The Development of a Resource Guide on Tobacco and Marijuana for Group Home Staff

by

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A Thesis Submitted to the School of Community Services in partial fulfillment of the requirements for the Honours Bachelor of Behavioural Psychology

St. Lawrence College
Kingston, Ontario
Canada.
March 4, 2019
Dedication

To my Nana and Poppa. You are my inspiration and our family’s greatest support system. You both have supported me in every decision that I have made, right or wrong. My biggest cheering section in each and every endeavor that I have participated in.

Without you both, my dreams could not have been made into reality. You believe in me endlessly. Your positivity, loyalty and genuine love for family is contagious.

I love you both.
Abstract

Early initiation of tobacco and marijuana use is an increasing concern among health care and mental health services as these substances are most commonly abused by adolescents. Research suggests that substance abuse among adolescents is a world-wide health problem. During the current study, staff in a residential group home confirmed that tobacco and marijuana abuse was problematic with the youth residing within the home. Staff noted a lack of empirical resources available for the purpose of education, identification and program delivery of substance abuse. In order to meet this need, a staff resource guide on tobacco and marijuana use was developed using relevant information and empirical evidence from current literature. The goal of the resource guide was to provide basic, practical, and understandable educational material with evidence-based resources on substance abuse of tobacco and marijuana. This will aid in enhancing program efficiency. The goal of this guide was to increase staff awareness of risk factors, knowledge of tobacco and marijuana, and to identify and intervene in substance abuse issues. It is commonly understood that staff who work with at-risk youth require the most current and validated information to demonstrate best practices for successful results. It was hypothesized that the resource guide would enhance staff awareness which in turn would lead to motivating the youth to attain their goals and make positive changes to successfully reintegrate into various settings. Due to time constraints there was limited feedback, however the feedback provided was positive. The Executive Director of the group home suggested the information and resources provided would be invaluable to the staff in the home and the layout was easy to understand and follow. Future recommendations would be to determine the efficiency of the resource guide in increasing staff awareness and decreasing substance abuse among the youth in the home.
Acknowledgements

I would first and foremost like to thank my mom and dad for their endless and consistent support. Thank you for pushing me to be the best that I can be and believing in me throughout these last four years. You are always there for me no matter what.

To my sister Brittnee, thank you for everything you do for me that allows me to be successful. Thank you for being there for me to lean on when stress gets the best of me. Thank you for your advice and listening ear. I will never fully be able to express how much I appreciate you.

To my girlfriend Heather for supporting me and allowing me to express my feelings and emotions through the tough times and the good times. Without you, these past four years are unimaginable. You are my rock.

My boy Rocky, thanks for being the best boy ever and always making me laugh and feel better during the hardest times.

Thank you to my college supervisor Hal Cain for supporting me throughout the process of completing this thesis. Also, to my placement supervisor Bruce Drummond for the endless support and for going out of your way to increase my knowledge and ensure I was enjoying my placement.

Thank you all for helping me along the way, and for the support you gave me to ensure I was successful. Without you all, this would not have been possible.
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Chapter I: Introduction

Substance abuse is the excessive and inappropriate use of any substance that results in harmful effects. Tobacco and marijuana have been shown to be the most widely used substances abused by adolescents (Ramo, Liu & Prochaska, 2012). According to the National Institute of Health (NIH, 2011), nicotine interference of the brain during adolescence increases the risk of further substance use. The National Institute of Drug Abuse (NIDA, 2015) estimates that approximately 1 in 11 young people will become addicted to drugs and most youth who smoke in their teens become regular smokers before they turn 18 years of age. Additionally, the NIDA (2015) reports that most adolescent drug use begins with nicotine and is often referred to as the “gateway” to marijuana use. Furthermore, the NIH (2011) suggests that adolescent marijuana use has the potential to influence other drug use and experimentation. On a global scale, approximately 20% of adolescents between the ages of 13 and 15 who use tobacco also co-use marijuana (Ramo, et al., 2012).

A National Commission for Protection of Child Rights study concluded that in India the mean age of tobacco onset was 12.3 years and for marijuana it was 13.4 years (Jiloha, 2017). In the United States (U.S.), the American Academy of Pediatrics (AAP, 2009) reported that approximately 1.4 million adolescents start smoking tobacco each year. Research by Ammerman, Ryan and Adelman (2014) shows that 6.5% of U.S. students in grade 8, 16.6% in grade 10 and 21.2% in grade 12 use marijuana. Health Canada (2012-2013) reported that approximately 603,000 students used tobacco and that the median onset age was 13.6 years old. Additionally, Georgiades and Boyle (2007), reported marijuana use among Ontario Grade 12 high school students to be 46.2% in 2005 making marijuana the most used illicit drug among adolescents in Ontario. Evidence on the widespread use of tobacco and marijuana heightens the need to investigate the effects on adolescent development (Georgiades & Boyle, 2007).

Adolescence is an important and vulnerable phase in life with many risk factors for substance use and abuse. It is apparent that substance use among this population is a real problem and more resources and education are needed to identify, motivate and deter youth from partaking in the use of tobacco and marijuana. Furthermore, Jiloha (2017) suggests that the earlier the onset the greater risk of future problems.

Future health problems from tobacco include cancer, respiratory illness and heart disease. Marijuana also affects the heart, lungs and increases the risk of psychosis (NIDA, 2015). Additionally, NIDA (2015) reports that marijuana affects body coordination and impairs thought processes. Substance abuse amongst adolescents contributes to other at-risk behaviours including aggression, sexual deviance, school failure and mental health issues (Pumariega, Burakgazi, Ünlü, Prajapati & Dalkılıc, 2014). In addition, normal functioning of the brain can be seriously impaired and have negative impacts on emotional and cognitive functions as the brain develops during adolescence (NIDA, 2015). Additionally, the NIDA (2015) states that substance abuse can trigger or provoke mental disorders, with a bigger risk to vulnerable populations such as adolescents.

There are many empirical studies that show adolescents who do not live in their family homes are more vulnerable to tobacco and marijuana use than their same age school peers who do live in their family homes (Siegela, Benbenishtya & Asto, 2016). In view of this, there are other key factors related to tobacco and marijuana use among adolescents who do not reside with their families. Siegela et al. (2016) report that adolescents who are currently residing outside of their family home, including foster and group homes, face additional and more unique challenges.
such as genetics, family dysfunction, maltreatment and trauma. They also suggest these youth are more likely to be exposed to parental substance use, including tobacco and marijuana, and criminal activities influencing a vicious cycle. These factors increase the risk of legal, behavioural, mental health and childhood trauma issues which increases the risk of substance abuse (Valkov, 2017). There continues to be ongoing research on adolescent tobacco and marijuana predictors to establish best practice treatments and interventions to deter its use.

Many factors contribute to adolescent use of tobacco and marijuana with identified risk factors often leading to appropriate intervention efforts. Interventions are therefore an important part of this guide. Research shows substance abuse can be deterred and treated through proper screening techniques and evidence-based interventions such as cognitive behavioural therapy (CBT) (Jiloha, 2017). Jiloha (2017) reports that pre-screening using brief questionnaires is an effective approach in identifying adolescents who are at risk of substance abuse and notes CBT as an efficient intervention among adolescent tobacco and marijuana users. The AAP (2009) also suggests that best-practice approaches of pre-screening and CBT are most effective in adolescents who are dependent on tobacco. CBT was also found to have the most research support by the highest quality of evidence for adolescent substance users (Becker, 2013).

A training and resource manual in place prior to this project, designed to improve the quality of care delivered by group home staff, is currently available in the office at Ventures Group Home. This manual provides support on various mental health and behavioural issues, best practices, screening and intervention techniques. During the time of this thesis that manual did not include a module on substance abuse. Staff at Ventures Group Home report that an estimated 90% of youth residing in the group home smoke tobacco and about 75% co-use with marijuana. Staff also report approximately 10% use other drugs, such as methamphetamine, in addition to tobacco and marijuana. It was recommended by the Executive Director and Behavioural Therapist that an educational and informative resource guide on tobacco and marijuana be developed and implemented. The key objective of the resource guide is to enhance education and provide applicable resources to staff for appropriate program delivery to youth with substance use problems. The Executive Director and Behavioural Therapist suggested that enhancing staff knowledge will aid in the ability to deliver fact-based and consistent information and assist them in understanding the impact of problematic substance use. It is anticipated that this resource guide will help staff encourage, motivate and promote positive decision making and cognitive restructuring towards the youth’s perceptions of substance use which will provide youth with more opportunities for future success. A reasonable approach to the development of this resource guide is to establish an evidence-based, generic and simplistic resource on Tobacco and marijuana. Through increased staff awareness, it is hypothesized that the role of the resource guide will be effective in program delivery, identification, and intervention of substance using adolescents.

The following chapter will include a detailed literature review on adolescent substance abuse with a focus on adolescents currently living in alternative placements such as foster and group homes under the umbrella of child welfare. The literature review will include the scope of tobacco and marijuana in the population of adolescence including statistics, prevalence rates and early onset. Evidence-based research was reviewed from a global or wide-based perspective. The gateway theory will be discussed as tobacco being a gateway to marijuana and additionally, vise-versa. Furthermore, the relationship and co-occurrence of tobacco and marijuana in young people will be examined. Risk factors will be identified and discussed through several different peer-reviewed articles with support from scientific research. Physical, mental health, and long-
term effects of tobacco and marijuana will be introduced and discussed as well as environmental and socio-economic risk factors. Information on child welfare will provide the reader necessary and relevant information to better understand the unique set of risk factors that youth under this spectrum face. Studies on statistical information on these risk factors and research will address additional challenges that these youth face. Lastly, treatment and intervention information will be discussed outlining promising outcomes from the use of screening techniques and intervention approaches, such as CBT to aid in the deterrence of tobacco and marijuana among adolescents.

Chapter III outlines the methods and steps for the development of the staff resource guide. Also, included in this chapter are the participants, setting, design, procedures and supporting information and the layout and content. Chapter IV presents the results of the staff resource guide and Chapter V provides a discussion on the project. The discussion chapter includes an overview of the project, the projects strengths, limitations and multilevel challenges. Additionally, contributions to the field of Behaviour Psychology of this thesis will be identified and discussed in Chapter V.
Chapter II: Literature Review

Tobacco and Marijuana Use in Adolescence

Tobacco and marijuana are the two most common substances used by adolescents worldwide (Ramo, Liu, & Prochaska, 2012). In addition, Prince van Leeuwen, Verhulst, Reijneveld, Vollebergh, Ormel & Huizink (2011) suggest that due to their unique vulnerability of risk taking behaviours and experimentation, adolescents have an increased risk of initiating tobacco and marijuana. Results from the 2005 Ontario Student Drug Use Survey led by The Centre for Addiction and Mental Health showed 22.9% of Ontario Grade 12 secondary students used tobacco while 46.2% used marijuana in the previous 12 months at least six or more times (Georgiades & Boyle, 2007). In 2015, the Canadian Centre on Substance Use and Addiction (CCSA) reported marijuana use among Canadian youth ages 15-24 as being twice as high when compared to adults. The Canadian Student Tobacco, Alcohol and Drugs Survey 2016-17 (CSTADS) was a national evidence-based survey used to measure alcohol, drug use and tobacco use within a group of students between Grades 7 – 12 (Health Canada, 2018). A sample of 52,103 Canadian students completed the survey between October 2016 and June 2017 showing that 18% of students (9,379) had used tobacco and 17% (8,858) had used marijuana at least once in the preceding 12 months. In addition, it was reported that the average age of first marijuana use was 14 and 13.5 years for tobacco.

The American Academy of Pediatrics (AAP, 2009) reports that adolescents who smoke tobacco are eight times more likely to experiment with marijuana. In the United States, as many as 1.4 million adolescents start smoking each year and tobacco dependency emerges early in the process (AAP, 2009). In addition, adolescents who move on to use marijuana are likely to become heavy smokers and become dependent on nicotine. (Ramo, Delucchi, Hall, Liu & Prochaska, 2013). Early use of marijuana has also been linked to the use of other illegal substances as well increasing the risk of developing a substance use disorder (Prince van Leeuwen et al., 2011). Tobacco and marijuana use regularly co-occur together and epidemiological statistics show the co-use of tobacco and marijuana expanded during the 1990’s throughout the world and that they reinforce and support one another (Ramo et al., 2012). Ramo et al. (2012) suggested that the co-use of tobacco and marijuana increases the likelihood of dependence and the many physical and psychological problems associated with their use. The prevalence of adolescent tobacco and marijuana use supports a need for increased awareness and education for front line workers in the field of at-risk youth. Increased staff awareness will elevate program efficiency in assessing, identifying and treating substance use.

The Gateway Theory

The gateway effect is a theory of a pattern of initiation that progresses from one drug to another starting with a legal drug such as tobacco to marijuana to harder drugs (Richmond-Rakerd, Slutske, Deutsch, Lynskey, Agrawal, Madden, et al., 2015). According to the World Health Organization (WHO, 2016) many empirical studies during the 1970’s and 1980’s in Australia, USA and New Zealand were conducted on the gateway theory. During this time, smoking tobacco generally preceded regular marijuana use and tobacco was a predictor of marijuana use. The World Health Organization (2016) also reported that results from these studies showed that young marijuana users were also more likely to progress to harder drugs.
The “Gateway Theory” was established by Denise Kandel through observation of adolescents becoming involved in drugs in stages and in sequence, most notably tobacco to marijuana to cocaine. Kandel and Kandel (2014) view how the drug primes the brain to react to later drug use as the main premise of the gateway theory. This theory was later tested in mice by Denise and Eric Kandel (Kandel & Kandel, 2014). In a short-term longitudinal follow-up, Yamaguchi & Kandel (1984) re-interviewed and collected data from 1325 former Grade 10 and 11 (1971) New York State students nine years later. In 1980-81, data was collected on their history of drug use and must have been used at least 10 times. The sequence of progression tested was alcohol, cigarettes, marijuana and other illicit and psychoactive drugs. Their findings showed that each drug preceded the other 85% of the time and that the sequence involved at least one legal drug progressing to one or more illegal drug. Later, Kandel & Kendal (2014) developed a mouse model and tested the validity of the gateway theory using molecular biology to reveal the action of tobacco on mice by administering nicotine to them and then introducing a second drug (cocaine). The result of this test was that nicotine behaves as a gateway drug.

There is a powerful relationship between tobacco and marijuana (Mayet et al., 2011). Early use of nicotine can function as a gateway to marijuana use by priming the brain to create increased dopamine responses to marijuana and other drugs (WHO, 2016). The gateway theory’s proposal of a chain-like transition has proven that smoking is a strong predictor of marijuana being used in the future (Prince van Leeuwen et al., 2011).

**Reverse Gateway.** Richmond-Rakered et al. (2015) suggest an existence of a “reverse-gateway” in which marijuana precedes tobacco. Preventative measures and education on the effects of tobacco over the years has decreased the prevalence of cigarette smoking in adolescence. Research now indicates that 1 in 5 adolescents who smoke marijuana had never smoked cigarettes (Hindocha et al., 2014). As a result, the USA and Australia have seen an increase in early marijuana use prior to tobacco use (WHO, 2016). According to WHO (2016), this change has initiated the “reverse gateway” increasing the risk of marijuana use as a gateway for tobacco use. Additional research also documents that adolescents who become marijuana users first have a stronger likelihood to use tobacco, with a greater chance of becoming nicotine dependent (Ramo, Delucchi, et al., 2013). The Population Assessment of Tobacco and Health (PATH) Study, a two-wave longitudinal, self-reporting study from 2013 to 2015 included 11,996 youth aged 12-17 (Silveira et al., 2018). In their study, Silveira et al. (2018) showed that tobacco use initiated before marijuana use at wave I demonstrated a 5–6-fold higher rate of prevalence of marijuana use at wave II. Results for marijuana use preceding tobacco use showed marijuana had a 2 to 2.5-fold rate higher for tobacco use. The results revealed bi-directional links between tobacco and marijuana use as well as marijuana use to tobacco use. This study shows that beginning one of these substances will increase the risk of using the other and there is much research available that provides evidence for both the gateway theory and the reverse gateway theory showing that there is a link between tobacco and marijuana regardless of which substance is initiated first. This study also provides relevance to the current project as most of the targeted recipients co-use tobacco and marijuana.

**Route of Administration.** The fact that many adolescents mix tobacco with marijuana when smoking marijuana, creates a common denominator and route of administration by inhalation for smoking both cigarettes and marijuana joints (Mayet et al., 2011). This could play a vital role in the co-use, as well as the transition of tobacco to marijuana and vise-versa (Mayet
et al., 2011). Becker, Schaub, Gmel and Haug (2015), reflected on a qualitative study of 5,590 young males conducted by Amos and colleagues. Their study showed that co-administering tobacco and marijuana, such as smoking joints, provides a gateway to smoking cigarettes. Resulted by mutual administration, smoking both tobacco and marijuana may reinforce each other by acting as behaviour cues to each other (Becker et al., 2015). Furthermore, using both tobacco and marijuana can affect the same neural pathways, also known as the reward system, with mutual enhancement by both substances. Additionally, nicotine has the potential to prolong and heighten the distinctive effects of marijuana (Becker et al., 2015). Early initiation of either substance is an increasing concern among adolescents as evidence suggests the relationship of substance use is a common pattern among youth (Ramo et al., 2012).

**Challenges to the Gateway Theory.** While much research suggests that marijuana is a gateway to harder drugs, the NIH (2011) suggest that most people who use marijuana do not move on to use harder drugs. Additionally, the NIH (2011) remains cautious in also recognizing the importance of other factors such as socioeconomic risk factors and the easy availability of substances such as tobacco and marijuana as an alternative to the gateway theory within at-risk populations. Findings from a study conducted by Makanjuola and colleagues (2010) showed that the gateway theory was not valid in all cases. The aim of the study was to determine predictors of substance use patterns. The Nigerian study used self-reporting assessments and included 2,143 participants from 6 different cities in Nigeria. Participants were 18 years of age and older. The survey assessments were conducted in six different languages appropriate to the participant. Interviews were completed in the participants households from February 2002 to May 2003. The survey was administered in two parts: part one included a diagnostic assessment on drug use and mental health disorders and part 2 included assessments on risk factors, consequences and correlates of the diagnosed disorder. Their study concluded that 12% of tobacco users and 31.4% of marijuana users did not follow the typical pattern of the gateway theory for substance use progression and that early age of onset, mental health disorders and socioeconomic factors were related to the substances of choice.

**Biopsychosocial Risk Factors**

Early onset of tobacco and marijuana use is heavily related to future diagnosed substance use disorders (SUD) and supported research indicates that this can increase the possibility for multiple substance use and issues of psychopathology (Richmond-Rakerd et al., 2015). Approximately 8% of adolescents that are between the ages of 12 to 17 who initiate drug use meet the criteria for a diagnosable SUD or dependence (Becker, 2013). In order to be diagnosed with a SUD, normal daily functioning of school, friendships, family relationships and social activities are negatively affected (Becker, 2013). SUD’s are associated with multiple risk factors including: delinquency, deviant peer groups, low self-esteem, suicide, accidents, unsafe sexual behaviours, mental health, and intergenerational patterns which include genetic and environmental (National Institute of Drug Abuse, 2015). Furthermore, early onset of substance use contributes to short and long-term adverse side effects both physically and mentally, psychosocial adjustment and poorer outcomes in adulthood (National Institute of Drug Abuse, n.d.).

**Environmental Risk Factors.** Socioeconomic factors play a crucial role during the development of adolescence. Youth who come from families where parents smoke, have a lesser
education, lower income and family dysfunction have a greater risk of substance use (National Institute of Drug Abuse, 2015). Parents who use drugs or engage in criminal behaviour often contributes to a chaotic, stress-filled environment with the potential of child abuse and neglect (National Institute of Drug Abuse, n.d.). Poor parenting skills and a lack of parent-child bonding are high risk factors in adolescent substance use (Traube et al., 2012). These family conditions are harmful to the appropriate development of youth and may create a pathway for substance abuse in the next generation (National Institute of Drug Abuse, n.d.). Families who live in poverty tend to live in marginalized neighbourhoods where drug use and crime are high and school attendance is low or non-existent (Valcov, 2018).

The relationship connecting substance abuse, truancy, deviant school peers and early school dropout among adolescents has been shown in many empirical studies (Valkov, 2018). Drug-using peers can have a negative influence and adolescents may smoke or do drugs to feel accepted by peers with a perception of social acceptance and a better self-image (Carters & Byrne, 2013). A change of peer groups, lack of academic motivation in attending classes, studying, completing homework and setting goals can all be the result of substance use (Valkov, 2018). Substance abuse plays in a variety of problematic roles in school drop-out as it can be seen as a cause, while school drop-out can be a predictor of substance abuse (Valkov, 2018). Additionally, Valkov (2018) reports that one-third of students who drop out view their substance use as a factor for school dropout.

**Biological Risk Factors – Mental Disorders and Genetics.** Genetics, gender and mental illness are all biological risk factors for substance abuse in adolescence. Maturation and development typically occur when in the adolescent stage. It is also a time when mental disorders, substance abuse and at-risk behaviours begin to emerge (Canadian Centre of Substance Abuse and Addiction, 2018). According to the Canadian Centre of Substance Abuse and Addiction (CCSAA, 2018) the relationship is strong between mental health and marijuana use with potential adverse side effects in adolescence. Mental disorders and substance abuse can both precede each other and there is an association between substance abuse and eating disorders, oppositional defiant disorder, bi-polar disorders, conduct disorder, attention deficit disorder, and mood disorders (CCSAA, 2018). Carters and Byrne (2013) report that multiple studies have been able to show a relationship among low self-esteem, as well as an increased risk of lifetime substance use. Additionally, substance use is often seen as a role in depression and anxiety (AAP, 2009). Youth who have anxiety, depression and stress may initiate drug use as an aid to lessen their distress (National Institute of Drug Abuse, n.d.). In addition, the co-morbidity of marijuana use, and depression can contribute to suicide (CCSAA, 2018). Weiss, Palmer, Chih-Ping Chou and Johnson (2008) found a relationship between psychological factors of anxiety, hostility and depression and the prevalence of lifetime smoking. Data collected through a cross-sectional, longitudinal study of 4,724 Chinese students in grades 7 and 11 showed a 44% rate of association between adolescent smokers and anxiety, a 59% rate of association with depression and a 35% rate of association with hostility.

Genetic factors and heritability make up between 40 and 60% of an adolescent’s vulnerability to substance abuse and males are more susceptible to substance abuse than females (National Institute of Drug Abuse, n.d.). Studies on families and twins show that smoking plays an important genetic role and report there is a good probability that many genes contribute to the behaviour of smoking (O’Loughlin et al., 2014). Additionally, as reported by O’Loughlin et al. (2014) a meta-analysis that was recently conducted by Han et al. recognized a linkage of several
chromosomal regions to smoking behaviours. Furthermore, genome-wide studies have also acknowledged an association of variants in many nicotinic receptor genes (O’Loughlin et al., 2014).

At-risk youth who reside in group homes are the targeted audience of this project and all of them display multiple risk factors for substance abuse. Most of these youth have already initiated tobacco and marijuana use and have mental health issues, dysfunctional family lives, deviant peers and have received few academic credits due to school dropout or truancy.

**Child Welfare.** Child welfare is a service provided to families, children and youth to support family dysfunction and protect children and youth in need (Health Standards Organization, 2017). In Canada the child welfare system is made up of Children’s Aid Societies governed by provincial ministries who partner with foster care families and private organizations such as group homes to provide services to at-risk children and youth. Within the continuation of care, residential group homes represent the highest level of care, most expensive and are often the last placement in sequence of care (Baker & Calderon, 2004). Child welfare group homes provide twenty-four hour a day services to a population that exhibits mental health issues, as well as substance abuse issues in a therapeutic environment and are an important part of the child welfare system (Baker & Calderon, 2004).

The Health Standards Organization (HSO, 2017) reports that youth and families that are found to be a part of the child welfare system face many challenging circumstances such as mental health, violence, trauma, youth justice, sexual abuse and substance abuse. The HSO (2017) estimates that in 2013 there were approximately 62,428 Canadian youth placed in care of foster and residential group homes. Youth who are found in the care of child welfare are at a risk of being exposed to higher risk-factors including an environment where parents have substance abuse issues and participate in criminal activities (Siegel, Benbenishty & Astor, 2016). Additionally, the risk of being exposed to intergenerational trauma such as poverty, violence and maltreatment is high (HSO, 2017). The effects of generational maltreatment and trauma cause significant distress in adolescents contributing to delinquency and substance abuse (Brown & Shillington, 2016).

In comparison to their high school peers who live at home, adolescents involved in out-of-home care, such as the child welfare system, have a higher likelihood of using tobacco and marijuana (Siegel et al., 2016). Siegel et al., (2016) analyzed data from the 2012-2013 California Health Kids Survey, a bi-annual state-wide survey, and found that adolescents that have been placed in the child welfare system were at a greater risk to use tobacco and marijuana than students the same age. According to this survey, less than 1% (706 students out of 166,521) of high school students across California lived in out-of-home care under the child welfare system; however, 7.7% of youth living in their primary homes smoked tobacco in comparison to 24.6% of youth in out-of-home care. In addition, drug use, including marijuana, was reported at 18.3% of youth in primary homes compared to 37.7% of youth in the child welfare system. Furthermore, the survey indicated that adolescents involved in the child welfare system believed that the risks involved of using tobacco and marijuana was low and were less likely to develop an unfavourable opinion of other substance users (Siegel et al., 2016). These statistics show that youth in out-of-home care have more than double the likelihood to smoke tobacco or marijuana than youth in primary homes.

Childhood maltreatment is often the result of parental substance abuse and is a leading
cause of early onset of adolescent substance use (Singh, Thornton & Tonmyr, 2011). In addition, children in the child welfare system could potentially be put in a constant circle of substance abuse where youth have an increased risk to abuse substances if their parents do (Traube, James, Zhang & Landsverk, 2012). Singh et al. (2011) analyzed data from 55 child welfare agencies across Canada and examined a subsample of 2,767 children between the ages of 10 – 15 who were victims of maltreatment. The study was built on the findings of the Canadian Incidence Study of Reported Child Abuse and Neglect-2003. This study showed that 14% of youth being investigated for maltreatment by substance using parents had initiated substance use at an early age. Furthermore, the results showed that 16% of youth where maltreatment allegations had been substantiated by substance-using parents engaged in early initiation of substance use.

Youth who reside at the current placement of this project are placed through the area Children’s Aid Societies due to maltreatment and substance using parents. Many have experienced traumatic events which can include sexual or physical abuse. This increases their risk of addiction in comparison to their school peers who live at home.

**Effects of Tobacco and Marijuana**

**Brain Development.** According to the National Institute of Drug Abuse (NIDA, 2015) marijuana can have negative effects on the brain during adolescence. During adolescence, the brain is continuously developing which means marijuana use during this timeframe can negatively affect emotional and cognitive functions (NIDA, 2015). Additionally, substance use increases the risk of serious structural and functional brain changes and impairs executive functioning which could have serious and long-term consequences (NIDA, 2015). Substance abuse can change areas of the brain including the brain stem which oversees critical areas necessary for life, including breathing, sleeping and heart rate. Other areas of the brain affected by substance abuse are the cerebral cortex which controls areas of senses, memory, learning, problem solving, planning, impulse control, decision making and judgment while the limbic system controls the reward and pleasure circuit and affects instinct and mood (NIDA, n.d.).

Marijuana and tobacco activate the brain reward system which affects pleasurable activities and can drive the desire for drugs to addiction (AAP, 2009). Marijuana can release approximately 2 to 10 times the amount of dopamine in comparison to natural rewards and when the reward circuit is activated the brain remembers and teaches us to repeat the behaviour (NIDA, n.d.). Dopamine is a chemical that helps regulate emotions and feelings of pleasure and is what creates the high and feel-good feelings (NIDA, 2015). Brain chemistry can be altered and interferes with the ability to make choices and positive decisions (NIDA, 2015). Eventually the body will begin to crave drugs and attempt to create the amount of dopamine released by the substance used to maintain the rewarding feelings. Tolerance builds at this point and the need to increase the amount of substance arises increasing the risk for dependence and addiction (NIDA, n.d.).

**Long Term Effects.** The National Institute of Drug Abuse (NIDA, 2015) reports that nicotine is responsible for the deaths of nearly 100 million people throughout the world. Smoking cigarettes has an adverse effect on almost all organs in the human body and in adolescence, smoking diminishes lung growth which deteriorates their function (AAP, 2009). Furthermore, according to the AAP (2009), tobacco is responsible for other health related risks such as: cancer, respiratory illness, heart disease and diabetes. Likewise, marijuana use also
physically affects the heart and lungs as well as impairs thought processes, body coordination and increases the risk of psychosis (NIDA, 2015). Some studies have documented the outcomes of the poor relationship amongst adolescent tobacco and marijuana use with health and functioning (Georgiades & Boyle, 2007). Georgiades and Boyle (2007), analyzed the longitudinal associations from adolescent tobacco and marijuana users showing a reduction in life satisfaction, lower education, less personal income, lower physical health and depression in young adulthood. The data was collected from the Ontario Child Health Study (OCHS) from 1282 youth ages 12 to 16. The OCHS analyzed data on the health and psychiatric disorders in adolescents who engaged in substance use in 1983, 1987 and 2001. Follow-up showed that adolescent substance use had a negative effect on functioning in physical health (62% lower), personal income ($7,281 less per year), depression (3.44 times higher) and education (2.29 years lower). A reported 11% or 139 participants identified as daily tobacco users communicated having externalizing and internalizing disorders, family dysfunction, poor socioeconomic status and substandard academic outcomes.

The aim of the current placement is to provide supports to enhance the future success of the youth in their care. The current project aims to provide informative, generic and simple information with evidence-based resources for staff to promote awareness and motivation to youth in their care to make positive changes for a more successful future.

**Treatment & Intervention**

Research suggests that tobacco and marijuana use can be reduced with early intervention approaches including cognitive behaviour therapy (CBT), assessment and screening tools, motivational interviewing, and harm reduction aids (Jiloha, 2017). In addition, the American Academy of Pediatrics (2009) indicates that most adolescents suggest that they are open to the idea of giving up tobacco.

**SBIRT.** Screening, brief intervention and referral to treatment (SBIRT) is an evidence-based, cost effective and universal tool for the identification of substance use risk and brief intervention such as motivational interviewing and CBT (Levy & Williams, 2016). Screening for risky substance use within the adolescent age group is an efficient means of identifying youth who have an increased risk of self-harm through substance use (Jiloha, 2017). Screening tools are brief self-reporting and non-intrusive questionnaires, surveys or interviews and are the most reliable source of data collection (Winters & Kaminer, 2008). Screening tools that have the lowest number of concise validated questions that can extract detailed and authentic responses are considered to be the most appropriate (Levy & Williams, 2016). The aim of screening is not to diagnose but to define the client’s personal experience with substances using a grid ranging from no substance use to substance dependency in order to aid in the next steps (Levy & Williams, 2016). One example of a popular screening tool used in SBIRT is the CRAFFT and it is highly recommended by the American Academy of Pediatrics (Levy & Williams, 2016). It is found to not only be effective, but also a fast way to determine if adolescents are at an increased risk of developing substance use problems or the potential for substance abuse. Furthermore, it helps to guide brief discussions about substance use with adolescents (Levy & Williams, 2016).

Brief intervention (BI) is the next step after screening identifies the severity of a substance use problem. Brief intervention is a practice that provides feedback on unhealthy substance use while increasing the client’s awareness regarding risks related to substance use and
identifying discrepancies between their behaviours and goals (Becker, 2013). BI is a client-centered approach which uses positive reinforcement and the principles of motivational interviewing to enhance readiness to change, build motivation and work towards an attainable intervention (Becker, 2013). The principles of motivational interviewing include expressing empathy, accepting client’s resistance, paraphrasing and summarizing. SBIRT can help reduce the risk of self-harming behaviours and negative health outcomes for adolescents who screen for no risk, mild risk or moderate risk (Becker, 2013). Growing in popularity, SBIRT has been empirically proven in the adult population but few studies have been done in the population of adolescents (Mitchell et al., 2012). Mitchell et al. (2012) examined outcomes of 629 adolescents aged 14-17 from 13 New Mexico schools who received SBIRT services. Data from the service level, number of sessions and self-reported days of drug or alcohol use within the last 30 days were collected from the CRAFFT screening tool at base-line. The 6-month follow-up of 553 (87.9%) adolescents showed youth receiving intervention reported significant reductions in frequency of use. This study is promising in its effectiveness for the adolescent population.

**Cognitive Behavioural Therapy.** Early identification of substance abuse and effective treatments has become a public health priority for adolescents (Becker, 2013). Brief motivational interventions for adolescents and CBT have been found to be effective for adolescents at risk of substance abuse (Becker, 2013). The cognitive-behavioural model states that adolescents may engage in substance use as a form of coping with different environmental factors, as well getting ones needs met (Becker, 2013). Cognitive behaviour therapy is a kind of psychotherapy focusing on thoughts, feelings and behaviours and how they inter-relate. The goal of CBT is to help youth modify their thoughts to cope more effectively in replacing negative behaviours with more positive behaviours. CBT aids in the identification of triggers and avoidance of triggered events or circumstances and learning behavioural strategies and coping skills to be more effective in dealing with the problems that potentially influenced the individual to begin using substances (Becker, 2013). Studies show that CBT can reduce use and increase abstinence in tobacco users as well as marijuana users (Jiloha, 2017). Becker and Curry (2008) assessed 31 peer-reviewed randomized trials on interventions for adolescent substance abuse on 14 attributes of trial quality. In addition, the authors evaluated and scored the quality of evidence on each study to compare support for each intervention. Superiority in two or more methodological studies included brief motivational interventions and CBT. The median quality of evidence support (QES) amongst trials within a range of 2 to 12 was 7. Treatment approaches fell into five main categories which included: family-based therapy, CBT, parent training, adolescent group therapy and brief motivational therapy. Brief motivational interventions were representative of the second most continuously used treatment model with a median QES of 7 with a range of 5 to 11 and CBT was found to have the highest quality of methodological evidence for substance use interventions. The median QES for CBT studies were analyzed to be 7.5 with a range of 7 to 8.

**Comprehensive Assessments.** Referral for more comprehensive assessments, extensive evaluation and treatment is made when a positive screen for a SUD is determined after screening (Levy & Williams, 2016). Substance use disorders, or addiction, is a brain disease resulting from disruptions in the reward circuit of the brain from the repeated use of substances (NIDA, 2015). A comprehensive evaluation by a specialist in the field is necessary to assess for co-occurring mental health disorders and long-term treatment is necessary at this stage (NIDA,
A Substance Use Disorder is a treatable disease but withdrawal and relapse during treatment happen frequently and is a normal part of recovery (NIDA, 2015). Clients can experience physical and emotional symptoms from withdrawal such as insomnia, depression and anxiety; hence, causing relapse (NIDA, 2015). Evidence-based treatments such as CBT and behavioural strategies to help avoid and cope with stresses that trigger relapse is often used in long-term treatment for SUD’s. Additionally, treatment must be reviewed and modified regularly to fit the changing needs of the client for it to be effective (NIDA, 2015).

The intention of the current study is to provide educational and evidence-based resources to staff working with at-risk youth in out-of-home care who partake in tobacco and marijuana use at an early age. The intention is to aid in identifying and intervening in reducing or eliminating substance use, prevention of initiating more illicit substance use and referring youth to more advanced clinical treatment when determined necessary.

Summary

Substance abuse among adolescents is a world-wide health concern and effects of tobacco and marijuana have long-term harmful mental and physical health implications (Ramo & Prochaska, 2012). Statistics show that there is a high rate of early initiation with both marijuana and tobacco use, with an increased risk of co-use among adolescents (Ramo et al., 2013). Many environmental, biological and mental health risks are associated with adolescent substance abuse. Youth in out-of-home care are particularly at risk with increased risk factors of maltreatment, substance using parents and trauma (Siegel et al., 2016). The developmental changes in the brain during adolescence increases vulnerability for substance use and early onset is correlated with lifetime incidence of addiction (Levy & Williams, 2016). This makes adolescence a critical period and thus outlines the importance of early screening and intervention of substance use (Levy & Williams, 2016).

In order to meet the needs of youth in out-of-home care, it is important to increase staff awareness to expand their knowledge and resources to enhance proficiency in program delivery. The literature review establishes that not only is substance abuse detrimental to the population of adolescents by contributing to risky behaviours, but its association with a magnitude of other health issues carry into adulthood. Through this literature review, a staff resource guide will provide direct access to factual and evidence-based material and strategies on substance abuse, specifically, tobacco and marijuana. In their roles as front-line staff, tobacco and marijuana have been identified as the two most abused substances among the adolescent population they work with. This guide will aid staff in preparing youth for reintegration back into the community. By providing youth with the skills and knowledge needed to transition into adulthood, they will be more prepared and have an increased chance of a healthier and more successful future.
Chapter III: Methods

Participants

A target audience of staff who work with at-risk youth in a group home setting were the primary focus. The staff at the group home have various educational backgrounds which range from Behaviour Science Technology, Child & Youth Worker to Community Justice Degrees and many have been employed there for several years. These staff are both male and female, with an age range of 20 and above. In addition to the targeted group home staff, other staff who are employed in open custody and open detention facilities, teachers and adolescent care workers in school settings, addiction and mental health workers, child welfare case workers and other organizations who work with at-risk youth could benefit from this resource as well.

It is expected that staff users have a post-secondary education in the field of human studies such as behavioural science, child & youth worker, criminal justice, behavioural psychology, counselling, sociology, neurosciences, psychology, genetics, biology or addictions. Other aspects of target users expected are employment experience working in the mental health, youth justice or addictions field working with at-risk youth.

Setting

The residential group home setting is a two story, 6-bedroom home located in Southeastern Ontario. The home boasts a large backyard including a side area with a basketball court, family room, kitchen, 2 bath rooms, dining room, basement, laundry room and an office. There is a family-oriented theme throughout the home with pictures of the youth hanging on the walls and a decorative style that you would see in any family home. The home is a 24-hour operated facility and houses 8 male, at-risk youth ages 12-17 who exhibit serious behavioural, mental health and addiction problems. This home employs approximately 25 staff. These youth are placed by Children’s Aid Societies located in central and eastern Ontario and reside at the group home for approximately 6 months to two years. The group home is a privately-owned facility licensed under the Child and Family Services Act through the Southeastern branch of the Ministry of Community and Social Services and Ministry of Children and Youth Services.

Design

An evidence-based resource guide on tobacco and marijuana was developed as an educational resource for staff in a group home setting working with at-risk youth. The aim of this resource guide is to educate staff and youth on the lifelong psychological and physical effects of tobacco and marijuana. With this resource guide, it is the intention to encourage motivation in youth to reduce or eliminate substance use and make healthier and more positive life choices moving forward.

The educational resource guide is detailed but practical and informative providing staff with evidence-based resources and factual information to help recognize and understand the issue of substance use within their work environment. Due to a variety of different staff educational backgrounds, it was decided that a simple layout with definitions, appropriate steps, detailed information and examples would be the best approach to ensure the information presented is easy to understand and comprehend. Therefore, the resource guide is designed in a basic and straightforward format. The resource guide provides facts and statistics on tobacco
Tobacco and Marijuana, scientifically proven tools for screening, brief interventions and treatment. Also included are instructions on how to use these tools, coping strategies and stimulating exercises. This resource is not geared towards youth in the general public with no known risk factors of substance use.

**Procedures and Supporting Information**

Information gathered through direct observation of the daily milieu, evaluation of agency programming and a review of the youths’ needs identified a lack of resources and a need for an evidence-based resource guide on substance use. Communication with agency management and the home’s behavioral therapist confirmed this need. Feedback for the development of this resource was solicited through direct and informal communication with front-line staff, prime workers, the behavioral therapist, supervisors, and the Executive Director. Suggestions and ideas were also sought through informal conversations from child welfare case workers when visiting the group home, but no information or feedback was received.

Supporting information for this guide was collected from peer-reviewed, evidence-based and best-practice materials from the relevant literature review. Key search terms such as “risk factors of tobacco and marijuana in adolescence”, “adolescent tobacco and marijuana use”, “adolescents in the Child Welfare System and tobacco and marijuana use” were used to obtain information through Google Scholar and EBSCO database. Statistical information was collected from recognized and validated web-sites and community-based pamphlets and written or web-based information was utilized and modified as relevant information.

An evaluation of the expected impact of this guide was sought through informal staff feedback at the end of placement. After completion of the first draft, the author solicited feedback from the Executive Director and the Behavioral Therapist during the last week of placement through an unstructured and informal interview. The author asked open and closed ended questions on the simplicity and practicality of the information provided, the layout and the relevance of the guide. Closed ended questions such as “Did you find this guide easy to follow” and “Is there anything more you would like to see added?” and open ended questions such as “How do you view the information provided”, and “How do you view this guide as a practical tool for the staff?” were asked to gather feedback.

Unfortunately, the efficiency of this staff resource guide was not measured by the author due to time constraints regarding placement timeframes.

**Layout and Content**

The resource guide includes an operational definition of substance abuse and is user-friendly. It was developed in a point form format and divided into six subsections: Introduction to Substance Abuse, Tobacco and Marijuana, Risk Factors, Screening Assessment and Treatment, Behavioral Strategies and Community and Web-Based Resources. Identification and connecting sections in a logical transition was necessary in order to create consistency and flow in a manner that makes sense. Appropriate next “stages” or “steps” are important so that the reader does not lose track and get confused. It is believed that providing awareness of all pertinent information on the subject will maximize the effectiveness of this resource guide. An introduction and purpose of this resource tool is identified at the beginning of this guide to outline the rationale and its purpose.
**Section 1 – Introduction to Substance Abuse.** Understanding substance abuse and the stages of addiction is the first section of this manual. An introduction and definitions of substance abuse, substance abuse disorder, substance dependence/addiction and The Diagnostic Statistical Manual (DSM5) is important and relevant information to know and understand before proceeding any further in this guide. Also included in this section is the DSM5 criteria for a substance use disorder, withdrawal symptoms, relapse, facts and statistics on substance abuse. Knowing these facts and being aware of the differences is a first step to following and understanding the other sections in this guide.

**Section 2 - Tobacco and Marijuana.** This section will be narrowed down to the targeted substances. Definitions, facts and statistics on tobacco and marijuana will be identified in this section of the resource. Information was taken from the literature review and a web search of validated websites will be used to provide definitions and describe the actual substance. Topics included tobacco use disorder, marijuana use disorder, the gateway effect and adolescents as a vulnerable population is also discussed in this section. This section will allow staff to identify the scope of the issue at hand and understand the substance while knowing the facts.

**Section 3 - Risk Factors.** Environmental, biological and early initiation risk factors will be discussed in this section. Facts and statistics will be provided to educate staff on some reasons why at-risk youth use substances. This section will provide awareness and education on the nature and dynamics of substance abuse in youth and will help identify youth who are at-risk and help to create empathy and understanding. This section will also identify long-term health effects and consequences of tobacco and marijuana, the effects on the brain and the link between substance abuse and mental health. The intent is that staff will understand that addiction is a disease of the brain and not something that they can just quit. Once risk factors have been identified and understood, staff can initiate the next step in the resource guide.

**Section 4 – Screening, Assessment and Treatment.** Section 4 will describe evidence-based approaches for screening, brief intervention and referral to treatment (SBIRT). Definitions, validated screening tools such as CRAFFT Screening Questionnaire, Cage-Aid Screening Tool, Brief Screener for Tobacco, Alcohol and Other Drugs (BSTAD) and the Brief Screening to Intervention (S2BI) will be introduced. These brief screeners were downloaded from the public domain and are free to use. Motivational Interviewing (MI) is defined and the principles of MI and specific skills with example questions are presented. Motivational interviewing is a powerful tool for motivating change in clients and considering the strong relationships between workers and their youth, this could be a very successful tool. The stages of change will be outlined and described in this section and an introduction to the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) will be introduced and explained in detail. If the youth is not motivated to change then you cannot move on to the next stage and a different approach may be necessary. Next, comprehensive assessments and treatment are defined and cognitive behavioural therapy (CBT) will be defined and discussed in detail. Training and scoring are also outlined so that staff can use these brief screeners to help identify if youth are at risk of substance abuse. There are no comprehensive assessments included in this guide as they should be completed by the Behavioural Therapist.
Section 5 – Behavioural Strategies. Behavioural and coping techniques will be introduced and discussed in detail in this section. Triggers and maintenance techniques for relapse/prevention are described and youth exercises for program delivery are included. Also included is information and exercises on coping skills, emotion management and behaviour strategies. Relaxation techniques, anger management skills and stress management skills are outlined, and exercises included for these as well. These resources are invaluable and easy to use by all group home staff. These exercises were all downloaded from a website that the author registered and paid for.

Section 6 – Community and Web-based Resources. Resources within the community are identified with brief descriptions and contact information for staff to further their knowledge and be made aware of the additional resources available to them.
Chapter IV - Results

A Staff Resource Guide for Tobacco and Marijuana for At-risk Youth was created after a need was observed by the author and confirmed by group home staff. There was a lack of evidence-based resources available to staff on substance use, primarily tobacco and marijuana, two popular substances used by a majority of youth residing in Ventures Group Home. The final product of this thesis can be found in Appendix A.

The format of the resource guide follows a simple method in a logical sequence and is divided into subsections making the transition from one section to the next easy for staff to understand and follow. This layout maximizes the guide's effectiveness and increase staff awareness and knowledge on the subject. The guide provides scientific definitions, empirically proven statistics and other factual information on substance abuse among the population of adolescents. Evidence-based resources to aid staff in behavioural strategies, the screening, identification, intervention and referral of substance use problems among youth in the group home are also included.

It is the intention that by increasing staff awareness and providing them with the appropriate resources, staff will be more educated and skilled in the area of substance abuse and thus will enhance program delivery. With an increase in program efficiency and the ability to directly target problem areas such as tobacco and marijuana in a best-practice approach, it is likely that the youth will be motivated to engage in goal setting and making positive change. Feedback on this guide was sought through informal interviews with management and the behavioural therapist. Of the limited feedback that was provided, it was positive, with mention on the simplicity and format. Positive feedback was also delivered in regard to the lack of resources currently available at the group home on substance abuse, as well as the section on community resources. It was expressed that this resource guide would be an invaluable tool for all staff in the group home.
Overview

Peer reviewed research studies indicate that early initiation of tobacco and marijuana use is an increasing health concern in the adolescent population. Evidence suggests the co-occurrence of these substances is a common pattern among youth and early initiation increases the risk of dependence and is a potential gateway to harder drugs. Tobacco and marijuana are the most used substances among young people and research shows that adolescents are experimenting at a much younger age and that popularity, especially with marijuana, is growing. Additionally, the belief among young people that these substances are not harmful may contribute their growing popularity and early initiation. Many negative long-term effects have been established through empirical research and deficits in physiological, behavioural and physical health have all been associated with the use of tobacco and marijuana.

Tobacco and marijuana use were identified by staff at Ventures Group Home as a problematic area among the youth in their residence. Most of the youth residing in their home use tobacco and marijuana. The use of these substances often results in criminal activities such as stealing for money to purchase tobacco and marijuana, breaches of probation associating with deviant peer groups as well as AWOL (absent without leave) from the home or non-attendance at school. Mental health issues such as depression, impairment of cognitive functioning and lack of motivation are also related issues seen within these youth. Staff cited a lack of empirical resources available to them in the group home for the purpose of education, recognizing and program delivery on substance abuse. In order to meet this need, a staff resource guide on tobacco and marijuana was developed from empirical evidence gathered from the literature review as well as other reliable resources and best practice approaches. The overall goal of the resource guide was to provide simplistic, practical and easy to comprehend educational material and evidence-based resources on substance abuse, primarily tobacco and marijuana with a direct link to enhancing program efficiency and delivery. This guide was developed in a logical sequence to educate and increase staff awareness on tobacco and marijuana, substance use disorders and addiction, risk factors, motivational interviewing, screening, assessment and treatments as well as coping strategies. According to feedback received by management, it is believed that this resource guide has the potential to enhance staff awareness to recognize and identify substance issues and educate staff in best-practice approaches to reach the goal of harm reduction or abstinence.

A review of the literature revealed that tobacco and marijuana use among adolescents is a world-wide health problem. In order for youth who are at risk to receive the help they need, staff working with these youth must be aware of the issues at hand and engage in best practices and evidence-based approaches for ultimate results. It was hypothesized that the resource guide will enhance staff awareness while providing validated resources to increase motivation in the youth they work with to set goals in making positive changes for successful reintegration into families and communities. Furthermore, behaviour strategies included in the resource guide can be invaluable tools for youth to learn and adapt coping skills to deal with future pressures and triggers going into young adulthood. Although the hypothesis could not be tested, the resource guide was determined by management to be an effective tool for staff and it is expected that its implementation has the potential to motivate positive behaviour changes in the youth residing in the group home.
Strengths

A key strength of the resource guide is that it is based on empirically reviewed research from an extensive literature review. The resource guide includes factual information, validated best-practice approaches and strategies to help elicit positive change in clients. The layout of the resource is practical and follows a logical order to increase staff awareness and guide staff through necessary steps in a manner where it can be easily understood and followed. Given the fact that staff at Ventures Group Home have different post-secondary educational backgrounds, learning experiences and knowledge on substance use, this guide is not specific to one human service field but rather transdisciplinary and can be utilized by all staff in the home as the design is simplistic, user friendly and easy to read. All staff with a background or training in human behaviour studies should be able to utilize this manual. It covers all areas of substance abuse with factual statistics and detailed information. Additionally, this guide provides step by step directions in motivational interviewing, examples of validated screening tools, brief interventions and work sheets for coping skills that can be utilized by staff to better identify substance abuse problems and promote and encourage positive change in youth by reducing or eliminating substance use. In addition, the techniques included are easy and cost effective.

Another strength of this manual is that it supports the priorities of the group home and enhances the programs integrity by targeting the beliefs and goals of the group home. It is the goal of Ventures Group Home to promote socially acceptable behaviours of the youth they work with by restructuring cognitive distortions to enhance future success moving into young adulthood or reintegration back into families or communities by making positive behavioural choices, increasing academic success and employability. These are areas where substance abuse has been identified to have negative consequences. Additionally, as family support is provided by Ventures staff, parents and other family members of youth in care may benefit from this resource guide to aid in family education of substance abuse in working towards successful reintegration while coping techniques could be utilized for those parents who were previous substance users. Furthermore, parents of youth who live at home, school staff or other community agencies who work with at-risk youth may find the resource helpful in identifying risk factors and early identification of substance use.

On a societal scale, an additional strength of this guide is that it has the potential to contribute to the reduction or elimination of substances such as tobacco and marijuana in the population of young people, therefore, reducing future health care costs. Additionally, the potential risk of progression to harder drugs could be reduced impacting crime rates, poverty, and family dysfunction.

Limitations

The main limitation with this resource guide is that the hypothesis could not be tested and validated due to time restraints. Additionally, despite positive feedback from the group home Behavioural Therapist and the Executive Director, there was limited availability of front-line staff and prime workers for feedback. A very hectic and fast paced environment restricted feedback from those staff who would most benefit from the guide. A potential limitation for staff would be the lack of building a positive rapport with the youth. Although rapport building is an important aspect of behavioural concepts in this field there is no section included in this guide on it. Additionally, although motivational interviewing has been incorporated into this
guide, this is an area that takes practice to gain the skill and extensive training to ensure this skill is done properly. Without rapport building, motivational interviewing has the potential to be ineffective in increasing readiness to change.

Finally, most young people who experience substance abuse also face additional burdens such as mental health issues, stress or low self-esteem. This guide does not expand on additional issues that may co-occur with substance abuse which may limit the guides effectiveness on those youth who experience multiple issues.

Multilevel Challenges

Client. Motivation to change in this client population is a challenge. In regard to substance use, a majority of youth in Ventures Group Home co-use tobacco and marijuana and believe the risks to them are low; therefore, they are not motivated to change. While motivational interviewing techniques are included in the resource guide, resistance from youth is likely. Focus and engagement are other challenges among this population; therefore, staff must be aware of timeframes during program delivery to ensure youth are engaged and consuming information being relayed to them. Additionally, most have experienced traumatic events in their lives and exhibit serious problematic behaviours, emotional and mental health issues; therefore, substance use may be a coping strategy for them.

Program. Negative behaviours and consequences of youth are daily struggles within a group home setting. When behaviours reach the intensity of property damage, assaultive or self-harming behaviours or absence without leave (AWOL) the daily milieu and entire program of the home is thrown off. When youth receive consequences for negative behaviours, the youth may be taken off program meaning that while the youth still receives all necessities, they are not permitted to participate in in-house programming such as one-on-one programming, extra curriculum activities and reinforcers previously earned such as free time in the community are taken away. The challenge with this is when a youth is off program, it diminishes the opportunity for staff and youth to spend quality time and continue to build relationships. This creates barriers for staff to continue to motivate the youth to stay on task. Additionally, youths’ behaviours negatively affect other youths’ behaviours consuming front-line staff in crisis intervention, debriefing and report writing, with less time focused on programming and rapport building. Furthermore, living in a home with youth who all portray deviant behaviours, youth feed off each other and it is difficult for them not to engage in peer pressure.

Organization. Staff working in a group home require the necessary educational background, but also the ability to work in a fast-paced and highly demanding environment. This area of work is also desirable experience for future careers in corrections and policing. Staff turnover can be difficult for youth in the group home as they require a structured environment and sometimes feel abandoned and angry when staff that they have built therapeutic relationships would leave the organization.

Another challenge at the organizational level is the lack of communication among different organizations and agencies involved in the youth’s program/treatment plan. Each youth has a multi-disciplinary team of professionals for different aspects of their set goals and intervention. There is a multitude of different agencies involved with each youth such as schools, probation, psychiatrists, CAS workers, Maltby Centre, etc. and it can be challenging to
ensure that pertinent information between agencies flows appropriately and it also can be overwhelming for the youth.

One final notable challenge is funding. As in any organization, there are many areas that could be improved if more funding was available; staffing, psychological support and assessments and programming to name a few.

**Society.** The biggest societal challenge that exists for these youth is the stigma of being in a group home. Society still labels these youth as “criminals”, “bad kids” or “mentally disturbed”. The term “lock them up and throw away the key” is still an unfortunate mentality of some people today. This stigma can prevent these youth from success and makes it difficult to be educated, gain employment or be involved in community events such as sports or other groups. The lack of support can be frustrating and alienate youth, reverting them back into their old patterns and deviant peer groups where they are accepted.

**Contributions to the field of Behaviour Psychology**

The field of Behaviour Psychology focuses on the studying and changing of behaviours using evidence-based techniques and behavioural strategies. This thesis contributes to the field of Behavioural Psychology by increasing awareness of substance abuse through the development of an evidence-based resource guide for staff working with at-risk youth. The guide provides a behavioural framework by introducing and explaining behavioural psychology concepts such as motivational interviewing, screening and cognitive behavioural therapy. It also incorporates validated best-practice approaches, stress reduction techniques and behaviour strategies for coping skills.

This guide was created through empirically proven research collected through a detailed literature review and validated resources on substance abuse. Its main objective is to increase staff awareness on substance abuse and enhance theoretical knowledge to apply clinical skills to promote positive behaviour change in substance abuse among at-risk youth residing in a group home resulting in an improved quality of life. Ultimately reduced substance use or abstinence is the primary goal.

**Recommendations for Future research**

Due to the inability to implement and determine the efficiency of this resource guide before the end of placement, future recommendations would be to determine the effectiveness of this guide within the group home setting with a follow up after discharge. It would also be beneficial to build off this guide and expand current research to other drugs such as cocaine, meth and opioids. Additionally, given the high rates of concurrent disorders with substance abuse, a section on common co-occurring mental health disorders and substance abuse could be added in the future. Lastly, during the development of this manual, marijuana was legalized in Canada. It would be worthy to research the facts, statistics and the implications of legalizing marijuana for comparison and inclusion of the current research provided.
References


Appendix A – Staff Resource Guide on Tobacco and Marijuana for At-risk Youth

The Development of a Resource Guide on Tobacco and Marijuana for Group Home Staff for At-risk Youth
The Development of a Resource Guide on Tobacco and Marijuana for Group Home Staff for At-risk Youth

Zachary Revell [Student]

The procedures in this staff training manual/workshop are meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff.
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Introduction

An educational resource guide was developed to provide staff at a child welfare group home with factual and evidence-based information and resources on tobacco and marijuana. The key objective is to enhance education and provide applicable resources and educational tools to staff for appropriate program delivery to motivate youth with substance use problems. This guide was developed in a generic, simplistic and straight-forward manner for easy reference. It is the intention that this resource will aid staff in providing fact-based and consistent information to assist the youth in understanding the impact of problematic substance use. Through increased awareness, staff will be able to provide effective program delivery, identify and create appropriate interventions for substance using adolescents. It is anticipated that this guide will help staff to motivate positive change and restructure cognitive perceptions of adolescent substance use among this population, providing them with more opportunities for future success.

This resource guide will include components on the following:

❖ Substance abuse and addiction
❖ Tobacco and marijuana
❖ Physical and psychological risk factors
❖ Screening, Assessment and Treatment
❖ Behavioural Strategies
❖ Community and web-based resources

Rationale

An existing training and resource manual, at the time of this thesis, did not include a section on substance use. VGH provides services to a vulnerable population of substance using adolescents. Accordingly, tobacco and marijuana use are the most used substances among this population (Ramo, Liu & Prochaska, 2011). Research shows that the scope of tobacco and marijuana use is widespread with high numbers of youth engaging in these substances. Staff at VGH estimate that approximately 90% of youth referred to their program smoke tobacco and they approximate that 75% co-use with marijuana. There are many physical and psychological risk factors associated with tobacco and marijuana that have long-term harmful effects. Empirical-based evidence suggests that youth involved in the child welfare system, in comparison to their same-aged peers living with their families, are more vulnerable to substance use due to the unique set of risk factors that they face (Siegela, Benbenishtya & Astom 2016). Therefore, it is imperative to educate staff and provide easy access of important, factual and evidence-based information to enhance their knowledge and increase their awareness of the issue’s youth face in regard to substance use. This easy access will enable them to provide appropriate program delivery to substance-using adolescents.
Section 1
Introduction to Substance Abuse
What is Substance Abuse?

Substance abuse is the excessive and inappropriate use of any substance that results in harmful effects.

➢ A maladaptive pattern of substance use resulting in adverse consequences
➢ Overusing substances can lead to several harmful consequences including addiction, dependence, behaviour problems, school failure, mental health problems, physical illness, sexual diseases, lower economics, criminal behaviours and aggression.
➢ Substance abuse can lead to a substance abuse disorder and addiction
➢ Substance abuse can occur without dependence

Substance Use Disorders

➢ Substance abuse disorder (SUD) is a condition in which the use of one or more substance leads to a clinical impairment or distress in a person’s life
➢ A SUD can interfere with the ability to work, attend school and maintain healthy relationships with family and friends
➢ Different types including Tobacco Use Disorder and Marijuana Use Disorder
➢ Changes in appearance, actions and habits are indicators of a SUD
➢ Does not have a pattern of compulsive use despite problematic use
➢ There are three levels of substance abuse disorder: mild, moderate & severe
➢ Substance abuse affects millions of people each year
➢ Patterns of symptoms from continuous substance use despite resulting problems

Substance Dependence

➢ Also referred to as “drug dependence”
➢ Constitutes a cluster of cognitive, behavioural and physiological symptoms indicating continued substance use despite the occurrence of severe substance-related problems
➢ In the DSM-5 substance dependence has been combined with substance abuse and both have been replaced by the term “substance use disorder”
➢ Not synonymous with physical dependence
Addiction

➢ Addiction and dependence are components of a substance use disorder with addiction representing the most severe level of the disorder
➢ Generally applied to patterns of heavy, compulsive use of psychoactive drugs and an inability to stop substance use even though it is leading to severe and clinically relevant problems in many aspects of a person’s life
➢ Addiction is a disease
➢ A brain disorder characterized by uncontrollable engagement in rewarding stimuli despite the negative consequences
➢ Loss of control over the use of substances, difficulty reducing use, strong cravings, significant time spent trying to find, use and recover from substances
➢ Risky use
➢ Building a tolerance and going through withdrawal symptoms
➢ Psychological and/or physical dependence
➢ Physical, psychological and social problems
➢ Relapse often occurs
➢ Is treatable
The Diagnostic Statistical Manual (DSM5)

➢ A handbook used by health care professionals as a scholarly guide to the diagnosis of mental disorders. The DSM contains descriptions, symptoms and other criteria for diagnosing mental disorders and addictions
➢ Evidence-based and clinical research
➢ Is published by the American Psychiatric Association (APA)

DSM5 Criteria for a Substance Abuse Disorder

Substance use disorders are defined in the Diagnostic Statistical Manual (DSM5). There are three levels of a SUD:

- **Mild**
  - Two or three symptoms/criteria
- **Moderate**
  - Four or five symptoms/criteria
- **Severe**
  - Six or more symptoms/criteria

Symptoms or Criteria for a diagnosed Substance Use Disorder:

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.
Interesting facts ........

➢ In 2014, 21.5 million Americans ages 12 and up were diagnosed with a SUD
➢ Approximately 21.6% of Canadians in 2012 met the criteria for a SUD
➢ Youth aged 15 to 24 had a higher rate of substance use disorders than any other age group (11.9%)
➢ Males had a higher rate than females
➢ The National Institute of Drug Abuse (NIDA, 2015), estimates that 1 in 11 youth will have substance abuse problems
➢ Substance abuse in Canada is now recognized as a major health care problem that entails substantial economic costs.

Withdrawal

Withdrawal occurs when a substance user stops using. Various physical and emotional symptoms can occur during this time. Some common withdrawal symptoms include;

Mental & Emotional Withdrawal Symptoms

• Anxiety
  • Anxiety, panic attacks, restlessness, irritability
• Depression
  • Social isolation, lack of enjoyment, fatigue, poor appetite
• Sleep
  • Insomnia, difficulty falling asleep or staying asleep
• Cognitivie
  • Poor concentration, poor memory

Physical Withdrawal Symptoms

• Head
  • Headaches, dizziness
• Chest
  • Chest tightness, difficulty breathing
• Heart
  • Racing heart, skipped beats, palpitations
• GI
  • Nausea, vomiting, diarrhea, stomach aches
• Muscles
  • Muscle tension, twitches, tremors, shakes, muscle aches
• Skin
  • Sweating, tingling
**Relapse**

- Relapse is the return to drug use after an attempt to quit
- Relapse is an on-going risk for substance abuse recovery and for some life-long
- Relapse doesn’t mean you have failed
- Relapse is common and occurs between 40% – 60% during treatments
- Relapse is a normal part of recovery, however, can be dangerous as your body if a person tries to use the same amount as prior to treatment as it could have serious consequences as their bodies are no longer adapted to their previous usage
- In order to prevent relapse treatment plans should be reviewed frequently and modified to fit changing needs
- Most common triggers for relapse are stress, people, places, things and moods

**Why do Adolescents Use Substances?**

- To feel good, happy, pleasurable feelings
- Lessen feelings of distress from anxiety, depression or stress
- Curiosity
- Peer pressure
- Adolescents are more likely than adults to engage in risky or daring behaviours to impress their friends and express their independence from parental and social rules
- To cope or forget
- Increased socialability
- To fit in
Section 2

Tobacco and Marijuana
Tobacco

➢ Leafy green plant grown around the world.
➢ Thousands of chemicals but the most dangerous ingredient is nicotine.
➢ Nicotine is addictive
➢ Tobacco use is the leading preventable cause of disease, disability and death
➢ Nicotine accounts for approximately 100 million deaths each year
➢ No evidence suggests there is a difference between regular, light or menthol and that one is safer than the other.

Also known as;

✓ Cigarettes
✓ Butts
✓ Cigs
✓ smokes
✓ cigars
✓ bidis
✓ hookahs
✓ smokeless tobacco
✓ sniff
✓ spit
✓ chew tobacco
✓ smokes

Tobacco is highly addictive! Some signs of addiction……..

➢ Cannot stop smoking despite trying to quit
➢ Cravings
➢ Withdrawal symptoms – shaky hands, irritability, rapid heart rate, sweating
➢ Habitual time frames/triggers ie after you eat, when you wake up, with a coffee, while you drink alcohol etc
➢ Won’t attend places/events where smoking isn’t allowed
➢ Continue to smoke despite health problems
➢ Build a tolerance therefore need to smoke more to get the same effect
➢ Tobacco users have high relapse rates about 75% in first six months
Some facts on tobacco use…..

- Adolescents who smoke tobacco are 8 times more likely to smoke marijuana
- Nicotine has been found to increase the likelihood of future marijuana use
- The average age of tobacco use is 13
- The American Academy of Pediatrics (APP, 2009) estimates that 1.4 million youth start smoking each year
- Most youth who smoke in their teens will be life-long smokers
- Increased chances of risky behaviours
- Approximately 603,000 students in Ontario use tobacco
- Each day approximately 3,200 adolescents smoke their first cigarette
- Each day approximately 2,100 adolescents who were casual smokers become daily smokers
- Approximately 1 in 13 people will die prematurely from smoking
- Nicotine is a stimulant and a sedative
- Although smoking rates have been falling among youth in North America, they are still a concern
- A Canadian survey found that 18% of teens aged 15-19, and 26% of youth aged 20-14 were current smokers
- The average number of cigarettes smoked by daily adolescent smokers is 10 to 11 a day

Immediate effects of tobacco use…..

- Causes a rush of adrenaline
- Triggers an increase in dopamine (the brain’s happy chemical) which stimulates the area of the brain associated with pleasure and reward
- Increased alertness and concentration
- Increased blood pressure and heart rate
- Decreased blood flow
- Bad breath
- Dizziness, nausea, headaches, confusion
- Coughing

Tobacco Use Disorder/Nicotine Dependence

Nicotine Dependence is recognized as a medical condition in the Diagnostic and Statistical Manual (DSM5) of the American Psychiatric Association.

- An abnormal pattern of nicotine use which leads to a clinically significant impairment or distress. The addictive nature of nicotine includes obsessive use, reinforced behaviours and continuous use after abstaining and physical dependence and a tolerance build up
**Criteria for being diagnosed with a Tobacco use Disorder;**

There are 3 levels of the disorder:

- **Mild**
  - Two or three symptoms/criteria

- **Moderate**
  - Four or five symptoms/criteria

- **Severe**
  - Six or more symptoms/criteria

When an individual uses tobacco for more than a year and a minimum of two of the symptoms are present, a diagnosis will occur. The symptoms for a tobacco use disorder are as follows;

- Inability to quit or reduce despite repeated efforts
- A great deal of time is spent obtaining, using (chain-smoking) and recovering from the effects of nicotine
- Cravings
- Social, recreational or occupational activities are given up or reduced because of smoking
- Nicotine is still being used regardless of a physical or physiological effect caused by nicotine
- Relinquishing responsibilities
- The use of tobacco in harmful situations or settings (ie pregnancy)
- Necessity to increase amount of nicotine to continue its effects
- Withdrawal symptoms

**Tobacco Withdrawal Symptoms**

- Irritability
- Attention problems
- Sleep problems
- Weight Gain
- Depression
- The use of another drug or more nicotine is used to lessen symptoms
- Increased appetite
Did you know?

According to the DSM(5), some of the factors for a tobacco use disorder are;

Marijuana

- Greenish-gray mixture of the dried flowers of *Marijuana sativa*, shredded leaves, stems, seeds, resin (hashish), black liquid (hash oil)
- Is addictive
- Has 500 chemicals but THC is the mind altering one
- The amount of THC in marijuana has increased in the past few decades
- Marijuana extracts such as hash oil, wax and shatter have 3 to 5 times more THC than the plant itself
- Smoking or vaping can deliver dangerous amounts of THC
- Stimulates the brain's reward system reinforcing behaviour/dependence
- Regular use can result in various degrees of impairment
- Although no reported deaths from overdosing from marijuana, there have been multiple reported emergency room visits for psychotic reactions, shaking, anxiety, paranoia and hallucinations

Also known as;
- Blunts
- Buds
- Dope
- Grass
- Herb
- Joint
- Mary Jane
- Pot
- Reefer
- Smoke
- Weed
- Hash
- Hemp
**Synthetic marijuana**
- K2
- Spice
- Man-made chemicals and highly dangerous
- Sometime cause overdose deaths

**Method of consumption…..**
- Smoked as a cigarette (joint, spliff, blunt)
  - when smoked, effects take place right away and last a few hours
- Edibles (in food)
  - effects may take place 30 minutes to two hours after taking them and can last up till 12 hours
  - because it takes longer to kick in a person may believe it is not working for them prompting them to take more in a short amount of time intensifying the effects
- Vaporizer (vape pens or pipe or bong)
- Dabbing (consumed as an oil, wax or shatter)

**Short term effects of marijuana**
- Feeling “high, relaxed and happy
- Changes in perception
- Time distortion
- Increased blood pressure and heart rate
- Red eyes
- Dry mouth
- Lack of coordination
- Low concentration/attention span
- Lack of memory
- Lack of judgment
- Slowed reaction time
- Confusion
- Decision making is impaired
- Anxiety or panic
- Food cravings
Marijuana Use Disorder/Dependence

➢ Approximately 10% of marijuana users will develop a marijuana use disorder
➢ People who begin using marijuana before the age of 18 are 4-7 times more likely to develop a marijuana use disorder
➢ Depends on many factors such as genetics, age of onset, their environment, the use of other drugs, family dynamics and peer groups
➢ Relapse is common

Criteria for being diagnosed with a Marijuana use Disorder;

There are 3 levels of the disorder;

<table>
<thead>
<tr>
<th>Level</th>
<th>Symptoms/Criteria</th>
</tr>
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<tbody>
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<td>Severe</td>
<td>Six or more symptoms/criteria</td>
</tr>
</tbody>
</table>

When an individual uses marijuana for at least one year and a minimum of two of the symptoms are present, accompanied by significant impairment of functioning and distress a diagnosis will occur. The symptoms for a marijuana use disorder are as follows;

- Inability to quit or reduce despite repeated efforts
- A great deal of time is spent acquiring, using or recovering from the effects of marijuana
- Cravings/desires – including intrusive thoughts, dreams, etc.
- Social, recreational or occupational activities are given up or reduced because of marijuana
- Marijuana is still being used despite adverse consequences from its use such as poor productivity, failed relationships, criminal behaviours, poor physical and mental health, etc.
- Difficulty containing use - used in larger amounts over a longer period of time
- The use of marijuana in potentially dangerous situations ie driving
- Tolerance build up. Necessity to increase amount of marijuana to continue its effects
- Withdrawal symptoms
Marijuana Facts and truths......

➢ 1 in 11 youth will use marijuana
➢ In 2005, 46.2% of grade 12 students in Ontario reported using marijuana
➢ Youth aged 15 – 24 reported twice as much marijuana use than adults.
➢ The average age for marijuana use is 15
➢ Marijuana use can lead to harder drug use such as cocaine and meth
➢ 6.5% of US students in grade 8 use marijuana
➢ 16.6% of US students in grade 10 use marijuana
➢ 21.2% of US students in grade 12 use marijuana
➢ Across Canada 20.6% of students in grades 10-12 use marijuana
➢ Approximately 46.2% of Ontario students have used marijuana
➢ 33% of young Canadian substance users use marijuana daily
➢ Early use of marijuana can lead to a substance use disorder
➢ One in 6 youth who initiate marijuana use will become dependent
➢ Globally, marijuana is the most frequently used illicit drug
➢ Canadian youth have the highest rates of marijuana use compared to their peers in other developed countries

In addition . . . .

According to the DSM-5, some risk factors for Marijuana Use Disorder include;

- Family History of chemical dependence or marijuana use and/or an unstable family environment
- History of conduct disorder or Antisocial personality Disorder
- Low Socio-Economic Status
- History of tobacco smoking
- Poor Academic performance
More Facts and statistics on Tobacco and Marijuana

➢ Adolescents have a higher risk of initiating tobacco and marijuana
➢ Tobacco and marijuana are the most common used substances among adolescents and usually co-occur
➢ Tobacco and marijuana reinforce each other which raises the chance of dependence
➢ Globally, approximately 20% of adolescents between the ages of 13 and 15 co-use tobacco and marijuana
➢ Normal functioning of the brain may be affected negatively on emotional and cognitive functioning during development.
➢ Youth in out of home care are twice as likely to use tobacco and marijuana then peers the same age living with their families
➢ Drug use was reported as 18.3% for youth in primary homes compared to 37.7% of youth who live in foster or group homes
➢ Nicotine is a gateway for marijuana and vice-versa
➢ The earlier the onset of use the greater the risks and development of a SUD
➢ Youth view tobacco and marijuana as a low risk
➢ Adolescents who progress from tobacco to marijuana are more prone to be heavy smokers and nicotine dependent
➢ 2.9% of 12 and 13-year-old adolescents will initiate marijuana each year
➢ Lifetime marijuana use is reported by 17% of Canadian students in grades 7-9
➢ Approximately 29% of 15-17-year-old adolescents and almost half of 18-19-year-old adolescents have use marijuana in Canada
➢ When compared internationally, Canadian boys report the highest frequency of marijuana use (more than 40 times in their lifetime)
➢ A recent Canadian survey showed that students in grades 5 to 9 had tried smoking cigarettes at some point
➢ In Canada, the latest statistics show that tobacco, alcohol and illegal drug use contribute to 21% of all deaths, 25% of potential years of life lost, and 19% of days spent in hospital for Canadians aged 15 or older
The Gateway Effect

➢ The National Institute of Drug Abuse reports that most adolescent drug use begins with nicotine, often referred to as the “gateway effect”
➢ The gateway effect is the theory of a pattern of initiation that progresses from one drug to another starting with tobacco
➢ The gateway theory is well-founded
➢ The intent of the gateway hypothesis is to identify at-risk populations, such as adolescents, who have a greater probability of making that transition
➢ The gateway hypothesis was founded by Denis Kendal through observation of adolescents involved in drugs in stages and in sequence, most notably tobacco to marijuana to cocaine
➢ Is empirically proven
➢ Recently, many empirical and evidence-based research has determined that the reverse-gateway effect also exists, where marijuana precedes tobacco
➢ Research now indicates that 1 in 5 adolescents who smoke marijuana have never smoked cigarettes. This suggests that adolescents who use marijuana first are more likely to use tobacco with a greater chance of becoming nicotine dependent
➢ Given the fact that many adolescents mix tobacco with marijuana when smoking marijuana, there is a common denominator of administration by inhalation. This could play a vital role in the association between the two
➢ Resulted by mutual administration, smoking both tobacco and marijuana may reinforce each other by acting as behaviour cues to each other
➢ Nicotine has the potential to prolong and heighten the distinctive effects of marijuana
➢ The co-use of tobacco and marijuana affects the same neural pathways, also known as the reward system, with mutual enhancement by both substances
➢ High rates of marijuana use have been proven to precede other illicit drugs
Section 3
Risk Factors
## Risk Factors

Adolescence is a crucial developmental stage with an area of vulnerability in relation to substance abuse.

<table>
<thead>
<tr>
<th>Environmental</th>
<th>Biological</th>
<th>Early Use</th>
</tr>
</thead>
</table>
| • Home & Family  
• Peers and School  
• Socioeconomic | • Genetics  
• Mental disorders | • Can lead to Substance Abuse  
• Can lead to addiction |

### Environmental Risk Factors

- Parents or older family members who abuse alcohol or drugs, smoke tobacco or who engage in criminal behaviour, can increase children’s risks of developing their own drug problems.
- Abusive and dysfunctional home life
- Maltreatment and trauma
- Deviant peers and peer pressure
- Low income and uneducated parents
- Low academic outcomes
- School drop-out/low academic achievement

### Biological Risk Factors

- genetic factors account for between 40 and 60 percent of a person’s vulnerability to addiction; this includes the effects of environmental factors on the function and expression of a person’s genes.
- A person’s stage of development and other medical conditions they may have are also factors
➢ Adolescents with mental disorders are at greater risk of drug abuse and addiction
➢ Hostility, mood traits, anxiety, depression are all risk factors for adolescents
➢ Stress, low self-esteem, social acceptance and self-image
➢ Males are more likely to develop a SUD than females

**Early Onset of Substance use…….**

➢ Adverse side effects of physical and mental health issues, psychosocial adjustment, school and work performance, other drug use and career opportunities
➢ The more potential for serious structural and functional brain changes and impairment of executive functions such as memory, learning, problem solving, judgment, planning and control of impulsivity
➢ Poorer outcomes in adulthood
➢ Increased risk of addiction and substance use disorders
➢ Increased risk of initiating harder drug use
➢ Risky behaviours such as unprotected sex and driving under the influence

**Additionally…….**

➢ Substance use behaviour is complex and a wide range of risk factors have been identified and classified with reference to the individual, the family, the peer group, school and environment.
➢ Experts agree that the cumulative number of risk factors, rather than any one specific risk factor, increases the likelihood of substance use or abuse.
➢ Age is perhaps the strongest determinant. Generally, substance use increases with age during adolescence, peaks in the mid to late 20’s
➢ Other individual-level risk factors include attitudes and beliefs about the risks of use, impulsivity and sensation seeking

-interesting facts……

✓ Approximately 10% of youth have reported driving under the influence
✓ Marijuana is associated with a significantly increased risk of collision and injury
✓ Marijuana use is the fastest rate of transition to a SUD
✓ Risk of reporting or being diagnosed with schizophrenia in adulthood is doubled in individuals with regular marijuana use in adolescence
✓ Link between youth marijuana use and increased risk of suicide
Youth and families who are involved in the child welfare system face many additional challenging circumstances such as mental health, violence, trauma, youth justice, sexual abuse and substance abuse.

This population of youth are exposed to higher risk-factors including an environment where parents have substance abuse issues and participate in criminal activities.

Additionally, the risk of being exposed to intergenerationally trauma such as poverty, violence and maltreatment is high.

The Health Standards Organization estimated that there were 62,428 Canadian children and youth in out-of-home care in 2013.

These youth are usually victims of childhood trauma and maltreatment and exhibit serious behavioural, emotional and mental health issues.

Childhood maltreatment is often the result of parental substance abuse and is a leading cause of early onset of adolescent substance use.

Substance abuse has been identified as a serious factor within youth and families involved in the child welfare system.

**Long Term Effects of Tobacco & Marijuana**

**Tobacco…..**

- Nicotine has an adverse effect on almost every organ in the body.
- Increases risk of cancer.
- In adolescence smoking diminishes lung growth which deteriorates the function of the lungs over time.
- Is responsible for respiratory illness, heart disease, stroke, infertility in women and diabetes.
- Poorer functioning in adulthood.
- Lack of socioeconomic resources.
- Externalizing and internalizing disorders.
- Addiction and tobacco dependency.
- Nicotine is responsible for the deaths of nearly 100 million people worldwide.
- If current smoking trends continue, the cumulative death toll for this century has been projected to reach 1 billion.

**Marijuana…..**

- Marijuana effects the heart and lungs.
- Impairs body coordination.
➢ Impairs thought processes
➢ Increases the risk of psychosis
➢ Negative effects on emotional and cognitive functions
➢ Leads to substance use disorders and increases the risk for multiple substance use
➢ Increases the risk of mental health issues
➢ Poorer functioning in adulthood ie health, life satisfaction, income etc.

**Other negative effects of substance abuse**

➢ Criminal behaviours
➢ Loss of peer/family relations
➢ Communicable diseases such as HIV due to unsafe sexual behaviours
➢ Persistent anti-social behaviours

**Substance abuse and the Brain**

Drugs can alter important brain areas that are necessary for life-sustaining functions and can drive the compulsive drug abuse that marks addiction. During adolescence, the brain is constantly developing. Using substance during this time has many negative effects on the brain and increases the risk of emotional, behavioural and cognitive functioning.

Brain areas affected by drug abuse include:

<table>
<thead>
<tr>
<th>The brain Stem</th>
<th>The cerebral cortex</th>
<th>The limbic system</th>
</tr>
</thead>
</table>
| • controls basic functions critical to life, such as heart rate, breathing, and sleeping. | • divided into areas that control specific functions. Different areas process information from our senses, enabling us to see, feel, hear, and taste. The front part of the cortex enables our ability to think, plan, solve problems, and make decisions. | • the brain’s reward circuit  
• regulates our ability to feel pleasure  
• Feeling pleasure motivates us to repeat behaviours  
• can be activated by substance abuse  
• is responsible for our perception of other emotions, both positive and negative, which explains the mood-altering properties of many drugs. |
Most substances target the brain’s reward system by flooding it with dopamine releasing a “feel good” feeling.

During brain development, if dopamine is released too frequently from drugs, your body will begin to crave them.

The human body will attempt to create the amount of dopamine released by the substance used to maintain this feeling. This is how tolerance builds, the need to increase the amount of substance needed and increasing the risk of dependence and addiction.

**How does early onset and long-term drug use affect the brain?**

- Impairments in attention
- Impairments in memory and verbal learning
- Declines in IQ
- Impairments in impulse control
- Impairments in planning and problem solving
- Impairments in emotional regulation
- Impairments in decision making and judgement
- Disruption of motivation and moods
Mental Health Issues and Substance Abuse

Is there a link between marijuana use and mental health?

➢ There is a strong relationship between mental health and marijuana use
➢ Marijuana use has potentially adverse effects in adolescence
➢ Marijuana use leads to an earlier onset of psychotic symptoms and is a major risk factor for schizophrenia
➢ The co-morbidity of marijuana use and depression contribute to suicide
➢ Substance abuse and mood disorders often co-occur
➢ Increased risk of depression for youth who use marijuana

➢ Adolescent marijuana use is associated with bi-polar disorder
➢ Frequent marijuana users report higher amounts of anxiety
➢ There is a direct link between marijuana use and eating disorders

Adolescence is a time of maturation and development. It is also a time when mental disorders, substance abuse and at-risk behaviours begin to emerge.

➢ High rates of substance use are involved in childhood disorders such as ADHD, ODD and CD
➢ Externalizing (high levels of impulsive risk taking and aggression) and Internalizing (anxiety and depression) represent the two most common pathways to substance abuse
➢ Mental Illness and substance abuse can both precede each other
Drug abuse and mental illness often co-exist. In some cases, mental disorders such as anxiety, depression, or schizophrenia may precede addiction; in other cases, drug abuse may trigger or exacerbate those mental disorders, particularly in adolescence.

Adolescents who start using drugs before the age of 15 are at an increased risk of adverse effects on physical and mental health, psychosocial adjustment, school drop-out, other drug use, substance abuse disorders, criminal behaviours, risky sexual activities, accidents, family and friendship breakdown and poorer future outcomes.

The earlier the onset of substance use and the longer the use, the more serious consequences of the structural and functional brain changes that impair maturation of executive functions such as working memory, learning, problem solving, judgment, planning and control of impulsivity.

Early onset of marijuana predicts increased risk of addiction, psychosis, depression and anxiety disorders.
Section 4
Screening, Assessment and Treatment
Research suggests that tobacco and marijuana use can be reduced with early intervention approaches such as screening and assessment tools, motivational interviewing, cognitive therapy, and harm reduction aids (Jiloha, 2017).

**Screening, Brief Intervention and Referral to Treatment (SBIRT)**

**Screening**

- An assessment for risky substance use behaviours using standardized screening tools
- The main purpose of screening is to identify red flags that may lead to the identification of serious substance abuse problems

**Brief Intervention**

- Brief motivational and awareness-raising intervention given to risky or problematic substance users.
- Increase readiness for change

**Referral to Treatment**

- A referral for brief therapy such as Cognitive Behavioural Therapy or additional assessment/treatment is made for clients who screen in need of further intervention

**SBIRT**

- The primary goal of SBIRT is to identify and effectively intervene with those who are at moderate or high risk of consequences due to their substance use
- SBIRT is a brief and highly adaptive evidence-based practice with demonstrated results used to identify substance abuse risk levels and provide intervention
- Reliable in quick identification and assessing the severity of substance abuse
- Based on motivational interviewing strategies and stages of change
- Additional resources; 
Screening

- Research suggests that Tobacco and Marijuana use can be reduced or eliminated with appropriate assessment and screening tools and intervention approaches
- Often occurs as part of a brief semi-structured interview
- The first step in finding the appropriate help for an adolescent with substance abuse problems is an initial screening followed by an in-depth assessment of the adolescent’s presenting symptoms and needs
- Screening for risky substance use among adolescents is an efficient means of identifying youth who are at a high risk of substance abuse
- Screening tools are brief self-reporting, non-intrusive questionnaires, surveys or interviews
- Screening is administered so that results can form the basis of a treatment plan and identify a level of substance use such as abstinence, mild/moderate or severe/addiction
- The best screening tools are ones that contain the lowest number of brief, validated questions that can extract accurate and reliable answers
- A structured process that indicates a problem may exist and, depending on the tool or questions used, an indication of the potential severity of the problem.
- Assists to determine if intervention is required and at what level
- The screening tool is the first step of assessment before moving on to further comprehensive assessments (if necessary) and interventions

Screening Result Levels for Intervention

- **No problem indicated**
  - Provide positive confirmation and reinforcement/praise
  - Offer information to support continued no/low risk

- **Hazardous or Harmful Use/behaviours**
  - Provide brief intervention

- **Possible dependence or addiction indicated**
  - Advise need for further, more comprehensive assessment and refer to specialist
Validated Screening Tools

CRAFFT Screening Test Questionnaire……

- A short, six-item questionnaire designed to screen for risks in substance abuse
- The CRAFFT is both a screening tool and a brief assessment instrument
- Quick and effective way to determine if youth are at a high risk of substance problem use, abuse or dependence
- Guides brief discussions about substance use with adolescents
- The scale is based on six questions referring to youth behaviours in relation to substance use over the past 12 months
- Stands for Car, Relax, Alone, Friends/Family, Forget, Trouble in relation to the 6 questions asked
- Can be administered verbally or through a written self-report
- Is a validated and reliable tool found to be highly predictive of presence of Substance abuse for 12-18-year-old youth
- Assesses several potential indicators of substance-related risks and impairments
- Is easy to use
- Recommended by the American Academy of Pediatrics
- Scores from this assessment tool have been validated and found to be predictive of substance abuse
- A positive CRAFT should be followed by a more comprehensive drug use history ie age of first use, current patterns, impact on mental/physical health
- This assessment tool is available in the public domain
# The CRAFFT+N Questionnaire

To be completed by patient

Please answer all questions honestly; your answers will be kept confidential.

During the PAST 12 MONTHS, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing alcohol? Put "O" if none.

2. Use any marijuana (weed, oil, or hash, by smoking, vaping, or in food) or "synthetic marijuana" (like UK2, "Spice") or "vaping" THC oil? Put "O" if none.

3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter-medications, and things that you sniff, huff, or vape)? Put "O" if none.

4. Use any tobacco or nicotine products (for example, cigarettes, e-cigarettes, hookahs or smokeless tobacco)?

---

**READ THESE INSTRUCTIONS BEFORE CONTINUING:**

- If you put "O" in ALL of the boxes above, ANSWER QUESTION 5, THEN STOP.
- If you put "4" or higher in ANY of the boxes above, ANSWER QUESTIONS 5-10.

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

   - [ ] No
   - [ ] Yes

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

   - [ ] No
   - [ ] Yes

7. Do you ever use alcohol or drugs while you are by yourself, or alone?

   - [ ] No
   - [ ] Yes

8. Do you ever forget things you did while using alcohol or drugs?

   - [ ] No
   - [ ] Yes

9. Do your family or friends ever tell you that you should cut down on your drinking or drug use?

   - [ ] No
   - [ ] Yes

10. Have you ever gotten into trouble while you were using alcohol or drugs?

   - [ ] No
   - [ ] Yes

---

**NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:**

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general information for release of medical information is NOT sufficient.

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For more information and versions in other languages, see http://ceasar.org.
Each "yes" answer is scored as "1" point and a CRAFFT total score of two or higher identifies "high risk" for a substance use disorder and warrants further assessment.

CRAFFT Screening Tool for Adolescent Substance Abuse

Scoring and Interpretation:

Part A: If "yes" to any questions in Part A, ask all 6 CRAFFT questions. If "no" ask CAR question then stop.

Part B: Score 1 point for each "YES" answer.

<table>
<thead>
<tr>
<th>CRAFFT Score</th>
<th>Degree of problem related to alcohol or other substance abuse</th>
<th>Suggested Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>No problems reported</td>
<td>None at this time.</td>
</tr>
<tr>
<td>2+</td>
<td>Potential of a significant problem.</td>
<td>Assessment required.</td>
</tr>
</tbody>
</table>

References:
**CAGE-AID Screening Tool.....**

- Is a questionnaire where with the potential advantage of screening for alcohol and drug problems can be done conjointly rather than separately
- The CAGE-AID focusses on lifetime use in screening for drugs other than alcohol
- Focusses on discussion toward the behavioural effects of drug use rather than toward the number of drinks or drugs
- The CAGE-AID has been validated as a four-item self-report as a screen for substance use disorders among adolescents
- This assessment tool is available in the public domain
CAGE-AID Questionnaire

Patient Name ________________________ Date of Visit ___________________

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions: YES NO

1. Have you ever felt that you ought to cut down on your drinking or drug use? Y  N
2. Have people annoyed you by criticizing your drinking or drug use? Y  N
3. Have you ever felt bad or guilty about your drinking or drug use? Y  N
4. Have you ever had a drink or used drugs first thing in the Morning to steady your nerves or to get rid of a hangover? Y  N

Scoring:

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties The CAGE-AID exhibited:
Sensitivity Specificity One or more Yes responses 0.79 0.77
Two or more Yes responses 0.70 0.85

**Brief Screener for Tobacco, Alcohol and Other Drugs (BSTAD)…**

- Developed by the National Institute on Alcohol Abuse and Alcoholism
- Brief, reliable and practical short screening instrument for youth based on epidemiologic data - scientifically proven to be effective
- Includes questions about alcohol, tobacco and other drugs
- Asks one question per substance
- Covers use in the past year as well as use in the past 30 and 90 days
- Prioritizes into one of three categories – no reported use, lower risk and higher risk
- Only takes a few minutes
- Self or interviewer administered
- Easy to use
- 6-36 items, depending on responses
- Identifies tobacco, alcohol, marijuana and other substance use by respondent and their friends; also collects information concerning frequency of respondent’s substance use.
- Ideal for 12-17-year old’s
- If the respondent is aged 12-14, the friend’s questions are asked first. If the respondent is aged 15 to 17, the personal-use questions are asked first
- Can be completed online on the National Institute of Drug Abuse website

**Brief Screening to Intervention (S2BI)……**

- Developed by the National Institute on Alcohol Abuse and Alcoholism
- Identifies problematic tobacco, alcohol and marijuana and/or other illicit drug use
- Identifies the likelihood of a DSM-5 SUD
- Discriminates among no use, no SUD, moderate SUD and severe SUD
- Self or interviewer administered
- Available as an online tool
- Single frequency-of-use question per substance
### Brief Screener for Tobacco, Alcohol and Other Drugs (BSTAD)

<table>
<thead>
<tr>
<th>FRIENDS’ USE</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have friends who</td>
<td>smoked cigarettes or used other tobacco products in the past year?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>Do you have friends who</td>
<td>drank beer, wine, or any drink containing alcohol in the past year?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>Do you have friends who in the past year:</td>
<td>- sniffed or “huffed” anything;</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td></td>
<td>- took illegal drugs like marijuana (weed, blunts), cocaine, etc;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- took prescription medications that were not prescribed for them; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- took prescription or over-the-counter medications and took more than they were supposed to take?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSONAL USE</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past year, have you</td>
<td>smoked cigarettes or used other tobacco products?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>In the past year, have you</td>
<td>had more than a few sips of beer, wine, or any drink containing alcohol?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>In the past year, have you:</td>
<td>- sniffed or “huffed” anything;</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td></td>
<td>- taken illegal drugs like marijuana (weed, blunts), cocaine, etc;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- taken prescription medications that were not prescribed for you; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- taken prescription or over-the-counter medications and took more than you were supposed to take?</td>
<td></td>
</tr>
</tbody>
</table>

**[IF DRUGS ARE ENDORSED IN THE PERSONAL USE QUESTION, ASK THE FOLLOWING:]**

Which of the following substances have you used in the past year? (check all that apply)
- ☐ Marijuana or Hashish
- ☐ Cocaine or crack
- ☐ Heroin
- ☐ Amphetamines or methamphetamine (nonpharmaceutical)
- ☐ Hallucinogens (eg, Mushrooms, LSD)
- ☐ Inhalants

Which of the following medications have you used in the past year that were not prescribed for you or which you took more than you were supposed to take? (check all that apply)
- ☐ Prescription pain relievers (eg, morphine, percocet, vicodin, oxycontin, dilaudid, methadone, buprenorphine)
- ☐ Prescription sedatives (eg, Valium, Xanax, Klonopin, Ativan)
- ☐ Prescription stimulants (eg, Adderall, Ritalin)
- ☐ Over-the-Counter Medications (eg, Nyquil, Benadryl, cough medicine, sleeping pills)

**[FOR EACH SUBSTANCE WHERE USE WAS ENDORSED, ASK:]**

In the past 30 days, on how many days have you...
- smoked cigarettes or used other tobacco products/used alcohol/used [SUBSTANCE]? ☐ ☐ days

In the past 90 days, on how many days have you...
- smoked cigarettes or used other tobacco products/used alcohol/used [SUBSTANCE]? ☐ ☐ days

In the past year, on how many days have you...
- smoked cigarettes or used other tobacco products/used alcohol/used [SUBSTANCE]? ☐ ☐ ☐ days
# BSTAD Screening Tool Cutoffs and Scoring Thresholds

BSTAD asks a single frequency question for past year use of the three substances most commonly used by adolescents: tobacco, alcohol, and marijuana. Patients who report using any of these three substances are then asked questions about additional substance use. For each substance, responses can be categorized into levels of risk. Each risk level maps onto suggested clinical actions, summarized on the results screen.

<table>
<thead>
<tr>
<th>BSTAD Response</th>
<th>Risk Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 days</td>
<td>No Reported Use</td>
</tr>
<tr>
<td>1 day</td>
<td>Lower Risk</td>
</tr>
<tr>
<td>2+ days (alcohol or other drugs) and/or 6+ days (tobacco)</td>
<td>Higher Risk</td>
</tr>
</tbody>
</table>
Screening to Brief Intervention (S2BI)

The following questions will ask about your use, if any, of alcohol, tobacco, and other drugs. Please answer every question by circling your choice.

IN THE PAST YEAR, HOW MANY TIMES HAVE YOU USED:

Tobacco?

Never

Once or twice Monthly

Weekly or more

Alcohol?

Never

Once or twice Monthly

Weekly or more

Marijuana?

Never

Once or twice Monthly

Weekly or more

STOP if answers to all previous questions are “never.” Otherwise, continue with questions.
Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?

Never
Once or twice Monthly
Weekly or more

Illegal drugs (such as cocaine or Ecstasy)?

Never
Once or twice Monthly
Weekly or more

Inhalants (such as nitrous oxide)?

Never
Once or twice Monthly
Weekly or more

Herbs or synthetic drugs (such as salvia, “K2”, or bath salts)?

Never
Once or twice Monthly
Weekly or more

Developed at Boston Children’s Hospital with support from the National Institute on Drug Abuse.
## Screening Tool Cutoffs and Scoring Thresholds for S2BI

S2BI asks a single frequency question for past year’s use of the three substances most commonly used by adolescents: tobacco, alcohol, and marijuana. An affirmative response prompts questions about additional types of substances used. For each substance, responses can be categorized into levels of risk. Each risk level maps onto suggested clinical actions summarized on the results screen.

<table>
<thead>
<tr>
<th>S2BI Response</th>
<th>Risk Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>No Reported Use</td>
</tr>
<tr>
<td>Once or twice</td>
<td>Lower Risk</td>
</tr>
<tr>
<td>Monthly+</td>
<td>Higher Risk</td>
</tr>
</tbody>
</table>
**Brief Intervention**

**Goals of Brief Intervention…..**

- Increase awareness of the consequences of substance use
- Focuses on education
- Empower clients to take action
- Reduce health and psychological risks and risky substance use
- Promote treatment adherence and engagement
- Enhances motivation
- Guidance of the client to develop his/her own plan for change
- Focuses on whatever small steps the client is willing to make
- Change cognitive thinking patterns/errors in particular towards risk factors or behaviour

**Evidence Based Research shows brief interventions are…….**

- Low cost and affordable
- Most effective among clients with less severe problems
- Feasible and highly effective approach in reduction of substance abuse

**Stages of brief intervention…..**

1. Understand the clients view on substance use and build rapport
2. Provide feedback and brief advice
3. Listen for and build motivation, confidence and readiness to change
4. Provide feedback, negotiate goal(s) and identify strengths and barriers that may impact success
5. Exit at any stage if the client indicates they no longer want to continue
**Brief Intervention Principles**

- Client Centered
- Motivational Interviewing (MI)
  - Showing empathy
  - Involvement of client in the decision-making process
  - Rolling with resistance
  - Enhancing client’s motivation to change
  - Understanding and awareness of the client’s experiences
  - Appreciation for client’s experiences and opinions

**Did you know**?

- Among the more promising practices aimed at substance abuse is the use of motivational interviewing and the development of a therapist-client bond.

**Motivational Interviewing (MI)**

- Motivational Interviewing is a directed, client-centered counseling approach for eliciting behaviour change by helping clients to explore and resolve ambivalence
- The targeting of individual unsureness towards changing the problematic behaviours
- It is a practical, empathetic, and short-term process that takes into consideration how difficult it is to make life changes
- Supports self-efficiency
- One on one between clinician and client
- The use of negotiation and confidence building to persuade clients to make change
- Can help the client move through the emotional stages of change necessary to find their motivation.
- The first goal is to increase the person’s motivation and the second is for the person to make the commitment to change
- Motivation for treatment must be present in order for change to occur
- Motivational barriers are a big influencer towards ambivalence of wanting help or change. These barriers can include negative friend groups, substance abuse, depression or other mental health diagnosis
- In order for this to be successful, the individual must acknowledge the barriers in their way to change
- Motivational interviewing is often combined or followed up with other interventions, such as cognitive behavioural therapy (CBT)
Principles of Motivational Interviewing

Expressing Empathy…..

➢ Empathy is used throughout the entire process
➢ Communicating with empathy helps put the client’s feelings into perspective without being judgmental, critical or blaming
➢ An attitude of acceptance helps to facilitate change

Developing Discrepancy…..

➢ The goal is to create and enhance a discrepancy between the client’s present behaviour and their goals and values
➢ Use internal vs. external motivators ie their own reasons or views as opposed to their friends or family’s reasons or views
➢ The client should be able to voice their reason to change

Rolling with Resistance…..

➢ Refers to a client’s behaviours that are in opposition to making desired changes ie continue to put themselves in risky situations
➢ The clinician attempts to roll with the client’s resistance by not arguing the points but by continuing to make sure the client feels heard through the use of reflections
➢ Resistant behaviours can indicate that the counsellor needs to shift their approach
➢ Continue to actively involve the client in the problem-solving process
➢ Essentially solutions to the problems should come from the client

Supporting Self-Efficacy…..

➢ The client need to believe in the possibility of change
➢ Show belief in your client’s ability to change. You can influence the outcome if they feel you believe in them
➢ The client is responsible for selecting the kind of change they wish to make and making that change
Specific Skills of Motivational Interviewing…..(OARS)

1. Open ended questions

✓ “What are the good things about your substance use?”
✓ “Tell me about the not so good things about it?”
✓ “What concerns you about your substance use?”
✓ “How do you feel about your substance use?”
✓ “What would you like to do about your substance use?”

2. Affirmation

✓ Statements of appreciation and understanding
✓ Helps build rapport
✓ Confirming the client’s strengths and efforts to change helps to build confidence and encourages readiness to change
✓ Examples
  o “Thank-you for coming in today, I appreciate it”
  o “I appreciate that you are willing to discuss your substance use with me”
  o “That’s a great idea”
  o “I can tell that you are a very strong person”

3. Reflective listening

✓ A statement guessing at what the patient means
✓ It is important to reflect back the underlying meanings and feelings the client is expressing as well as the words they are using
✓ Essentially it is like being a mirror for the client – repeating what the client has said to you so that they can hear what they have communicated
  o “You are surprised your scores shows you are at risk?”
  o “It is really important for you to maintain your relationship with your family?”
  o “You understand your substance use is causing you financial strain?”
  o “Your angry because your friends are suggesting you have a problem with substances?”

4. Summarizing

✓ An important way of gathering together what has been said and discussed
✓ Prepares the client to move on
✓ Adds to reflective listening and empowers the client
✓ Hear it three times – patient, clinician, summary
✓ Most important things can be emphasized
✓ Needs to be brief and concise
  o “So you enjoy smoking marijuana at parties but on the other hand you
don’t like how much it costs and that concerns you. You are finding it
difficult to pay your car payment because all your money is going to
marijuana. As well, your friends don’t smoke marijuana so don’t want to
hang out with you anymore and this makes you upset. As well, you are
finding it difficult to remember things.”

5. Eliciting change talk

✓ A strategy for helping the client resolve uncertainty or hesitation and is aimed at
enabling the client to present the arguments for change. The four main categories
of “change talk” are;
  o Recognizing the disadvantages/consequences of not making the
appropriate changes
  o Recognizing the advantages of making change
  o Expressing optimism about making changes
  o Expressing an intention to make a change
  o Use of confidence rulers

✓ Examples of “change talk”
  o Ask direct open questions
    ▪ “What worries you about your substance abuse:?”
    ▪ “What do you think will happen if you don’t make changes?”
    ▪ “How confident are you that you want to make this change?”
    ▪ “How important is making this change to you?”
    ▪ “What would be the worse consequence to continue in the
direction you are going?”
    ▪ “What would be the best thing to happen if you are successful in
making the wanted changes?”
    ▪ “What are the most important things in your life?”

Substance Use Motivation Ruler.....

➢ The substance Use Motivation Ruler is a tool derived from motivational interviewing
➢ It is used asking your client to pin-point, on a scale of 1 to 10, how motivated they are to
end their drug use
➢ The lower the number the less motivation the client has ie 1 meaning not at all and 10
meaning completely motivated
The motivation rulers is used to build compliance and focus on what motivates the client. Ask
them why they respond the way they did and then to re-evaluate by asking what would have to
happen to move up on the scale
Substance Use Motivation Ruler

Are you motivated to end your substance use? Rank your motivation on the ruler from “1” to “10.” A “1” means that you have absolutely no motivation to end your use, and a “10” would mean that you are completely ready and have no doubt.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Why is your motivation where it is? Why not lower? Even if you marked only a “2” or a “3,” there must be a reason you didn’t write “1!” List some of your motivators.

1. __________________________________________

2. __________________________________________

3. __________________________________________

4. __________________________________________

5. __________________________________________
**Stages of Change**

- The stages of change direct the typical course of recovery
- Behaviour changes take time and change passes through several stages
  - Precontemplation, contemplation, preparation, action, maintenance, relapse
- Helps clients understand the process in ending substance abuse

### Pre-contemplation

- The individual engaging in the use either does not want to change or does not recognize the need for change.
- Denial is very common with individuals with substance use problems. Along with denial, engaging in conversation about the problem substance use can be very difficult during this stage.
- The individual has no intention on change.

### Contemplation

- This is the stage where individuals engaging in the substance use begin to consider change
- The individual begins to see reasons to change but are still hesitant, so the problem behaviour continues
- Moving past contemplation can be difficult
Preparation

- The preparation stage consists of planning of change. This means that the individual acknowledges the issues presented by them and have decided to make a change
- Individuals begin to think about how to make the change
- Minor changes are made at this stage. Cutting down, quitting and modifying consumption methods may occur in this stage
- Still may not have completely ended unwanted behaviours

Action

- Significant steps are taken to end the problematic behaviour
- Recognizing and avoidance of triggers, seeking help or other steps to avoid temptation happen at this stage
- Withdrawal may happen at this stage

Maintenance

- The changes made during the action stage are maintained
- Continuance of avoiding triggers
- The individual may continue to face challenges however at this point they have successfully changed their behaviour for a significant period of time

Relapse

- After making changes individuals may return to their previous problematic behaviours
- Relapse is common
**The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)**


- SOCRATES is an instrument designed to assess readiness for change in substance abusers.
- The instrument yields 3 factorially-derived scale scores:
  - Recognition (Re)
    - provides information about the client’s level of awareness or consciousness of and acknowledgement of the link between substance use and current problems.
  - Ambivalence (Am)
    - provides information about whether the client is certain or uncertain that he or she has or doesn’t have a problem. These scores are neither good nor bad; they simply indicate the amount of energy the client is spending in thinking about the change process or in debating the pros and cons of change.
  - Taking Steps (Ts)
    - considers evidence that a client is starting to take steps, or has already taken some steps, to change behaviour.
- The SOCRATES provides information on client strengths and needs in the areas of treatment readiness.
- This tool is designed to give a general measure of the motivation of problem drinkers and drug users to enter treatment.
### Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drug use. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for every statement.

<table>
<thead>
<tr>
<th></th>
<th>NO! Strongly Disagree</th>
<th>No Disagree</th>
<th>? Undecided or Unsure</th>
<th>Yes Agree</th>
<th>YES! Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I really want to make changes in my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Sometimes I wonder if I am an addict.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. If I don't change my drug use soon, my problems are going to get worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I have already started making some changes in my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I was using drugs too much at one time, but I've managed to change that.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Sometimes I wonder if my drug use is hurting other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
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<td>---</td>
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<td></td>
</tr>
<tr>
<td>7. I have a drug problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I'm not just thinking about changing my drug use, I'm already doing something about it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I have serious problems with drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Sometimes I wonder if I am in control of my drug use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. My drug use is causing a lot of harm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I am actively doing things now to cut down or stop my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I want help to keep from going back to the drug problems that I had before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I know that I have a drug</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>16. There are times when I wonder if I use drugs too much.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I am a drug addict.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. I am working hard to change my drug use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.</td>
<td>1</td>
<td>2</td>
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## Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A)

Transfer the client's answers from questionnaire (see note below):

<table>
<thead>
<tr>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking Steps</th>
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<tr>
<td>Totals: Re:</td>
<td>Am:</td>
<td>Ts:</td>
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Guidelines for Interpretation of SOCRATES-8 Scores

Using the SOCRATES Profile Sheet, circle the client's raw score within each of the three scale columns. This provides information as to whether the client's scores are low, average, or high relative to people already seeking treatment for substance use problems. The following are provided as general guidelines for interpretation of scores, but it is wise in an individual case also to examine individual item responses for additional information.

RECOGNITION

HIGH scorers directly acknowledge that they are having problems related to substance use, tending to express a desire for change and to perceive that harm will continue if they do not change.

LOW scorers deny that drugs are causing them serious problems, reject diagnostic labels and do not express a desire for change.

AMBIVALENCE

HIGH scorers say that they sometimes wonder if they are in control of their drug taking, are doing drugs too much, are hurting other people, and/or have a dependence. Thus, a high score reflects ambivalence or uncertainty. A high score here reflects some openness to reflection, as might be particularly expected in the contemplation stage of change.

LOW scorers say that they do not wonder whether they use drugs too much, are in control, are hurting others, or are dependent. Note that a person may score low on ambivalence either because he "knows" his drug use is causing problems (high Recognition), or because he "knows" that he does not have drug problems (low Recognition). Thus, a low Ambivalence score should be interpreted in relation to the Recognition score.

TAKING STEPS

HIGH scorers report that they are already doing things to make a positive change in their substance use and may have experienced some success in this regard. Change is under way, and they may want help to persist or to prevent backsliding. A high score on this scale has been found to be predictive of successful change.

LOW scorers report that they are not currently doing things to change their drug use and have not made such changes recently.
**Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A)**

<table>
<thead>
<tr>
<th>DECILE SCORES</th>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking Steps</th>
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<tbody>
<tr>
<td>90 (Very High)</td>
<td>19-20</td>
<td>39-40</td>
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<tr>
<td>80</td>
<td>18</td>
<td>37-38</td>
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<tr>
<td>70 (High)</td>
<td>35</td>
<td>17</td>
<td>36</td>
</tr>
<tr>
<td>60</td>
<td>34</td>
<td>16</td>
<td>34-35</td>
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<tr>
<td>50 (Medium)</td>
<td>32-33</td>
<td>15</td>
<td>33</td>
</tr>
<tr>
<td>40</td>
<td>31</td>
<td>14</td>
<td>31-32</td>
</tr>
<tr>
<td>30 (Low)</td>
<td>29-30</td>
<td>12-13</td>
<td>30</td>
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<tr>
<td>20</td>
<td>27-28</td>
<td>9-11</td>
<td>26-29</td>
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<tr>
<td>10 (Very Low)</td>
<td>7-26</td>
<td>4-8</td>
<td>8-25</td>
</tr>
<tr>
<td>RAW SCORES (from Scoring Sheet)</td>
<td>Re=</td>
<td>Am=</td>
<td>Ts=</td>
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Screening versus Assessment

- Identifies current needs immediately
- Determines need for further evaluation, assessment and treatment
- Short and quick to administer and score

Assessment

- Comprehensive
- Individualized to meet needs & identify strengths
- Gathers key information & enables practitioner to identify health concerns or diagnoses

Comprehensive Assessments

➢ The next step after screening. If a positive, high-risk screening is obtained a formal, comprehensive assessment should be considered as a next step
➢ The assessment process is used to obtain enough clinical information to make appropriate treatment or referral decisions
➢ A comprehensive assessment usually requires more structure and skill than a general screening
➢ Comprehensive; usually considers multiple domains of functioning
  o to evaluate the severity of the problem
  o nature and consequences of the youth’s substance-using behaviour
  o examine other potential problem areas related to substance using
  o to identify/develop treatment plans/intervention
➢ Gathers information that is more detailed regarding patterns of substance use
  o history of substance use
  o severity of involvement with substances
  o conceptualization of reasons for the use of substances
  o factors that contribute to involvement with substances
  o does the youth meet the diagnostic criteria for a specified substance-related disorder?
  o history of treatment services if any
  o evaluation of associated factors
    ▪ Peer groups, leisure activities, environmental risks, legal problems, mental health, sexual history, education, home life and family history of substance abuse
➢ Should be conducted by a professional in a clinical setting
➢ Gathers key information & enables practitioner to identify health concerns or diagnoses and identify strengths and barriers that may impact treatment engagement
➢ Once a diagnosis is made, an intervention plan can be put in place
Substance Use Disorders are a manageable and treatable disease

**Treatment**

- Once screening and assessment have determined a substance use problem the next step is to set goals and determine an intervention plan.
- Treatment approaches should be tailored to address the patient’s drug use patterns and drug-related medical, psychiatric, and social problems.
- Evidence-based research in the treatment of substance use disorders has led to the development of interventions such as:
  - Individual therapy
  - Group therapy
  - Support Groups
  - Medication
- Treatment enables people to counteract the addictions’ powerful disruptive effects on their brain and behaviour to allow them to regain control of their lives.
- May take several rounds of treatment before changes are made.
- Treatments usually involve planning for specific ways to avoid the addictive stimulus with the intentions of finding healthier ways to find satisfaction and build coping skills.
- Behavioural treatments help engage people in substance use disorder treatment, modifying their attitudes and behaviours related to drug use and increasing their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive use.
- Psychoeducation, including cognitive behavioural therapy, has been a proven treatment for substance abuse.
Cognitive Behavioural Therapy

- Cognitive behavioural therapy (CBT) is a practical, short-term psychotherapy that helps people set goals, develop skills and strategies for coping and avoiding situations in which they are most likely to use drugs.
- CBT strategies are based on the theory that in the development of maladaptive behavioural patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviours by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it.
- By becoming aware of irrational thoughts, you can learn to change them.
- Evidence-based and highly effective treatment.
- Ongoing assessment during the course of treatment is utilized to measure improvement and to amend treatment plan as necessary.
- Helps people examine how they make sense of what is happening around them and how these perceptions affect the way they feel and behave.
- Research suggests that skills learned through CBT approaches remain after the completion of treatment and throughout their life time.
  - Identifying distorted thinking
  - Modifying beliefs
  - Relating to others in different ways
  - Changing behaviours.
- CBT is often combined with pharmacology.
- Cognitive-behavioural interventions include, but are not limited to:
  - Education
  - self-monitoring
  - Cognitive restructuring\relaxation
  - Exposure
  - Emotion regulation
  - Interpersonal effectiveness
  - Stress management
  - Patient motivation and feedback.
The Cognitive Model

**Situation…..**

- Anything that happens to a person
- Situations are ultimately outside of the individual’s control but they can be influenced by behaviours

**Thoughts…..**

- What a person thinks or believes about a situation
- How the person interprets an event

**Emotions…..**

- How a person feels about a situation
- Emotions are not necessarily based on logic, but they are influenced by thoughts and beliefs

**Behaviour/Response…..**

- The person’s actions and behaviours in response to their thoughts and feelings about a situation
A central element of CBT is anticipating likely problems and enhancing patient’s self-control by helping them develop effective coping strategies by:

- Exploring the positive and negative consequences of continued drug use
- Self-monitoring to recognize cravings early and identify situations that might put one at risk for use; developing strategies for coping with cravings and avoiding these high-risk situations

Cognition – Terms & Definitions…..

Conscious thoughts

✓ Rational thoughts and choices that are made with full awareness

Automatic thoughts

✓ Thoughts that flow rapidly, so that you may not be fully aware of them
✓ This may mean you can’t check them for accuracy or relevance
✓ In a person with a substance abuse problem, these thoughts may not be logical

Schemas

✓ Core beliefs and personal rules for processing information
✓ Schemas are shaped by influences in childhood and other life experiences

Thinking errors

✓ Commonly known as cognitive distortions, are irrational beliefs that contribute to uncomfortable emotions and unwanted behaviour

Decatastrophizing

✓ When catastrophizing, the importance of a problem is exaggerated, or the worse possible outcome is assumed to be true
Cognitive Restructuring

Our thoughts influence our feelings and behaviours. We can change the way we think in order to feel and act better.

➢ Refers to the process of challenging and changing irrational thoughts
➢ Helps to bring thoughts into focus and examine them for irrational thinking
➢ Leverages the powerful link between thoughts, feelings, and behaviours to treat problematic areas
➢ Identifying negative thoughts
  o Identifying how our thoughts impact emotions and whether or not they are accurate
➢ Increasing awareness of thoughts
  o What thoughts led me to this moment?
  o Look for negative emotions ie anger
  o Identifying awareness of situations where cognitive distortions impact mood and behaviour – warning signs
  o Identify specific triggers
➢ Change negative thoughts

Did you know……..

❖ CBT is briefer than other therapies and is time-limited
❖ A sound therapeutic relationship is necessary, but not the focus
❖ CBT is a collaborative effort between the client and clinician
❖ CBT uses the Socratic Method
❖ CBT is structured and directive
❖ CBT is based on an educational model
❖ CBT theory and techniques rely on the “inductive method”
❖ Homework is a central feature in CBT
Section 5
Behavioural Strategies
**Triggers**

- Triggers are anything that can cause an individual to want to use. This can consist of people, settings, or objects etc.
- By identifying triggers, it will allow the user to either avoid these triggers all together, or learn and work towards coping with them
- Learning to recognize and respect triggers for substance use can make a significant impact on recovery
- Strategies and preparation are needed to help avoid or manage triggers
- When you choose to expose yourself to triggers, you are setting yourself up for relapse
- You will have to make sacrifices in order to reduce or eliminate triggers ie making new friends, engaging in different activities, choosing not to go the party, etc.

**Maintenance/Relapse Prevention**

- This process begins once the individual is motivated to change and willing to begin treatment.
- Change never ends with action. Without a strong commitment to maintenance, there will surely be relapse, usually to precontemplation or contemplation stage.
- Most successful self-changers go through the stages three or four times before they make it through the cycle of change without at least one slip. Most will return to the contemplation stage of change. Slips give us the opportunity to learn.
- When dealing with substance use problems it can be difficult to counter-react the euphoric effects of the marijuana and tobacco. This can become a constant challenge as the substances create such a reinforcing effect for the individual
- Use reinforcers on/for change
- Remain alert to high-risk situations. Focus is on relapse prevention
**Trigger/Maintenance Exercise #1**

**Trigger:** A stimulus—such as a person, place, situation, or thing—that contributes to an unwanted emotional or behavioural response.

**The Problem**
Describe the problem your triggers are contributing to. What’s the worst-case scenario, if you are exposed to your triggers?

---

**Trigger Categories**
Just about *anything* can be a trigger. To begin exploring your own triggers, think about each of the categories listed below. Is there a specific emotion that acts as a trigger for you? How about a person or place? List your responses in the provided spaces.

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<tr>
<th>Emotional State</th>
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<td>Places</td>
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<td>Things</td>
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<tr>
<td></td>
<td>Thoughts</td>
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<td>Activities / Situations</td>
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**Tips for Dealing with Triggers**
- Oftentimes, the best way to deal with a trigger is to avoid it. This might mean making changes to your lifestyle, relationships, or daily routine.
- Create a strategy to deal with your triggers head on, just in case. Your strategy might include coping skills, a list of trusted people you can talk to, or rehearsed phrases to help you get out of a troublesome situation.
- Don’t wait until the heat of the moment to test your coping strategy. *Practice!*
In this section, you will develop a plan for dealing with your three biggest triggers. Review your plan regularly, and practice each of the strategies.

Describe your three biggest triggers, in detail.

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<th>Trigger</th>
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Describe your strategy for avoiding or reducing exposure to each trigger.

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<th>Trigger</th>
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Describe your strategy for dealing with each trigger head on, when they cannot be avoided.

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People, Places and Things Coping Skills – Exercise #2

Specific people, places, and things can remind us of past drug use. Avoiding these triggers can be an effective way to reduce the likelihood of relapse. List five people, places, or things that might make you more likely to relapse.

People, places, and things:

1. 
2. 
3. 
4. 
5. 

What if you’re unable to avoid these people, places, and things? What if you come into contact with them accidentally? Briefly describe how you can deal with each of the people, places, and things listed above.

How I can deal with dangerous people, places, and things:

1. 
2. 
3. 
4. 
5. 

The Therapist Aid, 2012
Relapse Prevention Plan – Exercise #3

Five warning signs that I might use:

1.

2.

3.

4.

5.

Five people who I can call to help me get through a craving:

1.

2.

3.

4.

5.

Five things I can do to get my mind off of using:

1.

2.

3.

4.

5.
When I am tempted to use – Exercise #4

Check off the situations in which you would be most tempted to use drugs or tobacco. Write in your own situations if you don’t see them listed.

____ When I am having withdrawals
____ When I want to have just one cigarette or one joint
____ When I want to see if I can handle using in moderation
____ When I have a headache
____ When I am worrying about something
____ When I have a dream about drugs
____ When I am tired
____ When I’m in pain
____ When I’m depressed
____ When I’m angry
____ When I want to relax
____ When I’m at a party
____ When I see drugs and cigarettes on TV
____ When I’m happy
____ When my friends are using
____ When I am on vacation
____ When I am bored

Adapted from the Therapist Aid, 2012.
Some helpful tips in avoiding relapse…..

- Reminder yourself that cravings will eventually pass. Do your best to distract yourself and ride it out.
- Focus on exchanging past drug or tobacco use with newer, more positive activities such as going to the gym
- Don’t try to do this alone. Have a support system put in place.
- Don’t become complacent. Relapse can happen years after you’ve quit using. It probably won’t ever be safe to “just have one”.
- Avoid situations that you know will put you at risk of relapse, such as spending time with friends who use drugs or going places that remind you of your past use.
- Have a plan in place for when things get stressful
- Come up with new rituals ie how you celebrate birthdays and special holidays
- The decision to relapse is made when you put yourself in risky situation, long before you actually use.
- Don’t view relapse as a failure. Falling back into old patterns because of a slip will only make the situation worse

**Coping Skills**

- Build strong relationships/strengthen current relationships
- Attend support groups
- Build new relationships
- Social support
  - Friends, family, group members, sponsors
- Diversions
  - Resist cravings by replacing with an activity such as a walk, movie, yard work, reading, bike ride, journal, music, etc.
- Build new long-term habits
  - Join the gym or a sports team
  - Volunteer
  - Employment or enhancing professional development skills
  - Focus on existing relationships ie Sunday dinners, etc.
- Focus on healthy lifestyles
  - Sleep
  - Exercise
  - Healthy diets
  - Ensuring medication compliance
- Practice new anger management, relaxation and stress management skills
Coping Skills for Relapse Prevention- Exercise #5

**Coping Skills:** List activities or skills you enjoy that can get your mind off of using.

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**Social Support:** Who are three people you can talk to if you are thinking about using?

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</table>

**Consequences:** How will your life change if you relapse? How about if you stay sober?

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<thead>
<tr>
<th>Outcomes of Relapse</th>
<th>Outcomes of Sobriety</th>
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Therapist Aid 2012, therapist Aid.com
Manage Emotions/Relaxation

Deep Breathing

- Deep breathing is a simple technique that’s excellent for managing emotions.
- A relaxation technique performed by purposefully taking slow, deep breaths. When practiced regularly, deep breathing provides both immediate and long-term relief from stress and anxiety.
- Deep breathing is an easy way to relax and let your worries go. You can do it pretty much anywhere, and it only takes a few minutes.
- Helps ease stress. It can also lower your blood pressure and heart rate and relax tense muscles.
- When you learn healthy ways to relax, it can be easier to avoid unhealthy choices.
- When you’re relaxed, you can be more mindful.

Progressive Muscle Relaxation

- Progressive muscle relaxation (PMR) is a powerful technique with long-term benefits for stress and anxiety. When practiced regularly, the positive effects of PMR can become generalized. This means that the reduced levels of stress and anxiety will last well beyond the practice period.
- Progressive muscle relaxation is based upon the simple practice of tensing, or tightening, one muscle group at a time followed by a relaxation phase with release of the tension.
- This exercise can provide an immediate feeling of relaxation, but it’s best to practice frequently.
- Creates a feeling of relaxation both physically and mentally.
- Takes approximately 15 minutes to complete.

Addictions can serve as an escape from uncomfortable emotions such as stress, anxiety, and anger. In order to manage avoidance of relapse, new ways of coping will need to be learned.

Relaxation skills are excellent tools for the treatment of stress, anxiety and anger. Additionally, they are easy to use and offer immediate relief from symptoms.

Relaxation puts your body and mind at rest.

Triggers and warning signs should determine when to use relaxation techniques.
Journaling

- Writing about personal experiences gives your brain the opportunity to process information and organize it into manageable chunks.
- Some of the many benefits of journaling include improved mental wellbeing, and the reduction of uncomfortable emotions.
- As you journal, be sure to describe your feelings alongside the facts of your experiences
- Journaling serves as an escape or emotional release and forces you to check out on everything else and focus more on you
- Journaling can reduce stress by helping one get rid of negative thoughts
- Journaling helps with problem-solving

Imagery

- Guided imagery is a stress management technique, where you use your imagination to picture a person, place, or time that makes you feel relaxed, peaceful and happy
- Imagery is slightly different from other stress management techniques, in that it relies on the use of all of your senses
- Your brain has the power to turn thoughts into real emotions, and physical responses. Think about it: Your mouth waters at the thought of your favorite food, and a happy memory can make you laugh.
Deep Breathing Techniques - Exercise #6

How Deep Breathing Works

During periods of anxiety, the body triggers a set of symptoms called the stress response. Breathing becomes shallow and rapid, heart rate increases, and muscles become tense. In opposition to the stress response is the relaxation response. Breathing becomes deeper and slower, and the symptoms of anxiety fade away. Deep breathing triggers this response.

Instructions

Sit back or lie down in a comfortable position. Close your eyes, if you would like to do so. When you’re learning, try placing a hand on your stomach. If you breathe deeply enough, you should notice it rising and falling with each inhalation and exhalation.

1. Inhale. Breathe in slowly through your nose for 4 seconds.
2. Pause. Hold the air in your lungs for 4 seconds.
3. Exhale. Breathe out slowly through your mouth for 6 seconds.
4. Tip: Pucker your lips, as if you are blowing through a straw, to slow your exhalation.
5. Repeat. Practice for at least 2 minutes, but preferably 5 to 10 minutes.

Tips

• If it isn’t working, slow down! The most common mistake is breathing too fast. Time each step in your head, counting slowly as you do so.

• Counting out your breaths serves a second purpose. It takes your mind off the source of your anxiety. Whenever you catch your mind wandering, simply return your focus to counting.

• The times we use for each step are suggestions and can be lengthened or decreased. Lengthen the time if it feels natural to do so or decrease the time if you feel discomfort.

Therapist Aid, 2017
Progressive Muscle Relaxation Script – Exercise #7

Progressive muscle relaxation is an exercise that reduces stress and anxiety in your body by having you slowly tense and then relax each muscle. With experience, you will become more aware of when you are experiencing tension and you will have the skills to help you relax. During this exercise, each muscle should be tensed, but not to the point of strain. If you have any injuries or pain, you can skip the affected areas. Pay special attention to the feeling of releasing tension in each muscle and the resulting feeling of relaxation.

Sit back or lie down in a comfortable position. Shut your eyes if you’re comfortable doing so.

Begin by taking a deep breath and noticing the feeling of air filling your lungs. Hold your breath for a few seconds.

Release the breath slowly and let the tension leave your body.
Take in another deep breath and hold it.

Again, slowly release the air.
Even slower now, take another breath. Fill your lungs and hold the air.

Slowly release the breath and imagine the feeling of tension leaving your body.
Now, move your attention to your feet. Begin to tense your feet by curling your toes and the arch of your foot. Hold onto the tension and notice what it feels like.

Release the tension in your foot. Notice the new feeling of relaxation.
Next, begin to focus on your lower leg. Tense the muscles in your calves. Hold them tightly and pay attention to the feeling of tension.

Release the tension from your lower legs. Again, notice the feeling of relaxation. Remember to continue taking deep breaths.
Next, tense the muscles of your upper leg and pelvis. You can do this by tightly squeezing your thighs together. Make sure you feel tenseness without going to the point of strain.

And release. Feel the tension leave your muscles.
Begin to tense your stomach and chest. You can do this by sucking your stomach in. Squeeze harder and hold the tension. A little bit longer.

Release the tension. Allow your body to go limp. Let yourself notice the feeling of relaxation. Continue taking deep breaths. Breathe in slowly, noticing the air fill your lungs, and hold it.

Release the air slowly. Feel it leaving your lungs.
Next, tense the muscles in your back by bringing your shoulders together behind you. Hold them tightly. Tense them as hard as you can without straining and keep holding.

Release the tension from your back. Feel the tension slowly leaving your body, and the new feeling of relaxation. Notice how different your body feels when you allow it to relax.
Tense your arms all the way from your hands to your shoulders. Make a fist and squeeze all the way up your arm. Hold it.

Release the tension from your arms and shoulders. Notice the feeling of relaxation in your fingers, hands, arms, and shoulders. Notice how your arms feel limp and at ease.
Move up to your neck and your head. Tense your face and your neck by distorting the muscles around your eyes and mouth.

Release the tension. Again, notice the new feeling of relaxation.
Finally, tense your entire body. Tense your feet, legs, stomach, chest, arms, head, and neck.
Tense harder, without straining. Hold the tension.

Now release. Allow your whole body to go limp. Pay attention to the feeling of relaxation, and how different it is from the feeling of tension.
Begin to wake your body up by slowly moving your muscles. Adjust your arms and legs.
Stretch your muscles and open your eyes when you’re ready.

Therapist Aid 2017
### Journaling – exercise #8

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thoughts</th>
<th>Emotions</th>
<th>Behaviours</th>
<th>Alternate Thought</th>
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Therapist Aid 2017
Imagery – Exercise #9

Think about some of your favorite and least favorite places. If you think about the place hard enough—if you really try to think about what it’s like—you may begin to have feelings, you associate with that location. Our brain has the ability to create emotional reactions based entirely off of our thoughts. The imagery technique uses this to its advantage.

Do this technique by sitting back or lying down in a comfortable position. For best results close your eyes.

Make sure you’re somewhere quiet without too much noise or distraction. You’ll need a few minutes to just spend quietly, in your mind.

Think of a place that’s calming for you. Some examples are the beach, hiking on a mountain, relaxing at home with a friend, or playing with a pet.

Paint a picture of the calming place in your mind. Don’t just think of the place briefly—imagine every little detail. Go through each of your senses and imagine what you would experience in your relaxing place. Here’s an example using a beach:

a. Sight: The sun is high in the sky and you’re surrounded by white sand. There’s no one else around. The water is a greenish-blue and waves are calmly rolling in from the ocean.

b. Sound: You can hear the deep pounding and splashing of the waves. There are seagulls somewhere in the background.

c. Touch: The sun is warm on your back, but a breeze cools you down just enough. You can feel sand moving between your toes.

d. Taste: You have a glass of lemonade that’s sweet, tart, and refreshing.

e. Smell: You can smell the fresh ocean air, full of salt and calming aromas.
Anger Management Skills

➢ Recognize your anger early
  o Learn the warning signs that you’re getting angry so you can change the situation quickly
  o Some common signs are feeling hot, raising voices, balling of fists, shaking, and arguing

➢ Take a time-out
  o Temporarily leave the situation that is making you angry
  o If other people are involved, explain to them that you need a few minutes alone to calm down.

➢ Deep Breathing
  o Take a minute to just breathe
  o Count your breaths: four seconds inhaling, four seconds holding your breath, and four seconds exhaling.

➢ Exercise
  o Exercise serves as an emotional release. Chemicals released in your brain during the course of exercise create a sense of relaxation and happiness

➢ Express your anger
  o Once you’ve calmed down, express your frustration. Try to be assertive, but not confrontational. Expressing your anger will help avoid the same problems in the future

➢ Think of the consequences
  o What will be the outcome of your next anger-fueled action? Will arguing convince the other person that you’re right? Will you be happier after the fight?

➢ Visualization
  o Imagine a relaxing experience. What do you see, smell, hear, feel, and taste? Spend a few minutes imagining every detail of your relaxing scene.
Anger Coping Skills – Exercise #10
Be Aware of Triggers

Anger triggers are the things that set you off. Knowing your triggers, and being cautious around them, will reduce the likelihood of your anger getting out of control.

How to use triggers to your advantage:

- Create a list of your triggers and review them daily. Reviewing your triggers will keep them fresh in your mind, increasing the likelihood you notice them before they become a problem.
- Oftentimes, the best way to deal with a trigger is to avoid it. This might mean making changes to your lifestyle, relationships, or daily routine.
- Because it isn’t always possible to avoid triggers, have a plan when you must face them.
- For example, avoid touchy conversations when you are tired, hungry, or upset.

Practice Deep Breathing
Deep breathing is a simple technique that’s excellent for managing emotions. Not only is deep breathing effective, it’s also discreet and easy to use at any time or place.

Sit comfortably and place one hand on your abdomen. Breathe in through your nose, deeply enough that the hand on your abdomen rises. Hold the air in your lungs, and then exhale slowly through your mouth, with your lips puckered as if you are blowing through a straw. The secret is to go slow: Time the inhalation (4s), pause (4s), and exhalation (6s). Practice for 3 to 5 minutes.

Keep an Anger Log
Following an episode of anger, take a few moments to record your experience. This practice will help you identify patterns, warning signs, and triggers, while also helping you organize thoughts and work through problems.

- What was happening before the anger episode? Describe how you were feeling, and what was on your mind. Were you hungry, tired, or stressed?
- Describe the facts of what happened. What events triggered your anger? How did you react, and did your reaction change as the event continued to unfold?
- What were your thoughts and feelings during the anger episode? Looking back, do you see anything differently than when you were in the heat of the moment?
Use Diversions
The goal of diversions is to buy yourself time. If you can distract yourself for just 30 minutes, you’ll have a better chance of dealing with your anger in a healthy way. Remember, you can always return to the source of your anger later—you’re just setting the problem aside for now.

| go for a walk | read a book | play a sport | listen to music |
| watch a movie | practice a hobby | go for a run | clean or organize |
| do yard work | draw or paint | do a craft | cook or bake |
| play a game | go for a bicycle ride | write or journal | take a long bath |
| play an instrument | call a friend | lift weights | go swimming |
| go hiking in nature | take photographs | play with a pet | rearrange a room |

Take a Time-out
Time-outs are a powerful tool for relationships where anger-fueled disagreements are causing problems. When someone calls a time-out, both individuals agree to walk away from the problem, and return once you have both had an opportunity to cool down.

How to use time-outs effectively:
- With your partner, plan exactly how time-outs will work. Everyone should understand the rationale behind time-outs (an opportunity to cool down—not to avoid a problem).
- What will you both do during time-outs? Plan activities that are in different rooms or different places. The list of diversions from above is a good place to begin.
- Plan to return to the problem in 30 minutes to an hour. Important problems shouldn’t be ignored forever, but nothing good will come from an explosive argument.

Know Your Warning Signs
Anger warning signs are the clues your body gives you that your anger is starting to grow. When you learn to spot your warning signs, you can begin to address your anger while it’s still weak.

| sweating | can’t get past problem | feel hot / turn red | clenched fists |
| headaches | becoming argumentative | raised voice | using verbal insults |
| pacing | aggressive body language | feel sick to stomach | go quiet / “shut down” |
Stress Management Skills

➢ Keep in mind that stress isn’t always a bad thing
  o Stress can motivate us to work on our problems
  o The goal is to manage stress, not eliminate it
➢ Talk about your problems, even if they won’t be solved
  o Talking about your stressors, regardless if you solve them or not, releases hormones in your body that reduce the negative feelings associated with it
➢ Prioritize your responsibilities
  o Focus on completing quick tasks first
  o Having too much to do can be stressful. Quickly checking off small tasks will seem like you are taking a load off
➢ Focus on the basics
  o Stress can start a harmful cycle where basic needs are neglected which leads to more stress
  o Make a point to focus on your basic needs such as eating well, hygiene, exercise and sleep
➢ Don’t put all your eggs in one basket
  o Balance your time and energy between several different areas in your life such as career, family, friendships, hobbies, etc.
➢ Take time for yourself
  o When personal time is neglected, everything else tends to suffer
  o Set aside time to relax and have fun
➢ Keep things in perspective
  o Don’t make little problems feel bigger than they are
  o Take a step back and think about how important your stressors really are…will they matter in a week, year, month?
➢ Keep a journal
  o Writing about your stressors will help you develop a healthier perspective
➢ Exercise
➢ Socialize
➢ Identify stress sources
➢ Recognize stress signals
➢ Identify your stress strategies
➢ Ask for support when needed
Introduction to Stress Management – Exercise #11

**Stress**: an emotional and physical response to demanding situations, including symptoms that may include worry, a feeling of being overwhelmed, increased heart rate, headaches, sleep difficulties, procrastination, and more.

Describe your largest source of stress, in detail.

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Briefly list two other stressors you are experiencing.

1. ______________________________________________________

2. ______________________________________________________

Circle any symptoms you have experienced in response to stress.

<table>
<thead>
<tr>
<th>Anger / Frustration</th>
<th>Anxiety</th>
<th>Decreased Sex Drive</th>
<th>Drug or Alcohol Use</th>
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<tbody>
<tr>
<td>Fatigue</td>
<td>Headaches</td>
<td>Indigestion</td>
<td>Muscle Tension</td>
</tr>
<tr>
<td>Nail Biting</td>
<td>Over or Under Eating</td>
<td>Procrastination</td>
<td>Sleep Difficulties</td>
</tr>
<tr>
<td>Social Withdrawal</td>
<td>Teeth Grinding</td>
<td>Worry</td>
<td>Other</td>
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</table>
Contrary to popular belief, not all stress is bad. The stress response is a powerful tool used by your body to increase the odds of overcoming obstacles. It’s when stress becomes too intense, or lasts for too long, that it becomes problematic.

The negative effects of stress can be reduced with the use of social support, emotional management skills, maintaining a healthy life balance, and attending to basic needs. In the following pages, we’ll explore each of these strategies.

**Social Support**

Even when your social support cannot solve a problem, just talking can sometimes be enough. When we talk about our problems, hormones are released inside our brains that ease the undesirable symptoms of stress.

List three people who you can turn to for support.

<table>
<thead>
<tr>
<th>Name:</th>
<th>How they can help:</th>
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How can you use social support to ease one of your current stressors?

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**Emotional Management**

Stress can trigger many emotions such as anxiety, self-doubt, and anger. When these feelings are ignored, they can exacerbate the original stressor. Remember, emotional management isn’t about eliminating emotions—it’s about dealing with them in a healthy way.

When faced with unpleasant emotions, do you have any habits or tendencies that worsen the situation?

---

List two ways that you have successfully handled unpleasant emotions in the past.

1. 
2. 
Life Balance
Stress can be especially destructive if your life is heavily focused on one area. For example, a person who is only focused on a relationship will struggle if their relationship becomes rocky.

Rate each of the following life areas from 1 to 5. A “1” means that you devote little attention to this part of your life, while a “5” means that you devote a high amount of attention to this area.

<table>
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<th>Career</th>
<th>Family</th>
<th>Fun / Recreation</th>
<th>Spirituality</th>
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</thead>
<tbody>
<tr>
<td>Socializing</td>
<td>Intimate Relationship</td>
<td>Education</td>
<td>Other</td>
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</table>

Based upon your ratings, are there any areas where you would like to devote more attention?

Basic Needs
During periods of high stress, many people take shortcuts when it comes to their basic needs. Examples include sleep, a healthy diet, exercise, and other forms of self-care. When basic needs are neglected, health and mental well-being deteriorate, which contributes to additional stress.

Circle any basic needs that you tend to neglect during periods of high stress.

<table>
<thead>
<tr>
<th>Sleep</th>
<th>Healthy Diet</th>
<th>Exercise</th>
<th>Medical Adherence</th>
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<tbody>
<tr>
<td>Personal Hygiene</td>
<td>Social / Love Needs</td>
<td>Managing Addictions</td>
<td>medical adherence medications, appointments, etc.</td>
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<td>Other</td>
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Describe the steps you can take to protect your basic needs during periods of high stress.

Therapist Aid, 2012
Section 6
Community and Web-based resources
Community Based Resources

Maltby Centre (Formerly known as Pathways)

✓ Provides mental health services for children and youth 18 years or younger
✓ Offers a variety of different programs for those who live in the Kingston/Napanee area
✓ Multiple locations
✓ Monday to Friday 8:30 to 4:30
  o  613-546-8535 or 1-844-855-8340
✓ After hours and on weekends
  o  613-544-4229
✓ 24 hours kids help phone line
  o  1-800-668-6868
✓ On-line 24/7 support
  o  www.kidshelpphone.ca

Youth Diversion - Kairos

✓ Kairos is a counselling service which specializes in treatment for youth who are experiencing any level of substance abuse, personally or with a family member.
✓ Service is available as an outreach program in all local elementary and secondary schools, as well as alternative education sites and group homes.
✓ Treatment is based on a harm reduction approach.
✓ Staff assist clients to identify and set their own treatment goals in the areas that may be having a negative impact on their lives.
✓ Assessment services are also available to assist clients who may require residential treatment.
✓ Staff also share their expertise through public education sessions and professional development workshops for staff of other agencies.
✓ 559 Bagot Street
  Kingston ON, Canada

  P: 613-548-4535
  F: 613-548-1747

  info@youthdiversion.org

Addictions & Mental Health Services - KFLA

Youth Support Program

✓ The Youth Support Program provides mental health and addiction support and services to youth aged 16 to 24 in the Kingston and surrounding areas
✓ 613-544-1356/613-544-4229 (Kingston & Frontenac)
✓ 613-354-7521 (Napanee, Lennox & Addington)
Street Health

✓ The Street Health Centre is 365 days a year harm reduction health centre.
✓ Counsellors with Street Health Centre are able to work with people on a variety of issues, including basic needs, referrals, life skills, support and personalized counselling on issues related to drug use, addictions, sexual health, mental health, Hepatitis C, smoking cessation, pregnancy child protection issues complicated by substance abuse and practical needs.
✓ 115 Barrack St.
  Kingston ON K7K 1G2
  Phone: 613.549.1440

Kids Help Phone Line

✓ 24 hours a day
✓ 1-800-668-6868

Detox Centre – Hotel Dieu Hospital

✓ The Detox Centre offers a confidential, short-term, non-medical, 22-bed, co-ed residential service for people 16 years old or older, who are intoxicated, in withdrawal related to their substance use, waiting for intake into a treatment program, or are in danger of a relapse.
✓ 240 Brock Street, Kingston, Ontario
  Phone: 613-549-6461

Web-based Resources

National Institute Drug on Drug Abuse for Teens

✓ The latest scientific information on drug abuse and addiction from the National Institute on Drug Abuse (NIDA)
✓ Fact sheets, statistic and links to special sites on marijuana, tobacco, etc.
✓ On-line activities for fun and learning
✓ https://teens.drugabuse.gov/drug-facts
✓ https://teens.drugabuse.gov/
Heads Up – Scholastic Canada

✓ Close-ups on common drugs of abuse
✓ Pop-up diagrams exploring the brain and the effects of drugs on the body
✓ Teaching support, including printable skills pages
✓ www.scholastic.com/HEADSUP
✓ http://headsup.scholastic.com/

Therapist Aid

✓ worksheets, videos, guides, and other tools to aid mental health professionals in the course of their work.
✓ https://www.therapistaid.com/
References


Canadian Centre on Substance Use an Addiction (2015). The effects of marijuana during


doi: 10.1016/j.addbeh.2011.06.009


doi: 10.1016/j.childyouth.2017.10.043


National Institute on Drug Abuse (2018). Drug Screening and Assessment Resources; Chart of evidence-based screening and assessment tools for adults and adolescents. *Brief Screener*
for Alcohol, tobacco and other drugs. Retrieved from

https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-

practice/additional-screening-resources


