Precourse Training

How to Deliver Brief and Effective Treatment for Youth/Young Adults using Motivational and Cognitive Therapy"
MET & CBT

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Evidence Based Solutions
Thank You NADCP, NDCI, OJJDP & CSAT!!

Pre-course Topics

Adolescent & Young Adult

- Development
- Brains/Drugs/Rewards
- Recovery Essentials
- Evidence Base Treatment
- Structured Treatment
- Collaborating & Building Rapport

The changing teenage brain

Adolescent Development

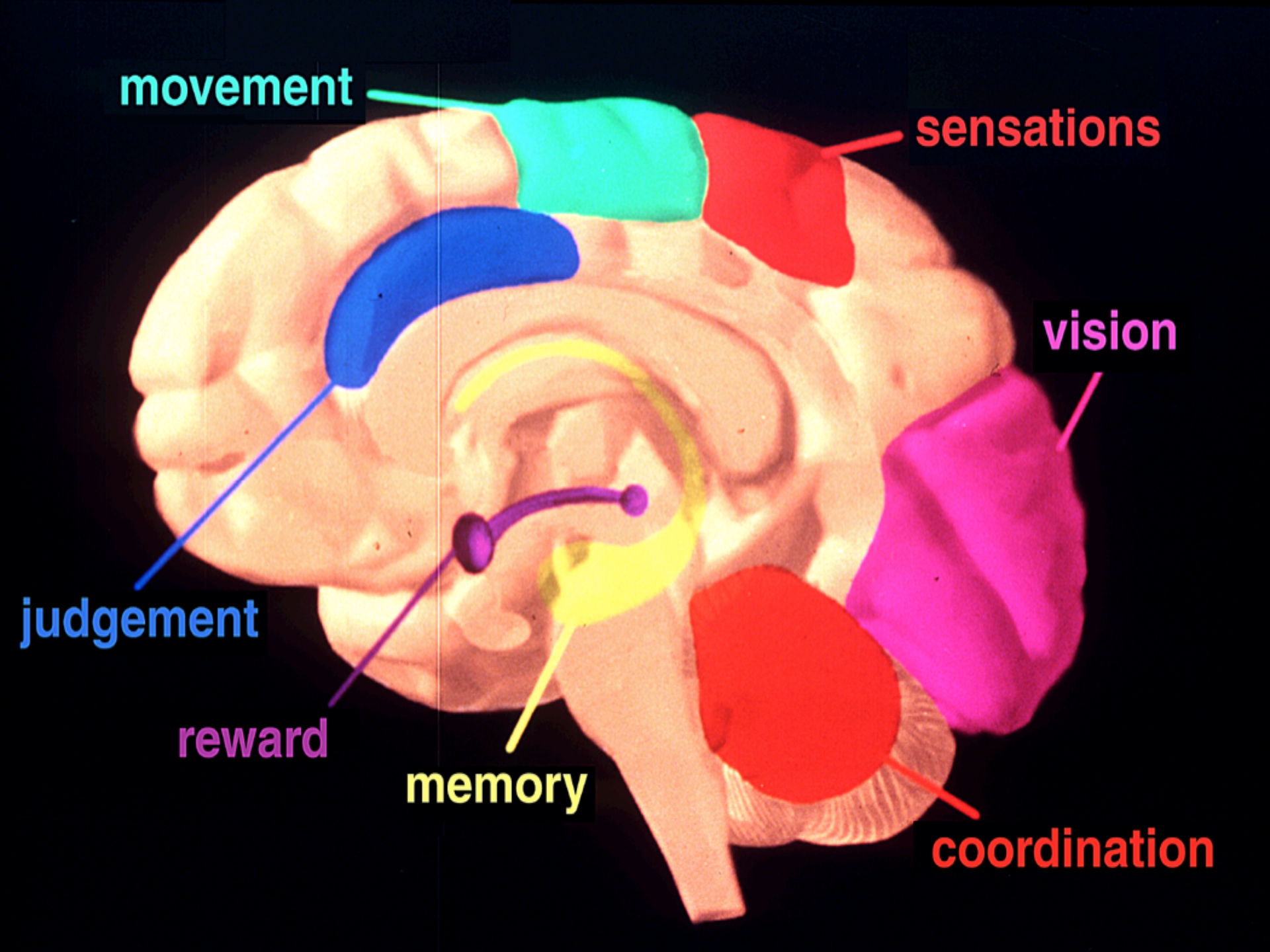
- New science of development – risk taking, affects of substances, and the primary importance of frontal lobes to help inhibit impulse
- Researchers are creating a new understanding for the stages of life –
- 0 – 25yrs. for a fully functioning cerebral cortex.

Resources

- Aaron White - Duke University
- Susan Tapert, Greg Brown - UCSD Linda Spear – SUNY Binghamton
- Jay Giedd – National Institute of Health
- Cynthia Berthea – Oregon Primate Center
- Nora Volkow – NIDA
- Alan Booth – Pennsylvania State University
- Elizabeth Bates – UCSD
- John Mazziota – UCLA
- Chuck Nelson – University of Minnesota
- Scott Swartzwelder – Duke University

Adolescence

- Transition from childhood (dependence) to adulthood (independence)
- Characterized by a collection of brain, hormonal, physical, and behavioral changes that help prepare one to survive outside the nuclear family
- Increase time with peers
- Increase risk seeking/novelty sensation
- Increase in family conflicts
- Puberty (sexual maturation)
- Significant Brain Changes : 10-25 years of age

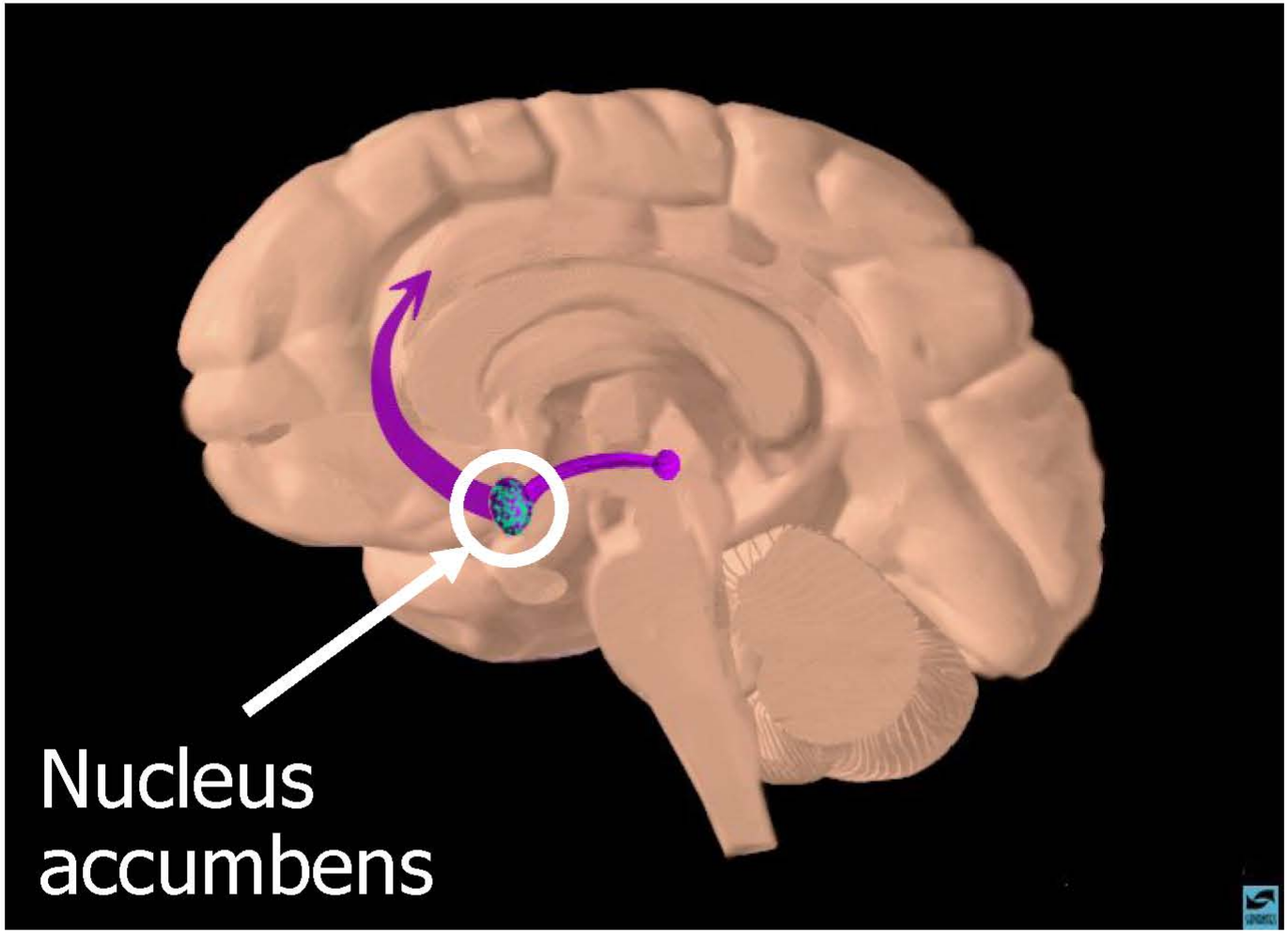

movement
sensations
vision
judgement
reward
memory
coordination

Progression of brain development

- Back to front development results in:
  - Preference for physical activity
  - Less than optimal planning and judgment
  - Impulsive behaviors (more risky)
  - Minimal consideration of negative consequences

Winters, K. (April 23, 2009). Teenage brain development: Implications for preventing drug abuse. PIRE teleconference.

The reward system



Teens often get less pleasure from daily activities

Tale of Two Systems

Socio-emotional system

- Responsible for processing emotions, social information, reward and punishment
- Changes result in:
  - Increased/easier emotional arousal (both positive and negative emotions)
  - Increased attentiveness to social information
  - Increased desire for rewards
  - Increased sensation-seeking

Steinberg, 2007, New Research on Adolescent Development: Implications for Substance Abuse Prevention and Treatment. JMATE Plenary Address

Timing is everything

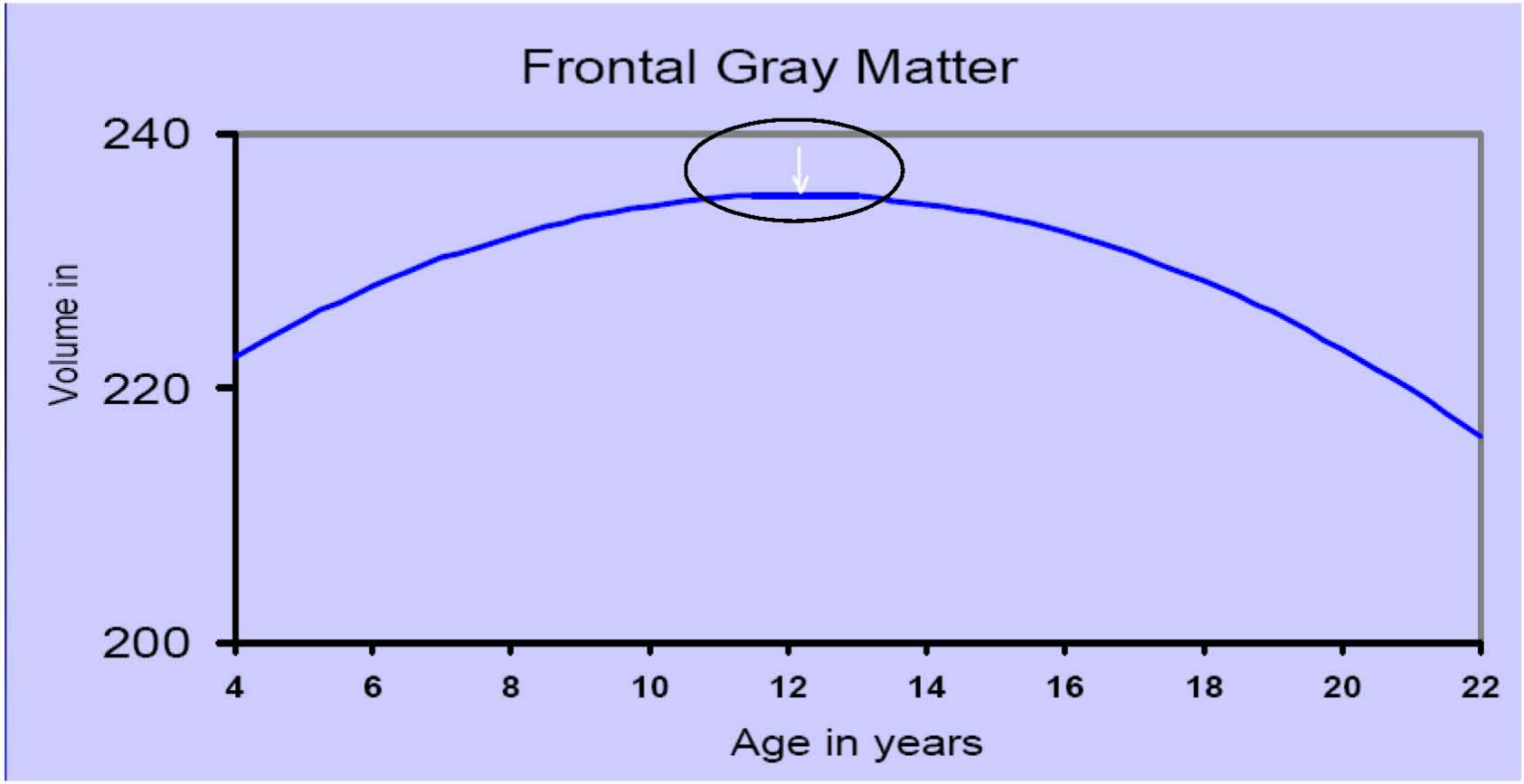
- The excitation of the socio-emotional system occurs early in adolescence, around puberty
- This excitation affects reward-seeking behavior
- Some evidence that adolescents need "more" of a reward to experience the same level of "rewardingness"
- Greater drive toward more intense rewarding experiences (including sex and drugs)
- Stronger feelings of negative emotion when rewards not forthcoming (implications for depression)

Steinberg, 2007, New Research on Adolescent Development: Implications for Substance Abuse Prevention and Treatment. JMATE Plenary Address

Frontal lobes

- Planning, decision-making, impulse control, memory, language, attention, and more
- Work by Dr. Jay Geidd at NIH indicates that the frontal lobes are Seriously remodeled during adolescence

Frontal lobe development



Gray matter levels peak at 11 or 12 and then decline as the brain wires itself based on experiences during adolescence

Cognitive control system

- Changes result in:
  - Better emotion regulation
  - More foresight & planning ahead
  - Better reasoning
  - More impulse control
    - Learn through imitation
    - Brain can inhibit inappropriate imitation
    - Relies on working memory to do so
    - Working Memory within Prefrontal Cortex
- Development is progressive inhibition!

Cognitive control system: Adolescents vs. Adults

- By mid-adolescence, adult levels of cognitive control can become evident
- Mature use of working memory not evident until late adolescence
- Adolescents rely primarily on more primitive wired brain areas and the nonmature prefontal area
- Adults rely on prefrontal, hippocampus, promotor cortex – freeing up prefrontal to use reasoning, judgment, other functions
- Adolescents more vulnerable to lack of cognitive control

Population Background

Adolescence Use Prevalence

Illicit Drug Use

- 21% of 8th graders
- 36% of 10th graders
- 48% of 12th graders

Once in lifetime

Prescription misuse:
highest rate so far
2.6% - 4.4% in H.S.

MTFS 2006

Alcohol

- 6% of 8th graders
- 19% 10th graders
- 30% of 12th graders

Drunkenness in month prior

Young Adult Use Prevalence

Illicit Drug Use

- 21% use illicit drugs
- 19% of use marijuana
- 4.8% use Psychotherapeutics
- 3.3% Pain Relievers

NSDUH 2013

Alcohol

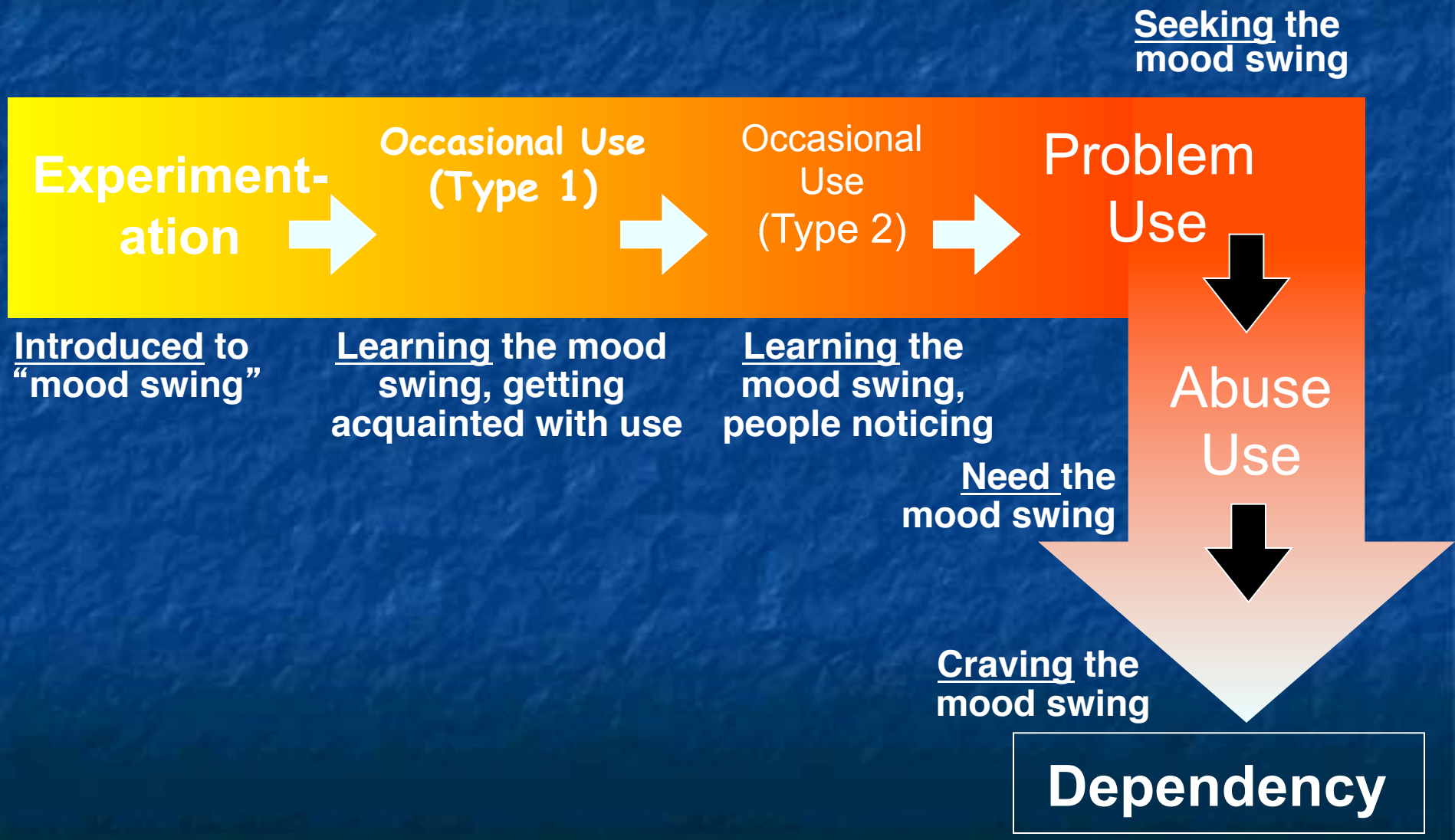
- >60% Use Alcohol
- 37.9% Binge Drinking
- 11.3% Heavy Drinking

Tobacco

18-21 = 27.1%

21-25 = 32.8%

Pathway Toward Addiction



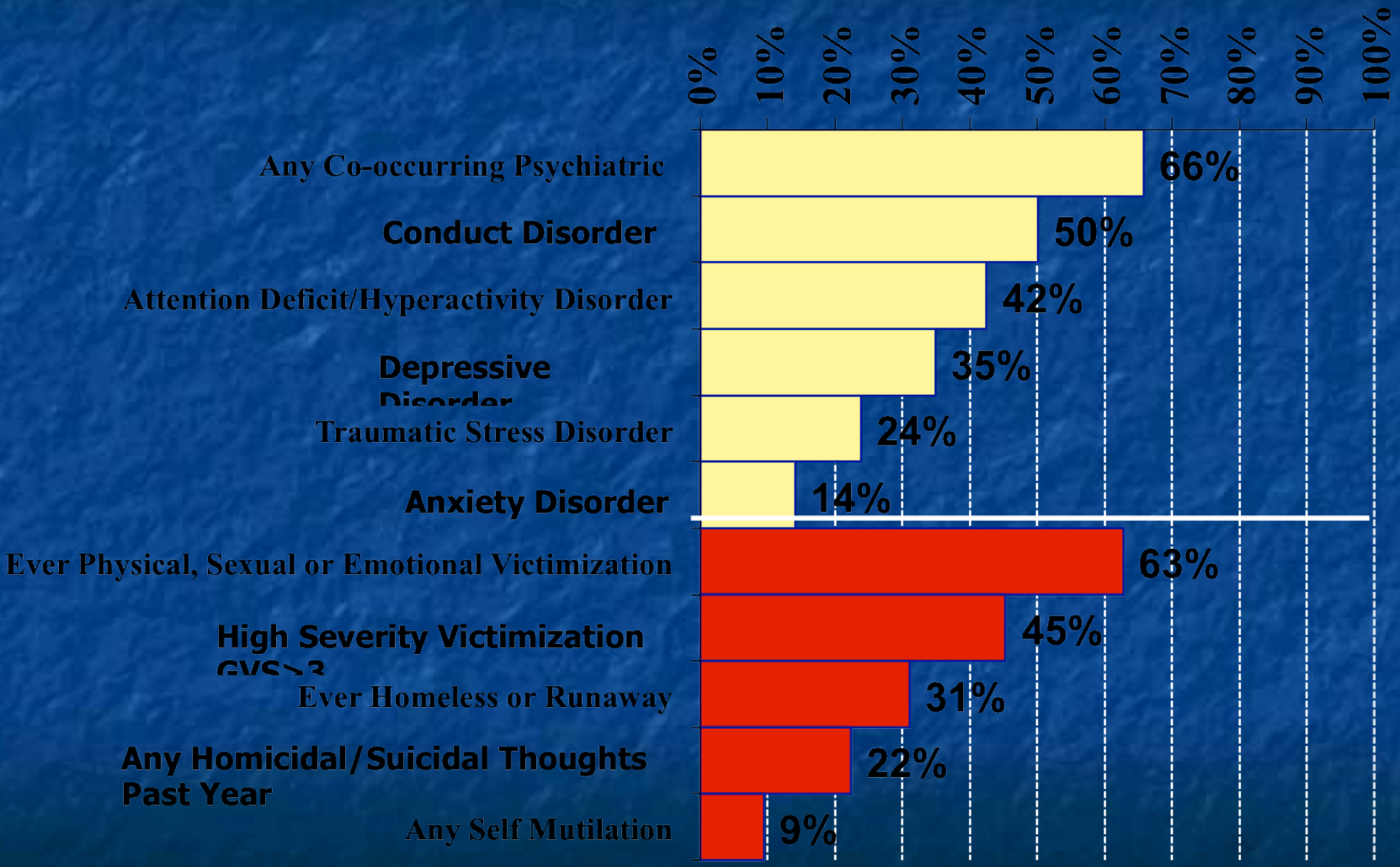
Critical Problems

- 75% of all deaths in 10-24 yr olds result from four factors associated with substance use: Motor Vehicle Crashes, Suicide, Homicide and other unintentional injuries
- Impaired peer relations
- Depression
- Anxiety
- Low Self esteem
- Increase Rate of STDs, Teenage Pregnancy, Date Rape

Many Factors are Associated with Substance Use Disorders

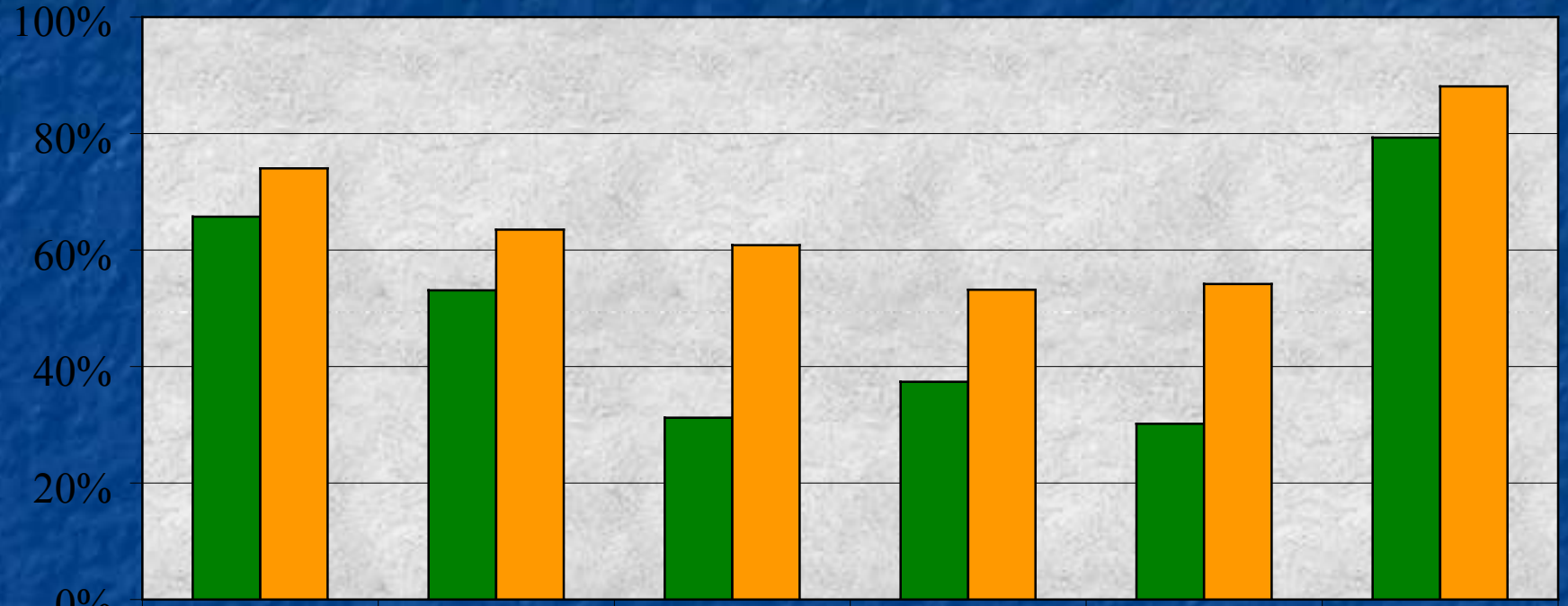
- Early “dis-temperment” hard to “self soothe”.
- Trauma/Victimization History
- Learning Difficulties
- Social Impairments
- Deviant Peer Group
- Prior Mental Health Problems
- Family History of Substance Use Disorder & Mental Health Problems
- Delinquent Behaviors

Co-Occurring Psychiatric Problems Ages 12- 18 years



Source: CSAT AT 2007 dataset subset to adolescent studies (N=15,254)

Multiple Co-occurring Problems By Gender



	Conduct Disorder	ADHD	Major Depressive Disorder	Generalized Anxiety Disorder	Traumatic Stress Disorder	Any Co-Occuring Disorder
Male	66%	53%	31%	37%	30%	79%
Female	74%	64%	61%	53%	54%	88%

Source: CSAT's Cannabis Youth Treatment (CYT), Adolescent Treatment Model (ATM), and Persistent Effects of Treatment Study of Adolescents (PETS-A) studies

The Role of Reward

- Powerful biological force for our survival.
- Brain wired to repeat rewarding activities.
- Life sustaining activities, such as eating, activate a circuit of specialized nerve cells devoted to producing and regulating pleasure.
- Many (if not all) drugs of abuse operate through a common neural mechanism associated with approach & appetitive behaviors =nucleus accumben's.
- Dopamine and Endogenous Opioids

How Drugs & Alcohol High-Jack Your Brain Controls

- Drugs act directly on the more primitive brainstem and limbic system structures.
- Using overrides the cortex in controlling our behavior.
- In effect, they eliminate the most “human” part of our brain from its role in controlling our behavior.
- New research on adolescent brain function demonstrates that the use at this critical time changes critically impacts memory and behavior

Chronic Relapsing Disorder

- ***Substance Use Careers Last for Decades***
- ***Median Duration of 27 years from First Use to 1+ years Abstinence***
- Up to 2/3rds Can Slip in the First 90 Days After Treatment
- ***It Can Takes Decades and Multiple Episodes of Treatment***
- ***Median Duration of 9 years and 3 to 4 Episodes of Care***
- ***It takes a Year of Abstinence before less than 50% relapse***
- ***Even after 3-7 years of abstinence about 14% relapse***

Source: Dennis, Foss & Scott (2008)

Recovery Essentials

Interviews with many long-term recovering alcoholics yielded the following list of essentials to remain sober (G. Valliant, Presentation 2001)

- Compulsory Supervision – (sponsor etc.)
- Replacement Activities – (physical, mastery – pleasure)
- Alternate Love Relationships (non-guilt)
- Seeking the Spiritual (not religiousity)

Evidence Based Treatment

Too Few Hours of Influence, so
Use Them Well !!

Why adopt evidence based treatment?

Discuss

Evidence Based Tx

- Standard approach
- Ensures that clinicians deliver treatment backed by research - increasing the accountability of our field.
- Helps our clients understand what they are getting into, and what is expected of them
- Increases retention and outcomes
- Increases the specificity of supervision
- Increases referral source understanding and respect for our approach

Why it might be a bad thing?

Discuss.

Why it might be a bad thing - Answers

- Forces all clinicians to deliver the same treatment.
- Reduces the art & creativity of the clinical process.
- Turns the interaction with the client into a "cookbook"
- Client's real needs are ignored.
- Adds to the list of pressures and paperwork we already are too busy to accomplish.
- I have to really read the manual and use the handouts as described.

Common terms

- **Efficacy** – demonstrates an impact under optimal conditions
  - Participant exclusion criteria
  - More intense, technical training, supervision
  - Lower caseloads/productivity requirements
- **Effectiveness** – demonstrates an impact under real-world settings

Treatment efficacy: How well do research-based treatments work?

- 2 Meta-analyses examined treatment outcome effects for manualized, research-based adolescent interventions
- Treatment effect sizes ranged from .58 to .82
  - *Average of 58-82% of adolescent clients receiving treatment were better post treatment compared to untreated populations.*

  (Weisz et al., 1987, Weisz, Weiss, et al., 1995)

Treatment effectiveness: How well do non-research-based treatments work?

- Review of 14 studies of treatment effectiveness for children and adolescents receiving clinical services in the community
- Services were NOT evidence based or researched
- Mean effect size across studies was -.001.
  - *Average treated youth faired no better after treatment than youngsters in control group*

(Weisz & Jensen, 2001)

MET CBT

- A Structured Treatment Approach
- Rationale to use it for adolescents = brief, effective and developed for youth!

MET CBT

- Based on Combined Theories of Change
- To be effective must be confident of your ability to motivate and help elicit behavior change
- MET CBT has roots in trans-theoretical model of change and social learning, behavior theory (classical conditioning, cognitive behavior theory and social psychology.

Stages of Change Model
Prochaska & DiClemente, 1986

MET CBT : How it works to build change?

- MET - Rapport & Collaborative Goals
- Is the Youth Ready, Willing & Able?
- How can I collaborate to help build internal motivation?
- Addiction viewed as a negative repeated coping habit
- CBT - Skill Lessons, In Session Skill Practice & Real Life Practice
- Youth Learns to:
- Become more aware of situations/emotions
- Aware, Avoid, Cope & Replace

MET CBT

- Standard but Flexible approach
- Deliver Essential Activities But Creatively Fit:

- To Incorporate into Existing Program
- Split Sessions
- Adjust to Youth/Community Needs
- Deliver as Individual or Individual Plus Group Sessions
- Every Session: Agenda & Handouts to Help Ensure Easy Adherence

	Intake Session	MET/CBT 1	MET/CBT 2	MET/CBT 3	MET/CBT 4	MET/CBT 5	Recommendation Session Summarize
	Assessment Gain?	Rapport Feedback Discussion	Goals Knowledge is Power	Assertive Communication Refusal	Social Support Replacement Activities	Problem Solving Relapse Prevention	Discuss Motivation Progress
Attendance							
Participation							
UA							
Real Life Practice	N/A						
Behavior Change	N/A						

Structured Treatment

Intake – Assessment & Collaboration Questions Leading to Feedback Report

Session One: Rapport, Orientation, Feedback Summary

Session Two: Goal Setting & Knowledge is Power

Session Three: Assertive and Refusal Communication

Session Four: Social Supports & Replacement Activities

Session Five: Problem Solving, Relapse Prevention Planning & Feedback

Structured Treatment

MET CBT is a structured intervention with a series of essential components to be delivered in each session -

- Sessions are typically divided into three main phases – law of the thirds.
- **Phase One** in session 1 =rapport building
- **Phase One** in sessions 2-5 includes:

  rapport

  review of progress

  review of between session practice

These can be remembered by the acronym R.R.P.

Structured Treatment

- **Phase Two** = A single or several intervention activities (as in Personal Feedback Discussion, Goal Setting,, Assertive Communication, Seeking/Giving Support & Problem Solving etc.) This part is where skills training, in session practice and demonstration of acquired skill development occurs.
- **Phase Three** = Summary, Linking Treatment Activities to Real Life and Eliciting a Specific Commitment to Real Life Practice

Session Delivery Components

- Timing
- Delivering the Three Session Phases
- Delivering the Essential Elements
- The Ratio of Therapist Talk to Client Talk
- Embodying the MI spirit –R.U.L.E. - OARS, DEARS
- Delivering Effective Skills Training – teaching & coaching using CBT
- Getting Specific Commitment for Practice

The Importance of Rapport!

- Collaboration
- Working Alliance

Collaborating & Rapport

- Working with youth/young adults provides us with an incredible opportunity to affect the fabric of the individual and our society as a whole.
- Most mental illness and addictions begin during developmental stages of our lives.
- To work with youth, we must be willing to listen, be curious and get to know each individual, not just their problems.

Collaborating & Rapport

- The MET CBT intervention uses the idea of rapport building, collaboration and basic motivational interviewing skills to produce an initial working alliance for the entire treatment process.
- While the creation of therapeutic alliance is honored throughout all sessions, a special focus is given to "rapport" activities in the first two sessions and in the initial parts of all CBT sessions.

Collaborating & Rapport

- Essential from the "Get-Go"
- Build rapport using basic MI (motivational interviewing) skills – Open Questions, Affirmations, Reflections, & Summaries.
- Best to follow the essential motivational RULE while starting out – resist the righting reflex, do everything to understand your client, listen well, and express empathy.
- Do not try to change anything right now?

Collaborating & Rapport

- Start by using the MI skills to develop a conversation about the youth's life –
- What are their Interests? (music, books, movies, sports)
- What are their Strengths – Weaknesses
- What do they really like to do?
- How do they spend their time? (peers, gangs etc.)
- What is one accomplishment/aspect in their life they are most proud of - in any domain.

Collaborating & Rapport

- If needed, remember by using the acronym - HEADSS Interview – Questions about Homelife – (Relationships with Family/Friends), Education, Affect (feelings), Drugs/Alcohol, Sex, Smoking (Chewing –Nicotine)
- Setting up a working collaboration from the "get go" will set the tone for how the work will continue.
- The youth needs to be the one expressing what their life is about and how they see themselves in it – you need to see "the movie of their life"
- This will help you assess readiness - do they want change or not?

Collaboration: Working Alliance

- Building a collaboration is one of the four components of the MI spirit – the others include respecting the client's right to make choices, helping to elicit the client's motivation and demonstrating compassion.
- Over 1,000 research findings (Orlinsky, Rønnestad, & Willutzki, 2004) demonstrate that a positive alliance is one of the best predictors of outcome.

Collaboration: Working Alliance

- In the Cannabis Youth Treatment Study, an early working alliance created within the first two sessions predicted the best outcomes Dennis et al, 2004).
- Research demonstrates that a working alliance will correlate with the outcome of the entire intervention regardless of type or length of treatment delivered. "A moderate but reliable association between good working alliance and positive therapy outcome was found"
- Relation between working alliance and outcome in psychotherapy: A meta-analysis. Horvath, Adam O.; Symonds, B. Dianne Journal of Counseling Psychology, Vol 38(2), Apr 1991, 139-149.

Assessing Readiness and Quality of Recovery Strengths

- During the rapport building phase of the initial treatment – you can assess the quality of the youth's recovery assets/ risks.
- Special interest on the quality of family, school experiences, peer relationships, community supports & moods as well as other developmental vulnerabilities will set the tone of possible needs.

Assessing Readiness and Quality of Risks

- Can parents/guardians help in the youth's treatment? Are they willing now if not in the past?
- Understanding the parental/guardian ability to model, motivate and monitor (3 Ms) the youth's activities is also a critical area to assess as it is a known risk factor leading to early and continued use.

Assessing Readiness and Quality of Recovery Strengths/Risks

- Understanding and focusing on youth's desire to participate in pro-social interests/ activities is important – as this area is a primary recovery asset.
- We often look at both the youth's participation in both immediate pleasurable activities (easy to engage and satisfying) and MASTERY type activities – (which are initially harder and challenging throughout life).