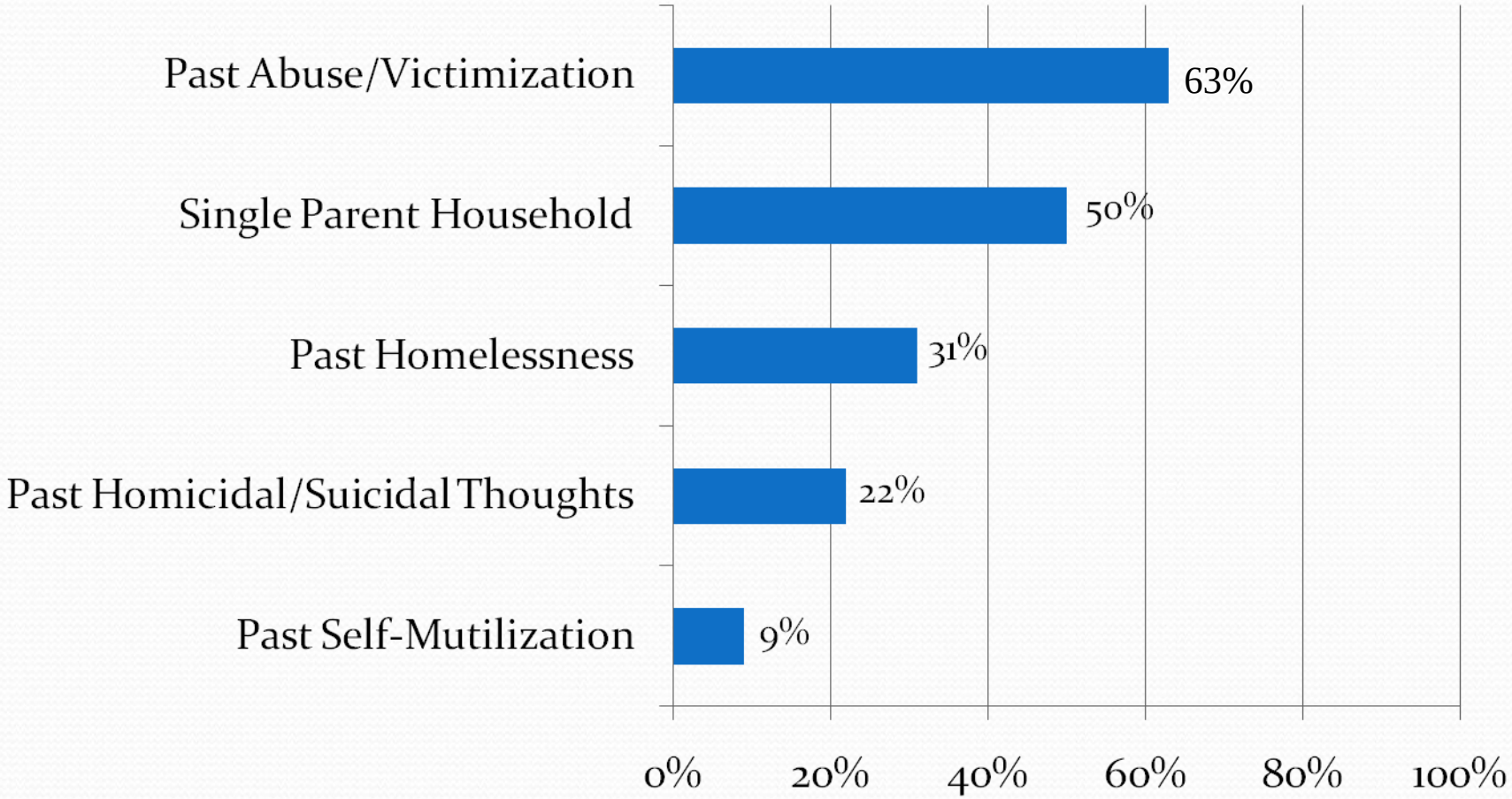
Aggression:

- Adolescents who use illicit drugs are twice as likely to engage in violent behavior as their non-using counterparts. Half of all youth who use drugs engage in aggressive behavior which often leads to arrest (Dennis, 2007).

Teen pregnancy:

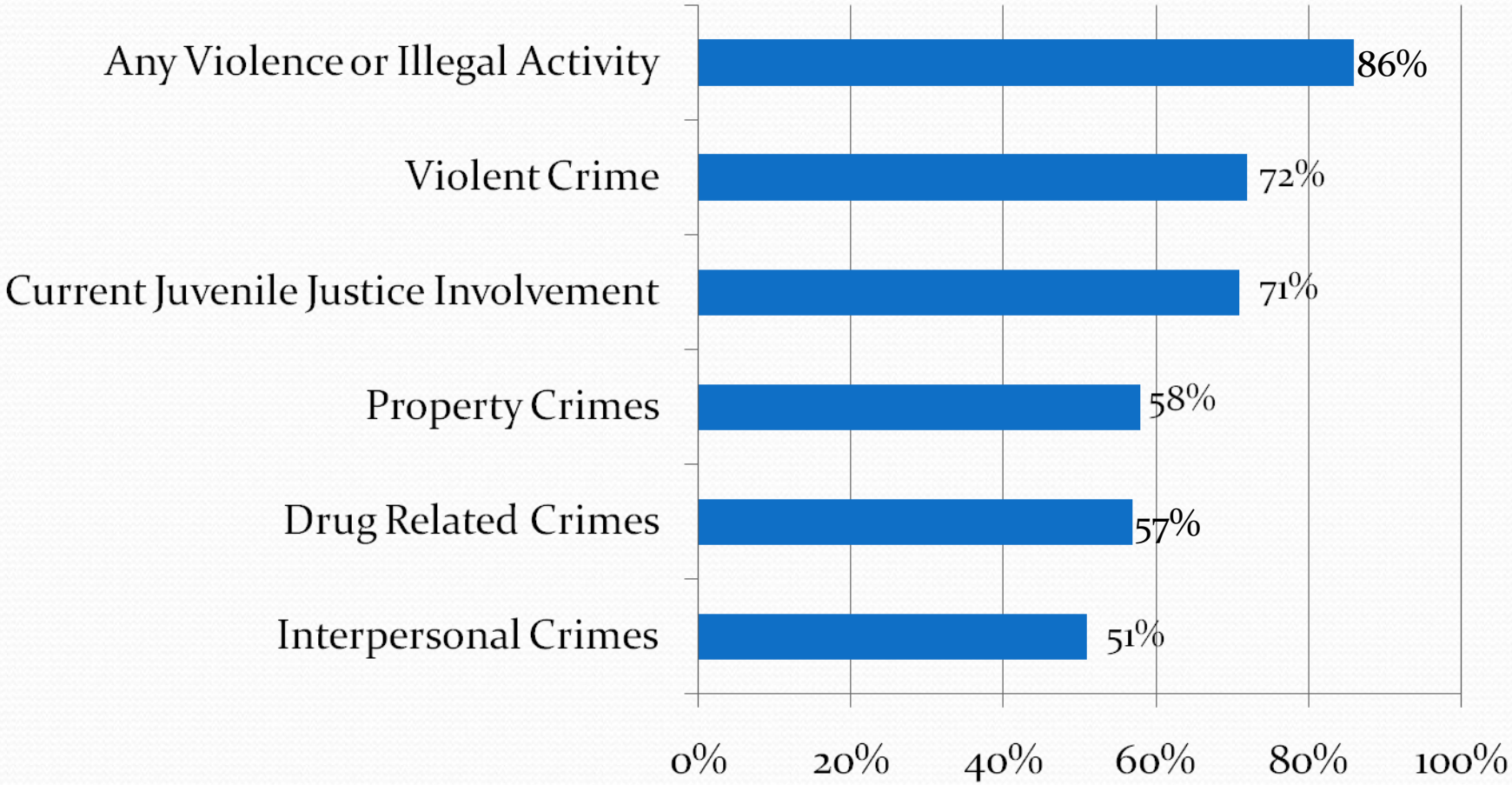
- Adolescents who use alcohol while sexually active increase their risk of pregnancy.

Other Issues for Consideration:



Source: Dennis, 2007

Past Year Crime and Violence:



Source: Dennis, 2007

Adolescents who use illicit drugs are almost twice as likely to engage in violent behavior as their non-using counterparts (50% vs. 27%)

Some good news

- Research has shown that a student entering high school with a history of violence is not likely to commit an act of aggression (at school) if the student believes there is at least one educator that thinks well of them! (Garborino)

- Maintaining positive relationships with youth are critical to prevention work!!

Disruptive, Impulse-Control, & Conduct Disorders

- Angry, irritable mood/loss of temper
- Argumentative/defiant behaviors (often toward authority & rules)
- May deliberately annoy others
- Outbursts (verbal or physical)
- “Blows” things out of proportion-not premeditated (impulse or anger based)
- Bullying, threatening, or intimidating others
- Destruction of property
- Running away
- Lack of remorse or guilt may accompany above

So…Expect Multiple Problems

- 1 in 3 clients in outpatient treatment have multiple psychiatric diagnoses in addition to substance use disorder
- Few present with just one problem
- 45% of youth in treatment acknowledge 5-12 major problem areas such as have been described above

Screening, Assessment & Diagnosis

Brief Overview

SBIRT

- S=screening
- BI=brief intervention
- RT=referral to treatment

- Being utilized widely in many settings.

Simple Screening Convention

Most initial screening instruments ask:

- Have you attempted recently to cut down or control your use?
- Has anyone expressed concern about your drinking or drug use recently?

<u>Any yes response indicates likely problematic use.</u>

Assessment of Substance Use

Might persons ever minimize their reporting of alcohol/drug use? YES

So begin by asking and recording the person's response to the following:

"How much alcohol do you drink (or drugs do you use) in a typical week?"

DO NOT ASK-"Do you drink alcohol" or "Do you drink excessively, or "Is your drinking problematic."

Assessment of Substance Use

- For individuals stating any level of alcohol/drug use:
- “What types?”
- Ask for specific amounts and pattern.
- Ask if they would be willing to talk more about or consider a referral.
- Be sure to follow-up!

Brief Screening Tool-Adult (modified from CAGE)

In the past year:

C = Cutting down on substance use considered?

A =Annoyed by others who criticize your use?

G = Guilt felt about your substance use?

E = Eye openers necessary?

(1) yes response=AT RISK→ must ask about amount and frequency, etc.

(2) or more: CURRENT PROBLEM→ referral likely indicated.

(3) or more: DEPENDENCE (until ruled out) → immediate treatment likely indicated.

Youth Screening-CRAFFT

Part A:

During the PAST 12 MONTHS, did you:

1. Drink any alcohol (more than a few sips)?

Not counting sips of alcohol during family or religious events

2. Smoke any marijuana or hashish?

3. Use anything else to get high? (Includes illegal drugs, over the counter and prescription drugs, things that sniffed or "huffed")

Any yes answer- proceed to section B.

CRAFFT cont.

Part B:

1. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?

2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, fit in?

3. Do you ever use alcohol/drugs by yourself, or ALONE?

4. Do you ever FORGET things you did while using alcohol/drugs?

5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?

6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?

Scoring: 2 or more yes answers is positive; indicates need for additional assessment

Substance Use Disorder Diagnosis DSM-V

Diagnostic Criteria is usually met when:

a. substance use has led to significant impairment or distress and
b. (2) or more of the following have occurred in the last 12 month period:

1. Substance is taken in larger amounts or over a longer period of time than intended
2. There is a persistent desire or unsuccessful attempts to cut down
3. A great deal of time is spend obtaining, using, or recovering from the substance's effects
4. Craving, or a strong desire or urge to use the substance
5. Use has resulted in failure to fulfill a major role obligations at work, school, or home
6. Continued use despite having recurring social or interpersonal problems caused or exasperated by the substance use
7. Important social, occupational, or recreational activities are given up or reduced because of the use
8. Substance is used in situations when it is physically hazardous
9. Use is continued despite having physical or psychological problems likely caused by the use
10. Tolerance (need to use more to achieve desired effect or marked diminished effect when using same amount
11. Withdrawal effects (or use of a similar substance to avoid withdrawal effect)

Severity in most cases is based on the following:

2-3 symptoms=mild
4-5 symptoms=moderate
6 or more symptoms=severe

Diagnosis is made by:
Naming the code, followed by the severity, and then the specific substance in the class of substance.
For example: 304.00 moderate *heroin* use disorder.

Also included is Non-Substance Related Disorders:

Gambling Disorder 312.31

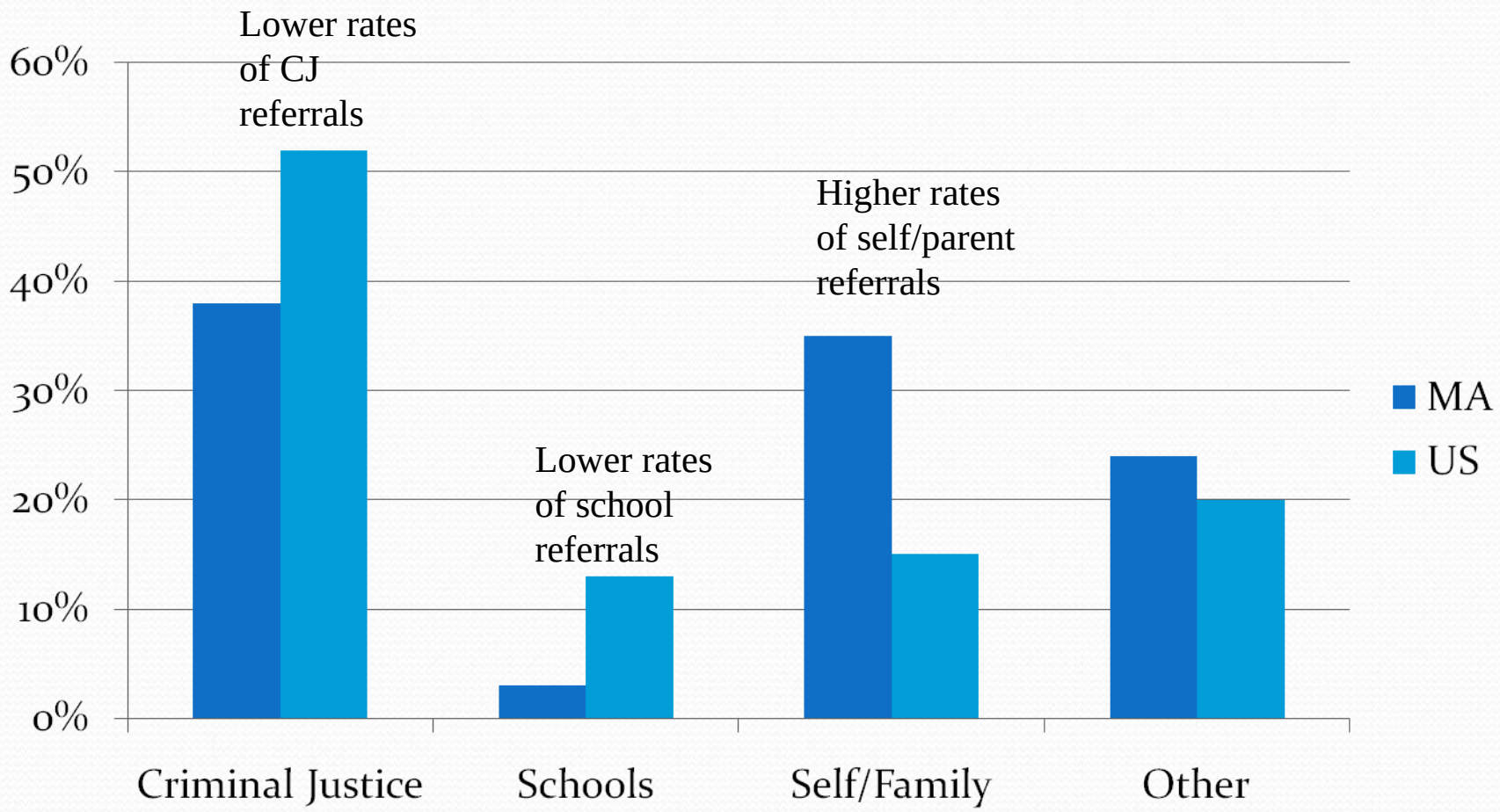
Conduct Functional Analysis

- See Workbook

Treatment Systems

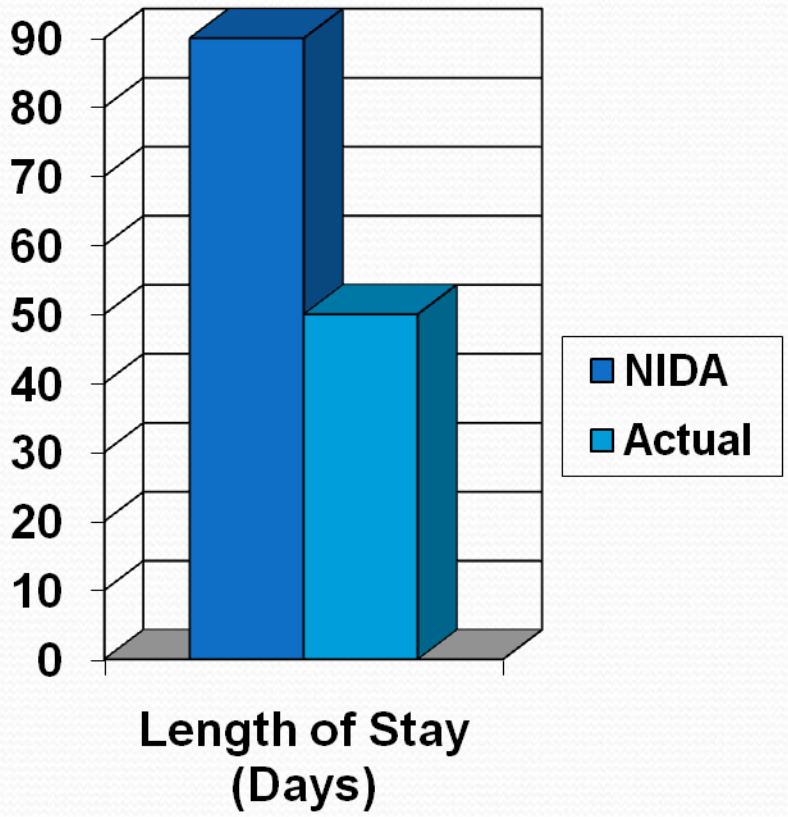
- Less than 1 in 10 adolescents with substance use disorders receive treatment
- However, Massachusetts has 13% more admissions for 15-19 year olds than national average (MassChip)
- Over 88% treated in the public system

Referral Sources



Source: Dennis, 2007

Most Clients do not Remain in Treatment for the Recommended Amount of Time



- Average length of stay across all service types is 50 days
- Minimum recommended time is 90 days
- Only 25% stay the 90+ days recommended

Dennis, 2007

Most do not Receive Continuing Care

- 53% of clients drop out or are terminated prior to completion (some “age out”)
- In fact, only 10% receive “step-down” or outpatient care following residential treatment – despite recommendation that this occur for all clients
- Within youth services many clients “age out.”

Key Points

- Courts, parents and schools must continue to find ways to share information and resources
- Engaging and retaining clients in treatment is critical

Engaging and retaining clients in treatment is critical

Treatment Access & Resources

- Review of key resources
- Complete pages 17-18 in Workbook

Motivational Interviewing

Overview & Brief Practice

Motivational Interviewing

How is it useful when working with adolescents in addiction treatment settings?

Adolescents are often highly ambivalent about:

- Treatment/remaining in treatment
- Reducing or stopping their drug use
- Addressing other harmful behaviors

- MI works with clients in a way that does not evoke resistance (e.g. getting confrontational, labeling, etc.).

Motivational Interviewing

A person-centered, directive method for enhancing internal motivation to change and resolving ambivalence.

It helps to get people unstuck.

Introduction

- Originally developed to address substance use disorders
- Has been found to be effective across a wide range of behaviors; (reducing problem drinking, gambling, and HIV risk behaviors)
- Also found effective in promoting exercise, diet, medication adherence
- Generalizable to many processes of human behavior.

Goal

To help people who are conflicted about their behavior to change, while not evoking resistance (e.g., getting confrontational, blaming, labeling)

Studies have shown that confrontational approaches can actually make people less likely to change.

Motivational Interviewing

Helps people to:

- Explore their ambivalence
- Appreciate the disadvantages of the status quo
- See the advantages of change
- Feel optimistic about the possibility of changing
- Desire, prepare for and move toward change

What Triggers Change?

Often includes life consequences and/or dissatisfaction with the status quo…however…

…part of the person wants to continue to do what he or she has always been doing….

…and another part wants things to be different.

Stages of Change

- ***MI considers the stage of change that the person is in***; suggests that we tailor our interventions to the person's readiness to change.

- MI is specifically designed to be used when people are in the early stages of change.

Stages of Change

Pre-contemplation> explore likes/dislikes of the current situation

Contemplation> build commitment to change/increase discrepancy between the current behavior and the person's goals/values

Preparation> create a plan for change…and discuss what to expect

Action> implement the plan

Maintenance>monitor

Relapse>may occur and result in return to a previous stage

Pre-contemplation

The client is not really considering change: seeks treatment or change due to outside pressures such as family, legal, or social services, for instance.

Tasks:

- Raise doubt about the harmful effects of the behavior that is concerning us
- Increase the perception of risks and problems that will result from continuing the behavior

How to Begin a Conversation

Raise a concern: ask permission to the discuss topic. Explain that you are not looking for immediate change or action per se.

"I wonder if it would be ok with you if we talked about why you are in so much trouble right now?"

"I wonder if it would be ok with you if we talked about your drinking habits for a minute?"

"I'd like to get a better idea of how you feel about your being on probation, and don't worry, I'm not going to lecture you, ok?"

Contemplation

The person seesaws between considering and rejecting change.

Tasks:

- Show interest in how the behavior has affected an area of the person's life (maintain a spirit of curiosity)
- Evoke from the person possible reasons to change, and the risks of not changing

Preparation

- The client appears committed to change in the near future but is still considering what and how to do it.

Tasks:

- Clarify goals and strategies
- Offer up a menu of choices

Action ► Maintenence ► Relapse

- Once the person is in action, MI is not used in the same way, but may be re-introduced as needed.

This means:

- We can work with people who are not particularly motivated to change
- We can work with people at any stage of change they are at
- We must discover what really matters to people and what behaviors prevent them from getting what they truly value.

Never say:

- This person is so unmotivated!

  Always try to figure out:

  What is this person motivated for?
  What is important to this person?

Four Principles of Motivational Interviewing

1. *Express Empathy*.

   Seek to understand where the person is, without judgment and through reflections/affirmations, etc.

   This doesn't mean that you necessarily endorse the person's position, but that you completely and totally understand where they are at and how they feel.

   You want to understand the person's perspective reflect that they know that you know it. Skillful reflective listening goes with being empathic.

Empathic listening is essential to minimizing resistance

- *Empathy is one of the most important elements of motivational interviewing*; **high levels of empathy during treatment have been shown to be associated with positive treatment outcomes across different types of psychotherapy.**

Express Empathy

This is the first, and perhaps most important, principle of MI. Listen closely and then reflect back to the person what they have said without adding anything. This is referred to as reflective listening.

Example: "Drinking relaxes me; it's what I look forward to after school."

Response: "It sounds like an important part of your day."

Example: "I wish people would just mind their own business!"

Response: "When people question you it really bothers you."

Reflective Listening

Reflective listening says:

- "I hear you."
- "I'm accepting, not judging you."
- "This is important."
- "Please tell me more."

It is NOT responding by: directing, warning, advising, persuading, agreeing, disagreeing, labeling.

Responding to Resistance

- *Simple reflection* – basically do not respond with resistance
- *Amplified reflection* – reflect back in an amplified way
- *Double sided reflection* – use *and*, not *but*…to point out both sides of the ambivalence

Examples of Reflections

- Simple: Client: I'm really not sure about what to do.
  Therapist: There is some confusion.

- Amplified: Client: I can't quit completely. What would my friends think?
  Therapist: It isn't even an option to quit.

- Double-Sided: Client: I know I'm a heroin addict but I am not convinced that I need to give up booze completely.
  Therapist: So you're sure that you have a problem with opiates and you are questioning your alcohol use a bit. Can you tell me more about what you are wondering about?

Accurate Empathy Practice

- Complete page 5 in Workbook

Practice

Simple Reflection: Client: ***"I haven't felt this overwhelmed in a long time…I feel like I'm losing my mind!"*** Therapist response:

_____

_____.

Amplified Reflection: Client: ***"I'm not sure why people are so concerned. It's not a big deal really."*** Therapist response:

_____

_____.

Double-Sided Reflection: Client: ***"I have thought about returning to AA, <u>but</u> I'm reluctant because of some of the things I've said to people in the program."*** Therapist response:

_____

_____.

Complex Reflections

- Amplified/Double-Sided Reflection:

Client: My kids aren't thrilled with my smoking pot, but after I put them to bed I don't see any problem with smoking weed. It's my life!

Therapist: On the one hand, your children are somewhat upset with you right now, and on the other you don't see any way at all that weed could possibly harm them.

Four Principles of Motivational Interviewing

2. *Develop Discrepancy.*

   Is intentionally directive and is directed toward the resolution of ambivalence in the service of change.

   You want to amplify from the person's perspective, a discrepancy between present behavior and broader goals.

   You want to magnify within the person the importance of change. By doing this, discrepancy, if increased, will override the inertia of the status quo.

Four Principles of Motivational Interviewing

2. *Develop Discrepancy* (continued).

When you hear a possible consequence expressed by the person, you have a slight opening and you want to open it up more. "it costs a lot of money" or "sometimes I spend too much"…"it has hurt relationships in the past"…or even something very small… "occasionally I missed work on a Monday due to drinking"…you can repeat it or say it back without using exact words (paraphrase)

Also review with people the pros and cons of what they are doing and the pros and cons of changing and doing something different…and see how the scale measures.

Developing Discrepancy

Involves exploring some part of the person's behavior that is not consistent with what is good for them… that they raise. This often occurs naturally through asking open ended questions. Must first uncover the person's priorities and values, as motivation comes from the discrepancy between current behavior and future goals.

Ask Open-Ended Questions

Notice that with closed ended questions you may not get very far…

Do you ever drink when you're lonely or upset? (Closed)

Does drinking help you feel better or sleep more easily? (Closed)

Start with the positive: “What are some other things you like about drinking?” (Open)

…then can ask: What are some things you don’t like about drinking? (Open)

How do you cope with being lonely and upset? (Open)

How do you feel the day after you have stop taking your medication? (Open)

What might work for you if you did decide to change? (Open)

How so?

Listen for the Word 'BUT'

The word 'but' often indicates some ambivalence or an opening for more conversation. For instance:

Example: "I know I'm smoking more than I should, but it relaxes me; it's what I look forward to at night." Then reflect back both sides of what the person is saying.

Response: "*On the one hand* you know it's not healthy, however *on the other hand* you do get something from it."

Frequently used Open-Ended Questions

"What worries do you have about your [behavior]?"

"What are you afraid might happen if things continue as they are?"

"What might be some advantages of changing your [behavior]?'

"What might be better for you if you did change your [behavior]?"

Example

- A person might say that smoking relaxes her, and a typical response might be “Can’t you think of something else that relaxes you?” or “You know smoking will destroy your lungs,” which puts the person on the defensive.
- A better, MI approach would be, “It would be hard to give up something that is relaxing. What would have to happen for you to consider quitting smoking?”

Four Principles of Motivational Interviewing

Key Point.

The person should present the arguments for change. Change is motivated by a perceived discrepancy between present behavior and important personal goals or values that the client has.

You want the person to get uncomfortable with the status-quo and what is happening.

Changing is always the person's decision and choice.

Four Principles of Motivational Interviewing

3. *Roll With Resistance (dancing vs. wrestling).*
   - Avoid arguing for change.
   - Resistance is not directly opposed
   - New perspectives are invited but not imposed.
   - Person is the primary resource in finding answers and solutions.
   - Resistance is a signal to respond differently.

Roll with Resistance

Basically refers to not continuing to suggest, challenge, etc. when "resistance is noticed." Resistance is actually seen as a problem with the helper's approach. It is a sign to slow down or back off; that the person is not ready, willing, or able to take in the information or respond as we envision.

Responding to Resistance

Always remember that humans like to have some choice and to be able to make their own decisions.

If people are told to do something, they will often resist it to maintain some sort of control.

The person must voice the argument for change – not us.

So we must help people while remembering the decision is *always* theirs!

Advice?

Because people don't like to be told what to do, ask permission before giving any advice, and (ideally) make sure you have established a good working relationship.

Give advice only when individuals will be receptive to it, and target advice to the stage of change the person is in.

Four Principles of Motivational Interviewing

4. *Support Self-Efficacy.*

The person's belief in his/her own ability to carry out and succeed in a specific task.

- In MI we must enhance the person's confidence in his or her ability to cope with obstacles and succeed. Often people have low confidence resulting from past perception of failure.

- A person's belief in the possibility of change is an important motivator. The person, not the helper, is responsible for choosing and carrying out the change.

Supporting Self-Efficacy

Refers to not necessarily presenting ourselves as the expert in another person's life. Let them "lead the way" whenever possible and work to increase a person's confidence in their ability to change while recognizing their change efforts. Involves affirming…

"You are very courageous to be so revealing about this."

"You've accomplished a lot in a short time."

Building Motivation for Change

- What not to do.
  - Don't ask yes and no questions.
  - Don't take sides.
  - Don't be an expert.
  - Don't label.
  - Premature focus trap.
- What to do.
  - **OARS** –
  - Ask open ended questions
  - Affirm
  - Reflective listening
  - Summarize

Some Ideas

- Ask: How important is it for you to .....?
  How confident are you, if you decided to do...that you could do it?

- *Importance Ruler*: On a scale of 0-10, how important is it for you to change now? If the person states that they are at a 6 on 0-10 scale, ask "why are you at a 6 and not a 0 or 2?"...Not "why are you not at a 7 and not a 10?"
  Can ask: "What would have to happen to go from 6 to an 8?"

- *Explore the decisional balance* and have them talk about the pros and cons of present circumstances.

- *Elaborate:* How so? In what ways? Why do you say that? <u>Get specific examples.</u>

Readiness Ruler

- What is it you are thinking of or looking to change: _____.
- Are you not prepared to change, already changing or somewhere in the middle?

Not prepared to change Already changing

0 1 2 3 4 5 6 7 8 9 10

Exercise

- Something about yourself that you want to change, need to change, should change, have been thinking about changing, but you haven't changed yet (i.e. – something you're ambivalent about).
- Listen carefully with a goal of understanding the dilemma; give no advice.
- Ask these four open questions:

Exercise

- Why would you want to make this change?
- How might you go about it, in order to succeed?
- What are the three best reasons for you to do it?
- On a scale from 0 to 10, how important would you say that it is for you to make this change?
- Follow-up: And why are you at ___ and not zero?
- Give a short summary/reflection-
- Then ask: "So what do you think you'll do?" and just listen with interest.

Some Other Ideas

- *Querying extremes:*
  - What concerns you most about--?
  - If you continue this way, what are the worst things that could happen to you?
  - Also, if you change…what would be the really good things about it?
  - If you are successful, how would things be different?
- *Looking forward*
  - If you change, how might things be different for you?
  - If you don't make changes, how do you see your life in 10 years?
- *What things are most important to you?* Does _____ compromise that or impact on it?

What is Change Talk?

The person verbalizes disadvantages of the status quo.

The person verbalizes advantages of change.

The person expresses optimism about change.

The person expresses intention to change.

Responding to Change Talk

- *Elaborate*—when a person expresses an interest in changing or concern about the status-quo, you want to show interest and ask for elaboration. Say things like:
  - In what ways? How so? Give me an example. How come? What's so bad about that? Are there other reasons why you want to change? Do you have other concerns about your current behavior?
- *Reflect*—reflecting change talk helps to elicit further elaboration and exploration. Paraphrase what the client said.

Responding to Change Talk

- *Summarize*—what the person has stated, with their ambivalence, but moves them toward change….

- *Affirm*—by commenting positively on the person's plans to change.

Notice the Strength of Commitment Language

HIGH

- – I will / promise / swear / guarantee
- – I intend to / agree to / am ready to
- – I plan / expect / resolve / aim to
- – I hope to / will try to / will see about /
- – I guess / think / suppose I will

LOW

Enhancing Confidence

- *Brainstorm about plans that could work*…and then pick the ones that stick out the most…and you can sometimes give advice and suggestions based upon your experience.

- *Hypothetical change* – if you did succeed, how did you think you did it? Why did it work? If the big obstacle wasn't there, how would you go about doing it?

Enhancing Confidence

- How might you go about making this change?
- Inquire about past successes and how they did it?
  How else could you do it?
- Confidence ruler can be good –
- Inquire about personal strengths and resources – have you ever wondered if you could do something, you put your mind to it, and you did it?

Responding to Change Talk-Low Confidence

- *Shift focus* – shift the person's attention away from what seems to be a stumbling block.

- *Reframe and help the client to see things differently* – I have tried so many times and failed…can be reframed:
  - Failures are at least trys.
  - A limited success is still a success.
  - I can't do it can be reframed as maybe you weren't ready last time.

- *Emphasize personal control and choice.*

Contemplation to Preparation:

- Ensure that ample time is given to explore the reasons someone wants to change
- Discuss anticipating challenges
- Reinforce their decision to initiate healthier choices

Resolution of Ambivalence

- Ask if there is something…even a small step towards change that they would like to commit to
- Don’t be surprised if the person wishes to move back to contemplation…be patient!

Once a Commitment is Achieved

- Ambivalence doesn't go away so don't push too hard…give people time to think about it…
- Don't over-prescribe treatment…
- Can give advice and suggestions, but with the person's permission or when asked for…

Once a Commitment is Achieved

- *What to do…in directing client toward action*
  - Can re-summarize.
  - And ask some key questions – what do you think you want to do now? Where do we go from here? So what's the next step for you? What would be a good place to start?
  - It is always in their court, so get their input!
  - Insure that goal is their goal.
  - Can suggest some thoughts and ideas and ask: "What do you think will work for you?"

Summary

- Resistance is indicative of poor treatment/change outcomes
- We do not want to create more resistance; yet we easily can if not careful
- When resistance is encountered, change strategies

Summary

- Use reflective listening
- Ask the person to describe the issue- “what concerns you about __”
- Accentuate how current behavior undermines what the person truly values
- Clarify goals (if possible)
- Affirm- “you already have some good ideas about change”

Summary

- Move towards change planning
- Ask- “where do you think you want to go from here?”
- Don’t prescribe (or overprescribe) specific strategies…let the person decide
- Explore possible barriers to achieving goals
- MI techniques not so important once “scales have tipped” in the action stage of change

Conclusion

- Careful listening and reflecting is central to MI; this minimizes resistance.

- Recognizing and responding to change talk is critical to MI practice-and includes directing the person toward goal clarification.

Principles of Harm Reduction

- No wrong door to recovery
- Assertive approaches to outreach and early intervention
- Use of strengths-based assessment protocols
- Focused retention strategies; persons do not need to be alcohol/drug free to be in care
- Expanded menu of professional and peer recovery support services
- Opportunities for community engagement/service

Paradoxical Type Interventions

- Use of *amplified reflections* such as, "*So there are literally no negative things about your substance use*." CAUTION-don't overuse these!
- 'Guru Question,' "*Imagine you are a wise, enlightened person who was faced with giving advice to someone just like yourself; what advice would you give them*?"
- Statements such as, "*It could be challenging to make decisions that will benefit you in the long term*!"

Values Clarification

- Ask "*What regrets (if any) do you have related to past decisions and substance use*?"
- Ask "*What types of things do you value more than substance use*?"
- Ask "*If you imagine a better future; what would this look like*?"
- Ask "*What interests do you have that you would like to pursue*?"
- Ask "*What long-term goals do you have*? *How might substance use negatively affect your long-term goals*?"

Helping Youth Discover & Clarify Values (Identity)

- *"What do you feel is unique and distinct about you?*
  "How might your friends describe you?
  "Is this how you see yourself?"

- *"What types of things do you think you are leaning toward in terms of who you want to become?"*
  "Are you working toward these goals now?"

Individualized Treatment

- Understand youth stressors
- Understand how substance use is reinforced within their social-emotional context
- What opportunities exist to fulfill/replace the legitimate needs that substance use serves (help youth adopt healthier alternatives to coping)?

Adolescent Community Reinforcement Approach

In Practice

Adolescent Treatment Research & Approaches

- Prior to 1997- only a handful of studies
- Need for further research was spurred by a 53% increase in admissions (1992-1998)
- 115% increase in clients presenting for marijuana use disorders- and virtually no research on this group

Adolescent Treatment Research & Approaches

- Cannabis Youth Treatment Project (CYT)
- Studied 12-18 year olds with symptoms of cannabis use
- Outpatient settings nationwide- largest study to date
- 5 manual driven interventions were tested

Cannabis Youth Treatment Project Modules

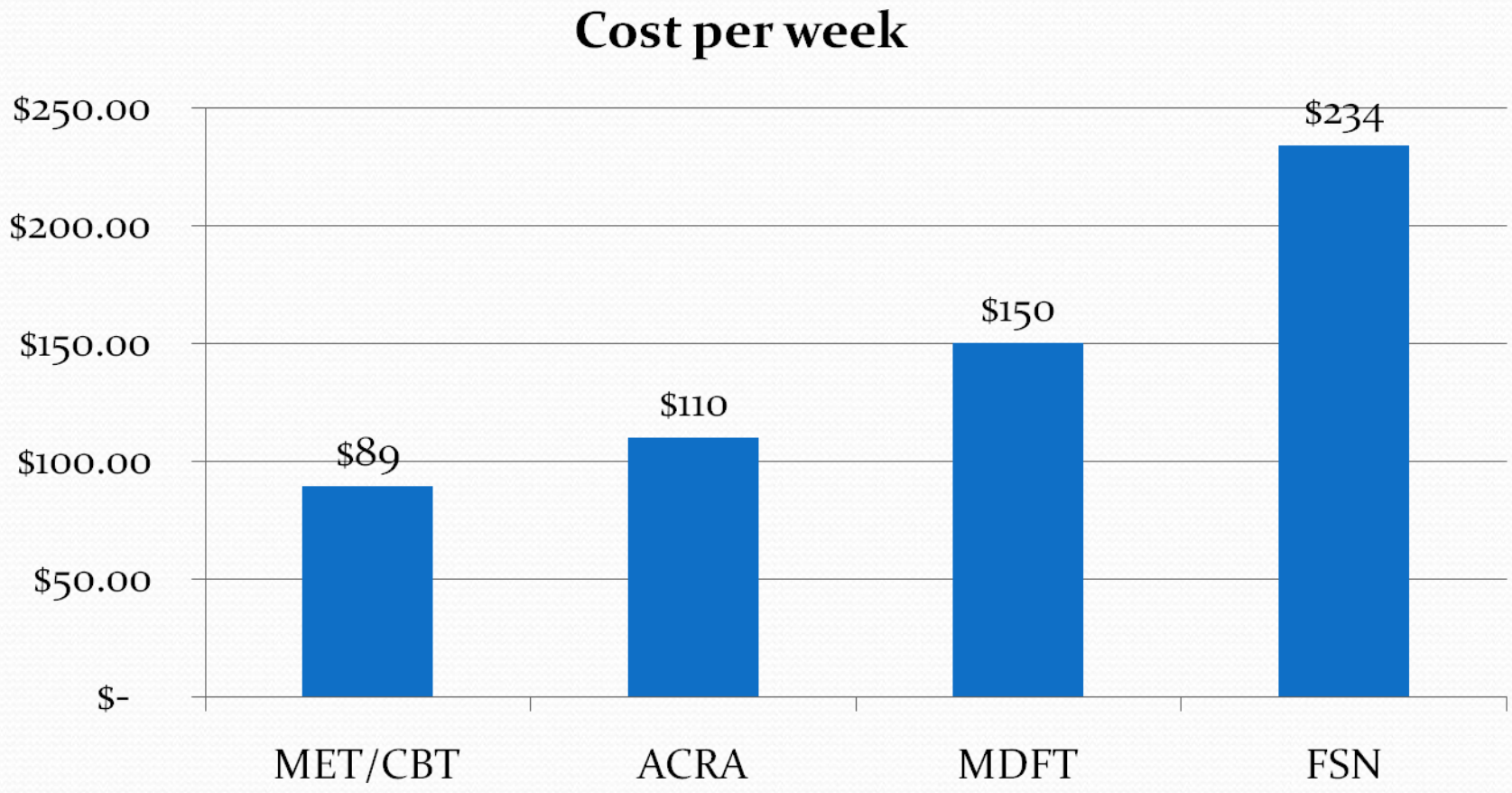
- Motivational Enhancement Therapy and Cognitive Behavioral Therapy (MET/CBT5)
- MET/CBT7
- Family Support Network (FSN)
- Multidimensional Family Therapy (MDFT)
- Adolescent Community Reinforcement Approach (ACRA)

At least 150 agencies nationwide have implemented A-CRA in their programs.

Outcomes

- Similar across interventions
- Reduced substance use by 35%
- Reduced recidivism from 40% to 29%
- Reductions in other key measures

Cost Effectiveness



Adapted from Dennis, 2005

ACRA Treatment Structure

- 10 individual sessions with the adolescent

- 4 sessions designed to engage the caregiver
  -2 individual sessions with the caregiver
  -2 sessions with the caregiver and adolescent

Clinician prerequisites:

- Comfort level with motivational and behavioral therapies (not overly “confrontational” or cognitive in approach)
- Masters or Bachelors degree in counseling, social work or health science field preferred
- Experience working with difficult client populations
- At least rudimentary knowledge of developmental stage theory
- Substance abuse counseling experience

Formal Training Requirements

- 3.5 Day intensive with developers of the model (Chestnut Health Systems) and knowledge test at completion
- Ability to upload digital audio taping of sessions for review by expert raters
- Commit to weekly individual supervision and bi-weekly conference calls (group supervision)
- About 6 month process in all.

Key Concepts

- Positive and enthusiastic approach
- Uses lay language (keeps it simple)
- Flexible
- Uses role-play
- Uses homework
- Incorporates principles from motivational, behavioral, and social systems theories

Key ACRA Tools/Procedures

- Functional Analysis
- Sobriety Sampling
- Systematic Encouragement
- Happiness Scale

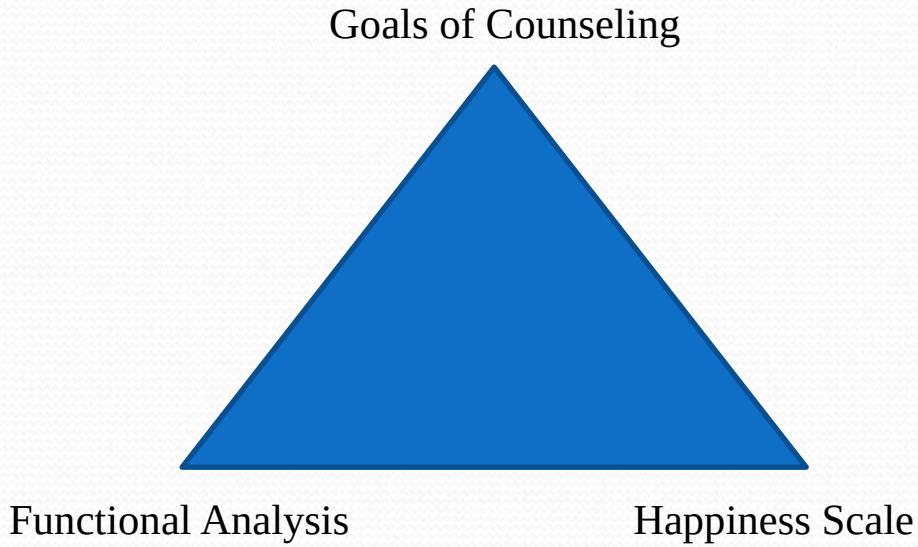
Relapse Prevention and Skill Building

- Connecting the client to new activities
- Role playing refusal skills
- Role playing effective communication
- Brainstorming realistic alternatives to try (problem solving)
- “Behavioral” experiments (homework) assigned during each session

A-CRA Targets Major Risk Factors

- Poor social skills- through positive approach and various communication skills exercises (positive relationships)
- Substance using peers- through connecting youth with new activities in the community (hobbies)

The ACRA Triangle



- Goals are determined by the Functional Analysis and Happiness Scale
- Completed during assessment process and revisited frequently (approximately every 2 weeks)

Source: CYT Volume 4, 2001

Functional Analysis

- Conducted for Substance Use and Pro-social Activities
- Detailed exercise used to identify specific context and reinforcers related to behavior

Functional Analysis

- External triggers
- Internal triggers
- Behavior: what, how much, for how long
- Short-term positive consequences
- Long-term negative consequences

*Conducted in above order

Happiness Scale

- Detailed assessment of client's satisfaction with 16 major life areas using a 1-10 rating scale

-drug use/non-use
-relationships
-school
-hobbies
-legal issues
-money management
-emotional life
-communication

Happiness Scale

- Client rates areas based upon how happy they are on the day it is completed
- Therapist begins by focusing on 1 or 2 high rated areas
- Client identifies areas they would like to improve
- Leads naturally into problem solving, communication or role play exercises

Other Core Sessions (relapse prevention and skill building)

- Actively connecting the client to new activities (pro-social encouragement)
- Role playing refusal skills (relapse prevention)
- Role playing effective communication
- Brainstorming and then selecting realistic alternatives to try (problem solving)
- "Behavioral" experiments (homework) assigned during each session

Vignette #2

- Communication Skills (see ACRA specific packet)

Review Handouts

- Daily ‘Reminder to be Nice’
- Sample behavior contracts (Family Support Network)

Other Interventions Incorporated (as needed)

- Urine testing
- Anger management
- Job seeking skills
- Sobriety Sampling

Urine Screening

Drug	Approximate Detection Time in Urine Samples (up to)
Alcohol	12-24 hours
Cocaine & Amphetamines	3 days
Hallucinogenics (LSD, Ecstasy)	3 days
Opiates	3 days
PCP	3 days (casual use), 3 weeks (heavy use)
Sedatives (Benzodiazepines & Barbiturates)	3 days (casual use), 3 weeks (heavy use)
Cannabis	3-30 days (depends on level of use, chronic use longer)

Above is general guidance only based upon much training, experience, and many sources.
Urine test kits can range widely in price from $10-$50. Hair follicle tests can cost as much as $200.

Sessions Targeting Caregivers

- Session 1:

- Promotion of critical parenting practices

a. Not using substances in front of client

b. Reducing blame

c. Giving positive feedback

d. Monitoring behavior

e. Staying involved

- Session 2:

- Review importance of staying positive/not blaming

- Review effective communication and role play a scenario

- Assign homework

Sessions Targeting Adolescent and Caregiver

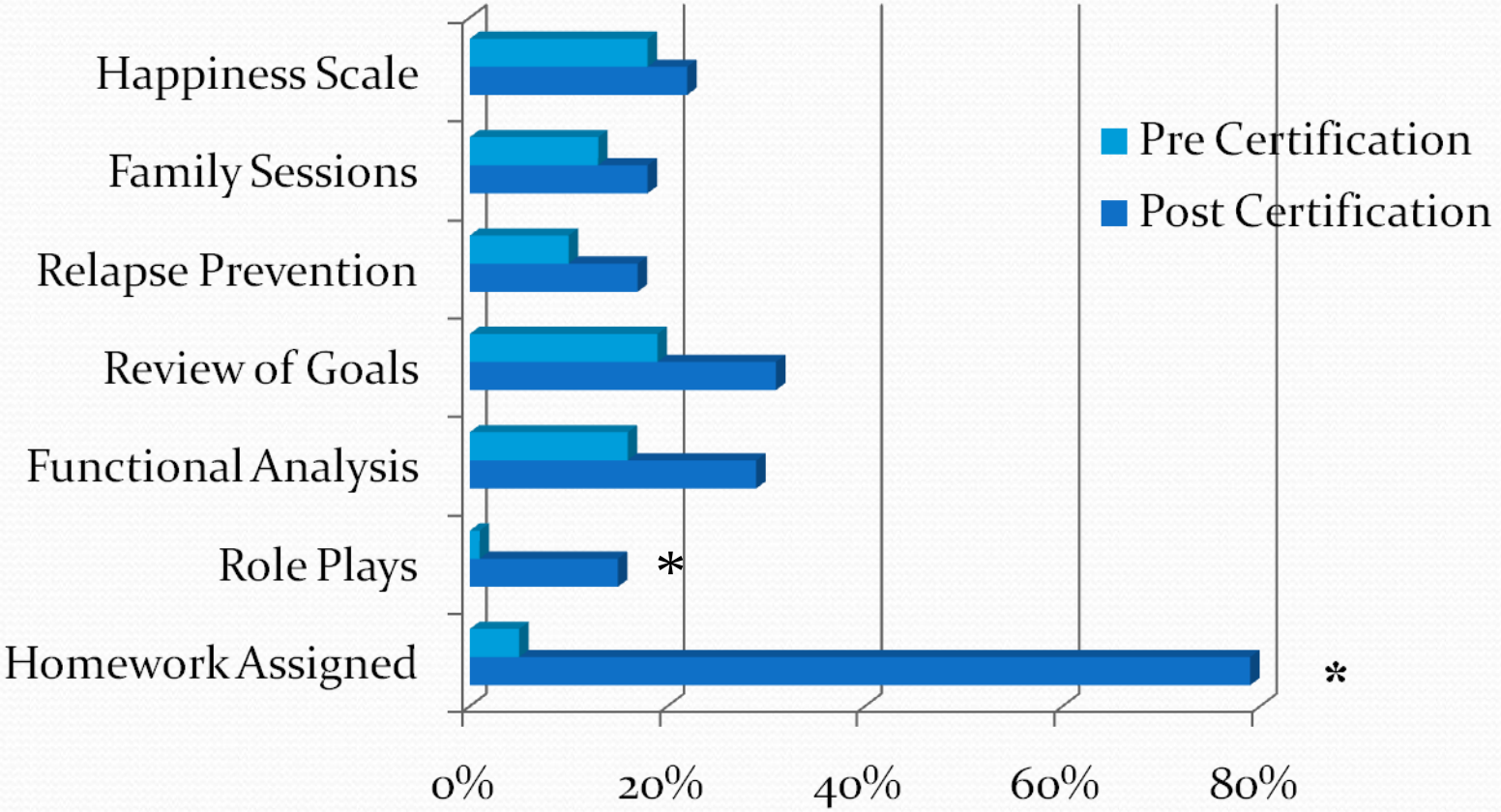
- Session 1:
- Reinforce positive efforts made by both
- "3 positive things" exercise
- Review communication skills
- Role play
- Assign task of saying positive things about each other daily

- Session 2:
- Complete happiness scales
- Continue work on communications skills
- Continue role plays based on needs
- Assign homework

Clinician Responses to Manualized Treatment and ACRA

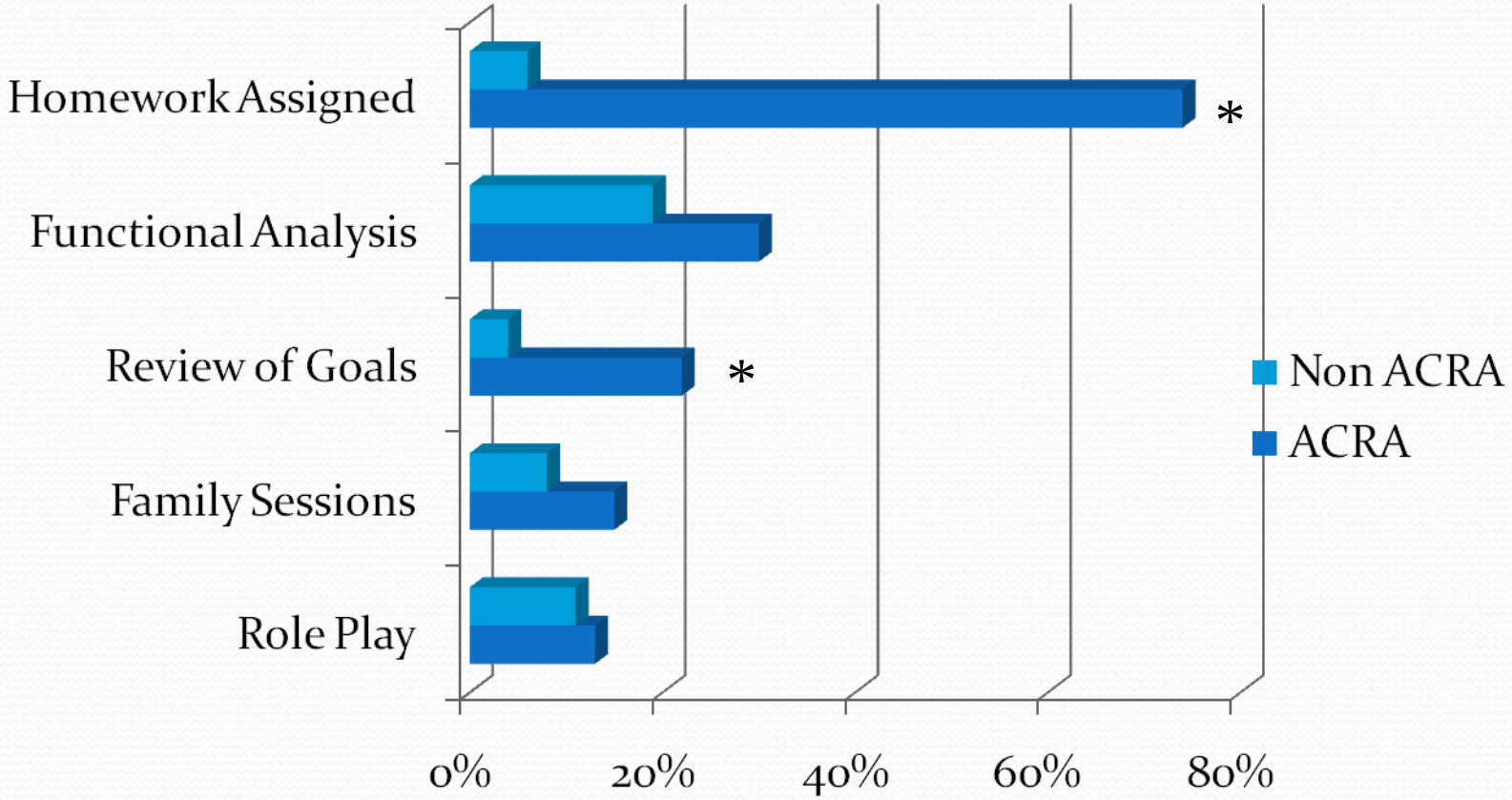
Pros	Cons
- Helps provide clinical focus in sessions - Flexible enough to individualize to clients - Allows for "check-in" time at beginning of session	- Some terms (i.e. happiness scale) seem odd - Doesn't always "meld" with clinicians approach - Requires role-plays which are challenging to conduct in distracting settings

In Session Clinical Techniques

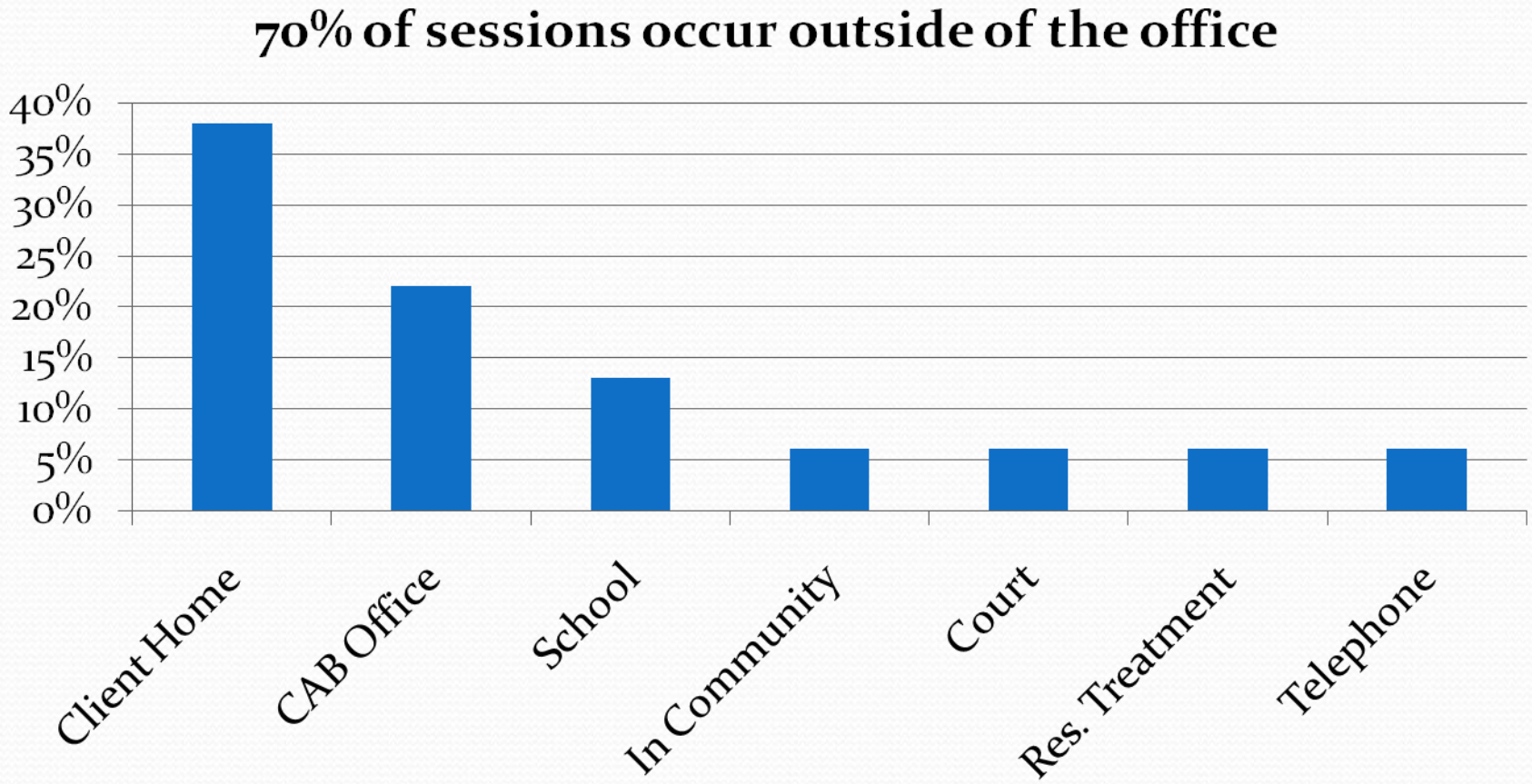


Clinical Intervention Comparison

ACRA Certified vs. Non-Certified



Where Sessions Occurred



Implementation Challenges

- Initial associated cost (grant made absorbing this much easier)
- Although ACRA model is designed to be flexible, training constraints cannot adequately address this
- Research language can be an issue- “procedure” vs. “intervention”- staff need to connect with the model
- Ongoing supervision to address issues of “drift”
- Connecting lower income youth to school-based, community-based or faith-based related activities

Implementation Challenges

- Engaging parents and caregivers (increasing caseload)
- Finding a balance between sanctions and positive reinforcement with legally involved youth
- Engaging adolescents in a group setting*
- Ongoing funding for meaningful incentives*
- Staff turnover*

*Not ACRA specific

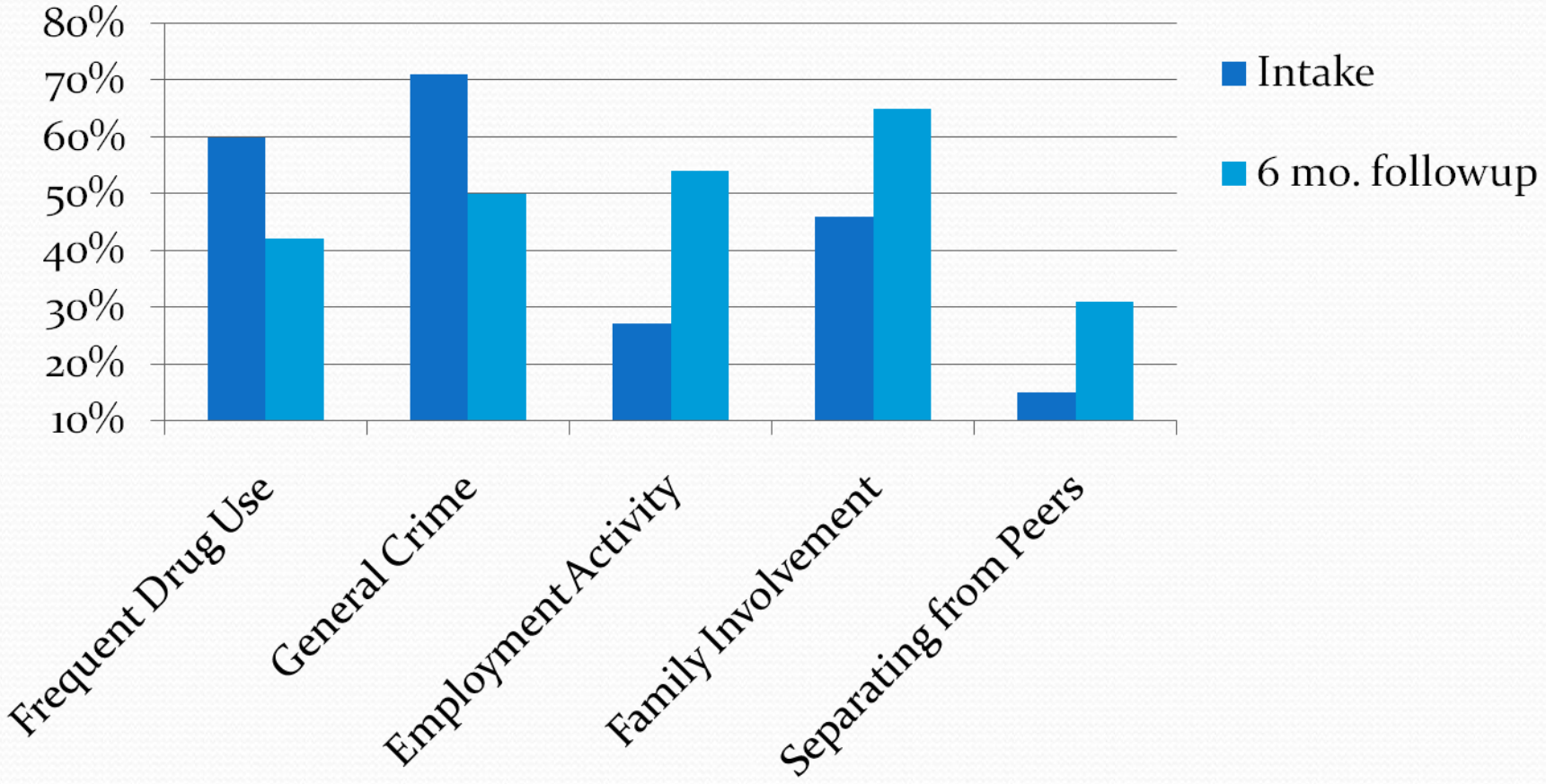
Implementation Successes

- Youth respond to positive reinforcement and welcome help in connecting to new resources
- Clinicians have increased skill in choosing specific interventions to meet the needs of our clients
- Clinicians have increased comfort with/use of role playing and more consistently review treatment goals and assign “homework” to shape behavior change

Implementation Successes

- The ACRA model fits nicely with the drug court which also places great emphasis on praising the efforts of youth
- Consistent collection of multiple data sets is helping to identify needs and opportunities for improvement
- Less than 10% no-show rates for appointments (meeting majority of clients and caregivers at home or in community)

Intake to 6 month Follow-up



Next Steps- Considerations for Communities and Practitioners

- Insure that multiple affiliations are in place if you hope to make a lasting impact on youth

- Spend time selecting the best interventions you can practically carry out and supervise appropriately or select core principles from EBPs and integrate into existing programming

- Consider that engaging clients in services should have greater or equal weight to high expectations around change at first

Considerations for Communities and Practitioners

- Remember that positive outcomes in substance use, legal and academic realms are mediated by the number of extracurricular activities adolescents are involved with and length of time in treatment

- Involve parents and other caregivers- teach them about motivational incentives and ways to leverage these- as this is a promising practice

Conclusion / Summary

- Matters less what level of care client is in (i.e. outpatient vs. residential) than the duration of care and ongoing follow-up
- Often in order to engage and help adolescents we need to work harder than they do (at least at first)
- Evidence Based Practices should be utilized as much as possible, however they only are part of the solution

Conclusion / Summary

- Research, practitioners, and managed care companies are beginning to take seriously the notion of continuing care (i.e. “recovery checkups”)

- Families are doing a good job of referring clients into treatment, however courts and schools can do better

- Treatment programs in conjunction with the community must continue to explore innovative ways to keep adolescents engaged in treatment- two thirds of clients are still struggling after 12 months of treatment

Resources Related to Presentation

- Northeast Behavioral Health/Lahey Health Behavioral Services (formerly CAB Health & Recovery Services)- provides a full continuum of treatment options for adolescents and their families- 1-978-968-1700 www.nebhealth.org
- Cannabis Youth Treatment Series- can be retrieved/ordered through SAMHSA's National Clearinghouse 1-800-729-6686 or http://store.samhsa.gov/home
- Chestnut Health Systems- presentation links and adolescent related research- www.chestnut.org
- National Institute on Drug Abuse- www.drugabuse.gov

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