A Substance Use Practice Guide for School Mental Health Professionals:

Guidance for Use of the Screening, Brief Intervention and Referral to Treatment (SBIRT) Framework in Schools

School Mental Health Ontario

Santé mentale en milieu scolaire Ontario

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1.0

Purpose of this resource

This resource was developed as an extension to the *School Based Intervention Related to Student Cannabis Use Guide*, which was originally developed as a response to the April 2019, Substance Use Prevention and Intervention Survey that was sent to school mental health professionals across all Ontario school boards (see Appendix A for the full report). Of the 294 respondents, 92% indicated they would use a print/on-line resource related to cannabis and other substances and there was strong endorsement for the need for a resource, alongside training, to provide information regarding:

1. Up-to-date **psycho-educational information** regarding cannabis use (including methods of use and effects).
2. **Screening and assessment** for cannabis and **other substance use concerns**.
3. **Early intervention strategies** to address and prevent consequences of cannabis and **other substance use**.
4. **Pathways and referrals** for students who require more intensive treatment related to cannabis and **other substance use concerns**.

To continue our response to the 2019 prevention and intervention survey, this resource will provide psycho-educational information, screening, brief intervention strategies and referral pathways for multiple substances, including alcohol, cannabis, E-cigarettes/vaping, and opioids. The selection of substances has been informed by research evidence on the most utilized drugs amongst young people.

2.0

Introduction

In this section, background information on prevalence rates and research evidence on the various substances are provided to support the rationale and considerations for addressing substance use in schools. Furthermore, this guide will use the Screening, Brief Intervention and Referral to Treatment (SBIRT) framework to guide school mental health (SMH) professionals in their approach to supporting student substance use.

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

The SBIRT framework is an evidence-based public health approach designed to advance early identification of substance use related problems, and to put effective supports in place that match the level of need.[1] Often this means offering brief preventive interventions that help young people before addictive behaviours have taken hold. It may also mean referring a student for more intensive support if that is deemed necessary. This framework has been used in medical and school environments[2]; with research indicating that SBIRT is a promising approach to identifying problematic substance use amongst young people in schools and guiding preventive care.[2] It can be used by SMH professionals to help to identify substance-related concerns and to guide brief intervention(s) that can reduce the harms associated with substance use.[3]

While SBIRT is often used in schools, studies on implementation have primarily been conducted within healthcare settings (e.g., emergency departments, primary healthcare). Possible barriers to SBIRT noted in these settings appear to be primarily related to insufficient training for service providers and time/resource constraints that impact effective implementation.[4] Being able to anticipate possible barriers to uptake and effective use of this protocol can help with developing effective provincial and board level supports.

2.2 Common use of substances amongst young people

When considering substance use, often there are associations with illegal or harmful drugs. However, it is important to define substances more broadly to include anything that changes the way the body or mind functions.[5][6] A substance in this context could also include medications used as prescribed or other things that produce a beneficial impact, like ceremonial or religious use of tobacco.[5] At the same time, many substances can indeed be harmful, particularly for young people as their brains are still in development until about age 25.

Alcohol is one of the most widely used psychoactive substances worldwide and in Canada[6][7] ; and there are also continuous and emerging concerns for cannabis, vaping and opioid use in Ontario.[8] In addition, research indicates that polysubstance use — the use of 2 or more drugs together — among young people are increasing.[9][10][11] As such, there is a need to prioritize substance use prevention and early intervention initiatives that curb substance use harms and increase coping skills.[8]

Given the increased discussions about youth substance use in Ontario schools, young people, parents/caregivers and school staff may approach SMH professionals with questions and disclosures about alcohol, cannabis, vaping and/or other substances. SMH professionals play a critical role in helping school staff, students and their families understand the effects of substance use (e.g., psychoeducation); and creating an environment where young people feel safe to disclose

and talk about their substance use. Given that youth are most likely to receive mental health services at school,[12][13][14] SMH professionals are in an ideal position to engage in promotion, prevention, screening, brief intervention, and referral to services related to mental health and substance use.[15][16][17]

2.3 Substance use continuum

A substance use continuum is a tool that can be utilized to assist in exploring substance use and decision-making non-judgmentally with young people while assessing for potential harm related to their substance use.

Figure 1. presents a substance use continuum which has been informed by the Ministry of Health and Long-Term Care Substance Use Prevention and Harm Reduction Guideline[18], which this continuum indicates that substance use occurs along a spectrum ranging from no use at all to experiencing a substance use disorder.

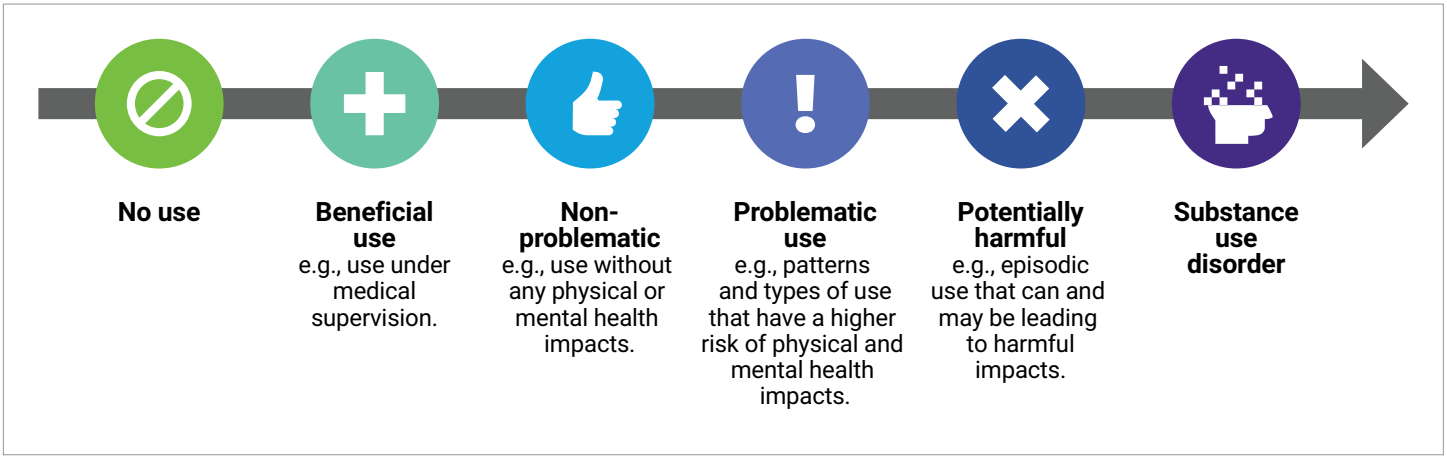


Figure 1. Substance use continuum

1. **No use.** A youth has not initiated use and therefore is not experiencing use-related problems. The youth may or may not be considering using substances.
2. **Beneficial use.** Youth may be using substances for medicinal purposes as guided by traditional practices or health professionals that may be providing them with some physical or psychological benefits. It is also important to note that youth may report experiencing benefits such as enhancing social relationships or a sense of belonging related to their substance use.
3. **Non-problematic use.** Youth may be using substances in a way that does not lead to problems. However, given the neurodevelopmental vulnerability of youth to the potential negative effects of drugs and alcohol on long-term health and well-being, any use among youth may pose some degree of problems.
4. **Problematic use.** Youth may use substances in a way that increases risk of adverse outcomes due to their neurodevelopmental vulnerability — since their brains are not yet fully developed. Youth may also be using in a riskier way, i.e., not in accordance with other lower-risk use guideline suggestions. However, this problematic use may not be related to current impairment.
5. **Potentially harmful use.** Youth may be using substances in a way that is causing them problems, but not yet experienced all the symptoms associated with a substance use disorder.
6. **Substance use disorder.** Youth can develop symptoms which are classified as clinical diagnosis of a substance use disorder — an impairment that is clinically significant and impacting multiple areas of daily functioning (e.g., unable to meet work and school expectations) and health.[19]

2.4 Substance use health

Substance use health is a principle developed by CAPSA (previously known as Community Addiction Peer Support Association), that includes the health of the whole population across the entire substance use spectrum.[20] This principles shifts away from illness-only models, recognizing that they exclude most people in Canada around their health related to substance use. CAPSA's Substance Use Health Spectrum (see figure 2) outlines an individual's relationship with substances, ranging from no use to substance use disorder.[21] The Substance Use Health Spectrum emphasizes an inclusive approach to substance use, indicating that everyone is on the spectrum, regardless of the amount or its purpose (e.g., traditional, cultural, medicinal).[21][22] The spectrum highlights the impacts of stigma and other health effects of substance use, signaling opportunities for health promotion no matter a person's relationship to substance use.[21] By focusing people's experiences as it relates to their health, the spectrum encourages the use of non-stigmatizing and non-judgmental language.[21] For the purpose of this guide, the substance use continuum (figure 1) will be used to identify substance use risk, but there are important features of the CAPSA spectrum that highlight the important recognition that anyone can experience challenges to their substance use health and that we should approach this with compassion in a non-stigmatizing manner.

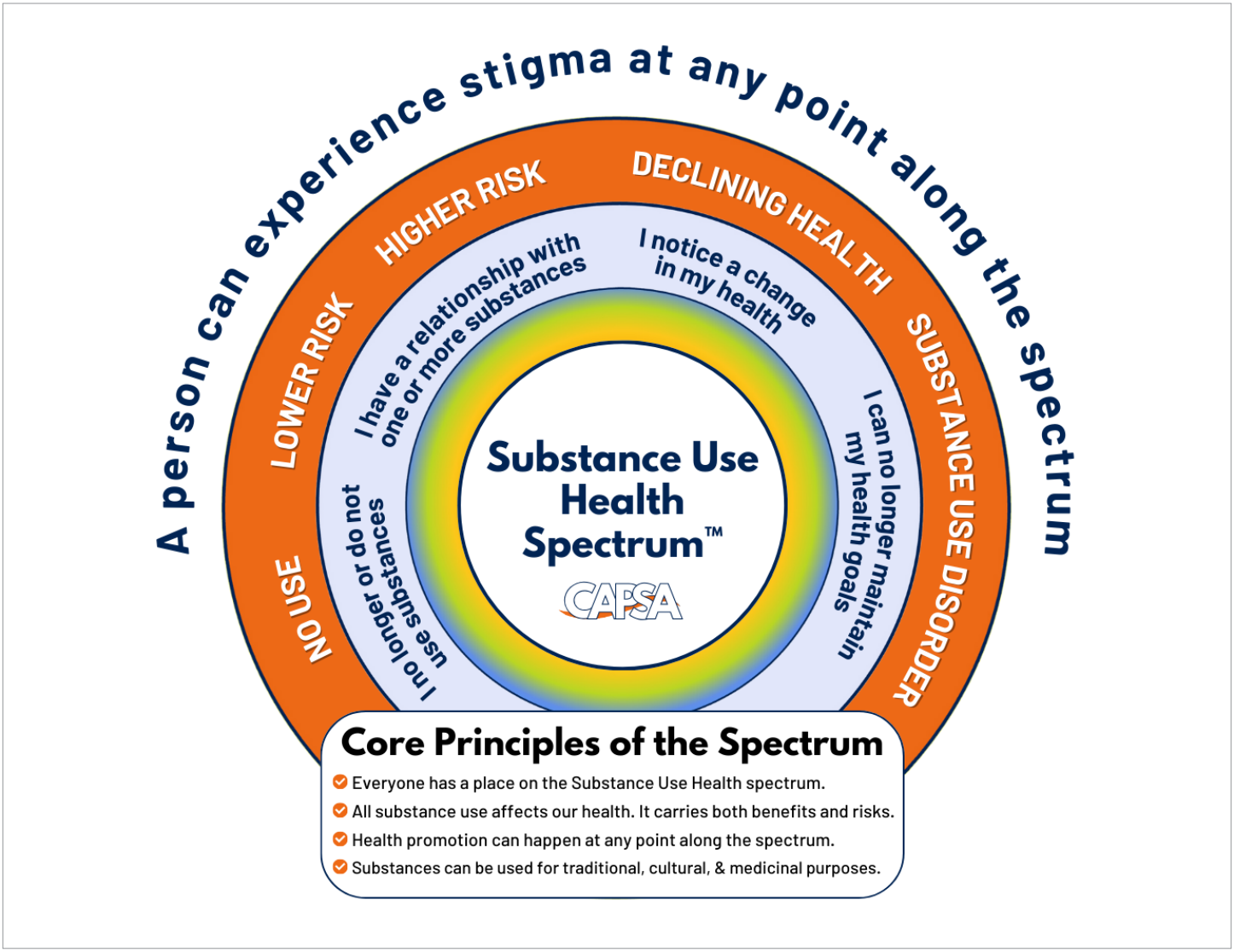


Figure 2: CAPSA Substance Use Spectrum[23]

2.5 Stigma

Stigma is considered one of the leading factors preventing people who experience problematic substance use to reach out and gain access to treatment and support from services and loved ones.[24] CAPSA (2020) suggests that "stigma is best understood as a deeply held set of false beliefs about a group of people with at least one attribute in common. This allows the judgement, oppression and discrimination of those people to take place. This is done by either overt actions or silent complicity to those actions".[25] Stigma related to help-seeking for substance use concerns often occurs in the form of stereotyping, labelling and discrimination. For example, the use of words such as "addict", "a drunk" or "substance abuser" to describe a young person is stigmatizing and does not model person-first language.[26] Additionally, for some young people, they may experience self-stigmatization — an internalization of their issue with substance use, and heavy shame and guilt about their substance use behaviour — which may result in worry about being shamed or discriminated against if they speak about it or seek treatment. Unfortunately, this results in a missed opportunity for early identification and treatment which could help a young person to avoid more addictive cycles of behaviour.

SMH professionals play an important role in supporting students through experiences of stigma and self-stigma as they navigate their care journey. They can also help to educate parents/caregivers and school staff more broadly about the impact of the language they use in talking about addiction and substance use with students.

2.6 Cultural considerations and socio-cultural factors in substance use intervention

Young people's attitudes, beliefs, and behaviours around substance use are deeply influenced by their cultural backgrounds, which can include family values, community norms, and social expectations. By recognizing and integrating cultural perspectives of our students in our care delivery, we can better support young people in making informed, healthy choices regarding substance use.

Studies suggest that individual factors, peer influences, family and parental factors, and various community factors can all impact the likelihood of adolescent substance use.[27] It is also important to know that the racial/ethnic disparities that exist among adolescence also impact substance use prevalence as well as physical and mental health outcomes, this is largely in relation to negative circumstances vis a vis the social determinants of health (e.g., classism, inequitable access to health care, systemic racism, etc.).[28] The minority stress model,[29] is one framework that helps us to understand that different minority groups experience different stressors that can lead to physical and mental health disparities.[30] This is further described in SMH-ON's Leading Mentally Healthy Schools Resource, which highlights this model as one way to understand the relationship between external stressors (e.g., discrimination, stigma) and mental health (e.g., anxiety, substance use) for marginalized people. While this model is dated, and the term 'minority' is now replaced with more identify-affirming language, the principle of this model still holds utility. To apply this model, when speaking with students about substance use, it is important to consider that some young people turn to substances (e.g., cannabis, alcohol) as a response to the impact of stressors such as discrimination and racism.[31][32] For example, according to the Mental Health Commission of Canada,[33] some youth from marginalized communities use cannabis in response to experiences of stigma and discrimination. For SMH professionals, it is critical to consider these factors in their provision of support to students and how it may influence students' views towards substance use, ambivalence towards change, and barriers to further services (if needed).

Further to the minority stress model, The Identity-Affirming School Mental Health Frame provides guidance to reflect on, to meet the needs of every student and affirm their intersecting identities. With this frame, SMH professionals can develop an identify-affirming approach to their practice, that is responsive and reflective of the students they serve. In addition, it is important that SMH professionals consider the disproportionate burden, and the historical oppression, intergenerational trauma, and unique difficulties different groups experience. For example, the legacies of colonialism, including ongoing intergenerational trauma, have had disproportionate impacts on Indigenous young people, resulting in higher rates of

problematic substance use in this population. Unfortunately, rather than the compassionate and active reconciliation response for these injustices, Indigenous young people who struggle with substance use often face shame and stigma.[34][35] Before SMH professionals engage with Indigenous students, they are encouraged to think about additional factors that may lead to early substance use, such as their peer and family influences and barriers to cultural identity, which are often rooted in systemic inequalities.[36] Given the unique experiences among this group, SMH professionals are also encouraged to seek out the appropriate supports that are cultural-based, holistic and identity affirming.[32] Similarly, for Black students, it is essential to recognize how historical experiences of oppression (e.g., slavery, segregation), ongoing systemic racism, and current inequities in surveillance, policing and criminal charges can influence health outcome and substance use patterns.[37][38] For SMH professionals, it is important to seek the necessary information and resources (e.g., cultural-specific services, family, religious leaders), with consent, that would be helpful to addressing the student's reported need for help; and seek culturally adapted, evidence-based programs (e.g., culturally adapted CBT) for youth with substance use concerns to reduce health disparities and meet the unique needs.[39]

In preparation for speaking to young people and their parents/caregivers about substance use, SMH professionals can consider ways to reflect on the possible cultural and historical experiences of the student and their own personal biases. The SMH-ON cultural humility tool is one way to reflect on personal beliefs, values and biases, that may interact with the therapeutic relationship with the student. In completing this tool, SMH professionals will better position themselves to engage in school-based support that is identity affirming.

3.0

Asking young people about substance use

For some SMH professionals, they routinely ask all students who they support about their substance use, in an effort to normalize the conversation and to explore potential risks. For others, asking about substance use may be an unfamiliar and potentially uncomfortable process that may lead to discomfort. Before asking a student about their substance use, it is essential for SMH professionals to engage in self-reflection about their attitudes and beliefs toward substance use, including stigma associated with substance use, personal values and possibly their own experiences with substance use.

In approaching our work with students, SMH professionals must work to establish a safe and trusting therapeutic alliance. Without it, a student may not be forthcoming with vulnerabilities about themselves and their experience with substances. They may also be concerned with confidentiality, school disciplinary consequences and judicial/legal consequences (e.g., underage drinking, possession of illegal drugs). Focusing on the student and SMH professionals' relationship, first, will help to create a supportive environment for screening for substance use and will help to mitigate any concerns related to students and/or family members becoming upset with talking about and screening for substance use in schools, without context and rapport. **As such, it is recommended that SMH professionals consider building their therapeutic alliance before applying the SBIRT framework, just as they would before introducing any brief intervention protocol.** This is supported in the literature, which has found that young people and service providers who have developed a strong early therapeutic alliance, together, demonstrated favourable mental health and substance use treatment outcomes.[40][41] SMH professionals are equipped to engage, build a therapeutic relationship and support students. They can begin by using their introductory conversation/questioning they are accustomed to for school mental health services to build rapport. It is important to note that given that some students may meet with a SMH professional for a single appointment or a few meetings, establishment of a strong rapport may not be possible before talking about substance.

The repetition of some key messages is intentional throughout this guide to emphasize important points. For example, we invite SMH professionals to keep in mind that, as noted above, when asking young people about their substance use, it is important to reflect on personal values and biases (e.g., use of the SMH-ON cultural humility tool) and to consider that various backgrounds, cultural and religious identities influence students' openness and attitudes about substance use.

3.1 Responding to student hesitancy to talk

It is not uncommon for students to be hesitant to talk about their substance use with SMH professionals. There are various reasons that can contribute to discomfort or resistance. This can include concerns relating to confidentiality and fear of negative consequences, legal involvement, or discipline.[42] Another reason is that the student might not be concerned about their use or might not understand the negative consequences of their using patterns.[32] This is especially true in communities, families, or peer groups where there is increased normalization about substance use. Another reason for youth to be reluctant to discuss is the stigma associated with using substances.[43][44]

When encountering student hesitancy, **SMH professionals can focus on continued engagement with the young person,** a non-judgmental approach, exploration of attitudes and beliefs around substance use and talking about substance use at school. **In addition, it is recommended that SMH professionals discuss school policy and code of conduct directly with the student so that they understand that the clinician will not be reporting their substance use unless they are a danger to themselves or others, and so they understand the natural consequences associated with this behaviour at school. It is also always important to reiterate the limitations of confidentiality in practice/duty to report.** The use of Motivational Interviewing (MI) core skills such as OARS (open ended questions, affirmation, reflection, summarize) and rolling with resistance can be used to help guide ongoing conversation about substance use.[45] Details are provided in the section below on Motivational Interviewing in schools to address mental health concerns.

4.0

Concurrent disorders

A concurrent disorder refers to the presence of a substance use and a mental health disorder, with both requiring treatment. This may also be referenced as co-occurring disorders or comorbidity.[46] In general, individuals who have a mental health disorder are twice as likely to experience substance use problems, compared to individuals who do not experience mental health disorders.[47] This co-occurrence of substance use and mental health disorders is highest among older adolescents.[47] For example, an Ontario study (2021) found that early internalizing and externalizing mental health concerns in young people is associated with at-risk substance use in adolescence.[48] In addition, in 2017, Ontario youth who reported higher cannabis use also reported high symptoms of psychological distress, externalizing behaviours (e.g., stealing, fighting, running away, vandalizing, etc.), attention deficit hyperactivity disorder (ADHD), suicidal thoughts or attempts, and who have received mental health services in the past year (see Figure 3).[49] Further, students reporting high mental health symptomatology also use cannabis more frequently than students without symptoms of mental health concerns (see Appendix B for specifics on measures and frequency of use). In 2023, the Ontario Student Drug Use and Health Survey reported that approximately 11% of 3,586 secondary school students reported using cannabis, to manage concerns related to anxiety and depression.[50] Overall, this Ontario data reinforces the importance of a concurrent focus on mental health and substance use.

The graph below demonstrates that 19% of students in Grade 7-12 report using cannabis within the past year. Among students with high levels of mental health symptomatology, the prevalence of past-year cannabis use is higher. For example, of students reporting high levels of externalizing behaviours, 59.2% reported past year cannabis use.

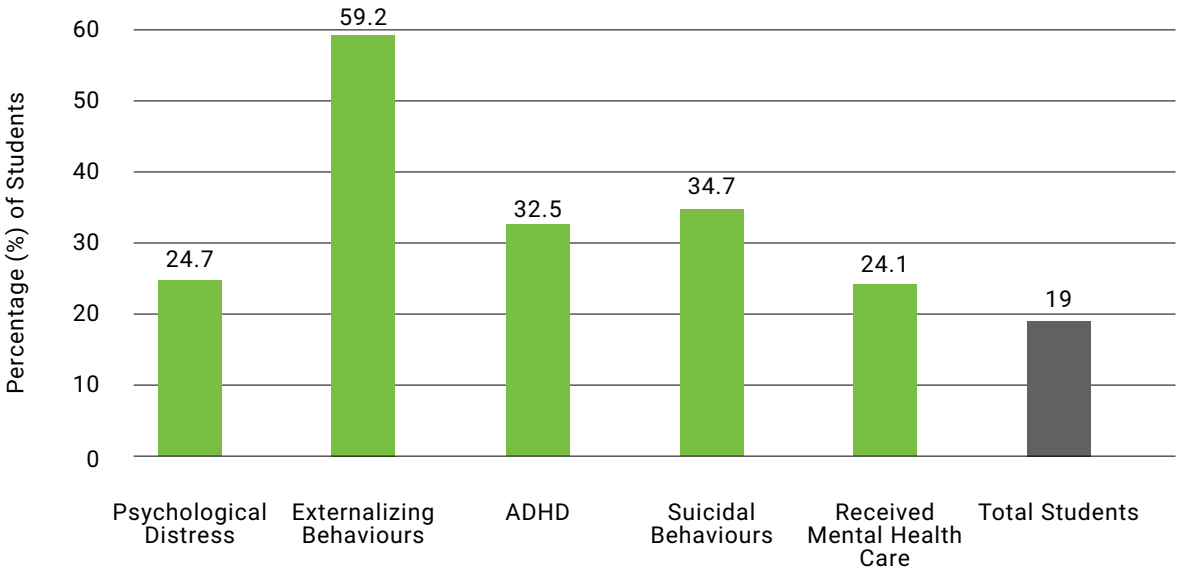


Figure 3. Percentage of Ontario Students Grades 7-12 Reporting Past Year Cannabis Use in General and Across Subgroups of Students with Mental Health Symptomatology. Data comes from the Ontario Student Drug Use and Health Survey 2017 (OSDUHS).[8]

5.0

Substance use prevention

Prevention of substance use, and its related harms is essential. Given that adolescence is a time for possible substance use experimentation, school-aged children are often the population for prevention.[4] Tier 1 activities centred on mental health promotion is a part of substance use prevention. As such, the school environment is an ideal location to nurture the conditions for positive mental health and well-being, which has the potential to encourage a healthy lifestyle and curb decisions that may lead to concerning substance use. The SMH-ON Leading Mentally Healthy School resource for administrators provides recommendations and tools for leading a mentally healthy school. This information can be used to establish the leadership foundation for substance use prevention activities in schools. At tier 1 prevention activities such as substance use psychoeducation, skills training and programs that have promise to delay substance use[51] can be used to address a range of substances (e.g., illegal substances, prescription medicines) and higher risk use as well as bolster skills in the area of self-control, social problem solving and drug resistance skills.[9] At tier 2, SBIRT has been recommended as a prevention strategy for substance use prevention research.[52]

Moreover, the implementation of the Ministry of Education's mental health modules (i.e., MH78 and MH10 curriculum) may lead to further discussions in schools about the inclusion of tier 1 mental health and substance use programming. As such, SMH professionals may be approached with requests to deliver class-wide or targeted programming. In addition to substance use prevention and literacy programs, emphasizing mental health promotion and SEL done well — ensuring attention to cultural responsiveness and identity-affirming approaches — is a part of substance use prevention.

If initiating and choosing prevention-based programming is not an easy process, the SMH-ON decision support tool can help mental health leadership teams (MHLT) determine programming that is a fit for their school environment and student population.

6.0

Overview of substances

This section provides a brief overview of the three most reported substances (alcohol, cannabis, opioids) used among young people and the use of e-cigarettes and vaping. The Government of Ontario indicates that the legal age to purchase and use substances such as cannabis and alcohol is nineteen. Therefore, for school-aged children, the use of substances is not permitted. Even among those who can legally access cigarettes or vapes, smoking and vaping are prohibited in various places, including in and around schools.[53]

6.1 Alcohol

Alcohol is the most consumed substance reported by high-school students, with 25.1% of grade 9 students reporting past-year alcohol use and rates increasing to 60.7% for grade 12 students.[54] According to the 2023 OSDUHS data report, 6% and 14.6% of youth in grades 7 and 8, respectively report past year alcohol use.[41] Furthermore, a significant proportion of secondary students engage in **binge or heavy episodic drinking** (HED), which is defined as consuming four or more drinks for females and five or more drinks for males on one occasion.[55] Heavy episodic drinking heightens risks related to alcohol consumption and contributes to a higher proportion of youth who require medical/hospital services due to alcohol.[56] The trend towards HED increases as young people progress through their educational journey; the percentage reporting binge drinking significantly increases with grade, from 2.2% of 8th graders to 21.9% of 12th graders.[57]

Canada's low-risk drinking guidelines for adults detail the volume of alcohol per occasion and per week that would stay below serious harms; the guideline reflects recent research related to cancer risk and long-term outcomes associated with alcohol. As the Canadian Centre on Substance Use and Addictions (CCSA) states, "drinking alcohol, even a small amount, is damaging to everyone, regardless of age, sex, gender, ethnicity, tolerance for alcohol or lifestyle."[58] (p. 1) See figure 4.

Figure 4. Alcohol consumption per week[58] — Canada Centre on Substance Use and Addictions

6.2 Cannabis

Presently, cannabis is one of the most commonly used psychoactive substances.[59] It is a plant that is made up a group of chemicals called cannabinoids, including both THC (delta-9-tetrahydrocannabinol) and CBD (Cannabidiol) are commonly used as stress-coping mechanisms, with negative life events and coping difficulties associated with habitual or heavy use.[60][61]

A variety of influences contribute to non-medical cannabis use in youth, including biological, psychological, familial, social, and societal factors.[62] Adolescents have reported using this drug to be social, enhance activities, cope with their problems, expand perceptions, and conform to social norms.[63] Many also use cannabis to manage stress, relax and relieve health problems such as chronic pain, insomnia, anxiety, and other mental health challenges.[61] The role of traumatic stress in the development of cannabis use disorder is often overlooked, although research suggests that there is an association between trauma (e.g., PTSD) and cannabis use disorder.[64][65] Furthermore, a Canada-wide study found many teens who use cannabis are from families where there is a permissive attitude towards cannabis use, or where parents/caregivers also use cannabis, or where parents/caregivers do not really monitor their child's substance use activity.[66] There is a genetic basis for cannabis use and patterns of consumption may be intergenerational in some youth.[67][68]

Also noteworthy is the link between cannabis and psychosis. Psychosis is a condition characterized by varying degrees of disconnection from reality, delusional beliefs, hallucinations, restricted emotional expression, reduced motivation, social withdrawal, and disorganized thoughts/behaviours.[69] A single high dose of THC can induce temporary psychotic symptoms (particularly paranoia) in healthy groups[70], while youth with genetic predisposition, past experiences of psychosis, and younger age are at increased risk for prolonged psychotic episodes after THC use.[71] Frequent and high-dose THC use is consistently associated with more severe positive symptoms, higher rates of psychiatric hospitalization, and earlier development of psychotic disorders.[72] According to the World Health Organization, unlike THC, CBD-based cannabis products (containing little or no THC) do not induce psychotic symptoms.[73]

For additional details on cannabis use and student mental health, see the School Based Interventions Related to Student Cannabis Use Practice Guide for School Mental Health Professionals. SMH professionals may also consider a review of the Canada's lower risk cannabis use guideline — a prevention tool for risks associated with cannabis use — and the Knowing your Limits guide by the Canadian Centre on Substance Use and Addiction, which provides information and tips/tools on understanding and reducing cannabis use, as a resource to support their work with students.

6.3 Opioids

Opioids are a classification of a drug. They can be non-prescription, such as illicitly manufactured fentanyl or heroin ("street drugs") or prescribed, such as morphine or codeine (prescription opioids, often used for pain relief). The prevalence of fentanyl use, a highly potent opioid, during the past 12 months has remained low and stable among Ontario students in Grades 9 to 12 between 2017 and 2023.[74]

The non-medical use of prescription pain relievers refers to use without one's own prescription or a doctor's supervision. Estimates of non-medical use of prescription opioids vary across studies, which may be due to factors such as the nature of the question asked, the examples of opioid pain relievers included in the question, the response options provided, and other possible factors. A national study conducted during the 2021-22 academic year indicates that 3.2% of grade 7-12 students in Canada reported using prescription pain relievers in the past 12 months for "non-medical reasons or to get high."[75] An Ontario study conducted in 2020-21 indicates that 12.7% of grade 7-12 students reported using prescription pain relief pills at least once in the past 12 months "without a prescription or a doctor telling you to take them".[76] Further, in Ontario, the percentage of youth reporting the use of nonmedical prescription pain relievers was significantly higher among girls compared to boys in 2021 and 2023; there was little difference by grade (across grades 7-12).[88][90] There is some evidence that gender minority youth are more likely to report nonmedical use of prescription opioids compared to girls and boys.[77] Moreover, the concerns for opioid overdose are reflected in the rate of opioid-related deaths and emergency visits.[78] For example, the opioid-related deaths among those ≤ 19 years old amounted to 1% of all opioid-related deaths in 2023.[79]

6.4 E-Cigarettes and vaping

E-cigarettes are battery-operated devices that hold, heat, and vaporize e-liquids that often (but not always) include nicotine. While e-cigarettes do not contain tobacco, and therefore are often considered to be harmless, e-cigarette use has been found to be associated with poisonings, burns, increased heart rate, higher risk of respiratory symptoms, and addiction when nicotine is present.[80][81][82] The e-liquids in vapes also contain other harmful chemicals (e.g., propylene glycol, glycerol, and ethylene glycol) and the long-term effects of use remain unknown.[83]

E-cigarette use, often and hereby referred to as vaping, has shown drastic increases among young people across high-income countries in recent years.[84][85][86] For example, among Canadian grade 7-12 students, vaping has increased from around 18% in 2014-15[87] to 29% in 2021-22[88] and is now the most commonly used nicotine product among youth. In 2021-2022, 17% reported vaping in the past 30 days which was higher in girls (19%) compared to boys (15%).[74] Although vaping is often seen as a harm-reduction approach that may reduce combustible tobacco cigarette use in adults (a positive public health outcome), there is concern that vaping among younger people may lead to uptake of later cigarette smoking that may not have occurred otherwise (a negative public health outcome).[89] While the rise in vaping has occurred alongside declines in adolescent cigarette smoking[90], young people who vape have more than 3 times the odds of initiating tobacco smoking compared to those who never vape.[91] Among Canadian students in 2021-22, 14% had tried both cigarette smoking and e-cigarette, of which 53% tried e-cigarettes first[88] up from 27% in 2014-15.[87] Many are concerned that the rise in vaping will reduce or flip the public health gains made in tobacco use over the past three decades.

For vaping, while evidence is relatively new, high rates of co-occurring vaping and emotional problems have been found[92][93] with some evidence showing emotional problems to be associated with later onset of vaping and vaping to be associated with later worsening of emotional problems.[92][94] Notably, around 1 in 5 Canadian students who vape nicotine report vaping to relax or relieve tension, with an additional 20% reporting vaping because they are addicted.[88] Moreover, recent data suggests a strong association between e-cigarette use with nicotine and depression among young people.[95][96]

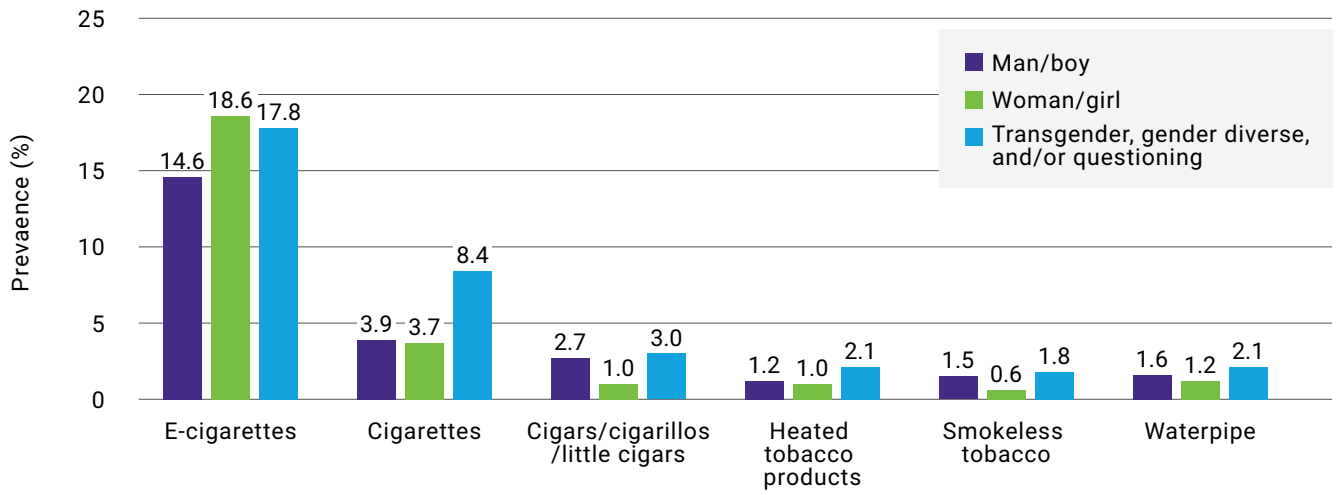


Figure 5. Past-30-day use of e-cigarettes and tobacco products, by gender, Canada 2021-22 (https://www.canada.ca/en/health-canada/services/canadian-student-tobacco-alcohol-drugs-survey/2021-2022-summary.html)

Of note, Ontario implemented a menthol cigarette ban in 2017 as part of their "tobacco control strategy"[97] and currently restricted availability of flavoured e-cigarettes other than tobacco, mint and menthol in specialty vape stores.[98] Ontario's menthol cigarette ban has already shown an increase in quit attempts and quitting among former menthol cigarette smokers.[99] Around the world, many different approaches are being explored to try to further restrict smoking[100] and curb vaping[101] among young people, though research is needed to understand the effectiveness of these regulations and restrictions. For example, the Ontario Ministry of Education department plans to install vape detectors and increase regulations for vaping in schools.

6.5 Additional substance use

Young people may use substances beyond those that have been discussed in this guide. Additional substances that youth may use are listed in the table below.

SUBSTANCE	BRIEF OVERVIEW
Cannabis edibles	To infuse food (e.g., brownies, candies) with cannabis is considered an edible. It is critical to understand that the absorption of cannabis (i.e., THC) in an edible occurs more slowly (approximately 1-3 hours), and to feel the effect is a gradual process.[102][103] As such, there is a risk that youth may over consume to feel the effect.[102]
Stimulants • Amphetamine • Cocaine • Methamphetamine • Energy drinks	Stimulants are a broad category of drugs that increase the level of activity in the central nervous system (CNS) resulting in increased heart rate, attention, alertness, and energy.[104] Stimulant drugs include caffeine, nicotine, cocaine, crack, methamphetamine (meth), and prescription medications such as methylphenidate (Concerta or Ritalin) or dextroamphetamine (Dexedrine). Prescription stimulants are most used to treat people diagnosed with attention deficit hyperactivity disorder (ADHD) and are used by 4.7% of youth aged 15-19.[104] Problematic use has been reported by 59.7% of postsecondary students aged 17 to 25 who are prescribed these drugs.[104] Illicit stimulant use is an uncommon but dangerous phenomenon among youth. Meth is used by 1.2% of grade 7-12 students and cocaine is used by 0.6% of students aged 15-19, though this number increases to 9% of young adults aged 20-24.[105][106] Caffeinated energy drinks are marketed to boost endurance, and mental/physical performance.[107][108][109] Seemingly, safe, energy drinks have the potential to be harmful (e.g., mood/depression, sleep difficulty, intoxication in high quantities).[110]
Hallucinogens (i.e., psychedelics) • LSD • Magic Mushrooms • Ecstasy/MDMA	Hallucinogens are substances that alter reality. They are associated with distorting what the user sees or hears, as reality. Lysergic acid diethylamide (LSD) is the most common synthetic hallucinogen.

7.0

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SMH professionals are well poised to implement SBIRT because of their clinical training and the association between substance use and mental health.[4] This framework can be implemented in different settings such as primary health care, hospitals, community and schools because health care professionals are often trained in and use SBIRT; which is comprised of 3 components:[4]

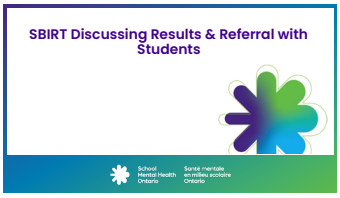
1. **Screening** – A quick assessment of the severity of substance use to determine the appropriate intervention.
2. **Brief Intervention** – The use of intervention to discuss substance use and enhance motivation to change.
3. **Referral to Treatment** – Referral for extensive and specialized substance use care.

The application of a compassionate care approach to the implementation of SBIRT can help SMH professionals to build a trusting and non-judgmental relationship that can support their progression through each component of this approach. CAPSA has defined compassion as "the skill to be in the presence of someone while wishing them well, whatever that is in the moment. It is not demanding or controlling of any outcome"[111]. When applied, the SMH professional will demonstrate an unconditional positive regard, empathy and compassion toward the student, without directing their outcome.[111]

7.1 Screening

For substance use, it is recommended that SMH professionals engage in early identification and intervention. This begins with screening and monitoring for any substance use and concurrent mental health concerns. Within the SBIRT model, screening involves the use of a tool to assess for at-risk substance use. This can be achieved by universally administering a screening tool to all young people referred to school-based mental health services or only those referred to services because of substance use concerns.[9] The screen is designed to gather information on behaviour and health values.[4] There are different screening tools that SMH professionals can use to assess the extent of a student's substance use. There are general and specified screening tools. **Keep in mind that the use of screening tools should be accompanied by a conversation with the student and is best done after rapport has been established.** For example, when screening for cannabis use patterns, SMH professionals should ask students about their unique reasons for use and attitudes toward the normalizing of substance use. Identifying consumption motives can highlight unmet needs and help inform the student's goals. Clinicians should also seek to understand how substance use plays a role in family dynamics to discern the need for a referral or recommendation for family-based interventions.

Click here to view a PowerPoint video on more information on preparing for and having the conversation about substance use and screening with students.



Keep in mind that SMH professionals should consider socio-cultural factors when choosing a screener and when discussing the results with the students. For example, the Thunderbird Partnership Foundation has developed a resource, *Developing a "Basket of Mental Health and Addiction Screening and Assessment Tools" for Use with First Nation Clients*, that proposes different assessment tools that would be more culturally appropriate for First Nation communities.

In addition, screening for substance use follows best practice guidelines for working with young people. For example, when assessing for smoking and vaping, there are guidelines and evidence-based texts that recommend regularly assessing for smoking and vaping among adolescents in an effort to prevent or delay onset and intervene early.[112][113][114] Therefore, it is important for SMH professionals to screen and continuously monitor patterns of substance use or any reductions or cessation in use. This contributes to both comprehensive clinical conceptualizations and assessments of treatment outcomes.

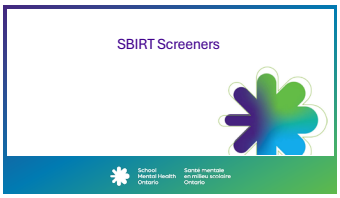
As an example, some important questions to ask students about vaping and tobacco use include:[112][113] [114]

1. **Have you ever smoked, vaped, or used other tobacco or nicotine products?** This gets at lifetime use. It is helpful to specifically ask about e-cigarettes or other tobacco products in addition to smoking when talking with young people.
2. Ask about current use status. **How often do you vape and smoke?** This will help to understand the extent of use in relation to the substance use continuum.
3. To screen for possible tobacco or nicotine dependence from cigarette smoking, these questions may help to gauge possible dependence:
    a. **Do you currently smoke? If so, how often?** If daily, this generally indicates a higher risk of dependence and problems.
    b. **How many cigarettes do you have per day?** If they indicate >=10 per day, this generally indicates a higher risk of dependence and problems.
    c. **Do you smoke right when you wake up?** If <30 minutes between waking up and smoking, this generally indicates a higher risk of dependence and problems.
4. To assess possible nicotine dependence from vaping, it may be helpful to use the e-cigarette dependence scale.[115] Any yes responses to the following questions indicates possible dependence:
    a. When I have not been able to vape for a few hours, the craving gets intolerable.
    b. I drop everything to go out and get e-cigarettes or e-juice.
    c. I vape more before going into a situation where vaping is not allowed.
    d. I find myself reaching for e-cigarettes without thinking.
5. The Hooked on Nicotine Checklist (HONC) can also be used for screening nicotine dependence from vaping in school students.[116]
6. As young people often use both cigarettes and e-cigarettes, dual use and former smoker status should be enquired explicitly.
    - **Are you currently using both cigarettes and e-cigarettes?**
    - **Did you previously smoke but quit by switching to vaping?**

Below is a list of possible screening tools that can be used with young people from the ages of 12 to 21.

CLASSIFICATION	SCREENING TOOL	DESCRIPTION
Alcohol	AUDIT (Alcohol Use Disorder Identification Test)	• 10-item screener developed by World Health Organization (WHO) • For more information on the AUDIT visit the AUDIT Screener website.
Cannabis	CUDIT-R (Cannabis Use Disorder Identification Test)	• 8-item screener for adolescents
General Screen	CRAFFT (Car, Relax, Alone, Forget, Family/Friends, Trouble)	• 9-item screen for adolescents • Required to sign up to access screening tool for English and French. • For more information on the CRAFFT visit the CRAFFT Screener website.

Click here to view a PowerPoint video on more information about substance use screeners and a suggested decision tree when the initial school-based referral is not substance-use related.



SMH professionals screening reflections [2][4][9]

- **Referral context:** Is the student referred to the SMH Professional at the recommendation of the school (e.g., concern about academic performance, behaviour, attendance), the parent/caregiver (e.g., concern about student and family functioning), self-referred (e.g., student concerned about their own substance use) and/or youth justice system involvement (e.g., legal consequence for substance use).
- **Co-occurring mental health concerns:** Is there any concern about suicidal ideation, psychosis, depression, and anxiety? Possible concurrent disorder may influence stage of change and responsiveness to school mental health services.
- **Feedback plan:** How and when will the screening results be shared with the student? Note the importance of using non-stigmatizing language in describing concerns.

SMH professionals response to screening results:[2][4][9]

- If results are below threshold (no concern or sporadic):
  - explain the results
  - provide positive reinforcement (e.g., "how might these results be helping you reach your goals?")
  - explore reasons for no use or minimal use
  - provide advice that focus on nonuse to preserve health[4]

- If results are above threshold (concern about substance use):
  - explain the results
  - explore if student feels there is reason for concern and consider the stages of change
  - explore how their use is impacting (or not) areas of their life. The substance use continuum can be a guide in your conversation with the student.
  - explain possible school-based brief interventions
  - introduce a conversation that explicitly encourages behaviour change, such as a reduction or cessation of substance use or reduction of associated risk, such as driving while impaired
  - explore an explicit conversation about behaviour change (e.g., reduction or cessation of substance use)[4]

7.2 Brief intervention

This section is intended to add to your existing "toolbox" based on evidence and practice considerations related to school-based interventions. While the information in this guide focuses on individual interventions with students, this content can be used to support SMH professionals in their work with parents/caregivers and peers.

Cultural considerations

As SMH professionals embark on this work and consider the application of various treatment modalities, it is important to begin by grounding your practice in your knowledge and understanding of cultural considerations and the socio-cultural factors operating in the life of the client. Beginning by centring the identity and experiences of the student, SMH professionals can better understand the factors and experiences that impact the student and how that may shape the work with the student in school. This invites SMH professionals to frame their interventions more responsively, honouring, or potentially embedding, the context of the student's journey, including factors which may contribute to, or sustain the substance use or addiction concern, in a context of which recognizes contributing factors, including oppression and impacts of colonization.

See section on cultural considerations and socio-cultural factors in substance use intervention for further guidance on integrating cultural considerations in addictions treatment with students.

Components of brief intervention

The classification of a brief intervention includes 6 components (FRAMES) — Feedback, Responsibility, Advice, Menu, Empathy and Self-efficacy:[9]

Feedback

SMH professionals provide an overview of the students' substance use patterns and discusses information and facts about substance use and its potential harm and invites feedback from the student about their discussion (e.g., SMH professionals can use the elicit-provide-elicit motivational interviewing (MI) technique for a psychoeducation discussion about substance use). More on MI is found in this section, below.

Responsibility

SMH professionals emphasize that it is the student's choice about their decision to change (e.g., SMH professionals can use the transtheoretical theory of change model to guide conversation).

Advice
SMH professionals invite student permission/consent; to share with them recommendations on possible options to change behaviour (e.g., Would you be okay with me sharing with you some options for support or intervention?)

Menu
SMH professionals discuss possible brief intervention options in schools and in the community.

Empathy
SMH professionals display empathy and self-awareness to be nonjudgemental and non-stigmatizing toward the student.

Self-Efficacy
SMH professionals support the student and foster an environment of hope and optimism.

Brief interventions are provided to students who score moderate to high-risk based on the screening tool score.[117] During this stage, the SMH professional supports and facilitates a conversation related to student's motivation to change their substance use.[4][9] **In other words, the focus is on readiness for change rather than risk-focused conversations and referral to treatment.**[4] The readiness ruler is one way to identify motivation for change and intervention. The readiness ruler is a scale of 1 (not ready) to 10 (very ready). **SMH professionals may introduce the readiness conversation by asking how ready the student is to change their behaviour. For example:**

> *"We have talked quite a bit about your experiences with multiple substances, and how it is impacting your physical and mental health, and I am wondering, using this readiness ruler, where 1 is not ready and 10 is very ready, how ready you feel to make a change? Know that I am still here to support you regardless of where you are on this readiness ruler."*

For a student response lower on the readiness ruler, consider a focus on exploring reasons for change and change talk; and for scores higher on the ruler, affirm the motivation and suggest resources and/or a community referral for specialized treatment.[4][9]

For students who consent to proceed with a SMH professional, there are evidence-based brief interventions that can be used from the recommended 1 to 4 session model to guide this SBIRT step.[4][9] In the school context, it is more likely that the SMH professionals would continue to provide support beyond the 4th session.

While there are multiple brief interventions such as Brief Coping Interventions and Brief Intervention for School Clinicians (BRISC) that can be used in the school setting, this guide will use Motivational Interviewing (MI) and Cognitive Behavioural Therapy (CBT) as the exemplary brief interventions for the SBIRT framework. In addition, the Transtheoretical Model is used to illustrate the importance of the stages of change in the discussions about readiness for behavioural change.

Using Motivational Interviewing (MI) in schools to address substance use and mental health concerns

Motivational Interviewing (MI) approaches are grounded in a non-judgmental communicative approach that has the goal of enhancing and eliciting motivation to change and subsequent behaviour change (see Appendix C for a Motivational Interviewing Tip Sheet). MI does this by resolving ambivalence and by building intrinsic motivation for change, rather than focusing on external motivation (such as punishments, consequences or rewards from family, school or justice system).[118] MI is identity affirming as it respects and values the student's personal values, experiences, and autonomy throughout the entire process. By focusing on the student's own reason for change, MI helps them to align their actions with their sense of self-identity, promoting self-empowerment and self-direction.

MI is a multi-layered approach which starts with the spirit of MI. This provides a foundation for SMH professionals to foster a sense of agency within the student by acknowledging that they are the experts on their own life by emphasizing the importance of developing a partnership with the student, acceptance for the student as they are, compassion for their experience all the while working to evoke motivation to make their desired change. MI summarizes this using the mnemonic PACE (Partnership, Acceptance, Compassion and Evocation).

The principles of MI are the next layer.[119] This provides the SMH professional with guidance on how to be with the student and facilitate the spirit of MI. The principles guide SMH professionals to recognize and resist the urge to correct for inform the students without first getting their buy-in. The principles guide SMH professionals to understand the perspective of the student and listen reflectively to their experience of their substance use while empowering them to explore the possibilities of change. MI Summarizes this using the mnemonic RULE.[119] See below.

R	Recognize	Recognize and resist the urge to correct or inform (the righting reflex, or our innate urge to correct clients and prescribe solutions).
U	Understand	Understand the perspective of the student.
L	Listen	Listen reflectively to the student's experience of their use.
E	Empower	Empower the client to explore change.

Using the spirit of MI and the principles to guide them SMH professional can then move through the four processes of MI; **Engage**, **Focus**, **Evoke and Planning**. These processes can be fluid and an SMH professional may use each one or more in any session with the student. **Engagement** is when the SMH professional is building a collaborative rapport with the student, it involves showing them that you understand their experiences and aspirations. **Focusing** involves collaboratively agreeing to intentionally bring the conversation into focus. **Evoking** is deliberately making space for conversations that bring about change talk. Below we will highlight some of the skills that can support this. **Planning** involves supporting the student to develop a pathway to reach their goal; this could be large or small steps towards their goal.

Throughout the four processes of MI and while being grounded in the spirit and principles of MI SMH professionals can use the following core skills and techniques:

- Elicit/ Provide/Elicit[119] — This is a collaborative approach for advice giving where you first ask the student what they would like to know about the advice you would like to provide; this also involves getting permission to share the advice. The SMH professional then shares the advice and tailors it to the students' needs then asks the student for feedback about how the new information makes sense to them.
- OARS[119] (see below) help to guide the SMH professional through the conversations that move though the MI processes.

O	Open	Open ended questions
A	Affirmations	Affirmations (acknowledge their current skills or steps towards making a change)
R	Reflections	Reflections (accurate empathy and reflecting on what they have said and/or what they may be experiencing — even if they have not vocalized it)
S	Summaries	Summaries (help organize thoughts and highlight "change talk")

- Amplifying/Recognizing Change Talk — While using MI the focus is on evoking motivation for change and as such it is important to be able to recognize Change Talk. The mnemonic DARN CAT can help support this.

EXAMPLES OF TYPES OF CHANGE TALK		EXAMPLES OF ELICITING STATEMENTS
Preparatory change talk (DARN)		
D	**D**esire "I want/hope/wish I could change"	"What makes you want to change your use?"
A	**A**bility "I think I could stop using if I wanted"	"If you decided to change your use, how do you think you would go about changing? How difficult do you think it would be? Have you made changes before?"
R	**R**easons "If I change my use, my relationship with my parents would be better"	"What do you not like about using cannabis?" (i.e., the cons of use)
N	**N**eed "I need to change because if I don't, my girlfriend will dump me"	"What might happen if you do reduce or stop using cannabis?"
Mobilizing change talk (CAT)		
C	**C**ommitment "I will/plan to stop using before bed"	"What is your goal for your cannabis use, if you have one? How do you plan to reach that goal or make changes?"
A	**A**ctivation "Although I still have some at home, I have not restocked in the past week"	"What are you ready to do right now?"
T	**T**aking Steps "I stopped using during the school day."	"What is next?"

- The MI Ruler — Helps SMH professionals identify where the student stands and encourages reflection that can lead to change talk. The ruler scales from 0 (no interest in change) to 10 (completely ready to change). Change talk can be elicited by asking questions like "You said that you are a five. What makes you a five and not a three?" The ruler can be used to explore change in terms of the student's readiness, commitment, confidence and how important the change might be to them at this time.

MI focuses on evoking "change talk" statements from the client that reflect their internal motivation for and commitment to change, including vocalized actionable steps to change. MI strategies work within the context of a supportive clinical relationship.[120]

In MI, you will hear the term "*roll with resistance*," which encourages you to recognize someone's stage of readiness to change rather than wrestling with them to convince them to change. The goal of MI is to create a collaborative partnership that facilitates a shared exploration of change. This is a natural connection to using BRISC and the Transtheoretical Model of Change. There is more information on this model of change below.

Using Cognitive Behavioural Therapy in schools to address substance use and mental health concerns

Cognitive Behavioural Therapy is foundational to many of the protocols that SMH-ON offers for SMH professional learning and training. Using CBT, SMH professionals can support students in learning how to recognize, explore and support change in the thoughts, attitudes, beliefs and assumptions related to their substance use and other problematic reactions to specific situations. It is critical that the application of CBT practices be grounded in an identity-affirming approach, that considers each student's culture, race, identities, beliefs and other intersectionalities to strengthen the meaningfulness and relevance of the approach to the student.

CBT is a tool, and like every good therapeutic tool, it must be used thoughtfully and intentionally to support the unique needs and strengths of each student. CBT that is identity affirming helps SMH professionals to reflect on the value of this tool and to differentiate its use in order to affirm student identities and intersectionalities. Naeem and colleagues suggest that "Cultural adaptation of CBT can be defined as 'making adjustments in how therapy is delivered, through the acquisition of awareness, knowledge, and skills related to a given culture, without compromising on the theoretical underpinning of CBT.[121]" (388-389)

When using CBT, there are many cultural considerations that will require adjustments and accommodations to the approach. For example, CBT uses a structured approach which may not be what the student expects in therapy. The student may need time to build trust and comfort with working together toward goals and where the student is positioned as the "expert" on themselves.

In the context of substance use, psychoeducation about the Thoughts-Emotions-Actions or TEA triangle (Figure 6) can be a good place to start some of the CBT work. Specifically, the "action" part of the triangle can be a starting point when referring to the use of a substance. The TEA triangle is best used with strong consideration of context (e.g., a student's culture, identities, and intersectionalities; situational factors; school/community factors). Additionally, historical, political, social, spiritual and intergenerational factors influence our thoughts, emotions and actions. How people view and express emotions, physical sensations, action/responses and thoughts varies across cultures and need to be considered for each student when using a CBT approach.

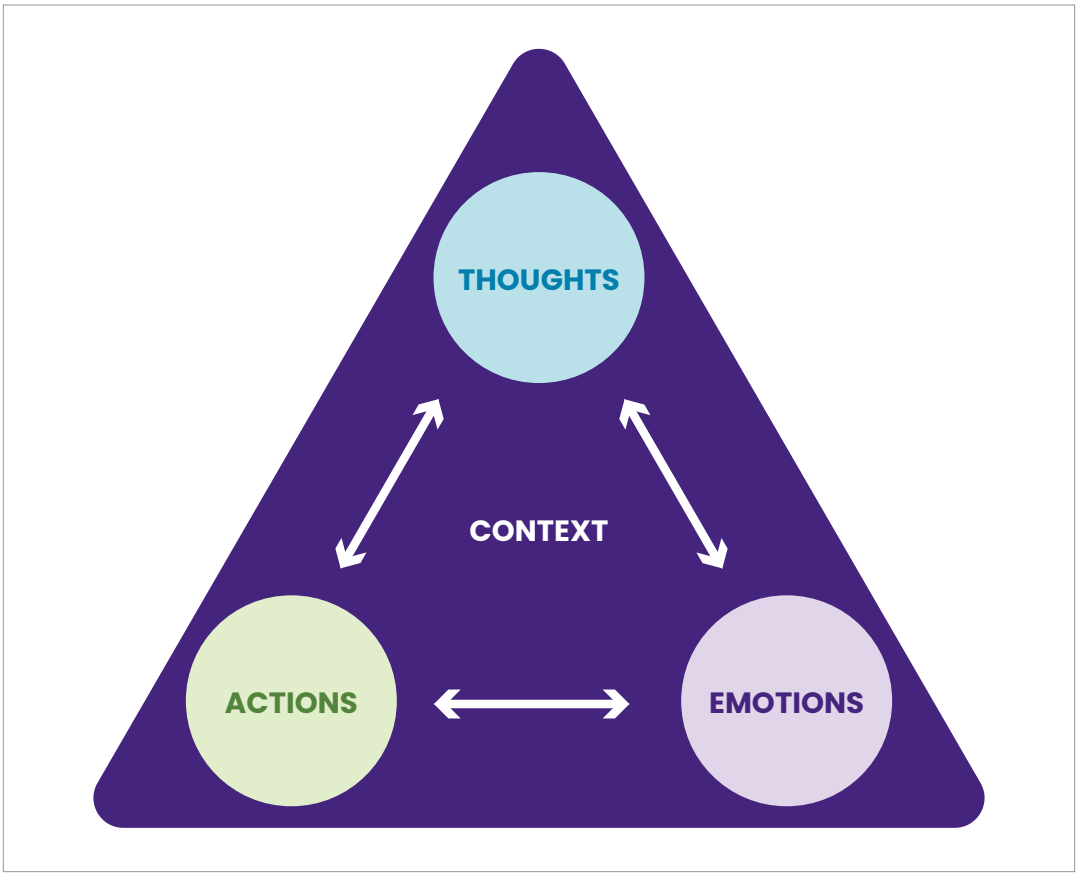


Figure 6. CBT TEA triangle

SMH professionals can include other CBT practices with a focus on substance use in several ways. Substance use involves automatic thoughts that may not be self-evident. Working with a student to help them identify the situations or emotions which occur before their use provides an opportunity to help them explore the thoughts that may trigger their

use. This can be particularly helpful in working with students who are preparing to change their use, have increased the amount they are using, are using in higher-risk ways, or have used substances that they previously would have avoided. If a student appears ready to reduce/change their substance use, CBT strategies may be a good approach to assist with their exploration. These strategies will be described in the next section.

The SMH professional may also want to ask some prompting questions to assist the student in **identifying thoughts** related to substance use.

These could include:

- What was going through your mind just before you began using substances?
- What were you telling yourself when you used a particular substance?
- What are your thoughts on what using substances says about you? Your life? Your future?
- What do you think may happen if you start to decrease your substance use? If you were to decrease and change your substance use, what is the worst thing that could happen?

The SMH professional can also ask prompting questions related to substance use and related emotions to assist them in further emotion identification and awareness.

These may include:

- Using one word, how can you best describe the mood you were feeling before you used a particular substance, such as alcohol?
- How intensely did you experience this mood/emotion/feeling?

The SMH professional can ask prompting questions to assist the student in identifying actions:

- What would I see you doing?
- Who are you with? What time of day is it? Where were you?

Transtheoretical model of change

As noted above, a critical step in working with someone related to their substance use is understanding their readiness to change. Too often, we assume that a person who is using substances will want to set a goal of abstinence and may implement an intervention that does not match their experience or goal.[122] Equally problematic is the assumption that if a person does not yet want to change their substance use, there is no work that can be done. **The myth surrounding someone having to "admit they have a problem" with substance use prior to assistance being provided can negatively impact our ability to engage with students who use substances.**

The Transtheoretical Model of Change (also called the Stages of Change Model) is widely accepted as a helpful guiding approach in the addictions field.[123] This model entails gaining an understanding of how ready a person may be to consider changing their behaviour and identifies the focus area for each stage of readiness. This model can be used for other behaviour changes as well and is a complement to the Cognitive Behaviour Therapy (CBT)CBT and MI strategies, which have been discussed in this resource. Understanding the stage of change of a student related to a problem behaviour such as substance use will assist a SMH professional in determining how best to use various CBT and MI strategies.

The Transtheoretical Model of Change explains change as occurring through 6 stages: precontemplation, contemplation, preparation, action, maintenance, and termination.[124] It is important to recognize that this is not a linear process and individuals will often move back to earlier stages.[124] It is important to note that individuals can be at a different stage

of change for different behaviours (and substances). Thus, a student may be in precontemplation around their use of cannabis and in preparation related to their use of alcohol. For each stage of change, different intervention strategies are considered effective to support a person in progressing to the next stage of change. It is also important to note that behaviour change related to substance use may not be focused on a goal of abstinence.

Guideline for sessions 1–4

This section is designed to provide suggestions on conversations to have with students who present concerns regarding substance use. Rather than prescribing steps for each session, this section provides ideas on the topics to review within the first four sessions with a student.

Suggestion 1: Review Confidentiality

At the beginning of any session with a student, regardless of the reason for referral, SMH professionals review privacy and limits of confidentiality.

This discussion may also include specific school and school board policies. Students may be concerned about their substance use being reported to school administration, parents/caregivers and other community agencies (e.g., probation services, Children's Aid Societies, Indigenous Child and Family Well-Being Agencies). It is important to be clear about if and when others will be informed about what the student says. Consultation with clinical managers can help to determine the disclosure threshold for student substance use.

Suggestion 2: Provide a review of the time together, setting the tone, and checking in

> **Note:** Throughout each session, it is recommended that SMH professionals continue to build and establish a safe, trusting, and positive rapport with the student.

It is important to create a non-judgmental and comfortable therapeutic environment to talk about substance use. Before talking about any substance use some of the following statements may be helpful to set the tone for your discussion:

- *"Our time together today is an opportunity to talk about how life events or circumstance may be impacting your wellbeing and your ability to succeed at school. I often ask students I see about their substance use as sometimes substance use can also be impacting their life. Also, sometimes if a student is using or exploring substances, it may be related to life events or how they are feeling."*
- *"My job is not to tell you what to do and control this process. I would like us to use the time we have together for an open conversation. There is a screener that SMH professionals use to have a conversation and understand more about at student's substance use, I would like to use a few minutes to complete it, today, and you and I can have a conversation about it afterwards. How does that sound?"*
- *"I am hoping that in our time together, we can talk a little about what has been going for you, to include any experiences you might have with substance use. I am here to be of support to you."*
- *"We understand that everything in life is connected—our mind, body, spirit, and the world around us. When we talk about substance use, we recognize it not just as an issue on its own, but as something that might be linked to deeper feelings, experiences, and our connection to our history."*
- *"Together, we'll work on finding balance and healing in all aspects of your life, honouring your strengths and the wisdom of your community and culture. Holistic care means we'll look at the whole picture, including how we can draw on your cultural values and traditions to support your well-being. I would like us to co-create a safe space for you to share your story, and I'm here to walk alongside you on your journey."*

Suggestion 3: Discuss the screen process and review screening results

In conversation with a student who has shared their experience with substance use, the SMH professional can explore their experience with substance(s) and use this as an opportunity to introduce and discuss the screening process to understand more about their experience with substance(s). A sample conversation is below:

Student: *Yes, I do drink, and smoke weed. But mostly I drink. I drink a lot with friends on weekends and sometimes weekdays, if it's a birthday or some kind celebration for something.*

SMH professional: *Okay, you mention you mostly drink, can you tell me more about your experience with drinking? For example, is this something that is new?*

Student: *Yes, new. I just started drinking, less than a year ago. It started off with one drink, then we play games and take shots and now I can drink more, like 3 beers, and something like 2-3 shots of liquor. It all depends on what we have on us that night.*

SMH professional: *Thank you for opening up about your experiences with alcohol. It sounds like there have been a few occasions when you've had drinks with friends, and I'd like to understand this a bit more to ensure you're staying safe. There's a simple questionnaire called AUDIT that can help us explore this further. Your responses would be kept completely private in your social work record. If you're comfortable, would you like to go through the questionnaire together?*

Student: *What do I have to do?*

SMH professional: *The AUDIT is a 10-question survey that asks you about your experience with drinking, your frequency, and amount of alcohol consumed.*

Student: *Okay, sure.*

SMH professional: *Okay, thank you! Here is a copy of the survey and I will give you some time to complete it and afterwards, we will go through it together.*

Afterwards, the SMH professional will meet with the student to review the results of the screener (This may occur in one session or separated into two sessions). Discuss with the student whether they were below the threshold (no concern) or above the threshold (concern). Following this conversation, you may suggest to the student the form of brief intervention that you recommend (e.g., psychoeducation, CBT).

For example, if the results of the CRAFFT indicate cannabis usage, you may have a similar discussion to the sample below.

SMH professional: *I noticed from the questionnaire that you smoke cannabis (add language from the screener). Can you tell me a little about your experience using cannabis? What benefits do you get from it?*

Student: *I've had really bad headaches for the past few years since my parents split up, so I feel like weed helps the pain go away a bit when my head is bad. Also, I get really nervous and shaky at night when I'm thinking about stuff, but it helps me chill so I can sleep better.*

SMH professional: *It sounds like cannabis is really important to you, and helps you feel better when you're anxious or in pain?*

Student: *Yeah, nothing else works*

SMH professional: *What do your parents and other family members think about it?*

Student: *My mom gets annoyed when I do it at home, but my dad doesn't care. He used to do it when he was younger so it's not a big deal for him. Sometimes I smoke with my brother.*

SMH professional: *I am wondering a little more about the really bad headaches you mentioned, have you spoken to a doctor about your headaches or anxiety before bed?*

Student: *I did once but he didn't really listen to me.*

SMH professional: *Hmm, that is hard, when you don't feel heard. I am wondering about whether it would be helpful if I talk to your parents and doctor about getting a referral to a pain and sleep specialist so you have other ways to manage pain and sleep better? Would you be open to that?*

Student: *I guess.*

SMH professional: *There are also ways you can reduce anxiety and manage pain through coping skills like relaxation strategies using cognitive behavioural therapy strategies. Is it OK if I show you some natural ways to feel better?*

Student: *Sure, that sounds good.*

Suggestion 4: Menu/Options for continued time together

After reviewing the screening tool with the student, the SMH professional can determine if the student is amenable to continuing to meet together to work on what was informed by the screening and/or other concerns (e.g., family, mental health, attendance). If so, the SMH professional can initiate a conversation about the student's goal(s) and select the intervention approach (e.g., CBT, Brief Coping Intervention, BRISC) that would best meet the student's need(s).

7.3 Referral to treatment

SMH professionals may determine that a student may need specialized treatment for their substance use. If the student provides consent to a community-based referral, this may result in a recommendation or referral to one or more of the following:

- family physician for further assessment and monitoring
- longer-term problematic substance use or addictions treatment (in-patient or outpatient)
- group intervention support
- family and youth-based treatment

SMH professionals should consider providing the student with information about what they can expect if referred to a community services provider.[4] This would contribute to a "warm handoff" – establishing a personal connection between the student and the service provider.[4] In the school setting, it is likely that SMH professionals would continue to support the student within the limits of their expertise and time; and may help with a return-to-school plan. As such, the collection of the appropriate consent forms will help to continue to align the supports that are being provided to the student.

Moreover, the Centre for Addiction and Mental Health has proposed a 4-quadrant model (Figure 7) that captures both the severity of the presenting mental health concern and substance use problem. When both occur simultaneously, this is referred to as a concurrent disorder, as noted above. The greater the severity, the more specialized the services need to be (as is the same for other mental health concerns). Indicators that a student may require more specialized services include:

- Disclosure from student, family and/or school staff that indicates increased severity of mental health concerns related to substance use (e.g., experiencing psychosis during or after use, engaging in self-harm or risk of suicide during or after use).

- Ongoing cannabis use causing severe impairment that is not improving with motivational and cognitive behavioural interventions delivered in the school setting.
- Regular use of other illicit drugs (such as opioids).
- Daily alcohol use showing symptoms of alcohol use disorder (withdrawal from alcohol use can be life-threatening and reductions/cessation of this use should be monitored by a medical professional).

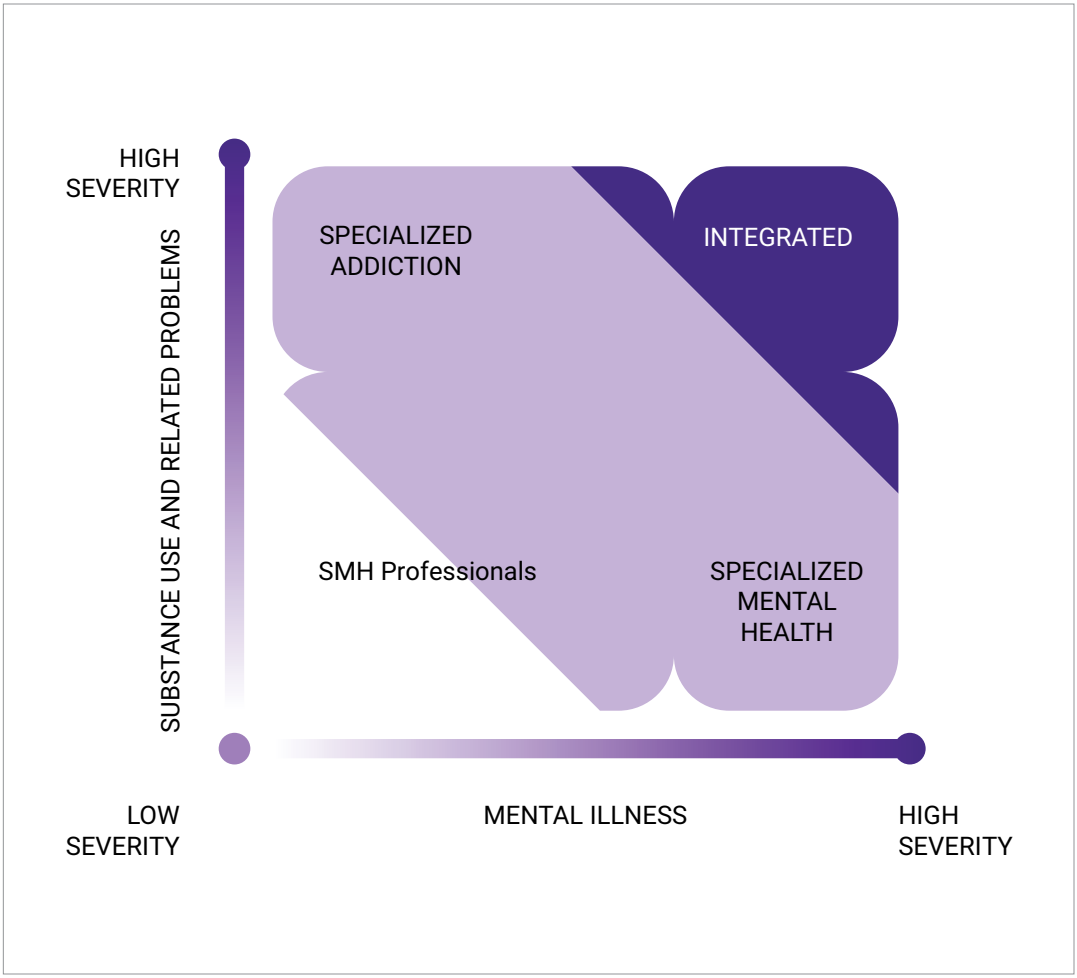


Figure 7. Adapted 4-Quadrant Model of Concurrent Disorders for SMH Professionals[124]

Clinical flow chart

This guide used the SBIRT framework to delineate the phases for screening and intervention for substance use. The clinical flow chart originally developed for the School Based Interventions Related to Student Cannabis Use Practice Guide has been adapted here to reflect the phases of SBIRT.

1. Screen and monitor for substance use and co-occurring substance use with mental health problems.
2. Provide brief intervention that is appropriate with the risk of substance use (e.g., lower-risk: psychoeducation; higher-risk: motivational interviewing and/or CBT or other brief interventions).
3. Concurrently treat substance use problems alongside mental health concerns with existing tools and techniques used by SMH professionals and to identify the need for a referral to specialized treatment.

Step 1: Screen for past or current substance use

NO USE REPORTED	PREVIOUS USE REPORTED	CURRENT USE REPORTED
• ask about student's thoughts about substances and if they have any questions • encourage student to share questions or concerns if they have any in the future	• determine degree of risk by using the screening results and follow-up questions (e.g., frequency, current emotional impact) • determine if student is thinking of using substances again • discuss situations and plans to continue to avoid substance use	• determine the degree of risk by using the screening results and follow-up questions (e.g., frequency, dosage, social and familial impact) • explore reason for use • determine if student would like to change their substance use • Engage in a discussion about the link between substance use and mental health (with student permission to learn about this information)

Step 2: Provide brief intervention for current substance use

PRE-CONTEMPLATIVE	CONTEMPLATION	PREPARATION	ACTION
1. Summarize discussion (re: readiness to change ruler). 2. Ask the student if there is anything that may indicate to them that they want to change in the future. 3. Ask permission to check in with them about their use again at a later session. 4. Provide information in a non- judgmental manner about use and possible connection to other presenting issues (e.g., anxiety). When providing treatment and skills related to other concerns, provide examples of how it may apply to substance use generally.	1. Summarize discussion (re: preliminary functional analysis and readiness to change). 2. Ask the youth if there is anything that may indicate to them that they want to change in the future. • Let the youth know that strategies to help them with their substance use are similar to strategies they are already learning within your sessions. If and when they decide they are ready to make changes, you can start actively discussing substance use during the sessions alongside other concerns. • Suggest self-monitoring or self assessment tools (if deemed clinically appropriate). • Suggest alternative activities or drug free reinforcement strategies (if deemed clinically appropriate). 3. Ask permission to check in with them about their use again at a later session. When providing treatment and skills related to other concerns, provide examples of how it may apply to their substance use.		1. Summarize discussion (re: readiness to change). 2. Let the student know about strategies to help them with their substance use. Ask permission to include substance use in future discussion and skills. • Suggest self-monitoring or workbooks. Suggest alternative activities or drug free reinforcement strategies.

Step 3: Consider referral to a specialized community mental health provider, substance use treatment and/or concurrent disorders treatment program.

Referral resources vary by region and board mental health teams often create linkages and partnership agreements with community partners to support better pathways to care. Knowing about services in rural and urban communities will help to discern viable options for the students and will help students and families in their connection with relevant services in community to appropriately coordinate care. For information in your region about available services, see Connex Ontario at connexontario.ca.

Additionally, it is crucial to centre the student and their identity when considering referrals. Culturally responsive and identity-affirming supports and services can foster trust and engagement, ensuring that the referral process is aligned with their values and needs. SMH professionals may need to explore, alongside students, their experiences, families and/or communities, beyond the common list of community services for referrals to specific culturally responsive and identity-affirming services.

The SMH-ON Circle of Support Resource is a guide for mental health leadership teams to support a coordinated approach to developing referral plans that reflect each board's local resources and opportunities.

Should there be considerable concern for substance use that is harmful or possible substance use disorder, and you have received student consent, suggest a referral to a specialized substance use treatment program and/or family medicine for further assessment. There are community addictions services (non-residential/outpatient) that will support young people who do not have a defined goal of reduction or abstinence and will use the Transtheoretical Model of Change in their approach to supporting a student in considering, preparing for and making changes in their substance use.

8.0

The role of parents/caregivers

There has been growing research attention on the involvement of family in addictions-based interventions.[125][126] Given that substance use may be a part of the family history[4][9] and normalized with the family, there may be multiple impacts of a young person's substance use on the family system. In some cases, this may have a profound impact on family functioning, thus, they are important contributors to the process of assessment and intervention.[9] Research suggests that family involvement in substance use interventions, in fact, is key in increasing the likelihood of a successful outcome for the substance user.[9][127]

In a school setting, it is likely that SMH professionals will spend most of their time meeting with students. However, where it is possible to involve the family member(s) (with consent) to help address the issue and develop a treatment plan, consider asking about:[9]

- parent/caregiver concern for the young person
- parent/caregiver hope(s) for the school-based mental health services
- parent/caregiver thoughts on how the SMH professionals can support their young person

The SMH professionals should consider access to resources and supports for the student and family, where appropriate, and whether there is parent/caregiver support that can support the intervention at school, or in the community (e.g., individual, group or family intervention).

Click here to view a PowerPoint video on more information about substance use and SBIRT conversation with parents/caregivers.

9.0

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10.0

Key resources

The following resource lists provide additional information for SMH Professionals as well as information which can be shared with educators, youth, parents and guardians. Inclusion on this list is not an endorsement. It is advised that any materials be reviewed before sharing and that board mental health leadership teams review professional development opportunities and additional resources prior to sharing.

SMH-ON and collaborators substance use resources

- School Mental Health Ontario and collaborators (e.g., CAMH) have developed a suite of information sheets on vaping and opioids for students, educators and parents/caregivers.
- Among the information sheets, is the practice guide for school mental health professionals: School-based interventions related to student cannabis use.
    - The getting help section from this guide: "If you or a friend need help to quit vaping or smoking, the first step is to talk to someone you trust. This could be a parent/guardian, family member, teacher, coach or guidance counsellor. If you are not ready to talk to someone you know, you can connect with a counsellor at Kids Help Phone by calling 1-800-668-6868, texting CONNECT to 686868 or visiting www.kidshelpphone.ca. Any conversation you have with Kids Help Phone is private. You can also contact a free Quit Coach for confidential support over the phone by calling Telehealth Ontario at 1-866-797-0000 or toll-free at 1-866-797-0007."

Resources to support whole school and targeted prevention initiatives

- District and school level mental health teams are encouraged to use the decision support tools provided by SMH-ON to guide the selection of awareness and prevention activities.
- The Public Health Agency of Canada partnered with Western University to develop educational resources for Canadian school stakeholders. The purpose of the project is to promote school-based initiatives that enhance positive youth development as a means of addressing problematic substance use and other adverse outcomes among youth.
    - Resources include an infographic, research briefs and whiteboard videos, and are available in English and French: www.canada.ca/en/public-health/services/beyond-health- education-preventing-substance-use-enhancing-students-well-being.html
- First Peoples Wellness Circle provides a substance use treatment and land-based healing report on their website: fpwc.ca/projects/substance-use-treatment-and-land-based-healing
- The Western University Centre for School Mental Health provides further information on their website related to preventing problematic substance use through positive youth development on their website: www.csmh.uwo.ca/research/positive-youth-development.html.
- OPHEA provides a resource database and cannabis education resources for educators: ophea.net/cannabis-education-resources

- For further guidance related to supporting collaborative partnerships between school boards, schools and boards of health, the Ministry of Health and Long Term Care created a School Health Guideline (2018) to provide direction to boards of health on required approaches to developing and implementing programs and services.
- In planning awareness and prevention activities, teams can access resources provided by the Canadian Centre on Substance Use and Addiction: www.ccsa.ca.
- Health Canada provides several links related to cannabis including laws and regulations, health risks (including risks related to pregnancy) and information about recalls and adverse reactions at: www.canada.ca/en/health-canada/services/drugs-medication/ cannabis.html.

Additional Resources:

- Health Canada: About vaping
- Health Canada: Talking with your teen about vaping: A tip sheet for parents
- Health Canada — Vaping: The Mechanics (infographic)
- Tobacco : Behind the Smoke (infographic)
- Health Canada (2021) On the Road to Quitting: Guide to becoming a non–smoker for young adults
- Smokefree Teen (US website)
- Health Canada: Smoking, vaping, and tobacco surveys, statistics, and research
- The Canadian Cancer Society's Smokers' Helpline also offers services to help you quit smoking or quit vaping or quit both smoking and vaping. You can access these services online at www.smokershelpline.ca or by texting iQuit to 123456".
- Indigenous Tobacco Program offers different quit smoking and vaping prevention supports to First Nations, Inuit, and Métis youth. One of their supports include the Talk Tobacco phone service, which has been developed to meet the need of the indigenous communities and can be accessed via going to talktobacco.ca or calling 1-833-998-8255.
- CCSAs Overcoming Stigma Online Training
- Families for Addiction Recovery

11.0

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Appendix A

Substance Use Prevention and Intervention Survey for School Mental Health Professionals: Summary Report

[Report prepared: **April 29, 2019** / Number of Responses: **294**]

What is your role in your school board? (check all that apply)

ANSWER	%	COUNT
Social Worker	52%	153
Psychologist / Psych Associate/ Psychotherapist/ Psychometrist	17%	49
Child & Youth Counselor	12%	34
Mental Health Leader	11%	31
Chief/Manager Social Work Services	4%	12
New Secondary School Mental Health Worker New Secondary School Mental Health Worker	3%	10
Chief/Manager Psychological Services	2%	6
Other: Consultant (4), Mental Health Clinician/Interventionist (2), Addictions worker, Guidance teacher, Superintendent of Education, Social Service Worker	3%	10
TOTAL	**100%**	**294**

How many years have you worked in school mental health?

ANSWER	%	COUNT
0-5 years	39%	116
6-10 years	25%	73
11-20 years	22%	64
More than 20 years	14%	41
TOTAL	**100%**	**294**

Experiences with substance use prevention and intervention:
Please choose how strongly you agree with each statement using the following scale from strongly disagree to strongly agree.

STATEMENT	STRONGLY DISAGREE		DISAGREE		NEITHER AGREE NOR DISAGREE		AGREE		STRONGLY AGREE		MEAN	ST DEV	TOTAL
	%	#	%	#	%	#	%	#	%	#			
1. Cannabis is commonly raised as a concern in the schools/ board I support.	3%	8	15%	43	16%	44	44%	123	22%	61	3.67	1.07	**279**
2. A resource that includes information on screening and assessment for substance use concerns would support me in my role.	1%	2	4%	11	16%	44	54%	153	25%	71	4.00	0.79	**281**
3. A resource that focuses on early intervention to prevent consequences of cannabis use would help me in my role.	1%	2	2%	6	11%	31	52%	147	34%	95	4.16	0.76	**281**
4. I require information on pathways and referrals for students who require more intensive treatment related to their substance use.	4%	12	16%	45	20%	57	34%	94	26%	72	3.60	1.15	**280**
5. I need more information about the effects of cannabis to provide timely and accurate information to students.	4%	11	14%	40	17%	47	46%	130	19%	53	3.62	1.06	**281**
6. I would like substance use prevention and intervention efforts to include other substances in addition to cannabis.	1%	4	1%	2	6%	18	48%	134	44%	123	4.32	0.75	**281**
7. I am confident in my ability to discuss substance use with parents/guardians, when appropriate in my role.	1%	4	10%	29	20%	56	47%	132	21%	57	3.75	0.94	**278**
8. I would like more information to support other staff (e.g., educators, administrators, clinical staff) related to prevention and early intervention for substance use.	2%	6	2%	6	12%	35	53%	150	30%	84	4.07	0.83	**281**

STATEMENT	STRONGLY DISAGREE		DISAGREE		NEITHER AGREE NOR DISAGREE		AGREE		STRONGLY AGREE		MEAN	ST DEV	TOTAL
	%	#	%	#	%	#	%	#	%	#			
9. I would use a print/ on-line resource related to cannabis and other substances.	1%	3	2%	5	6%	16	57%	159	35%	97	4.22	0.72	**280**
10. I would use training/ consultation related to cannabis and other substances.	1%	2	3%	9	12%	33	52%	146	32%	89	4.11	0.79	**279**
11. I am knowledgeable about ways to reduce harm of cannabis use for current users.	3%	8	26%	72	26%	72	39%	110	7%	19	3.21	0.99	**281**
12. I know the pathways to access services in my community for students requiring referrals for substance use.	3%	9	11%	32	15%	43	54%	151	16%	46	3.69	0.98	**281**
13. Service limitations in my area impact my ability to make referrals for substance use concerns.	4%	10	20%	55	29%	81	29%	81	18%	50	3.38	1.10	**227**

My board currently uses data about substance use patterns (e.g., CAMH Ontario Student Drug Use and Mental Health Survey) to support decision-making related to school programming for substance use prevention.

ANSWER	%	COUNT
Yes	16%	45
Unsure	74%	207
No	10%	27
TOTAL	**100%**	**279**

Appendix B

Frequency of Past Month Cannabis Use Among Grade 7 to 12 Ontario Students

Split by Sex, Gender, and Grade

Definition of sex and gender sub-groups: Students were asked to self-identify their sex (response options: male or female) and their gender (response options: male, female, transgender, none of the above, prefer not to answer). Please note we are unable to provide prevalence estimates for students self-identifying as transgender, other, prefer not to answer, or skipped the question entirely since these were only endorsed by a small number of students. To maintain anonymity, we have only presented estimates for male and female.

By Grade

In the LAST 4 WEEKS, how often (if ever) did you use cannabis? (% of students)

	GRADES 7-8 (ALL STUDENTS)	GRADE 9-10 (ALL STUDENTS)	GRADE 11-12 (ALL STUDENTS)	TOTAL STUDENTS (GRADE 7-12)
Never used in lifetime	97.4	82.6	61.4	78.2
Used, but not in the past month	1.7	8.4	16.2	9.7
Once or twice in the past month	suppressed	4.5	12.0	6.4
1 or 2 times a week	suppressed	2.1	3.8	2.2
3 to 6 times a week	suppressed	1.4	3.8	2.0
Daily	suppressed	1.0	2.7	1.4

Significant grade difference, p<.001

By Sex & Grade

In the LAST 4 WEEKS, how often (if ever) did you use cannabis? (% of students)

	GRADES 7-8		GRADE 9-10		GRADE 11-12		ALL GRADES (7-12)	
	FEMALE SEX	MALE SEX	FEMALE SEX	MALE SEX	FEMALE SEX	MALE SEX	FEMALE SEX	MALE SEX
Never used in lifetime	97.5	97.4	84.6	80.8	61.5	61.3	79.1	77.4
Used, but not in the past month	suppressed	1.9	8.0	8.7	17.7	14.7	10.0	9.3
Once or twice in the past month	suppressed	suppressed	4.4	4.6	12.9	11.2	6.7	6.2
1 or 2 times a week	suppressed	suppressed	1.5	2.6	3.6	4.0	2.0	2.5
3 to 6 times a week	suppressed	suppressed	suppressed	1.6	2.8	4.8	1.5	2.5
Daily	suppressed	suppressed	suppressed	1.6	1.5	3.9	0.7	2.1

Significant grade difference, p<.001

By Gender & Grade

In the LAST 4 WEEKS, how often (if ever) did you use cannabis? (% of students)

	GRADES 9-10		GRADE 11-12	
	FEMALE GENDER	MALE GENDER	FEMALE GENDER	MALE GENDER
Never used in lifetime	84.4	82.1	61.0	61.2
Used, but not in the past month	8.2	8.0	18.2	14.6
Once or twice in the past month	4.4	4.6	13.2	11.4
1 or 2 times a week	1.5	2.3	3.4	4.0
3 to 6 times a week	suppressed	1.3	2.9	4.8
Daily	suppressed	1.6	1.3	3.9

* **Please note** 135 students are not included in these prevalence estimates due to self-identifying as transgender, other, prefer not to answer, or skipped the question entirely. As this was a small proportion of students, prevalence estimates cannot be provided to maintain anonymity of respondents.

Split by Mental Health Symptomatology

- **Psychological Distress:** Students experiencing moderate to serious psychological distress indicated by score of 8 or greater on the K6.
- **Externalizing Behaviours:** Students endorsing >=3 out of 9 antisocial behaviours.
- **ADHD:** Students endorsing symptoms of ADHD.
- **Suicidal Behaviours:** Students endorsing any suicidal ideation or attempts over the past year.
- **Received Mental Health Care:** student endorsing any professional mental health care, i.e., "In the last 12 months, how often have you seen a doctor, nurse, or counsellor about your emotional or mental health?"

Percentage (%) of students with mental health problem reporting frequency of cannabis use in the past month
In the LAST 4 WEEKS, how often (if ever) did you use cannabis?

	PSYCHO-LOGICAL DISTRESS	EXTERNAL-IZING BEHAVIOURS	ADHD	SUICIDAL BEHAVIOURS	RECEIVED MENTAL HEALTH CARE	TOTAL STUDENTS
Never used in lifetime	70.1	34.5	63.6	60.4	72.6	**78.2**
Used, but not in the past month	12.6	16.2	12.3	14.0	12.3	**9.7**
Once or twice in the past month	8.9	17.3	11.7	12.0	6.5	**6.4**
1 or 2 times a week	3.0	7.5	4.0	3.6	2.2	**2.2**
3 to 6 times a week	3.8	17.8	6.4	suppressed	4.3	**2.0**
Daily	1.7	6.7	2.0	2.6	2.0	**1.4**

Percentage (%) of students with mental health problem reporting cannabis use or not in the past year

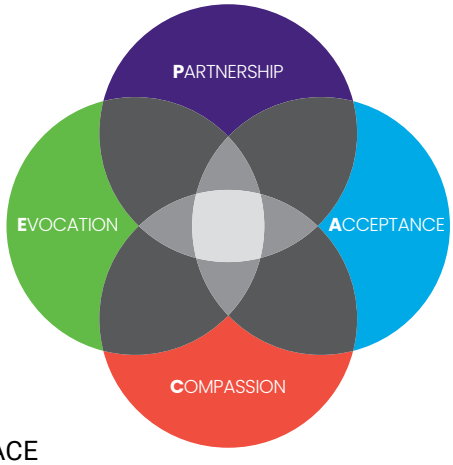
	PSYCHO-LOGICAL DISTRESS	EXTERNAL-IZING BEHAVIOURS	ADHD	SUICIDAL BEHAVIOURS	RECEIVED MENTAL HEALTH CARE	TOTAL STUDENTS
NO cannabis use in the past year	75.7	40.8	67.5	65.3	75.9	**81.0**
Used cannabis in the past year	24.7	59.2	32.5	34.7	24.1	**19.0**

Appendix C

Motivational Interviewing Tip-Sheet for School Mental Health Professionals

Motivational Interviewing (MI) Basics

The underlying "spirit" (or philosophy) of MI is even more important than the skills. While you are an expert in mental health, your client is an expert in their own life.

SPIRIT OF MI: PACE	PRINCIPLES OF MI: RULE
Partnership **A**cceptance **C**ompassion **E**vocation  *Also known as PACE	**R**esist the "righting reflex" The urge to "fix" the student. Arguing for change can have a paradoxical effect. **U**nderstand your student The student's reasons for change are most important because these will most likely trigger behaviour change. **L**isten to your student MI involves as much listening as informing. **E**mpower your student Convey hope around the possibility of change and support students' choice and autonomy re: change goals.

FOUNDATIONAL SKILLS IN MOTIVATIONAL INTERVIEWING: OARS

Open-ended questions encourage elaboration.

Affirmations promote optimism and acknowledge the student's expertise, efforts and experience of the student. Affirmations are not about the practitioner's approval.

Relections: the skill of accurate empathy:

- simple reflections: paraphrase, repeat the content.
- complex reflections: reflect what the student has said as well as what they are experiencing but has not yet verbalized (the meaning beneath the student's words).

Summaries: The best are targeted and succinct, and include elements that keep the student moving forward. The goal is to help the student organize their experience.

This tip sheet was adapted from the resource created by the CAMH TEACH Project and Ontario Lung Association. Miller. W. R. and Rollnick, S. 2013. Motivational Interviewing: Helping People Change. New York: Guilford Press. * Adapted from Miller & Rollnick. 2013, page 22

MI Quick Tips

CHANGE AND SUSTAIN TALK		
CHANGE TALK	…but…	**SUSTAIN TALK**
"I know I should use less weed…		…I like how it makes me feel."

TYPES OF CHANGE TALK: DARN CAT	HOW TO ELICIT? ASK…
PREPARATORY CHANGE TALK (DARN)	• "Why do you want to make this change?" • "If you decided to make a change, how might you be able to do it?" • "How would things be different if you changed?" • "How would things be better if you changed?"
Desire to change (wishes, hopes, wants)	
Ability to change (optimism)	
Reasons for change (benefits of change)	
Need to change (problems with the status quo)	*When you hear change talk you know you are doing it right.*
MOBILIZING CHANGE TALK (CAT)	**Commitment Language Predicts Change**
Commitment ("I will … ," "I plan to …")	• "What do you intend to do?" • "What are you ready or willing to do?" • "What have you already done?" • "What is your next step?"
Activation (steps that the student is already taking in support of a goal)	
Taking Steps (same as Activation; e.g., "I have started buying less each week and told my friend I am cutting back.")	

READINESS RULERS

Readiness rulers are a tool designed to elicit change talk. Use them to explore the importance student attaches to changing, and their confidence and readiness to change (on a scale of 1 to 10). "On a scale of 1 through 10, how important is it for you to quit or cut down on your use of cannabis?" "On the same scale, how confident are you feeling about your ability to quit or cut down?"

1 2 3 4 5 6 7 8 9 10

Low importance/confidence **Extremely important/confident**

Ask: "Why are you at _____ [lower #] and not a _____ [higher #]?"

"What would it take to go from [student's chosen #] to _____ [one number #]?"

Agenda mapping

Create a "bubble sheet" and invite the student to identify all the possible areas for change. You may choose to pre-populate some of the circles as shown in the example below. After inviting the student to share their priorities, ask: *"Given these possible areas of focus, what would you like to talk about in our time together today?"*

School Family Anxiety Cannabis ? ? ? ?

Miller. W. R. and Rollnick, S. 2013. Motivational Interviewing: Helping People Change. New York: Guilford Press.