

Manual Excerpt

**Workshop on Brief Intervention for
Drug-Abusing Adolescents**

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This manual provides an overview of the CD Rom workshop on a three-meeting brief intervention (BI) for mild drug abusing adolescents. It is recommended that users read this manual prior to beginning the workshop. It provides important contextual information for BI users as well as two appendices: Appendix A includes worksheets and suggested script pages from each BI meeting that can be printed for multiple uses; and Appendix B offers general background information about typical drugs of abuse by adolescents.

Summary of the Workshop

This self-directed workshop offers a basic training to counselors on the use of a three-meeting BI model for drug-abusing adolescents. Workshop topics include general counseling skills, with a focus on motivational enhancement strategies, and a detailed description of the model.

The standard use of the BI is on an outpatient, individual counseling basis over the course of three weeks. The first two parts of the model involve individual sessions with the adolescent; the third is an individual session with the primary parent or guardian.

Target audiences for the workshop are certified or licensed counselors who work with teenagers suspected of a drug problem, particularly teenagers with a mild or moderate form of drug involvement. The workshop's six components are expected to take about six hours to complete. Its structure allows for taking the workshop at a personalized pace. For those interested in obtaining 0.6 CEU credit for completing this training experience, instructions are provided at the end of the workshop.

Workshop Components

The workshop consists of these components:

Introduction:	Getting started
Session 1:	Habits of Highly Effective Counselors
Session 2:	Brief Intervention: Background
Session 3:	Brief Intervention: Basic Tools
Session 4:	Brief Intervention: Components of the 3-Meeting Program
Session 5:	Brief Intervention: Often Asked Questions

Development of the BI Model

The BI model was developed from existing adolescent and young adult programs organized around motivational interviewing (MI) and self-change programs (Breslin et al., 2002; Miller and Rollnick, 1991; Monti et al., 2001). This process involved reviewing existing clinical materials, consulting with brief intervention therapy experts, and local therapists.

A first version of the intervention was field tested with six drug-abusing adolescents. Feedback from the therapist and clients in that small pilot were used to refine the manual which was then tested more rigorously with a sample of 79 mild-to-moderate drug abusing adolescents (aged 14-17) who were identified in a school setting (Winters & Leitten, 2005). Student/parents were randomly assigned to receive either a two-meeting adolescent only (BI-A), two-meeting adolescent and additional one-meeting parent session (BI-AP), or assessment only control condition. Follow-up assessments showed that the adolescents in the BI-A and BI-AP conditions had significantly lower alcohol and other drug use days and fewer drug use consequences than the control group. Also, those receiving the BI-AP had significantly better outcomes on those measures compared to adolescents receiving BI-A. The six-month abstinence rates did not differ across groups. Based on the results of the pilot study, the workshop promotes the three-meeting (BI-AP) model.

Developmental perspective. The BI was designed for youth in the early stages of the developmental continuum. Anyone who exhibits signs of a dependence use disorder would not be a good candidate for this type of intervention. In cases such as these, more specialized treatment is required. The BI is aimed at youth who are early-stage users who may not meet formal abuse criteria or are not experiencing negative consequences from their use. Also, the core components of the intervention – motivational enhancement strategies - have been age-adjusted. These adjustments include simplification of concepts, heavy emphasis on participant engagement, and consideration of behavior change goals likely to be relevant to an adolescent client.

Abstinence is always the long-term goal. However, to start in motion the process of abstinence, it stands to reason that harm reduction is a logical early-stage goal of a time-limited intervention. Any behavior change that reduces harm is a positive result. By taking on this more flexible approach, it allows help for the adolescent who initially is resistant to change. Harm reduction goals may include:

- Change the means of administration of a substance
- Reduce driving under the influence
- Provide safe alternative to substances

- Reduce the frequency and/or intensity of the usage

The BI also emphasizes that behavior change goals need to be individualized. This is due to the heterogeneity of adolescent drug involvement. Each young person has their own reasons for their substance use and they each respond to different intervention methods. By using individualized goals and personalized feedback, the intervention can be more directly focused for each adolescent's specific needs.

For example, some of these adolescents may not be ready to stop using drugs altogether and therefore the objective would be to reduce the harm and risks involved with their usage. Others may be solely in the experimental stage and are unaware of the self-inflicting damage. In this case, abstinence is an appropriate goal. In either example, the main objective of this brief intervention is to help the adolescent recognize the dangers of using drugs and to make positive changes in his/her behavior. Put another way, the therapist's job is to act as a guide to help the adolescent through the use of Motivational Interviewing (MI).

Description of each meeting. Each of the three meetings is 60 minutes, delivered individually using an MI style.

Meeting 1 focuses on the results of an assessment and is designed to 1) elicit more information about the adolescent's substance use and related consequences and his/her perception of level of willingness to change (Prochaska et al., 1992); 2) examine the cause and benefits of change using the decisional balance exercise (Miller & Rollnick, 1991), and 3) discuss goals for change the youth wants to pursue. Consistent with an MI approach, the goals chosen by the adolescent may be abstinence or reduction in substance use.

Meeting 2 reviews the adolescent's progress with the agreed upon goals, identifying high risk situations that may frustrate attainment of goals, discussing strategies to address barriers toward goal attainment, reviewing where the client is in the stage of change process, and negotiating either the continuation of goals or advancing to more ambitious goals of substance use reduction.

Meeting 3, parent only except for a brief time at the end, follows the same MI interviewing style. This meeting addresses the following topics: reviewing their son or daughter's substance use problem, reviewing the parents' attitudes and behaviors regarding substance use by their child the child's personal life, discussing how parental monitoring and supervision can promote progress towards the child's intervention goals, and discussing concrete ways the parents can change their personal behavior to promote the health of their child. Meeting

3 ends with a brief meeting with the adolescent and parent in which the intervention goals and expectations are reviewed.

Rationale for BI

The development of effective, cost-efficient, and time-efficient interventions for mild-to-moderate drug abusing adolescents is an important, and yet under-studied priority in the health care delivery field. Pressures for shorter forms of drug abuse treatment are emerging from several sources: historical developments in the field that encourage a comprehensive, community-based continuum of care for a broad range of substance use problems; cost containment policies in the managed health care sector; and the expansion of community-based detection systems, such as in school and college health clinics.

BIs offer a strategy to address this treatment strain. Most BIs are typically two to four one-hour sessions, although some have been tried with adults for as brief as 10 minutes (CSAT 2003). BIs typically utilize the principles of motivational interviewing to raise awareness of the client's problems, offering a menu of options or strategies for accomplishing the target goals, and placing responsibility for change with the client. The style of the therapist is empathetic and encouraging rather than confrontational.

Whereas BIs with adults have received growing attention in the literature, interventions applied to youth are relatively under-studied. Among the studies involving young people, several have studied young adults (Borsari & Carey, 2000; Larimer et al., 2001; Marlatt et al., 1998; Monti et al., 1999; Roberts et al., 2000), and three have focused on adolescents (Aubrey, 1998; Breslin et al., 2002; McCambridge & Strang, 2004).

Aubrey (1998) used a motivational interviewing technique as part of a single assessment and feedback session for adolescents about to start drug treatment. At 6-month follow up, adolescents who received the assessment and single session had attended more treatment sessions and reported a reduction in heavy substance use as compared to those receiving treatment as usual. Breslin and colleagues (2002) compared the impact of a four-session, motivationally-based intervention and a psycho-educational control group with adolescent drug abusers. Outcome results at 6-months indicated significantly greater reductions for the brief intervention group in terms of alcohol and other drug use, consequences related to using, and increased confidence to limit intake in high risk situations (Breslin et al., 2002). McCambridge and Strang (2004) compared a one-hour motivational interviewing session intervention and an education-as-usual control condition. In comparison to the control group, those randomized to the motivational interviewing group reduced their use of tobacco, alcohol and cannabis, primarily through moderation of ongoing use rather than cessation

(effect sizes .37 - .75). The multi-site Cannabis Youth Treatment (CYT) study compared several conditions, including a five-session therapy comprised of Motivational Enhancement Therapy plus Cognitive Behavioral Therapy. This condition produced similar outcomes compared to all the longer-term conditions (Dennis et al., 2004).

The empirical evidence for the effectiveness of BIs for drug-abusing adolescents is based on a small handful of studies. Nonetheless, this small body of knowledge is generally encouraging. The three extant adolescent studies indicate that BIs are associated with modest improvement on the basis of pre-post comparisons and when compared to a control or comparison group.

Summary

The three-part BI has value in the context of a range of response options available to counselors when faced with a drug-abusing adolescent. The model is indicated for those youth with a mild-to-moderate form of drug abuse. Thus, the BI model is not appropriate for someone with a dependence use disorder. Also, youth with multiple co-existing behavioral disorders should receive additional treatment for these problems.