PART 1

APPROACHES & INTERVENTIONS

1.1 SUBSTANCE USE & MENTAL HEALTH INTERVENTIONS FOR YOUTH WHO ARE HOMELESS: THE COMMUNITY REINFORCEMENT APPROACH & MOTIVATIONAL ENHANCEMENT THERAPY

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INTRODUCTION

The relationship between mental health, substance use, and homelessness is complex. An estimated 48%–98% of youth who are homeless meet criteria for at least one mental health diagnosis (Hodgson, Shelton, van den Bree, & Los, 2013). Common disorders include depressive disorders, anxiety disorders, posttraumatic stress disorder, psychosis, substance use disorders, and attention-deficit/hyperactivity disorder (Hodgson et al., 2013). Between 69% and 86% meet criteria for a substance use disorder (Medlow, Klineberg, & Steinbeck, 2014). Compared with their housed peers, youth who are homeless have elevated rates of co-occurring substance use and mental health disorders (Hodgson et al., 2013; Kamieniecki, 2001). While mental health disorders and substance misuse can increase the risk of experiencing homelessness, homelessness itself can exacerbate pre-existing mental health issues and trigger new psychological symptoms and maladaptive behaviours, such as substance use (Hodgson et al., 2013). Given the limited access that youth who are homeless have to healthy coping mechanisms, substance use may be one of the only ways they have learned to cope with mental health problems and the challenges of homelessness.

Left untreated, substance use and mental health problems create additional barriers to exiting homelessness (Hodgson et al., 2013; Medlow et al., 2014). They can increase vulnerability, putting youth at further risk of street victimization (Bender, Ferguson, Thompson, Komlo, & Pollio, 2010; Whitbeck, Hoyt, & Yoder, 1999). Substance use and mental health problems are also associated with increased deviant behaviour, which can lead to arrests and legal trouble (Chen, Thrane, Whitbeck, & Johnson, 2006). They can also decrease motivation to improve the situation (Auerswald & Eyre, 2002). This complacency may decrease the likelihood that youth will seek assistance from social programs, obtain or maintain employment, or take steps toward stabilization (Auerswald & Eyre, 2002). Intervention efforts to improve the lives of these youth may have limited impact if underlying substance use and mental health problems are not treated.

Findings from clinical trials with youth experiencing homelessness have demonstrated promising substance use and mental health outcomes using the community reinforcement approach (CRA) and motivational enhancement therapy (MET). Slesnick, Prestopnik, Meyers, and Glassman (2007) first identified CRA as an effective intervention for this population in a randomized clinical trial comparing it with treatment as usual. Specifically, youth who participated in CRA reported increases in social stability and decreases in drug use and depression compared with youth who only received the usual drop-in centre services. In a follow-up study that compared CRA, MET, and case management, and that tracked outcomes for 12 months, participants in all three interventions showed reductions in substance use, depressive symptoms, and days spent homeless (Slesnick, Guo, Brakenhoff, & Bantchevska, 2015). CRA and MET have been associated with similar improvements among youth who leave home (Slesnick, Erdem, Bartle-Haring, & Brigham, 2013). Given the similarity in positive outcomes with CRA and MET that have been found in earlier clinical trials, service providers can choose between the two interventions based on the needs of their agency and clients (Slesnick et al., 2015).

THE COMMUNITY REINFORCEMENT APPROACH

THEORETICAL BASIS

CRA is an operant-based intervention that was developed by Hunt and Azin (1973) to treat alcohol use disorders. Meyers and Smith (1995) continued to adapt CRA to treat illicit drug use. Since CRA was originally developed to treat substance use, descriptions of this approach often use substance use as the targeted behaviour, but other problem behaviours, such as self-harm, can be targeted as well. Therapists can choose from a menu of modules to fit the needs of their clients.

Youth who are homeless often have an extensive history of negative experiences. Street culture and family of origin experiences tend to reinforce maladaptive behaviours and punish prosocial ones. Consistent with behavioural theory, CRA focuses on reinforcements and consequences of behaviours so that positive, non-substance–using behaviours are more reinforcing than substance–using (and other negative) behaviours. The intervention is guided by the assumption that people continue to use drugs or alcohol because their substance use is reinforced by their environment. Thus, CRA can be a powerful

intervention for youth who are homeless because it focuses on reshaping their relationship to their environment. Creating experiences of reinforcement for positive behaviours and reducing reinforcement for negative behaviours have the potential to set youth on a positive path. Meyers and Smith's (1995) CRA treatment manual provides a more detailed description of the theoretical assumptions guiding CRA interventions.

COMPONENTS OF CRA

CRA uses behaviourally based interventions and skills development to help clients reduce substance use. A full list and description of intervention modules and techniques, as well as worksheet templates and examples of techniques, can be found in the CRA treatment manual (Meyers & Smith, 1995). While CRA provides flexibility to implement modules that fit the needs of the client, several hallmark features should be implemented when using CRA, including the Happiness Scale and goals of counselling, functional analysis, and skills training with role-playing. The following section describes how these intervention components have been implemented in previous trials with youth experiencing homelessness.

The Happiness Scale and goals of counselling

The Happiness Scale (Meyers & Smith, 1995) identifies several areas of life that may be important to youth, such as employment, substance use, and relationships. The therapist asks clients to rate their level of happiness in each area. The scale is typically completed at the start of each therapy session. In the first session, it is used to identify the client's goals for counselling, and in subsequent sessions, it measures progress toward those goals.

After completing the Happiness Scale, the client and the therapist identify goals for areas in which the client reported dissatisfaction. They then develop an intervention to meet that goal and set a time frame. Identifying simple and achievable goals increases the chance of success. For example, if a client indicates being unhappy in terms of employment, the initial goal could be to identify one place where the client would like to work. Because youth who are homeless often have experienced failure and disappointment in many areas of their lives, setting up early success and positive interactions can boost their confidence and sense of self-efficacy. Over time, the achievement of small goals can lead to more substantial ones.

Functional analysis

Therapists should complete a functional analysis during the beginning phases of treatment. Sample forms for a functional analysis can be found in Meyers and Smith's (1995) CRA manual. The purpose of the functional analysis is to reveal the situations in which youth are most likely to use substances. First, the therapist identifies internal triggers (e.g., feelings, mood) and external triggers (e.g., fights with friends, getting money) for substance use. For example, a client might find that she always feels the urge to smoke after arguing with her romantic partner. Next, positive consequences of the client's substance use are identified. The therapist then helps the client find alternative behaviours that achieve the same positive outcomes. For example, if the client says smoking helps her calm down after a fight with her partner, the therapist helps her determine prosocial behaviours that are relaxing, such as listening to music or exercising. The therapist and the client also discuss the negative consequences of the client's substance use. Identifying negative consequences can motivate clients to decrease their substance use. In later sessions, the therapist can gently remind the client of those negative consequences. It is also recommended that the therapist complete a functional analysis of targeted prosocial behaviours with the client to highlight positive behaviours the client enjoys that can replace substance use. Additional functional analyses can be completed if the client wants to discuss other behaviours. The information gathered from the functional analysis informs the direction of treatment and helps the therapist determine which treatment modules to use.

Skills training and role-playing

CRA includes modules for skills training in several areas, including employment, communication, drug and alcohol refusal, relapse prevention, and problem solving. The specific skills targeted in the intervention depend on the counselling goals the client identifies. Regardless of the targeted skills, in-session role-playing is a critical component in building new skills. During role plays, the therapist identifies a situation the client may experience and coaches the client on how to handle it. Role-playing in session gives clients an opportunity to practise the skills they are learning and allows the therapist to observe and provide feedback on the targeted skill. Observation during the role play can help the therapist understand aspects of the skill that may be more challenging for the client. The therapist should reinforce positive behaviours observed during the role play. For example, if the target area is employment, the client can role play a job interview with the therapist. The therapist may observe that the client provides inappropriate responses to interview questions, but appears confident and makes good eye contact. The therapist can help the client develop more appropriate responses to the questions, but also commend the client

for appearing confident and using good body language. Whenever possible, therapists should engage clients in role plays because the more the client practises, the more likely the client will be to apply the skills learned in therapy to real-life situations.

MOTIVATIONAL ENHANCEMENT THERAPY

THEORETICAL BASIS

Motivational enhancement therapy (MET) was derived from principles of motivational interviewing, which was originally developed as a brief intervention for alcohol use problems after it was observed that brief therapies could be as effective as more intensive therapies at eliciting behavioural change (Miller & Rollnick, 1991). It was hypothesized that successful interventions have the same core components, and that the additional components of more intensive interventions may be unnecessary. As such, motivational interviewing was designed to incorporate the core components of successful interventions (Miller, Zweben, DiClemente, & Rychtarik, 1995). Miller and Sanchez (1994) used the acronym FRAMES to capture the core components of brief interventions:

- **Feedback** on personal risk or impairment;
- Emphasis on personal **responsibility** for change;
- Clear **advice** to change;
- A **menu** of alternative change options;
- Therapist **empathy**; and
- Facilitation of client **self-efficacy**.

MET was developed for a large substance use treatment trial called Project MATCH (Miller et al., 1995). Its development was guided by the treatment components identified by FRAMES (Miller et al., 1995). MET places the responsibility for change on the client. It posits that everyone has the ability to change, but that people have varying levels of motivation to do so. Prochaska and DiClemente's (1983) transtheoretical model outlines the different stages of change that a person may experience, including willingness and desire to change. MET is structured to encourage behavioural change by increasing motivation to change. The MET treatment manual developed by the National Institute on Alcohol Abuse and Alcoholism provides full details of the intervention (Miller et al., 1995). The following section explains how the intervention can be applied with youth who are homeless.

COMPONENTS OF MET

Session structure

MET is a four-session brief intervention that is separated into two phases of treatment: building motivation to change and strengthening commitment to change. Before the first session, the client completes an assessment of current substance-using behaviours. The first session focuses on giving the client structured feedback on the behaviours reported in the initial assessment. The feedback addresses the client's level of substance use in comparison with normative use and identifies possible problems caused by the substance use. The goal of the feedback is to increase the client's desire to change by identifying the risks and problems caused by substance use. The second session continues to focus on increasing the client's motivation to change and begins to move toward the second phase of treatment by developing commitment to change. The third and fourth sessions are offered as boosters to monitor progress and provide continued encouragement.

Phase 1: Building motivation to change

The first session focuses on eliciting the client's motivation to change. Behavioural change is unlikely to occur if the client feels the therapist is demanding change. MET provides guidelines and strategies for subtly guiding clients toward discussions about change and increasing their motivation. The following section describes these strategies.

Listening with empathy. While empathy is critical in any therapeutic relationship, MET specifies strategies therapists can use to convey empathy. A central tenet of MET is to meet clients where they are at, rather than trying to impose behavioural change on them. Clients decide the changes they believe would benefit their lives. The role of the therapist is to listen, and to help clients explore their desire for change. All interactions should convey a message of acceptance and support. A positive therapeutic relationship allows clients to examine their problem behaviours and desire to change in a safe and open environment.

Affirming the client. Instilling hope that change is possible is a necessary component of motivating clients to change. Clients must believe that they are capable of changing their behaviour. Therapists can encourage this by identifying clients' strengths and providing praise for their progress during therapy. Additionally, therapists can maintain a positive focus in sessions by reframing clients' negative statements. When therapists reframe a statement, they offer clients an alternative interpretation of the problem. For example, if a client says, "I've always been a screw-up; even my own family thinks I am a failure,"

the therapist could respond, “It sounds like you are hard on yourself. It seems to me that you are doing what you have to do to successfully survive on your own, even if you don’t always like what you have to do to survive. Hopefully, we can work together to figure out some strategies so you can not only survive, but also enjoy life.” Overall, helping clients develop a more hopeful and positive view of their situation is an important component of motivating them to change their behaviour.

Eliciting self-motivational statements. Therapists should not provide clients with reasons to change their behaviour, rather, the reasons for changing behaviour must come from the clients themselves, so they can develop self-motivation. Asking clients about their concerns about substance use is one way to elicit motivation to change. If a client struggles to identify any concerns, the therapist can present personal feedback and inquire about problems the client highlighted in the initial assessment. For example, a therapist could say, “I can see that you feel there are a lot of positives about your substance use, but in the assessment you completed, you reported that you spent more money than you would like on heroin. How do you feel about the financial impact that using heroin is having on you?” The therapist should always maintain a questioning approach with clients, and refrain from placing demands on them or telling them their behaviours are problematic. The therapist can also help clients determine discrepancies between their goals and their behaviour. For example, the therapist could say, “It sounds like you really want to get your own apartment. How do you think using heroin prevents you from getting an apartment?” Overall, the key is to use a non-confrontational approach, and to have clients formulate their own reasons for wanting to change their behaviour.

Handling resistance. MET handles resistance differently than do traditional therapies. Several therapeutic strategies may unintentionally evoke client resistance and thus must be avoided in MET. Typically, if a therapist confronts or argues with clients, they will respond with resistance and continue to defend their position. In MET, rather than arguing, the therapist provides a reflection of the client’s statement, or provides a reflection that amplifies the client’s defensive position. For example, if a client says, “I love smoking, I don’t want to quit,” the therapist could respond, “It sounds like there are things you really like about smoking and it doesn’t sound like it is causing you any difficulties.” This response gives the client a chance to identify opposing views to the original statement and develop a more balanced position. If clients still appear resistant, the therapist can shift the focus by directing the conversation away from the conflicted issue being discussed. Additionally, when clients are oppositional, the therapist is encouraged to

roll with resistance, which means accepting the resistance rather than trying to change it. Acknowledging and respecting resistance to change makes clients feel more open to discussing their ambivalence with the therapist.

Phase 2: Strengthening commitment to change

While the first phase of treatment emphasizes reasons for change, the second phase focuses on developing a plan for change. The therapist cannot move to this phase until the client is sufficiently motivated to change; thus, the therapist must be able to recognize readiness to change. The amount of time to reach the second phase varies for each client. Clients who are ready to move to this second phase often exhibit less resistance and provide self-motivating statements more often than they did in the earlier phase of treatment.

Making a plan. Once clients are motivated to change, it is important to help them develop a plan for change. The therapist must communicate free choice and ensure that the developing plan matches the client's desired changes. One strategy to help clients identify the changes they want is to help them recognize consequences of action and inaction by helping them visualize the consequences of not making any changes, as well as the consequences of making the desired changes. Once clients decide on the changes they wish to make, they may request information and advice on how to change. It is important that the therapist refrains from providing the client with specific instructions on how to change; instead, the therapist should help clients devise their own strategies that will work for them. The therapist can act as the expert and provide factual information when clients request it. For example, if a client wants to know if there is a drug to help reduce withdrawal symptoms from heroin, the therapist should discuss methadone or other medication options. Once a plan is developed, the therapist can ask the client to make a commitment to change. This can be a verbal commitment from the client, or the therapist and the client can complete and sign a change plan worksheet, which highlights the changes the client wants to make and how the client intends to make those changes. Some clients will not be ready to make a commitment to change, and it is important that the therapist respects their decision.

IMPLEMENTATION CONSIDERATIONS

HARM REDUCTION APPROACH

It is unlikely that youth who are homeless will present for substance use treatment. They may use illicit drugs and alcohol to cope with mental health challenges, trauma, and the stress of being homeless. Moreover, substance use is often an important aspect of street culture, giving youth a way to connect with others (Auerswald & Eyre, 2002). Initially, youth may be uninterested or hesitant to give up something that provides them with many immediate benefits. If they feel the therapist is pressuring them to quit using, they may not return to therapy. This means that rather than setting abstinence as the goal, treatment should involve identifying risk-reduction behaviours youth are willing to try. Those who do not want to abstain from substances may be willing to reduce their use or engage in safer practices (e.g., not sharing needles, not exchanging sex for drugs) if they understand the benefits of these new behaviours. As therapy progresses and youth experience the benefits of risk reduction, they may be motivated to further reduce their substance use.

Some youth may need treatment beyond what is provided by CRA and MET. The therapist can connect them with other resources. In cases of severe alcohol and/or drug addiction, youth may need medical care, such as detoxification services, in order to address physical withdrawal symptoms. Youth with opioid addiction may need help getting connected to an opioid replacement therapy program. Additionally, some youth may present with severe mental illness that requires a higher level of care than is provided by CRA or MET. Even when youth require more intensive treatment, CRA and MET can be useful approaches for beginning the engagement and linkage process.

HIERARCHY OF NEEDS

It may be difficult for youth who are homeless to feel motivated to address mental health and substance use problems if their basic needs are not being met. Applying Maslow's (1943) hierarchy of needs theory, this means that substance use and mental health interventions for youth experiencing homelessness need to also address youths' basic needs for food, shelter, clothing, and so on. Many strategies can be implemented to meet this goal; for example, in the trials discussed in this chapter, intervention took place at drop-in centres or shelters,

where the basic needs of youth could be met. Another strategy is to provide CRA or MET in conjunction with case management. One example of this is ecologically based therapy (discussed in chapter 2.5), which simultaneously provides housing assistance, CRA, and case management to mothers who are homeless. Overall, youth will likely be more willing to participate in therapy if their basic needs are also being met.

TREATMENT DURATION & CONTINUED CARE

To date, research has examined the effectiveness of a four-session MET intervention and a 12-session CRA intervention with youth who are homeless. While youth in the research trials tended to report improvements following participation in MET and CRA, most youth still reported continued substance use and problem behaviours; these youth may have benefited from more therapy. Agencies can offer additional sessions if they have the resources. It is sometimes necessary to set a predetermined number of sessions for research trials; however, real-world settings may allow more flexibility, with the number of sessions determined by the needs of the client and progress in therapy. As the termination of therapy approaches, client and therapist should discuss plans for care once treatment is completed, including whether the client will need or want additional therapy. The therapist should help connect the youth with follow-up care.

CONCLUSION

Substance use and mental health challenges are common among youth experiencing homelessness. CRA and MET have shown the most promise at addressing these challenges among this vulnerable population. Youth who are homeless exhibit unique challenges when presenting for treatment, and MET and CRA provide effective strategies for engagement and behaviour change. To date, clinical trials have demonstrated similar effectiveness of both approaches. Consequently, service providers may consider how each intervention fits with their agency's philosophy and available resources when deciding which intervention to implement. Regardless of the chosen intervention, service providers must ensure youth who are homeless are given the space to identify treatment goals that are meaningful to them. While progress may be slow given the extensive challenges these youth experience, research has demonstrated that with the right tools and support, change and behavioural improvement is possible, even for the most vulnerable youth.

Acknowledgement

This chapter was supported by National Institutes of Health (NIH) grants 2R01 DA013549 and DA016603.

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