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Acknowledgements

Acknowledgement and appreciation goes out to the youth addictions administrators, practitioners and researchers whose input and feedback has been invaluable in compiling this guide. Many thanks are also extended to the addictions practitioners who attended the training of trainers event in March 2008 and provided valuable feedback and suggestions on the contents of this youth curriculum.

Once again, my heartfelt thanks to Sherry Mumford and Dr. Akbar Bayanzadeh for their commitment to quality services for youth by initiating this project and their support and encouragement in seeing it through. Appreciation is also extended to Fraser Health, Vancouver Island Health Authority and Interior Health for providing the funding for this project.

I would also like to acknowledge the members of the Youth Addictions Treatment Competency & Curriculum Development Advisory Committee of the Ministry for Children and Families who developed the first youth alcohol and drug training in 1999.

Much appreciation also to the team at Page One Publishing who always does such a wonderful job and is a pleasure to work with.

Finally, I am deeply grateful to Jason, Sara and Jack for the endless patience, love and support throughout this project, even when it impeded on family time. You're the best.

Monica

Introduction: Core Addictions Practice

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Introduction

Overview

The treatment of youth is separate and distinct from that of adults and should be tailored to the unique needs of adolescents, not just based on adult models of treatment. In order for treatment to be effective, specific consideration needs to be given to the youth's physical, cognitive, and emotional development, their values and belief systems, level of motivation, family dynamics, and environmental influences (e.g., strong peer influence). Adolescents are also unlike adults in that their use of alcohol and other drugs stem from different reasons and they have a challenging time realizing how their use will impact them in the future. Young people are also at increased risk of victimization and exploitation by others when they become involved in problematic substance use. They methods and circumstances in which youth use alcohol and other drugs may also differ from adults, with youth more likely to be poly drug users, taking whatever is available and using drugs in environments that may bring additional risks, such as outdoors. The treatment of youth with substance use problems needs to consider all these unique factors in order to effectively meet the needs of this specific group.

Consequently, the *Youth Core Addictions Practice* (Y-C.A.P.) course has been developed as a supplemental course to the *Core Addictions Practice* (C.A.P.) course. Y-C.A.P. can be taught as a consecutive course or concurrently with the C.A.P course.

This course is intended for addictions and mental health staff, funded agency staff and allied professionals in the province of British Columbia, all of whom may work with youth and their families who experience problematic substance use.

The Y-C.A.P. course is a two day practical and skills-based course designed to introduce information, theories and concepts specifically about youth and their alcohol and drug use and to develop the strategies and skills needed for identifying, assessing and counselling those adolescents with problematic substance use and addiction.

Objectives of Y–C.A.P.

The objectives of the *Youth Core Addictions Practice* course are to ensure that all alcohol and drug service providers who work with youth have the essential conceptual framework and core competencies to provide the youth and their families in our communities with addictions services that are current and ensure that alcohol and drug services are provided in an effective, professional and consistent manner.

Core Components of Y–C.A.P.

MODULE I: THE CONTEXT IN WHICH TO UNDERSTAND YOUTH ALCOHOL AND DRUG USE

This module begins with a discussion on adolescent development, including the stages and tasks involved. Adolescent development poses unique issues for those working with youth including rapid growth of the brain and body, emotional and social influences on their behaviour, impact on development due to substance use, family dynamics and identity and self-esteem development. Considering a youth's alcohol or drug use within the context of adolescent development allows practitioners to work more effectively with youth. Next, protective and risk factors which research has shown to decrease or increase the likelihood that an adolescent will develop problems with substance use are discussed. The 40 Developmental Assets that the Search Institute in Minneapolis argue are the positive experiences and personal qualities that young people need to group up healthy, caring and responsible are presented. Lastly, the harm reduction framework is examined in the context of working with youth in the addictions field.

MODULE II: PREVALENCE, IMPACTS AND EFFECTS OF ADOLESCENT ALCOHOL AND DRUG USE

This module examines the reasons young people give for experimenting with alcohol or other drugs. Next, the prevalence of adolescent substance use, both in the general youth population and in the non-mainstream youth population, is discussed. The harms associated with patterns of use – due to mode of administration, intoxication, regular and prolonged use, and dependence – are covered. Lastly, how the needs of youth differ from those of adults are discussed.

MODULE III: CHANGE, MOTIVATION AND COLLABORATIVE APPROACHES WITH YOUTH

This module begins with a discussion on building counselling relationships with adolescents because the youth's perception of the relationship with the practitioner is second only to client factors in being responsible for gains made in therapy (Miller and Duncan, 2005). The Transtheoretical Model of Change is reviewed and its applicability to working with youth is discussed. Next, the effectiveness of using motivational interviewing with mainstream, non mainstream and ambivalent youth is highlighted.

MODULE IV: MAKING TREATMENT COUNT: CLIENT-DIRECTED, OUTCOME INFORMED WORK WITH YOUTH

This module discusses the ingredients to creating a positive context in which to work with youth including the key influences on the health and well being of youth, the impact of attitudes and biases, treatment principles and values, program philosophy and approach, the role of family, and informed consent and confidentiality. Barriers for mainstream and non mainstream youth to accessing treatment are also summarized. Next, information is presented on handling the initial contact with youth in a client-directed, outcome informed way and also completing a comprehensive screening and assessment. The importance of treatment planning is discussed along with the role of the family in the treatment process and case management.

Successful youth treatment is eclectic, holistic and comprised of a range of associated services which are described in this module, including child and youth mental health, child welfare, youth justice, youth forensic psychiatric services, youth services, youth in care organizations, health authorities and youth services in community agencies.

Lastly, relapse prevention is discussed and the six elements of best practice supporting relapse management or prevention with youth are identified.

MODULE V: SPECIFIC TREATMENT CONSIDERATIONS

When working with youth, certain groups of people warrant specific consideration. The two groups include in this module are youth dealing with concurrent disorders (both mental health issues and problematic substance use) and working with families.

Specific Considerations in Youth Populations

Youth are not a homogenous group – within this group are many subgroups of youth, whose circumstances and experiences create unique needs and situations that must be considered when working with each particular group. Research has identified specific groups of youth who are at higher risk for substance use than their peers, including the following:

- Runaway and street involved youth
- Youth involved with the criminal justice system
- Youth with concurrent substance use and mental health disorders
- Sexually abused and exploited youth
- Gay, lesbian and questioning teens
- Aboriginal youth

(CCSA, 2007)

Throughout this manual information specific to each of these groups will be included wherever possible.

MODULE I

The Context in Which to Understand Youth Alcohol and Drug Use

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Module I: The Context in Which to Understand Youth Alcohol and Drug Use

Adolescent Development

Adolescence is often described as the time of the greatest transition, growth and change in a person's life. Young people build on their early life experiences and begin the process of developing a mature, adult identity. It is a time of opportunity and growth during which enormous physical and psychological changes occur and key tasks are accomplished. These developmental tasks include separation from the family, establishment of autonomy and identity, and development of a personal value system (Currie 2001). Adolescent development poses unique issues for those working with youth including rapid growth of the brain and body, emotional and social influences on their behaviour, impact on development due to substance use, family dynamics and identity and self-esteem development (Chapman and Rokutani, 2006).

Having an understanding of the stages of adolescent development allows practitioners to work more effectively with youth. To best meet the needs of youth experiencing problematic substance use, alcohol and drug counsellors should view substance use issues within the context of adolescent development.

THREE STAGES OF ADOLESCENT DEVELOPMENT

Adolescent development can be divided into three main stages, though individuals may vary slightly in the exact age they enter or move from a particular stage.

THE STAGES OF ADOLESCENT DEVELOPMENT			
	Early Adolescence (ages 12-14)	**Middle Adolescence (ages 15-17)**	**Late Adolescence (ages 18 and up)**
Independence	• less interest in parental activities	• peak of parental conflicts	• reacceptance of parental advice and values
Body Image	• preoccupation with self and pubertal changes • uncertainty about appearance	• general acceptance of body • concern over making body more attractive	• acceptance of pubertal changes
Peer Relations	• intense relationships with same sex friends	• peak of peer involvement • conformity with peer values • increased sexual activity	• peer group less important • more time spent in intimate relationships
Identity	• increased cognition • increased fantasy world • idealistic vocational goals • increased need for privacy • lack of impulse control	• increased scope of feelings • increased intellectual powers • feelings of omnipotence • risk taking behaviour	• practical, realistic vocational goals • refinement of values • ability to compromise and to set limits

Adapted from Neinstein, L.S., Stewart, D.C. "Psychosocial Development of Adolescents" in *Adolescent Health Care: A Practical Guide*. Urban & Schwarzenberg, Baltimore (1984) page 40.

TASKS OF ADOLESCENCE

The following have been identified as the key tasks of adolescence:

- Physical maturity is achieved
- Sexuality is explored
- Social maturity changes toward a more adult level
- Intellectual and cognitive maturity is reached
- Intimate relationships are explored and established
- Independence is achieved from family of origin or circumstance
- Progress is made towards economic independence, through education and skill acquisition
- Development of a personal set of values and the self-discipline to stick with them

ADOLESCENT PSYCHO-SOCIAL DEVELOPMENT

Sexual Identity
- experimentation with sexual behaviour
- sexual activity
- STDs
- sexual orientation

Behaviour
- "try on" new behaviours
- inconsistent behaviours
- rebelliousness (may increase when youth are unduly restricted)
- experimentation & limit testing
- impulsive
- risk taking
- alcohol/drug experimentation very common

Peer Relations
- friends increasingly important
- support for independence
- meet social & intimacy needs
- options to parental values & expectations
- provides feedback
- peer acceptance of new behaviour
- cliques
- vulnerable to view of peers

Emotions
- anxiety about social status, independence, sexuality
- mood swings
- loneliness
- depression more common
- narcissism common

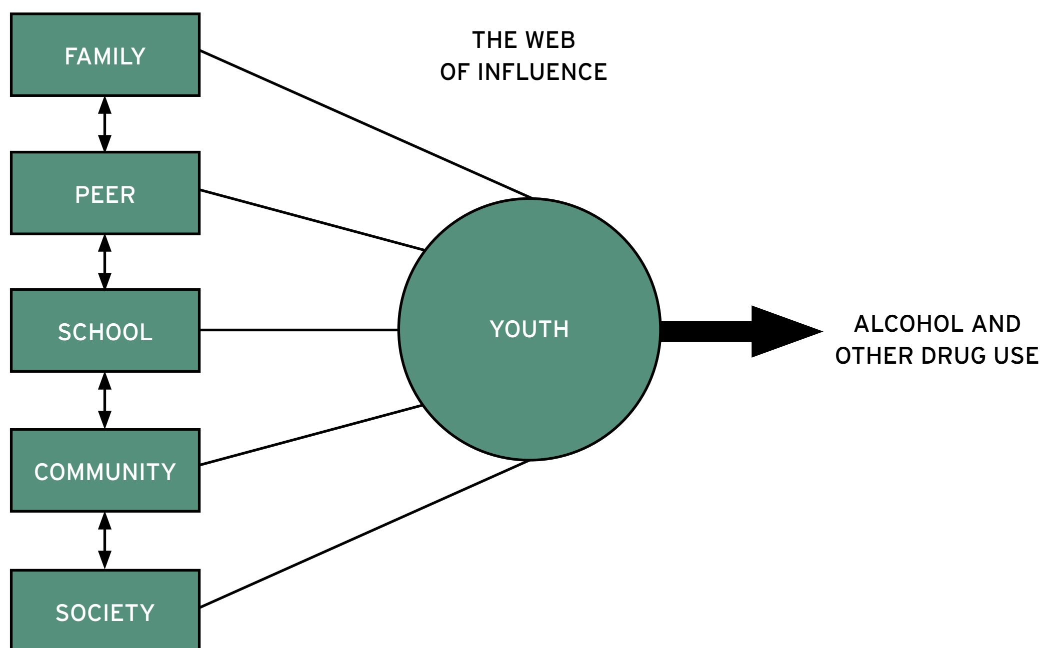
Family
- relations with family challenged in move towards independence
- want to take control, not necessarily ready
- adult response to this influences success of transition to adult life
- parents need to be firm/flexible about values, have clear expectations, take strong interest, encourage autonomous behaviour

Most adolescents manage the ups and downs of this time with the support of family, friends, communities and schools. Others, however, may have difficulty coping for individual, family or community reasons. There may be inadequate supports around them to meet their unique needs, or there may be barriers because of their gender, race, class or ability.

Adolescence is a time of exploration and experimentation where new behaviours are learned and tried out. The behaviours can include those which are high risk such as alcohol and drug use, unsafe sexual practices, drinking and driving, harmful eating and sleeping patterns. These risks can have long term effects on their health and well being and serious consequences for the youth themselves and others around them. The effects of alcohol and drug use on adolescents and their development will be explored in greater detail in Module II.

The Web of Influence

Understanding a youth's level of involvement with substance use is a complicated task that involves the interplay between individual factors and the context in which the individual lives. In the 1990s, researchers developed the risk and protective framework to describe the many factors that interact to increase or decrease the harms associated with substance use and misuse in youth. These are factors "used to identify aspects of a person and his or her environment that make the development of a given problem less (i.e. protective factor) or more likely (i.e. risk factor)." The protective and risk factors can be described in six major domains, which interact with each other to create the "Web of Influence" with the individual at the core. The Web of Influence model depicts how "all external influences are processed, interpreted and responded to based upon the characteristics the individual brings to the situation" (CSAP, 1999, p. 2). Substance use/nonuse is an individual outcome, but the behaviour of the individual is influenced by a host of interrelated external factors (CSAP 1999). It is important to note that risk factors do not predict future drug use.



Source: Center for Substance Abuse Prevention (1999). Understanding substance abuse prevention, toward the 21st century. A Primer on Effective Programs. CSAP Monograph, DHHS Publication No. (SMA) 99 – 3301. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S., Department of Health and Human Services.

Although many youth experiment with alcohol and other drugs, few become heavy users. From experimenting, some youth may stop using or use substances only occasionally. Others may regularly use substances, with little or no consequences. Still others may become substance abusers or become dependent on the substances. Though there is no "cause" of drug use problems in youth, research has shown a number of protective and risk factors which decrease or increase the likelihood that an adolescent will develop problems with substance use.

EXAMPLES OF KEY PROTECTIVE AND RISK FACTORS IN THE SIX DOMAINS

Domain	Protective Factors	Risk Factors
Individual	• Positive personal characteristics such as problem-solving skills, a positive sense of self, and flexibility, feel valued and valuable • Development and maintenance of resilient characteristics • Support from at least one significant adult • Bonding to societal institutions, such as school and church organizations • Social and emotional competencies, including good communication skills, strong values, good social skills, ability to make health choices and difficult decisions, ability to cope with new situations, responsiveness and empathy • Commitment to learning through a sense of the importance of life long learning and a belief in their own abilities	• Inadequate life skills • Low self-esteem and self-confidence • Emotional and psychological problems • School failure • Brain related traumas • Prenatal exposure to alcohol or other drugs (fetal alcohol spectrum disorder) • Basic personality development – early or late in development • Age at which substance use starts • Sexual orientation issues • Undiagnosed mental health issues, family history of mental health issues, learning disabilities • Isolation, not connected to peers, family, community • Orientation towards risk-taking • Approaches to decision making • Poor social competencies: poor social skills and a poor ability to problem solve, deal with stress, make difficult decisions, communicate with others and cope with new situations • Early antisocial behaviour with aggressiveness

Domain	Protective Factors	Risk Factors
Family	• Positive bonding among family factors • Positive parenting • Emotionally supportive parental/family milieu • Families who monitor adolescents' behaviours, including friendship choices and after school activities • Stable care and support from parent or other adult from an early age • Father involvement in childcare • Mother's education (higher level positively correlated with protection) • Set clear boundaries and expectations: clear rules, consistent consequences • Families who have high expectations about appropriate behaviour •Strong extended family network	• Family conflict, domestic violence, incest • Social isolation of family – poor extended family network • Poor child supervision and discipline • Poor family management • Parents are over or under involved in youth's life • Lack of communication or respect between family members • Family involvement with residential schools or child protection services • History of familial substance use problems
Peer	• Association with peers who are involved in school, recreation, service, religion, or other organized activities • Peers who have strong values about abstinence from alcohol or other drugs	• Peers whose attitudes and behaviours support alcohol and other drug use • Peers who engage in deviant behaviour
School	• Caring and support; sense of "community" and strong school spirit in classroom and school • High expectations from school personnel • Strong school-based network	• Ambiguous, lax or inconsistent rules and sanctions regarding drug use and student conduct • Lack of school bonding • Early signs of academic failure
Community	• Caring and support • Opportunities for youth participation in community activities	• Community disorganization • Lack of cultural pride • Inadequate youth services and opportunities for pro-social involvement • Communities in transition or favourable to alcohol and drug use
Society	• Media literacy (resistance to pro-use messages) • Decreased accessibility • Increased pricing through taxation	• Impoverishment • Unemployment and underemployment • Discrimination

INTERACTION AMONGST FACTORS

It is important to note that "risk and protective factors may have direct, indirect, inter-actional and even reciprocal effects on substance misuse… [and that] methodological difficulties abound in studies on causation and recent research has stressed that there are multiple pathways to substance misuse" (Stubbs, Hides, Howard and Arcuri, 2004). It is also important to note that many of the risk and protective factors listed here also relate to other problem behaviour such as youth crime, teen pregnancy, early school leaving and violence, therefore an alcohol and drug prevention program aimed at increasing protective factors and decreasing risk factors may have positive results in a number of different areas. A more complete understanding of the whole youth can be reached more accurately by examining what is happening in all of their life contexts which will then guide what steps need to be taken next.

Developmental Assets

Traditionally, prevention programs have focused on addressing risk factors. The current trend is to look more towards factors that protect youth from engaging in alcohol and other drug use and build internal resiliency.
The Search Institute in Minneapolis focuses on the framework of 40 Developmental Assets, which are "positive experiences and personal qualities that young people need to grow up healthy, caring and responsible" (Search Institute website). The assets are divided between external assets (positive experiences young people receive from the world around them) and internal assets (characteristics and behaviours that reflect positive internal growth and development of young people). Research at the Institute has shown that the more assets a youth has, the less likely they are to engage in high risk behaviour, such as alcohol or drug use. The chart below is based on surveys of almost 150,000 6th- to 12th- grade youth in 202 communities across the United States in 2003. Similar results have been found in the areas of tobacco use, depression and attempted suicide, antisocial behaviour, school problems, driving and alcohol and gambling.

	0-10 Assets	11-20 Assets	21-30 Assets	31-40 Assets
Problem Alcohol Use	45%	26%	11%	3%
Violence	62%	38%	18%	6%
Illicit Drug Use	38%	18%	6%	1%
Sexual Activity	34%	23%	11%	3%

Search Institute, 2003

In addition to protecting youth from negative behaviors, having more assets increases the chances that young people will have positive attitudes and behaviors, as these charts show.

	0-10 Assets	11-20 Assets	21-30 Assets	31-40 Assets
Exhibits Leadership	48%	66%	78%	87%
Maintains Good Health	27%	48%	69%	88%
Values Diversity	39%	60%	76%	89%
Succeeds in School	9%	19%	34%	54%

Search Institute, 2003

THE 40 DEVELOPMENTAL ASSETS FOR ADOLESCENTS

ASSET TYPE	ASSET NAME AND DEFINITION	
EXTERNAL ASSETS		
Support	Family support	Family life provides high levels of love and support.
	Positive family communication	Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).
	Other adult relationships	Young person receives support from three or more non-parent adults.
	Caring neighborhood	Young person experiences caring neighbors.
	Caring school climate	School provides a caring, encouraging environment.
	Parent involvement in schooling	Parent(s) are actively involved in helping young person succeed in school.
Empowerment	Community values youth	Young person perceives that adults in the community value youth.
	Youth as resources	Young people are given useful roles in the community.
	Service to others	Young person serves in the community one hour or more per week.
	Safety	Young person feels safe at home, at school, and in the neighborhood.
Boundaries and Expectations	Family boundaries	Family has clear rules and consequences, and monitors the young person's whereabouts.
	School boundaries	School provides clear rules and consequences.
	Neighborhood boundaries	Neighbors take responsibility for monitoring young people's behavior.

ASSET TYPE	ASSET NAME AND DEFINITION	
	Adult role models	Parent(s) and other adults model positive, responsible behavior.
	Positive peer influence	Young person's best friends model responsible behavior.
	High expectations	Both parent(s) and teachers encourage the young person to do well.
Constructive Use of Time	Creative activities	Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
	Youth programs	Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.
	Religious community	Young person spends one hour or more per week in activities in a religious institution.
	Time at home	Young person is out with friends "with nothing special to do" two or fewer nights per week.
INTERNAL ASSETS		
Commitment to Learning	Achievement motivation	Young person is motivated to do well in school.
	School engagement	Young person is actively engaged in learning.
	Homework	Young person reports doing at least one hour of homework every school day.
	Bonding to school	Young person cares about her or his school.
	Reading for pleasure	Young person reads for pleasure three or more hours per week.

ASSET TYPE	ASSET NAME AND DEFINITION	
Positive Values	Caring	Young person places high value on helping other people.
	Equality and social justice	Young person places high value on promoting equality and reducing hunger and poverty.
	Integrity	Young person acts on convictions and stands up for her or his beliefs.
	Honesty	Young person "tells the truth even when it is not easy."
	Responsibility	Young person accepts and takes personal responsibility.
	Restraint	Young person believes it is important not to be sexually active or to use alcohol or other drugs.
Social Competencies	Planning and decision making	Young person knows how to plan ahead and make choices.
	Interpersonal competence	Young person has empathy, sensitivity, and friendship skills.
	Cultural competence	Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
	Resistance skills	Young person can resist negative peer pressure and dangerous situations.
	Peaceful conflict resolution	Young person seeks to resolve conflict nonviolently.
Positive Identity	Personal power	Young person feels he or she has control over "things that happen to me."
	Self-esteem	Young person reports having a high self-esteem.
	Sense of purpose	Young person reports that "my life has a purpose."
	Positive view of personal future	Young person is optimistic about her or his personal future.

This list is an educational tool. It is not intended to be nor is it appropriate as a scientific measure of the developmental assets of individuals.

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Harm Reduction with Youth

As discussed in the *Core Addictions Practice Guide*, harm reduction is defined as:

> *Polices and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use.*
>
> (International Harm Reduction Association, 2002)

In addition to the concerns regarding harm reduction discussed in the *Core Addictions Practice Guide*, for example, harm reduction encourages drug use among non-drug users, adopting a harm reduction approach with youth carries additional controversies. Alcohol and tobacco are illegal substances for youth, as federal and provincial laws prohibit their sale to minors and there is little clear research that shows that a harm reduction approach with youth is effective and safe (Poulin, 2006). However, "proponents of harm reduction point to high rates of substance use among youth, the limited effectiveness of drug prevention programs and the difficulty of targeting programs to high-risk adolescents" (Poulin, 2006).

In its paper on harm reduction policies and programs for youth, CCSA outlines three main issues that distinguish harm reduction for youth from that of adults:

- The fledgling autonomy and ability of youth to make wise decisions concerning substance use
- Specific risks and harms associated with youth substance use
- Unique opportunities for drug policies and programs targeting youth

Poulin, 2006

Based on a systematic review of literature, Poulin (2006) concluded that various harm reduction strategies, such as brief motivational interventions, can be effective for youth in college and out-of-the-mainstream youth, due to these young people being predominately of legal age, they can be considered emancipated and their patterns of substance use places them at high risk of serious harm.

Conversely, for under-age youth still in school, the evidence is not as clear (Poulin, 2006). Traditionally, drug prevention education delivered in schools has been aimed at preventing or delaying substance use among youth but "the effectiveness of these programs has been repeatedly shown to be minimal" (Poulin, 2006). However, there is a gap in evidence to support shifting the approach in schools to a harm reduction one, thus leading Poulin (2006) to conclude that "the large number of under-aged youth potentially affected by a shift in school drug policy and programming – from having an explicit goal of abstinence to having one of harm reduction – makes this the single most important policy decision as regards harm reduction targeting youth."

One example of an approach to drug education in schools that is not strictly abstinence focused comes from California. The *Beyond Zero Tolerance: A Reality-Based Approach to Drug Education and School Discipline* program "offers a new model for honest, reality-based drug education with interactive learning, compassionate assistance and restorative practices in lieu of exclusionary punishment" (Skager 2007). More information on this program can be found at www.safety1st.org.

MODULE II

Prevalence, Impacts and Effects of Adolescent Alcohol and Drug Use

TOPIC	PAGE
Youth's Perception of Substance Use	**x**
Prevalence of Adolescent Substance Use	**x**
Prevalence of Substance Use in General Youth Population	x
Prevalence of Substance Use in Non-Mainstream Youth	x
Additional Resources	x
Harms Associated with Pattern of Use	**x**
Harms Due to Mode of Administration	x
Harms Due to Intoxication	x
Harms Due to Regular and Prolonged Use	x
Harms Due to Dependence	x
How do the Needs of Youth Differ from those of Adults?	**x**

Module II: Prevalence, Impacts and Effects of Adolescent Alcohol and Drug Use

Youth's Perception of Substance Use

Some experimentation with alcohol and other drugs is considered normal in adolescent development. Substance use meets some type of perceived need on the part of the person using, whether it is through a drug's effect (e.g., feeling of pleasure, relief of pain) or through the symbolism associated with its use. To effectively work with youth, it is important to understand youths' perceptions of substance use and to realize that youth drink or take other drugs because there are real or perceived benefits to using substances. While some reasons youth give for experimenting are similar to those of adults (e.g., stress relief), other reasons are much more reflective of the development stage they are in. Reasons young people give for experimenting with alcohol or other drugs include:

- Drugs are **acceptable and readily available** and provide a quick, often inexpensive way to have "fun"
- Youth are **curious** to experience what they have heard and read about substances
- Drugs let youth experience the world in a new and different way
- Some youth take drugs because of the **physical results** (e.g., nervous or anxious youth becomes more relaxed when drinking alcohol, taking methamphetamines and other drugs increases energy)
- Youth may use substances for **social reasons**. Especially for youth who are shy or anxious, drug use may give them increased confidence and self esteem or be more at ease within a group of peers.
- Using substances expresses **opposition to adult authority** and can be part of the process of separation from parents or to **assert their independence**
- Using substances symbolizes **developmental transition** (e.g., moving from a less mature to a more mature stage). In some families, the "first drink" is a rite of passage
- Drug use becomes a **coping mechanism** for dealing difficult situations, strong feelings (anger, frustration, stress, fear of failure), poor grades, social rejection, family conflict, family dysfunction and child abuse
- Drug use can be an attempt to **self-medicate** symptoms of mental health problems such as depression or anxiety
- Drug use can demonstrate a **personal identity**. It can be a way of showing that they are "cool" or "daring" or have characteristics valued in adolescent culture
- They might view drug use as a way of being accepted into a **peer group**
- They might believe drug use will make others **perceive them as adults**
- They feel **omnipotent and immortal** and therefore shielded from any potential consequences

Adapted from CAR-BC, 2006

Prevalence of Adolescent Substance Use

Since adolescence is a time of exploration and experimentation where new behaviours are learned and tried out, it is not at all surprising that the use of alcohol and other drugs typically begins in the adolescent years. The first part of this section will examine the prevalence of substance use among Canada and B.C.'s general youth population. The second part will examine the prevalence of substance use among specific groups of Canada and B.C.'s non-mainstream youth who have been identified as being at greater risk than their peers for problematic substance use.

PREVALENCE OF SUBSTANCE USE IN GENERAL YOUTH POPULATION

According to the Canadian Centre on Substance Abuse (2007):

> Recent Canadian surveys show that tobacco, alcohol and cannabis are the substances must frequently used by youth. In fact, international comparisons of alcohol and cannabis use by young people indicate that Canada ranks among the leading countries for rates of prevalence and frequency. (p. 5)

ALCOHOL

The Canadian Addiction Survey (CAS), conducted in 2004, is the first national survey dedicated to alcohol, cannabis and other drug use since 1994. Though the CAS included people 15 years and older, data specific to Canadian youth aged 15 – 24 has also been analyzed. The CAS found the following with regards to alcohol use among mainstream youth in Canada:

- Alcohol is the psychoactive substance most commonly used by Canadian youth, with 90.8% of youth having used alcohol in their lifetime and 82.9% having used alcohol in the past 12 months
- The mean age at which youth started drinking alcohol was 15.6 years
- There were no differences between males and females in the prevalence of current (83.5% versus 82.3%, respectively) or lifetime (90.8% versus 90.9%, respectively) alcohol use
- Males were more likely than females to drink more frequently, to consume more per occasion and to report drinking heavily
- Of the 82.9% of youth who consumed alcohol over the past year, over one third (36.9%) reported doing so at least once a week, and 33.7% reported consuming 5 or more drinks per typical drinking occasion
- The most common drinking pattern among youth is light/infrequent (38.7%)
- Among youth, 13.8% of past year drinkers reported heavy drinking at least once a week, and 46.0% reported doing so at least once monthly
- Youth had higher rates than the general population of reported lifetime harms (33.7% versus 24.2%) and harms in the past year (21.8% versus 8.8%) as a result of their own drinking
- Heavy/binge drinking (defined as drinking 5 or more drinks in a single sitting for males and 4 or more drinks for females) was particularly high among persons 15 to 24 years of age, peaking at 42.5% among persons 18 to 19 years of age

Source: Health Canada, 2007

The entire report on the Canadian Addiction Survey as well as the Highlights report can be downloaded at:
http://www.ccsa.ca/CCSA/EN/Research/2004_Canadian_Addiction_Survey/CanadianAddictionSurvey.htm

Substance Use by Canadian Youth, an in-depth analysis of alcohol and other drugs by youth and young adults aged 15 to 24 based on the information from the CAS can be downloaded at:
http://www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/adp-apd/cas-etc/youth-jeunes/youth-jeunes-eng.pdf

Alcohol Use in BC

The *Adolescent Health Survey* (AHS) conducted by the McCreary Centre Society is a questionnaire used to gather information about youth health in BC and contains questions about physical and emotional health, and about factors that can influence health during adolescence or in later life. Three AHS have been conducted in 1992, 1998, and 2003 and to date, over 73,000 students have participated. The survey is conducted in collaboration with the provincial government and pubic health system, and with the cooperation of BC's school districts. The *Adolescent Health Survey III* conducted in 2003 found the following with regards to alcohol use among mainstream youth in BC:

- The percentage of BC youth who have tried alcohol declined from 65% in 1992, to 57% in 2003.
- Binge drinking increased during the same period, among students who drank. Binge drinking is defined as having five or more drinks in a row, within a couple of hours. In 1992, 35% of youth who tried alcohol binge drank in the month before the survey. This number rose to 45% in 2003.
- The proportion of students who have tried alcohol increases with age, from 37% of students 14 and younger, to 67% of those 15 to 16 years old, and 79% of students 17and older.
- 15% of students who used alcohol first tried it when they were 10 or younger, 23% were 11 or 12 years old, 42% were 13 or 14, and 21% first tried alcohol at 15 or older.
- 68% of youth who used alcohol drank in the previous month, and 44% binge drank in the previous month: 25% binge drank on one or two days, 11% on three to five days, and 9% on six or more days.
- Alcohol use varied across BC:
    - Greater Vancouver had the lowest rate of alcohol use at 49%, and binge drinking at 39% of youth who used alcohol.
    - The Kootenays had the highest rate of alcohol use at 71%, and binge drinking at 53% of youth who used alcohol.
    - Rates were also high in the Northwest region, with alcohol use at 69% of youth, and binge drinking at 50% of those who drank.

The entire Adolescent Health Survey III report can be downloaded at:
http://www.mcs.bc.ca/rs_ahs.htm

CANNABIS

The CAS found the following with regards to cannabis use among mainstream youth in Canada:

- 61.4% of youth have used cannabis in their lifetime, and 37.0% have used it at least once in the past 12 months

- The mean age at which youth reported having the first chance to try marijuana, had they wanted to, was 14.6 years. The mean reported age of first use was 15.6 years.
- Lifetime use was higher in youth aged 18 to 19 (69.9%) and 20 to 24 (68.5%) than those aged 15 to 17 (39.3%). In addition, the rate of past-year use was highest in youth aged 18 to 19 (47.2%) followed by those aged 20 to 24 (36.5%) and 15 to 17 (29.2%).
- Males were more likely than females to have used cannabis in their lifetime (64.7% versus 58.0%) and in the past year (41.4% versus 32.3%)
- Almost 1 in 10 (8.2%) Canadian youth uses marijuana on a daily basis. Among current users, more than 1 in 5 (22.3%) youth reported using it on a daily basis over the past 3 months.

Health Canada, 2007

Cannabis Use in BC

The Adolescent Health Survey III conducted in 2003 found the following with regards to cannabis use among mainstream youth in BC:

- Overall, marijuana use among adolescents increased between 1992 and 2003, from 25% to 37%. But the number of youth who ever used marijuana decreased 3% between 1998 and 2003, following an increase from 25% to 40% between 1992 and 1998.
- Among youth who have used marijuana the percentage of youth who used three or more times in the past month increased from 30% in 1998, to 34% in 2003.
- The majority of adolescents (63%) did not use marijuana in 2003. 16% were experimental users, and 21% were current users (with 8% infrequent users, 5% frequent users, and 7% heavy users).
- Males and females were equally likely to have used marijuana (38% compared to 37%), but males were slightly more likely to be current users (22% vs. 20%).
- Males were more likely than females to be heavy users of marijuana (9% vs. 5%).
- The number of students who had ever used marijuana increased as teens got older, from 20% of those 14 and younger, to 45% of 15 and 16 year olds, and 56% of teens 17 and older.
- The percentage of current marijuana users increased with age, from 10% of those 14 years and younger, to 26% of 15 to 16 year olds, and 32% of those 17 and older.
- Among adolescents who have used marijuana, most first tried between the ages of 13 and 14.
- Heavy users were more likely to first try marijuana at a young age: 12% had used the drug at 10 or younger, compared to 3% of experimental, infrequent and frequent users.
- Marijuana use varied across the province:
    - Greater Vancouver had the lowest rate of marijuana use at 29%.
    - The Kootenays region had the highest rate at 51%.

TOBACCO

The CAS found the following with regards to tobacco use among mainstream youth in Canada:

- Almost 27% of Canadian youth aged 15 – 19 reported smoking cigarettes at least occasionally.
- Almost 31% of males under 20 and 23% of females under 20 reported that they smoke.
- Among those under age 20, smokers were 14 times more likely to consume alcohol than were their non-smoking peers.
- Approximately 98% of smokers aged 15-19 had consumed alcohol in the past year compared to 75% of non-smokers in this age group.
- Smoking youth also more likely to engage in binge drinking, with smokers 15-19 averaging about 5 drinks when they drank alcoholic beverages, compared to their non-smoking peers, who averaged two or three drinks.
- Almost 60% of youth who smoked met the criteria for hazardous drinking, compared to 23.7% for non-smoking youth.
- Smokers under 20 years old were more than 20 times more likely to use cannabis than their non-smoking peers.
- Approximately 31% of smoking youth reported using at least one other drug in the past 12 months.

CCSA has published a report entitled Risks Associated with Tobacco Use in Youth Aged 15-19 based on analysis of the 2004 Canadian Addiction Survey. This report can be accessed at:
http://www.ccsa.ca/NR/rdonlyres/2E6DC505-71FD-4CF7-8953-F63B3E409BEC/0/ccsa0113462006.pdf

The Health Canada Youth Smoking Survey monitors tobacco use in school aged children (grades 5-9). In 2004-05, the Youth Smoking Survey found the following:

- Prevalence of youth trying any tobacco product has been reduced by 50% since 1994 to 2004-05 with 21% of youth in grades 5 – 9 reporting ever trying any type of tobacco product in 2004-05.
- The average age of a youth first smoking a whole cigarette increased by ✥ year from 11.2 years in 1994 to 11.8 years in 2004-05.
- British Columbia has the lowest percentage of youth that ever tried smoking cigarettes (12%).
- Two main reasons that youth give for starting to smoke include "it's cool" (60%) and the behaviour of their friends (57%).
- Almost all youth, whether having ever tried smoking cigarettes, or not, believed that tobacco is addictive (88%) and that smoking can harm the health of non-smokers (87%).
- 23% of youth report that someone other than themselves smoked every day in their homes (reduced from 30% in 2002).
- Of all youth that had ever tried smoking cigarettes, 50% had also tried cannabis, compared to the 5% of youth that had never tried smoking cigarettes.
- Of those youth that had ever tried smoking, 91% had tried alcohol, while only 53% of those youth that had never tried smoking cigarettes had tried alcohol.

The full report on the 2004-05 Youth Smoking Survey can be found at:
http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/survey-sondage/2004-2005/result_e.html

More information about Tobacco can be found at the Health Canada's Tobacco Control Programme Web site.
http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/index_e.html#youth

Tobacco Use in BC

The *Adolescent Health Survey III* conducted in 2003 found the following with regards to tobacco use among mainstream youth in BC:

- Cigarette smoking among adolescents declined between 1992 and 2003, with a 22% decrease between 1998 and 2003.
- In 2003, 73% of students were non-smokers and only 7% of all students were current smokers.
- 22% of current smokers started smoking at 10 or younger, 27% started at 11 or 12, 35% were 13 to 14 years old, and 17% were over 14 when they started smoking.
- The prevalence of cigarette smoking varied across the province:
    - The Greater Vancouver and Capital regions had the lowest rates of current smokers at 6%
    - The Kootenays (10%) and Interior (9%) regions had the highest rates of current smokers
- In 2003, 12% of youth report that someone other than themselves smoked almost everyday or every day in their homes. This is a decrease from 19% in the 1998 survey.

The Fact Sheet on Tobacco Use Among BC Youth from the AHS III can be found at:
http://www.mcs.bc.ca/pdf/tobacco_ahs_3_fs.pdf

A Youth Fact Sheet on smoking can be found at:
http://www.mcs.bc.ca/pdf/Smoking_YFS_web.pdf

OTHER DRUG USE

The CAS found the following with regards to other drug use among youth in Canada:

- Among youth, cannabis was the most frequently reported drug used during one's lifetime (61.4%), followed by hallucinogens (16.4%), then cocaine (12.5%), ecstasy (11.9%), speed (9.8%) and inhalants (1.8%). The lifetime use of each of inhalants, heroin, steroids and drugs by injection was about 1%
- A greater percentage of youth than adults reported use of any of 5 illicit drugs (24.2% versus 15.2%) and any of 6 illicit drugs in their lifetime (62.1% versus 42.3%).
- The rate of lifetime and past-year illicit drug use other than cannabis (24.2% and 11.3%, respectively) was highest among 18- to 19-year-olds and youth from the Quebec region. In addition, the rate of lifetime and past-year illicit drug use including cannabis (62.1% and 37.9%, respectively) was also higher among 18-to 19-year-olds and youth from the Quebec region.
- Youth who had used in their lifetime were more likely than adults to report harm from their use of any of 8 illicit drugs (34.5% versus 20.7%) or any of 5 illicit drugs (59.5% versus 41.7%).

Health Canada, 2007

Other Drug Use in BC

The *Adolescent Health Survey III* conducted in 2003 found the following with regards to other drug use among youth in BC:

- Almost a quarter of BC adolescents (23%) had ever used these illegal drugs, but most youth (77%) never used illegal drugs. The number of drug users is down from 29% in 1998.
- Use of all types of illegal drugs decreased between 1998 and 2003.
    - In the 2003 survey, 10% of students had used illegal drugs three or more times in their lifetime, compared to 15% in 1998.
    - Rates of illegal drug use varied: heroin, injection drugs, and illegal steroids were the least common at approximately 1%, and mushrooms were the most common at 13%.
- Twenty-two percent of males and 24% of females have tried illegal drugs.
- Females were more likely than males to use prescription pills without a doctor's consent (11% vs. 7%).

Ever used an illegal drug:

	1998	2003
Mushrooms	16%	13%
Hallucinogens	11%	7%
Prescription pills without a doctor's consent	10%	9%
Cocaine	7%	5%
Inhalants	6%	4%
Amphetamines	5%	4%
Heroin	2%	<1%
Steroids	2%	1%
Injected an illegal drug	1%	<1%

- The proportion of students who had tried illegal drugs increased as teens got older, from 14% of adolescents 14 and younger, to 25% of those 15 to 16 years old, and 33% of teens 17 and older.

- The prevalence of illegal drug use varied among students across the province, from 20% who had ever used drugs in Greater Vancouver, to 30% in the Kootenay region.

POLY DRUG USE

- In their lifetime, 37.9% of youth reported using no illicit drug (excluding steroids and inhalants), 38.0% reported using cannabis only, 23.7% reported using some other illicit drug in addition to cannabis and only 0.4% reported using some other illicit drug only.

- Youth do not use cannabis or other illicit drugs in isolation; rather, most youth who currently use cannabis also consume alcohol (98.7%) and most youth who currently use illicit drugs also consume cannabis (91.3%) and alcohol (99.6%).

- When broken down into a user-type variable with four categories that are mutually exclusive, 24.2% of youth are illicit drug users (regardless of cannabis or alcohol use), 37.9% are cannabis users (never illicit drugs, regardless of alcohol use), 29.0% are alcohol users (never illicit or cannabis) and 8.9% are nonusers.
- With user-type broken down into all possible combinations of user, 23.7% of youth are lifetime illicit/cannabis/ alcohol users, 37.7% are cannabis/ alcohol users, 29.0% are alcohol-only users and 8.9% are non-users.

Health Canada, 2007

PREVALENCE OF SUBSTANCE USE IN NON-MAINSTREAM YOUTH

In discussing the prevalence of substance use in non-mainstream youth in its report, *Substance Abuse in Canada: Youth In Focus*, the Canadian Centre on Substance Abuse states:

The overlapping experiences of these groups of youth – all at higher risk for harmful substance use – are compelling: they have higher rates of trauma and loss, exposure to sexual and physical abuse and other types of violence, potential experiences of stigma and racism, as well as risk for psychological disorders that may increase their chances of victimization and make coping with subsequent trauma more challenging.

(CCSA, 2007, p. 17)

A brief overview of the prevalence of substance use in special populations of youth is included below.

MARGINALIZED AND STREET INVOLVED YOUTH

In 1998, the Public Health Agency of Canada launched the Enhanced Surveillance of Canadian Street Youth (E-SYS) project in response to the need for data on Canadian street youth. E-SYS "is a comprehensive data source that monitors rates of STIs and related infections, behaviours and risk determinants in the Canadian street youth population" (PHAC 2006). PHAC has published a report, *Street Youth in Canada: Findings from enhanced surveillance of Canadian street youth, 1999-2003*, which offers important information on this youth group. The following key findings were identified in the report:

- The ratio of males to females is approximately 2:1
- Approximately 15% of street youth reported their families had been homeless
- Conflict with parents was the principal reason most street youth reported for leaving home
- More than one-half of street youth reported having hung out on the streets all the time in the previous month
- More than one-quarter reported that social welfare was their main source of income
- In 2003, more than 35% of street youth reported they had dropped out of school or had been expelled from school permanently
- More than one-half of street youth reported emotional abuse or neglect
- Rates of chlamydia and gonorrhea in street youth are more than 10 times those in the general youth population
- Hepatitis B immunity level is gradually increasing among street youth; however, the proportion of street youth with no immunity remains high, at more than 40%

- Street youth are a sexually active population, with more than 95% reporting previous engagement in sexual activities
- On average, street youth reported having had no fewer than 17 partners in their lifetime
- Approximately one-quarter of street youth reported having traded sex at some point in their lives
- A high proportion of street youth reported not having used condoms during their most recent episode of sexual intercourse
- Street youth did not seem to modify their sexual behaviours after being diagnosed with a STI

(PHAC 2006 p. 5)

Alcohol

- Less than 10% of street youth reported drinking every day
- Approximately 40% of street youth reported recent alcohol intoxication

Tobacco

- Approximately 80% of street youth reported smoking daily
- Proportion of daily smokers decreased from 84.3% in 1999 to 78.8% in 2003

Other Drug Use

- Street youth who reported using one substance (alcohol, tobacco or drugs) were more likely to report using other substances (poly-drug use)
- A large majority (95%) of street youth reported having used drugs other than injection drugs
- Non-injecting drugs most commonly used in the previous three months were marijuana, crack and other forms of cocaine, crystal methamphetamine and ecstasy
- Nearly 20% reported having used injection drugs
- Injection drugs most commonly used by street youth were cocaine, heroin, morphine and speedball (combination of cocaine and heroin)
- Approximately one-third (30%) of IDUs reported not always using clean needles or equipment and 31% reported borrowing injecting equipment from someone else

(PHAC 2006)

A full copy of the report *Street Youth in Canada: Finding from enhanced surveillance of Canadian street youth, 1999-2003*, can be accessed at:
http://www.phac-aspc.gc.ca/std-mts/reports_06/pdf/street_youth_e.pdf

Marginalized and Street Involved Youth in BC

The most recent research on runaway and street involved youth in British Columbia was conducted by the McCreary Centre Society in 2006 in follow up to their 2000 health survey of marginalized and street involved youth which formed the basis of the report *No Place to Call Home: A profile of street youth in British Columbia*. The 2006 study, *Against the Odds: A profile of marginalized and street-involved youth in B*C, looked at many of the same issues as the 2000 survey, including information on alcohol and other drug use by this youth population. The 2006 study was conducted in nine communities across BC and involved 762 youth.

The following key findings from the survey helps set the context for the subsequent information on alcohol and drug use:

- Aboriginal youth were disproportionately represented among youth who were marginalized and street-involved, and the percentage has increased sharply since 2000 (from 36% to 57%)
- Gay, lesbian, bisexual and questioning teens were also over-represented among marginalized and street-involved youth: one in three females and one in ten males identified as gay, lesbian and bisexual
- Forty percent of the youth had spent time in government care and almost one in ten (9%) were in a foster or group home at the time of the survey
- Unlike in 2000, BC does not appear to be absorbing large numbers of youth from outside of BC
- Despite challenges with their parents and other family members, youth in the survey reported strong connections with their families
- More than one in three youth who were staying in an abandoned building, tent, car, squat, or on the street, were still attending school
- One in three of the youth reported that they were working at a legal job
- Smoking has declined since 2000 across the province, although three out of four of the youth were still current smokers
- More than one in four of the youth had been exposed to alcohol or marijuana before they became teenagers
- Marginalized and street involved youth were three times more likely to be physically and sexually abused than youth the same age in school (AHS 2003)
- More than one in three of the youth reported that they had been sexually exploited.
- More than half of youth reported one or more mental or emotional health concerns
- Youth/outreach workers were identified as among the most helpful professionals
- Youth, in each of the nine communities surveyed, identified job training and shelter as the most needed services.

(Smith, A., Saewye, E., Albert, M., MacKay, L., Northcott, M., and the McCreary Centre Society, 2007, p. 9)

Alcohol

- 85% had ever tried alcohol
- One in three had tried it before they were 11, rising to more than one in two (58%) before age 13
- Three out of four youth had used alcohol within the past month, but only 27% reported that they had drunk alcohol yesterday
- Binge drinking can increase the risk of harm from alcohol use
- Among those who drank, 76% reported binge drinking at least once in the past month, compared to 26% of youth in school
- 46% of those who drank yesterday had five or more drinks
- A greater number reported binge drinking three or more times a month, compared to youth in school: early

half of the youth reported this compared to only one in five youth in school

- Nearly one in ten of the youth reported binge drinking 20 or more days in the past month

(Smith et al., 2007, p. 34)

Marijuana

- Majority of youth had tried marijuana (91%) and one in four had tried it before they were 11
- 74% reported using marijuana in the past month
- 60% had used marijuana at least once yesterday
- Youth were introduced to marijuana early in life, often before they became street involved.
- Average age of first use was between 11 and 12 whereas the average age of first becoming street-involved was between 13 and 14
- More than one in four reported first using marijuana before age 11 (27%) and by age 14, 82% had tried it

(Smith et al., 2007, p. 35)

Smoking

- 12% reported they had never smoked
- 10% had not smoked in the past month
- 78% had smoked in the past 30 days (compared to 13% of youth in school – AHS 2003)
- 60% were smoking almost daily or daily, compared to 68% in 2000

(Smith et al., 2007, p. 33)

Other Drugs

- Majority of youth also reported trying a variety of other illegal drugs
- While more than two in three youth reported using some type of illegal drug yesterday, multiple drug use was less common
- Forty percent used only one drug yesterday, 18% used two drugs, another 5% used three drugs and 6% used four or more drugs
- On average, youth reported ever using about seven different kinds of drugs, including alcohol and marijuana
- Youth also reported experiencing a variety of negative consequences as a result of their alcohol and drug use, including passing out (48%) and fighting (31%)

	Used in past month	Used yesterday
Marijuana	77%	60%
Alcohol	74%	27%
Ecstasy	25%	3%
Cocaine	24%	7%
Mushrooms	21%	4%
Hallucinogens	15%	3%
Crystal Meth	14%	8%
Other amphetamines	11%	5%
Prescription meds without a prescription	12%	4%
Ketamine	9%	3%
Heroin	8%	4%
Injection Drugs	7%	4%
GHB	6%	3%
Inhalants	5%	2%
Steroids	4%	2%

(Smith et al., 2007, p. 36)

Drug and alcohol treatment

- 25% of youth reported that they had received alcohol and drug treatment and had accessed one or more of these treatments: detox services; outpatient treatment; a recovery home; and treatment centre
- 11% reported that they were refused the drug and alcohol treatment they felt they needed, with over half of these youth reporting they were turned away because the program was full
- For those youth who had received treatment for their alcohol and drug problems, detox and outpatient treatment were the most frequently accessed

(Smith et al., 2007, p. 37)

A full copy of the report *Against the Odds: A profile of marginalized and street involved youth in BC* can be accessed at: http://www.mcs.bc.ca/pdf/Against_the_odds_2007_web.pdf

YOUTH INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM

Health Canada (2001) reports that "there appears to be a strong relationship between youth substance abuse and direct involvement in the criminal justice system, although the nature of this relationship is not clear." This report found that youth involved with the justice system are often affected by Fetal Alcohol Spectrum Disorder (FASD) and other alcohol-related effects and that those that also have substance use disorders often have:

- Multiple (socio-economic/psychological/behavioural) problems;
- Chaotic social backgrounds, with limited education and family support (Kosky et al. cited in Spooner et al., 1996);
- Low motivation or ambivalence toward treatment, if treatment is mandated;
- Problems with violence which may make treatment participation difficult.

Health Canada 2001

Youth Involved in the Criminal Justice System in British Columbia

In 2005, the McCreary Centre Society surveyed 137 youth in BC custody centres about their health, their families, their behaviours, their experiences inside and outside the custody centre, and their expectations for the futures. The following findings with regards to alcohol and other drug use by BC youth in custody are included in the report Time Out II: A Profile of BC Youth in Custody:

Alcohol Use

- Virtually all youth in custody (99%) have tried alcohol at least once, and 84% drank alcohol in an average month before being in custody
- Sixteen percent drank alcohol on one or two days, 24% on three to nine days, 22% on 10 to 19 days, and 22% on 20 or more days. Ten percent of youth in custody drank alcohol daily
- About half of youth in custody (49%) first drank alcohol by the age of 10, compared to 9% of youth in school
- The majority of youth in custody (84%) binge drank at least once in an average month. Binge drinking is defined as five or more alcoholic drinks within a couple of hours. Nineteen percent binge drank on one or two days a month, 31% on three to nine days, 18% on 10 to 19 days, and 16% binge drank on 20 or more days. Among youth in school, a low 2% of students binge drank on 10 or more days in the past month.

Marijuana Use

- All youth in custody (100%) have tried marijuana at least once, the same as in the 2000 survey
- Three-quarters (74%) tried marijuana by the age of 12, compared to just 8% of youth in school
- Many youth in custody use marijuana frequently. Only 9% did not use the drug in an average month before being detained, 14% used it one to nine times, 12% used it 10-19 times, 9% used it 20-39 times, and more than half, 57%, used marijuana 40 or more times

Tobacco Use

- In 2005, 63% of youth in custody smoke daily, a decline from 75% in 2000
- 15% of youth in custody had not smoked in an average 30-day period before being detained in custody, 10% had smoked on one to nine days, and 13% had smoked on 10 to 29 days

Other Drug Use

- The majority of youth in custody centres (90%) has also used other illegal drugs at some time, including cocaine, mushrooms, hallucinogens, amphetamines, prescription pills without a doctor's consent, and heroin or inhalants, compared to 22% of youth in school
- Amphetamine use is up and hallucinogen and heroin use down among youth in custody, since the 2000 survey. This shift reflects a change in the availability of illicit drugs, as crystal methamphetamine has become more readily available
- In an average month before being detained, 58% of youth used cocaine, 51% used mushrooms, 50% used hallucinogens, 46% used amphetamines, 33% used prescription drugs, 10% used heroin, 10% injected an illegal drug, and 6% used inhalants
- Thirty percent of youth used cocaine 10 or more times, and 27% used amphetamines 10 or more times in an average month

Ever Used Other Illegal Drugs	Youth in Custody		Youth in School
	2000	2004	2003
Mushrooms	87%	80%	5%
Hallucinogens	83%	68%	7%
Prescription pills without a doctor's consent	42%	50%	9%
Cocaine	78%	80%	5%
Inhalants	14%	14%	4%
Amphetamines	40%	63%	4%
Heroin	41%	20%	1%
Injected an illegal drug	9%	11%	1%

YOUTH WITH CONCURRENT SUBSTANCE USE AND MENTAL HEALTH DISORDERS

See Module V

SEXUALLY ABUSED AND EXPLOITED YOUTH

Sexual exploitation occurs "when youth under age 19 trade sexual activities in exchange for resources, like money, drugs, gifts, food, services, shelter, transportation, or anything similar" (Saewyc EM, MacKay LJ, Anderson J, and Drozda C. (2008). Research has shown that a common response to sexual abuse and sexual exploitation during childhood or adolescence is substance misuse (CCSA 2007). Often drugs are introduced to youth as part of their exploitation when youth are coerced or lured into sex work on the street or youth who trade sex for food or shelter. Alcohol and other drugs may be used to try and manage moods, or "to cope with the shame and stigma of their work, and to blunt the experiences of the toxic environments they try to survive" (CCSA, 2007).

Sexually Abused and Exploited Youth in British Columbia

In May 2008, researchers at the University of British Columbia published *It's Not What You Think: Sexually Exploited Youth in British Columbia*. This study is based on data from surveys of marginalized and street involved youth or youth in custody conducted by the McCreary Centre Society. The following key findings of this study help to set the context for the subsequent information on alcohol and drug use:

- More than 1 in 3 street-involved and marginalized youth have been sexually exploited, as have 1 in 5 youth in custody.
- Males were just as likely to be sexually exploited as females. Among younger street-involved youth (ages 12-18), a greater percentage of males were exploited (34% vs. 27% of females in 2006). Among older street-involved youth (ages 19-25), a higher percentage of females reported sexual exploitation (53% females vs. 32% males).
- Among street-involved youth as well as youth in custody, gay, lesbian and bisexual teens were more likely to have been sexually exploited than their heterosexual peers. Fewer than half of sexually exploited street-involved youth identified as heterosexual.

- Aboriginal youth were disproportionately among those who were sexually exploited; one-third to one-half of sexually exploited youth identified as Aboriginal.
- While youth were most commonly exploited in exchange for money or drugs, they also exchanged sex to meet their basic needs: More than 1 in 3 youth were exploited in exchange for shelter, up to 1 in 4 for transportation, and up to 1 in 5 for food or clothing.
- Both men and women sexually exploit youth. Although the majority of youth (70%) had been exploited by males, half of youth (50%) had also been exploited by females.
- Sexually exploited youth may not recognize they are being exploited, or that it is a form of abuse. Youth did not always think exchanging sex for things like transportation or shelter was the same as exchanging sex for money or goods, and while all sexually exploited youth could have said yes they were sexually abused, a large number did not.
- Among younger street-involved youth, 1 in 5 were living at home when they were first sexually exploited; females were more likely to be sexually exploited while living with family than males were.
- However, for the majority of street-involved youth, sexual exploitation came after running away, being kicked out, or becoming street-involved; 3 out of 4 youth first left home at a younger age than first being sexually exploited.
- Sexually exploited youth reported more sexual and physical violence from a greater number of people than non-exploited youth.
- Exploited youth were 2 to 3 times more likely to have seriously considered or attempted suicide in the past year than nonexploited youth.
- Across the 5 cities that were surveyed in both 2000 and 2006, there were few changes between years. The percent of males being exploited decreased slightly (37% to 31%) and the percent of females has increased slightly (23% to 25%). Aboriginal females had the greatest increase, up from 16% to 23%.
- The age of first being exploited has gotten slightly older between 2000 and 2006. In 2000, the average age was 13.8 years, while in 2006 it was 14.8 years.
- The majority of sexually exploited youth in all the surveys said their communities needed more safe, affordable housing, and education, job training and work experience programs.
- Among older street-involved sexually exploited youth, only 25% had ever had a legal job, but more than 75% of them wanted a job. These youth thought that more education (43%), work experience and job training (35%), and help with a job search and resume (24%) would help them gain employment. Only 15% of sexually exploited youth who wanted employment thought they could do it on their own.
- Despite challenging life experiences, most sexually exploited youth were hopeful for the future. When asked where they saw themselves in 5 years, more than half of exploited youth expected to have a job, just under half expected to have a family (42- 44%) and 44-58% expected to have a home of their own.

Saewyc E.M., MacKay L.J., Anderson J., and Drozda C., 2008

Alcohol and Other Drug Use

- Youth were most commonly exploited in exchange for money or drugs
- Among street-involved youth in 2001 and 2006, significantly more females than males traded sex for drugs or alcohol (64% females vs. 31% males in 2001, 46% females vs. 31% males in 2006)
- Most sexually exploited youth reported being exposed to alcohol and marijuana at a younger age than being sexually exploited
- More than 3 out of 4 youth reported first drinking alcohol before being sexually exploited
- The overwhelming majority of sexually exploited street-involved youth first tried marijuana at a younger age than when they were first exploited
- Exploited youth were no more likely to have used alcohol or marijuana at young ages, but they were significantly more likely to have used heroin or other injection drugs than non-exploited youth, including heroin. More than two-thirds of older sexually exploited youth had used heroin compared to only 43% of non-exploited youth
- Exploited youth where also more likely than those not exploited to have ever used cocaine, hallucinogens, and amphetamines (including crystal meth)
- Inhalant, mushroom and steroid use was more common among exploited youth than non-exploited youth only in 2000
- Twice as many sexually exploited older street-involved youth had ever used injection drugs or prescription pills without a doctor's order (60% for both) compared to non-exploited youth

Saewyc et al., 2008

The full report, *It's Not What You Think: Sexually Exploited Youth in British Columbia*, can be found at: http://www.nursing.ubc.ca/PDFs/ItsNotWhatYouThink.pdf

GAY, LESBIAN AND QUESTIONING YOUTH

A growing body of research has shown that sexual-minority youth are more likely than their peers to smoke, drink, use cannabis and report problems with substance use and abuse (CCSA 2007). Sexual-minority youth are at a higher risk of experiencing violence, which might contribute to higher rates of substance use (CCSA, 2007).

Gay, Lesbian and Questioning Youth in British Columbia

The Adolescent Health Surveys conducted by the McCreary Centre Society, included the 2-4% of students overall who consider themselves gay, lesbian or questioning. This means there are several thousand LGB youth attending secondary school in BC. The data from LGB youth gathered in the Adolescent Health Survey has been compiled in a special report, *Not Yet Equal: The Health of Lesbian, Gay & Bisexual Youth in BC.* The following key trends for LGB youth from 1992 – 2003 helps set the context for the subsequent information on alcohol and drug use:

- Females in 2003 were more likely to identify as "mostly heterosexual" or bisexual, and less likely to identify as heterosexual and as unsure, than females in previous years

- Sexual and physical abuse declined among gay males, but rates of sexual abuse increases among bisexual females, and rates of physical abuse increased among lesbians
- The percentage of LGB students reporting discrimination on the basis of sexual orientation increased for gay males and bisexual teens across the three surveys
- LGB youth are waiting longer to become sexually active; the rates of those who have had sex by age 14 has decreased since 1992
- Rates of suicide attempts increased for lesbian and bisexual females over the three surveys, but declined for gay and bisexual males

Compared to Heterosexual Youth, LGB Youth were more likely:

- To have experienced physical and sexual abuse, harassment in school, and discrimination in the community
- To have run away from home once or more in the past year
- To be sexually experienced, and more likely to either have been pregnant or have gotten someone pregnant
- To be current smokers, to have tried alcohol, or to have used other drugs
- To have reported emotional stress, suicidal thoughts, and suicide attempts
- LGB youth were less likely to participate in sports and physical activity, and reported higher levels of computer time
- LGB youth felt less cared about by parents and less connected to their families than heterosexual teens, and for lesbian and bisexual females, less connected to school
- When bisexual youth reported high family and school connectedness, their probability of suicide attempts was much lower than for bisexual teens with lower connectedness, even when they had strong risk factors for suicide such as a history of sexual abuse and current symptoms of emotional distress

Alcohol Use

- More bisexual teens than heterosexual teens reported that they had taken at least one drink of alcohol in their lives (males: 68% vs. 60%; females: 80% vs. 57%)
- Gay and lesbian teens were as likely as heterosexual teens to have tried alcohol in their lives
- With respect to binge-drinking, compared to heterosexual youth the same age, gay males were only two-thirds as likely to report binge-drinking in the past month, while bisexual females were two times more likely to report binge-drinking

Marijuana Use

- Sexual minority teens were more likely than heterosexual teens to say they had ever tried marijuana. Fifty-three percent of bisexual males had tried, compared to 39% of heterosexual males. Likewise, 62% of bisexual females and 52% of lesbians had tried marijuana, compared to 36% of heterosexual females.
- Of those youth who had ever tried marijuana, bisexual males were two-thirds less likely while bisexual females were 2.5 times more likely to have been heavy marijuana users in the previous month, compared to heterosexual teens of the same age and gender.

- Similar to their heterosexual peers, the proportion of teens who reported they had ever tried marijuana increased from 1992 to 2003 for all sexual minority groups except gay males, whose rate dropped from 68% in 1992 to 40% in 2003. Twenty percent of bisexual males in 1992 had tried marijuana, while 53% in 2003 had tried. A sharper trend was evident for bisexual females, whose rate increased from 15% in 1992 to 62% in 2003. Lesbians also reported an increase from 35% in 1992 to 51% in 2003, although the proportion of lesbians who had tried marijuana peaked in 1998 at 64%.

Other Drugs

- Fewer than half of LGB youth reported ever trying any of these drugs, but a greater proportion of bisexual males reported that they had ever tried at least one of these drugs compared to their heterosexual peers (43% vs. 22%)
- Both bisexual (49%) and lesbian (51%) females were more likely than their heterosexual (21%) peers to try at least one of these drugs
- The proportion of youth who reported they had ever tried any one of these drugs has decreased among gay males (from 63% in 1992 to 25% in 2003), but has increased among lesbians (from 27% in 1992 to 51% in 2003)
- The percentage of youth who reported they had ever tried one or more of these drugs, aside from alcohol and marijuana, also increased for bisexual teens from 1992 to 2003, but the rates peaked in 1998 (at 47% for males and 60% for females)

The full report report, *Not Yet Equal: The Health of Lesbian, Gay & Bisexual Youth in BC*, can be found at: http://www.mcs.bc.ca/pdf/not_yet_equal_web.pdf

ABORIGINAL YOUTH

According to the *Canadian Profile 1997 and 1999* (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1997, 1999), Aboriginal youth:

- Are at two to six times greater risk for every alcohol-related problem than their counterparts in the general population
- Use solvents more frequently than other Canadian youth. One in five Aboriginal youth has used solvents; one third of all users are under 15 and more than half of all solvent users began using before age 11
- Are more likely to use all types of illicit drugs (First Nations and Metis youth) than non-Indigenous youth
- Begin using substances (tobacco, solvents, alcohol and cannabis) at a much earlier age than non-Aboriginal youth
- Aboriginal youth are also over-represented in many of the populations most vulnerable to HIV infection, such as inner city populations, sex-trade workers and incarcerated populations

http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/youth-jeunes/ii-7_e.html

Aboriginal Youth in British Columbia

In the Adolescent Health Survey III, conducted by the McCreary Centre Society in 2003, 2,478 students identified themselves as Aboriginal. This data, combined with the data from responses of Aboriginal students who took part in the 1992 and 1998 Adolescent Health Surveys, was combined together in a report entitled *Raven's Children II:*

Aboriginal Youth Health in B.C. The report contains the following points with regards to Aboriginal youth alcohol and other drug use:

Alcohol Use

- The percentage of Aboriginal youth who have tried alcohol has steadily declined, from 80% in 1992, to 73% in 1998, to 67% in 2003
- Still, more Aboriginal students (67%) have ever tried alcohol than non-Aboriginal youth (57%)
- A third of Aboriginal youth (33%) have never used alcohol in their lifetime, 23% used alcohol on one to nine days, 19% used alcohol on 10 to 39 days, 13% used alcohol on 40 to 99 days, and 12% used alcohol on 100 or more days.
- Nineteen percent of Aboriginal students who have tried alcohol were 10 years old or younger the first time, down from 23% in 1998.
- Twenty-nine percent first tried alcohol at 11 or 12 years of age, 38% first drank alcohol at 13 or 14, and 15% first drank at 15 years or older.
- Among Aboriginal youth who have drank alcohol, 31% had not had a drink in the previous month, 30% drank on one or two days, 18% drank alcohol on three to five days, and 21% drank on six or more days. Males and females were equally likely to have had a drink in the previous month (69%).
- About half of Aboriginal youth who drank alcohol (51%) did not binge drink in the previous month (considered five or more drinks within a couple of hours). Fifteen percent binge drank on one day in the previous month, 12% on two days, 11% on three to five days, and 11% on six or more days. The same number of Aboriginal males and females binge drank (49%), compared to 44% of non-Aboriginal youth. Among youth who use alcohol, patterns of binge drinking have not changed over the past decade.

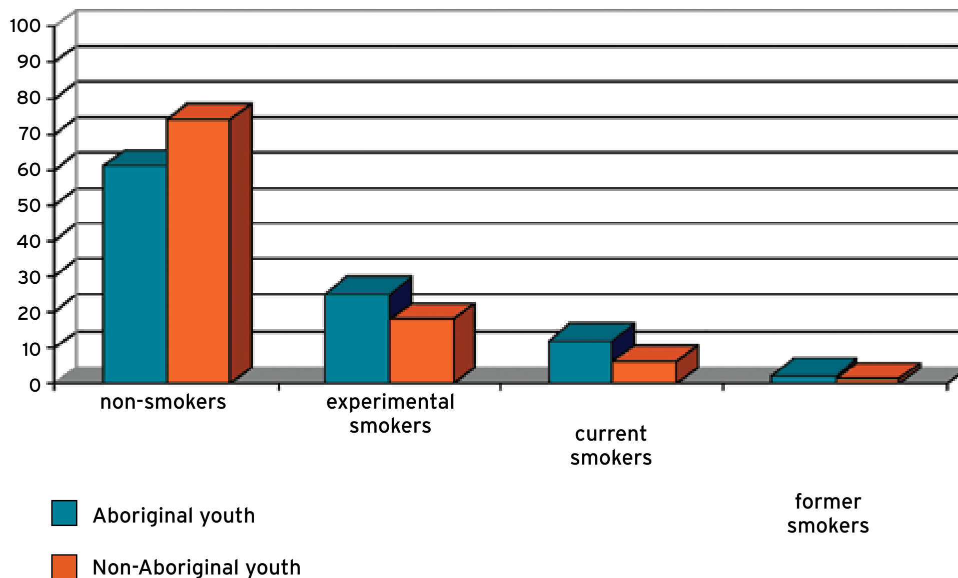
Marijuana Use

- Overall marijuana use among Aboriginal students has increased in the past decade: marijuana use increased dramatically between 1992 and 1998, from 46% to 60%, and then decreased to 53% in 2003. Marijuana use greatly increased among non- Aboriginal students as well.
- More Aboriginal youth (53%) had ever used marijuana than non-Aboriginal students (36%) and more Aboriginal females (55%) used marijuana than males (51%). The percentage of youth who used marijuana increases with age.
- Most Aboriginal youth who have tried marijuana were 13 or 14 years old the first time (46%), and 36% were 12 or younger the first time.
- In their lifetime, 47% of Aboriginal youth never used marijuana, 20% used marijuana one to nine times, 18% used it 10 to 99 times, and 15% used marijuana 100 or more times (up from 8% in 1992).
- Among Aboriginal youth who have tried marijuana, 40% did not use the drug in the previous month, 22% used once or twice, 14% used marijuana three to nine times, 7% used 10 to 19 times, 8% used 20 to 39 times, and 10% used marijuana 40 or more times in the previous month.
- More males (24%) than females (13%) used marijuana 20 or more times in the previous month.

- Patterns of use are similar among Aboriginal and non-Aboriginal youth:
  - Of non-Aboriginal youth who tried marijuana, 56% used it in the previous month, compared to 61% of Aboriginal youth.
  - 34% of non-Aboriginal youth used the drug three or more times, versus 38% of Aboriginal youth.

Tobacco Use

- There has been a dramatic decrease in smoking among Aboriginal students from 28% in 1998, to 12% in 2003.
- 25% of Aboriginal youth report that someone other than themselves smoked almost everyday or every day in their home
- Rates of smoking for Aboriginal youth are still higher than for non-Aboriginal youth



Smoking Definitions:
|Non-smoker: has never smoked a cigarette
Experimental smoker: has smoked fewer than 100 cigarettes in a lifetime
Current smoker: has smoked 100 or more cigarettes, and has smoked in the past month
Former smoker: used to smoke, but has quit

Other Drug Use

- Overall illegal drug use, not including marijuana, declined from 1998 among Aboriginal students:
- 32% of Aboriginal youth reported ever using any of the following illegal drugs: mushrooms, hallucinogens, prescription pills without a doctor's consent, cocaine, inhalants, amphetamines, heroin or steroids, compared to 39% in 1998.
- Use of hallucinogens, cocaine, inhalants and heroin declined significantly since 1998.

	1998	2003
Mushrooms	24%	21%
Hallucinogens	19%	10%
Prescription pills without a doctor's consent	13%	11%
Cocaine	11%	7%
Inhalants	8%	5%
Amphetamines	8%	6%
Heroin	3%	1%
Steroids	#	2%
Injected an illegal drug	#	#

# indicates insufficient data to make an accurate estimate

- Drug use was similar for Aboriginal males and females, with the exception of prescription pills: 14% of females versus 8% of males had used prescription drugs without a doctor's consent.

The full *Raven's Children II* report can be found at:
http://www.mcs.bc.ca/pdf/Ravens_children_2-web.pdf

Additional Resources

Reports specific to some regions of British Columbia have been produced:

Vancouver

In the summer of 2006, Vancouver Coastal Health conducted a citywide survey of over 600 youth aged 16 – 24 to measure youth attitudes and experiences with drugs and alcohol. The Vancouver Youth Drug Survey, entitled This is Not a Test, can be found at:
http://www.vch.ca/news/docs/2007_03_06_YouthDrugSurveyReport.pdf

Fraser Valley

Soon to be released report *School Based Prevention of Substance Use: Results from the Fraser Valle*y.
Contact Sherry.Mumford@fraserhealth.ca

Harms Associated with Pattern of Use

Researchers classify the health, safety, social and economic harms associated with patterns of use into four categories (CCSA 2007). These four categories are:

1. Harms due to mode of administration
2. Harms due to intoxication
3. Harms due to regular and prolonged use
4. Harms due to dependence

HARMS DUE TO MODE OF ADMINISTRATION

The manner in which a youth chooses to consume a substance will result in different risks and harms. Smoking increases the risks of future respiratory problems and injection increases the risk of overdosing (due to the potential of large doses which undergo immediate absorption), risk of infection at the needle site and the risk of contracting blood borne viruses such as Hepatitis C and HIV (CCSA 2007; Health Canada 2001).

HARMS DUE TO INTOXICATION

Those intoxicated by alcohol or other drugs expose themselves to the risk of additional harms. Physical harms, such as reactions to drug chemistry, acute toxic effects, overdoses, can be immediate. Other physical harms include intentional and unintentional injuries such as falls and traffic accidents (CCSA 2007). For example, during 2005, 818 people aged 16 – 25 were killed in road crashes in Canada. In 759 of these cases (92.8%) it was possible to determine if alcohol was a factor in the crash. Almost half of the 16 – 25 year olds (347) died in alcohol related crashes, representing 35% of all the people killed in alcohol-related deaths in 2005 (Traffic Injury Research Foundation of Canada, 2008). The 2005 Ontario Student Drug Survey found that 13.6% of all drivers in grades 10-12 reported driving within an hour of consuming two or more drinks at least once in the previous year. In addition, 28.8% of students in grades 7-12 indicated being a passenger at least once in the previous year in a vehicle driven

by someone who had been drinking alcohol. The Road Safety Monitor report (2006) found that 2.4% of respondents who indicated that they had used marijuana or hashish during the past 12 months indicated that they had driven within two hours of using it. Given that young Canadians have one of the highest rates of marijuana use in the world, it is not surprising that 60% of the marijuana/hashish drivers were under the age of 35 (Simpson, H.M., Singhal, D., Vanlaar, W.G.M., Mayhew, D.R., 2006). Research has shown that marijuana can play an important role in road vehicle crashes, especially when combined with driver inexperience and difficult road conditions because marijuana use affects tracking ability and increases the reaction time needed to respond to an emergency decision-making task. Quite concerning is the fact that despite this evidence, most young drivers and passengers commonly regard pot and driving as risk free, though they have little tolerance for alcohol-impaired driving (Canadian Public Health Association, 2005).

Intoxication increases youths' vulnerability and places them at increased risk of victimization and exploitation by others, particularly sexual exploitation as well as unprotected/unplanned sex. Causing injury to oneself, damage to property, violent behaviour, and having trouble with the justice system, school, friends and family are also possible harms associated with intoxication (CCSA 2007).

HARMS DUE TO REGULAR AND PROLONGED USE

Many long term health consequences are associated with regular and prolonged use of alcohol and other drugs. Problematic substance use impacts directly and indirectly on the health of individuals who use them, although the substance abuse literature primarily addresses long-term effects on adults. Discussing long-term effects of alcohol and drug use, such as respiratory diseases, liver disease, etc., is generally not an effective approach when working with adolescents since these consequences are so far in the future that at this time, may appear irrelevant to the youth. In addition, developmentally, many youth also have feelings of omnipotence so may falsely believe that these long term health effects will never affect them. That being said, the impact of regular and prolonged use of alcohol and other drugs in adolescence should not be underestimated and there are direct and indirect impacts of alcohol and drug use on the health of youth that are much more immediate. For example, during adolescence, the brain continues to grow and mature. Research on brain development has shown that the prefrontal cortex – the part of the brain that enables us to assess situations, make sound decisions and keep our emotions and desires under control – is still maturing during adolescence. Consequently, youth are at increased risk to make poor decisions. Repeatedly introducing drugs to the brain while it is still developing may have profound and long lasting consequences (NIDA). Other impacts on the brain can include memory loss and other cognitive deficits (CCSA 2007). Regular and prolonged use can also have lasting impacts on youth mentally. Youth have been identified as one group that is particularly vulnerable to experiencing concurrent disorders, with those aged 15 to 24 more likely to be affected than any other group. Adolescents with a substance use problem are about three times as likely to have concurrent mental health concerns as youth without a substance use problem. There is also a growing body of research that associates chronic heavy use of marijuana in adolescence with the exacerbation of symptoms of schizophrenia and psychosis in those already vulnerable to these disorders, though the relationship is not considered causal (CCSA 2007).

In their article, *Adolescents and Substance Abuse: What Works and Why?*, Chapman and Rokutani (2006) examine the impact of substance abuse on the developmental tasks of adolescents in the later stages of use:

Social
When a youth moves into the later stages of use, they tend to move out of the mainstream peer culture and into the drug-using subculture. Normal social developmental tasks, such as learning empathy and dating, are not developed; instead the youth identifies with a peer group characterized by inappropriate, antisocial behaviour. Identification with this subculture can also affect self-esteem and identity as the youth is ostracized by the mainstream culture (Chapman and Rokutani 2006).

Identity
Another developmental task in adolescence is the formation of an identity. A youth in the later stages of drug use becomes centered on the drug-use identity and the drug-using subculture. Exploring new ideas, new behaviours and new activities in order to develop morals, self-esteem, and self-control - all critical in the development of an identity – are undermined by the drug and subculture (Chapman and Rokutani 2006).

Learning
Other major tasks in adolescence are to develop expanded cognitive abilities, such as abstract thinking, coping skills and cognitive development. Drug use impacts the ability to concentrate, to remember and be motivated to learn (Chapman and Rokutani 2006).

Emotional
The various stressors involved in adolescent development as well as the increase in size of the amygdala, the section of the brain that generates emotion, all contribute to the mood swings typical in adolescence. The use of mood-altering substances can impact the emotional well-being of the youth in numerous ways including "intensifying mood swings, increasing impulsivity and self-destructive behaviours, and depending on substances to manage stressors" (Chapman and Rokutani 2006).

HARMS DUE TO DEPENDENCE

The risk of the harms discussed with regular and prolonged use of alcohol and other drugs increase and may be exacerbated when dependence occurs. For example, the physical and mental symptoms that occur during withdrawal from a substance increase when dependence occurs. Also, the social consequences of dependence may include problems with school, friends, family, work, finances and the law.

How do the Needs of Youth Differ from those of Adults?

As stated previously, though adults and adolescents share some of the same needs, the needs of youth also differ from those of adults in some significant ways which will impact on services for youth with problematic substance use. As described in *Services for Young People with Problematic Drug Misuse, A Guide to Principles and Practice* from the Effective Interventions Unit - Substance Misuse Division in Scotland, some of these important differences include:

Social Impact
The consequences of missing or under-performing at school can have a negative impact on later life changes that may be, or appear to be, irreversible. A chaotic lifestyle may seem acceptable and normal to a young person because they have fewer immediate responsibilities such as childcare or maintaining housing or employment. However, involvement as a juvenile with a negative and anti-social peer group, particularly where this leads to offending, has been found to be a strong predictor of adult behaviour.

Vulnerability
Young people involved in problematic drug misuse are highly vulnerable. In addition to the risks of their future prospects and the likelihood of later involvement in crime, they are at increased risk of victimization and exploitation by others, particularly sexual exploitation.

Physical Impact
Most young people will have been using drugs for a shorter period than adults who present to drug agencies. This tends to mean that the negative health effects of an abuse lifestyle – such as injecting related injuries or blood borne viruses – are less likely to be evident amongst either themselves or their peer group. However, the wider health needs of this group – particularly around mental wellbeing – should not be under-estimated.

Methods of Use
The ways in which young people take drugs may differ from adults. There is likely to be a higher degree of poly-drug use, with the young person taking whatever is available – including solvents, prescribed or illegal drugs –rather than pursuing one specific drug of choice. Drug use may change from week to week. Binge use of alcohol and other drugs often features little understanding or awareness of the consequences.

Circumstances of Use
The circumstances in which young people misuse drugs may differ from those of adults. Their lack of independence can mean that the drug use takes place in environments that may bring additional risks, such as outdoors and in the company of a much older peer group.

Perception of Risk
Young people consider themselves "immortal" and death or a serious deterioration in their ability to function can seem unimaginably distant. Many young people will not see their drug use as problematic and they may not make connections between the drug use and other issues in their lives. The positive and enjoyable aspects of drug use may still appear paramount.

Scottish Executive Effective Interventions Unit, 2003

MODULE III

Change, Motivation and Collaborative Approaches with Youth

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The Stages of Change Model — A Review	x
Applying the Stages of Change Model when Working with Youth	x
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Working with Ambivalent Youth	x
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Module III: Change, Motivation and Collaborative Approaches with Youth

Building Counselling Relationships with Adolescents

First interviews are critical with adolescents; many do not return for a second time. It may be difficult for young people to talk about their problems with anyone, and in fact, they may expect disapproval and judgment from most adults, especially about alcohol and drug use.

Relationship-building is the critical first task with adolescents. Without it, little else will happen. As discussed in the C.A.P. training, according to Miller and Duncan (2005) the youth's perceptions of the relationship with the practitioner is second only to client factors in being responsible for gains made in therapy. Probably most people around the adolescent have been focusing on what is wrong with him or her so the counsellor should instead help reframe his/her view into one of looking at strengths and positives in order to move forward. The main message must be that the adolescent will be treated as a person, who is in charge of his/her own life, and that the counsellor will be along for the ride helping and supporting them as required.

There are a number of factors to think about when trying to engage effectively with young people:

- Why they have come to you
- Barriers to service engagement for young people
- When, and where, they might want to see you
- The individuals working in services
- Building relationships with young people

Besides the basic counselling skills that are also important in working with adolescents, some basic guidelines for effective interviews include:

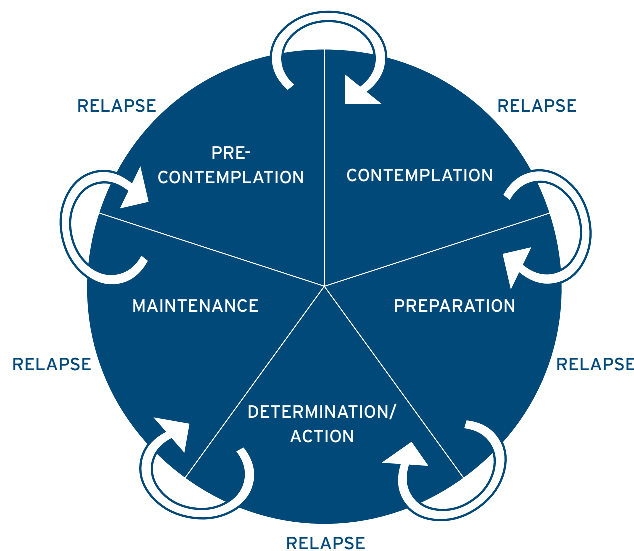
- Match the style and pace of the intake conversation with what the client seems to prefer
- Give adequate information about how your site works and what might be expected
- Give prospective clients choices (e.g., male/female practitioner, day/evening appointments, particular ethnic or language-fluent practitioner)
- Attempt to get some idea of what clients are hoping to achieve
- Without "promising the moon", assure the client that what they are calling for is what your site does
- Highlight the client's motivation to address the issues at hand when appropriate
- Don't ask overly sensitive or large amounts of information – stick with most important information
- Warmth, empathy, sincerity and respect are important
- Be clear about confidentiality considerations and the limits and exceptions related to it
- Accept your client's appearance and language – it's part of the package

- Find out what your client likes to be called – it may be different from their given name
- Through your responses, let your client know you value his needs
- Use appropriate non-verbal communication to let them know you're with them
- Firm and clear communication are important as is common terms
- Factual, objective and positively worded responses are encouraging
- Focus on the positive directions for the youth, rather than what they should not be doing
- Any assigned tasks should be small, step-by-step and achievable
- Avoid power struggles. Adolescents need to struggle with themselves, not with you, to figure out what to do
- Validate their self-perceptions – that is their reality
- Reinforce the positive behaviours; ignore the rest
- Deliver what you promise – be a trustworthy adult

Adapted from: Addictions Research Foundation, 1991 and Duncan and Sparks, 2002

The Stages of Change Model – A Review

The *Core Addictions Practice* course detailed Prochaska and DiClemente's Stages of Change Model. Below is a brief review of the different stages of change. It is important to remember that this model views change as a process, with individuals moving forwards and backwards through the various stages. Relapse is not seen as a failure, but as a common part of the change process and an opportunity to learn how to sustain change more effectively in the future. Each stage is associated with distinct cognitive, emotional and behavioural characteristics.



APPLYING THE STAGES OF CHANGE MODEL WHEN WORKING WITH YOUTH

By learning about a youth's stage of change and how they feel about changing behaviour, information can be tailored in different ways to make it relevant and useful to that person at that particular stage at that particular time. The more relevant the information is to the person, the more likely they are to listen and act on it. The following chart outlines different tasks the counsellor can do depending on their client's stage of change.

STAGES OF CHANGE & KEY PRACTITIONER TASKS

CLIENT STAGE	KEY PRACTITIONER TASKS
PRECONTEMPLATION	Raise doubt – increase the client's perception of risks & problems with current behaviour. Reassure client they will not be pressured into changing. Engage them to identify the harms associated with their behaviour.
CONTEMPLATION	Acknowledge client's desire to quit the behaviour and their desire to continue the behaviour. Encourage the client to realistically assess the risks associated with continuing the behaviour. Strengthen client's self-efficacy for change of current behaviour.
PREPARATION	Support the client to develop a change plan that is acceptable, accessible and effective. Assess the strength of the client's commitment to change. Help the client think creatively about how to develop the most effective plan.
ACTION	Support and reassure the client as they face unknown situations with new, untried skills. Careful listening and affirming clients that they are doing the right thing. Check with the client to see if he or she has discovered any parts of the change plan that need revision.
MAINTENANCE	Help the client identify and use strategies to prevent relapse. Assist client to pursue the new skills they have learned to handle on-going temptations (build self-efficacy).
RELAPSE	Resume the change efforts by attending to the tasks that go with the stage of change the individual has relapsed to, and not simply pick up where they left off before. Support the client to renew the processes of precontemplation, contemplation, preparation, and action without becoming stuck and demoralized due to relapse.

Source: Miller and Rollnick (2002). Motivational Interviewing. 2nd Edition.

IMPORTANT THINGS TO REMEMBER

- There are specific interventions for each stage of change. Therefore, it is important to recognize the client's stage
- Young clients who are in the pre-contemplative stage may be good candidates for brief interventions
- Young clients who are thinking about change may benefit from doing a functional analysis of their drug use, thereby identifying triggers and consequences
- Many youth are in the pre-contemplative stage when they are first seen for assessment or counselling, and are not yet prepared to change
- Youth frequently revert back to a previous stage and therefore, ongoing check-ins to identify the stage they are in is important
- Change is a process, not an event
- For someone who uses multiple substances, it is not uncommon to be in different stages. For example, a youth may be in pre-contemplation about alcohol use, in contemplation about cannabis and in action for cocaine

(Tupker, 2004)

For a youth friendly explanation of the stages of change, see the AADAC youth site:
http://www.aadac.com/124_753.asp

Motivational Interviewing

Another highly useful method of engaging with youth introduced in *Core Addictions Practice* is motivational interviewing. As you will recall, motivational interviewing is "a client centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller and Rollnick, 2002, p.25). Adolescents are typically not attending treatment because they choose to – they have been told to attend by an adult and are probably being told what to do by most of the adults in their lives. Motivational interviewing is a particularly useful approach when working with youth, many whom are in the pre-contemplative or contemplative stage of change, with low motivation and/or high resistance to changing their substance use. Ambivalence is a normal part of change and the natural response of anyone who is challenged about a behaviour about which they are ambivalent is to argue the other side. When working with youth, advice giving and other strategies that focus on actual behaviour change will be of limited value and will result in a common occurrence in the addictions field: the counsellor arguing for change and the client responding with resistance. Instead, by applying the principles of motivational interviewing – express empathy, develop discrepancy, roll with resistance and support self-efficacy – a youth's need to establish their own identity is not challenged. As Chapman and Rokutani (2006) state, "an adult who expresses understanding of the adolescents' world view (empathy)... [and] will listen rather than lecture, reflect the adolescent's thoughts and feelings rather than criticize, and stress that the adolescent has choices with whatever issue he or she is discussing" will be much more effective. This type of approach allows the youth to be self-directed, assert his/her own identity, develop thinking skills and think through consequences. With motivational interviewing, the counsellor takes a supportive role, respecting the client's autonomy and eliciting insight from the youth. This approach is also highly compatible with the developmental tasks of adolescents, allowing the youth to develop thinking skills, be self-directed, think through consequences and assert his/her own identity (Chapman, 2006).

EFFECTIVENESS OF MOTIVATIONAL INTERVIEWING WITH BOTH MAINSTREAM AND NON-MAINSTREAM YOUTH

Motivational interviewing has been found to be effective with unique populations of youth such as youth experiencing concurrent disorders, youth involved with the criminal justice system and youth engaging in risky behaviours (Sciacca, 1997; Miller 1999; Dunn 2003). Using an empathetic, non-judgmental style of counselling is particularly effective with youth who are often ambivalent about change. Guiding them to examine the costs and benefits of the substance use and allowing them the freedom to choose their own course of action increases the chances that a youth will move towards changing their behaviour. Other reasons why motivational interviewing may work well with young people include:

- Motivational interviewing emphasizes exploring and resolving the ambivalence about identity, roles and behaviours that is so common among young people
- Motivational interviewing's emphasis on being respectful, acknowledging choices and ambivalence, minimizing arguing and avoiding confrontation are approaches that work well with young people who so often have limited choices and controls
- Motivational interviewing's exploratory approach and emphasis on personal change goals seem to mesh with young people's curious and philosophical nature and desire for autonomy

- Motivational interviewing is consistent with the harm reduction approach that is appropriate for young people who do not have chronic substance use problems
- Motivational interviewing is particularly appropriate for prevention programs aimed at young people who have already engaged in substance use
- Motivational interviewing is helpful as a means of engaging and retaining young people in services, especially those who have been "forced" to enter treatment by families, schools or courts
- Motivational interviewing can be delivered in brief formats suitable to use in informal youth settings such as drop-in, recreational and placement centres

(Baer & Peterson, 2002, as quoted in Tupker 2004)

The strength of using motivational interviewing when working with youth can be illustrated by examining the four principles of motivational interviewing:

1. Express Empathy
    - Communicates respect for, and acceptance of, youth and their feelings
    - Encourages a nonjudgmental, collaborative relationship
    - Allows practitioner to be a supportive and knowledgeable consultant
    - Sincerely compliments rather than denigrates
    - Listens rather than tells
    - Gently persuades, with the understanding that the decision to change is the youth's
    - Provides support throughout the change process
2. Develop Discrepancy
    - Motivation for change is enhanced when youth see discrepancies between their current situation and their hopes for the future
    - Practitioner's task is to help focus the youth's attention on how their current behaviour differs from their personal values
3. Roll with Resistance
    - The simplest approach to responding to resistance is with nonresistance
    - Repeat the youth's statement in neutral form
    - Arguments are counterproductive
    - Resistance is a signal to change strategies
    - Defending breeds defensiveness
    - Labeling is unnecessary and can produce hostility
4. Support Self-Efficacy
    - Self-efficacy refers to people's beliefs about their capabilities

- Many youths do not have a well-developed sense of self-efficacy, and find it difficult to believe that they can begin or maintain behavioural change
- Improving self-efficacy requires eliciting and supporting hope, optimism, and the feasibility of accomplishing change
- This requires the practitioner to recognize the youth's strengths and bring these to the forefront whenever possible

(Florida Department of Juvenile Justice)

Working with the Ambivalent Youth

Many youth who arrive for an assessment or treatment will not be motivated or committed to change their alcohol and/or drug use. This is especially true for youth involved with the criminal justice system who are often mandated to treatment and have little or no support from family (Health Canada 2001). Motivational interviewing works extremely well with these youth who are in the pre-contemplative or contemplative stages of change.

When working with these ambivalent youth, the DEARS approach has been shown to be effective:

Develop discrepancy

- Compare positives and negatives of behaviour
- Compare positives and negatives of changing, in light of goals
- Elicit self-motivational statements

Empathize

- Ambivalence and pain of engaging in behaviour that hinders goals

Avoid arguments

- Don't push for change, avoid labeling

Roll with Resistance

- Change strategies in response to resistance
- Acknowledge reluctance and ambivalence as understandable
- Reframe statements to create new momentum
- Engage youth in problem-solving

Support Self-Efficacy

- Bolster responsibility and ability to succeed
- Foster hope with menus of options

Additional Resources

Canadian Centre on Substance Abuse (2007). The Essentials of… Motivational Interviewing.

http://www.cnsaap.ca/NR/rdonlyres/3FD52ED7-7C9A-4326-9CB7-2CC741A04419/0/PTEssentialsofMotivationalInterviewing20070322e.pdf

Miller, W.R. (1995). Motivational Enhancement Therapy with Drug Abusers. Department of Psychology and Center on Alcoholism, Substance Abuse and Addictions (CASAA), University of New Mexico.

http://motivationalinterview.org/clinical/METDrugAbuse.PDF

Motivational Interviewing Professional Training VHS Videotape Series
This series of videotapes (A-F) produced at the University of New Mexico, provides an introduction to motivational interviewing by the psychologists who developed them. The tapes are intended to be used as a resource in professional training, offering six hours of clear explanation and practical modeling of component skills.

Published: 1998
Source: William R. Miller, Ph.D., and Stephen Rollnick, Ph.D.
Directed by Theresa B. Moyers, Ph.D.
Website: http://casaa.unm.edu/

Motivational Interviewing: Resources for Clinicians, Researchers and Trainers
This website is intended to provide resources for those seeking information on Motivational Interviewing. It includes general information about the approach, as well as links, training resources, and information on reprints and recent research.
Website: www.motivationalinterview.org

MODULE IV

Making Treatment Count: Client-Directed, Outcome Informed Work with Youth

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Module IV: Making Treatment Count: Client-Directed, Outcome Informed Work with Youth

Context for Working with Youth

As discussed earlier, youth may have presenting internal and external risk factors that can negatively influence their development and well being. Therefore when working with youth it is essential to engage youth in developing protective factors within themselves to build resiliency. According to the Guidelines for Provision of Youth Services (2002), the following are needed:

Range of services and support programs

- Varying levels of intensity to meet the differing and changing needs of youth as they develop
- Provide the least disruptive intervention necessary
- Sensitive and responsive to cultural differences and the special needs of youth with respect to age, stage of development, gender, ability, sexual orientation, socio-economic status, spirituality, and lifestyle

Balance in our approach to adolescents

- Do not pass quick judgments on youth
- Understand healthy youth development
- Move beyond focusing on 'at risk', negative labels, problems, blaming and reacting in an ad hoc manner that focuses on fixing problems in isolation
- Understand that young people are partners, adults act as supportive mentors, planning is intentional and sets high goals

Multi-sector response

- Develop integrated services for youth by building formal and informal relationships between social service agencies; education agencies; school districts; law enforcement; mental health; youth justice; addictions; labour attachment initiatives; community-based organizations; faith-based organizations; and the private sector
- Promotes a seamless system of effective services and can be instrumental in both creating more resources and better utilizing existing ones

KEY INFLUENCES ON HEALTH AND WELL BEING OF YOUTH

The following three influences have been identified as key to the health and well being of youth (Guidelines for the Provision of Youth Services 2002):

1) Youth Empowerment as a Youth-Centred Approach

- Value and respect young people and acknowledge that they are the experts in regards to their own lives. This expertise is crucial to the process of facilitating the identification of supports and services leading to successful outcomes for youth

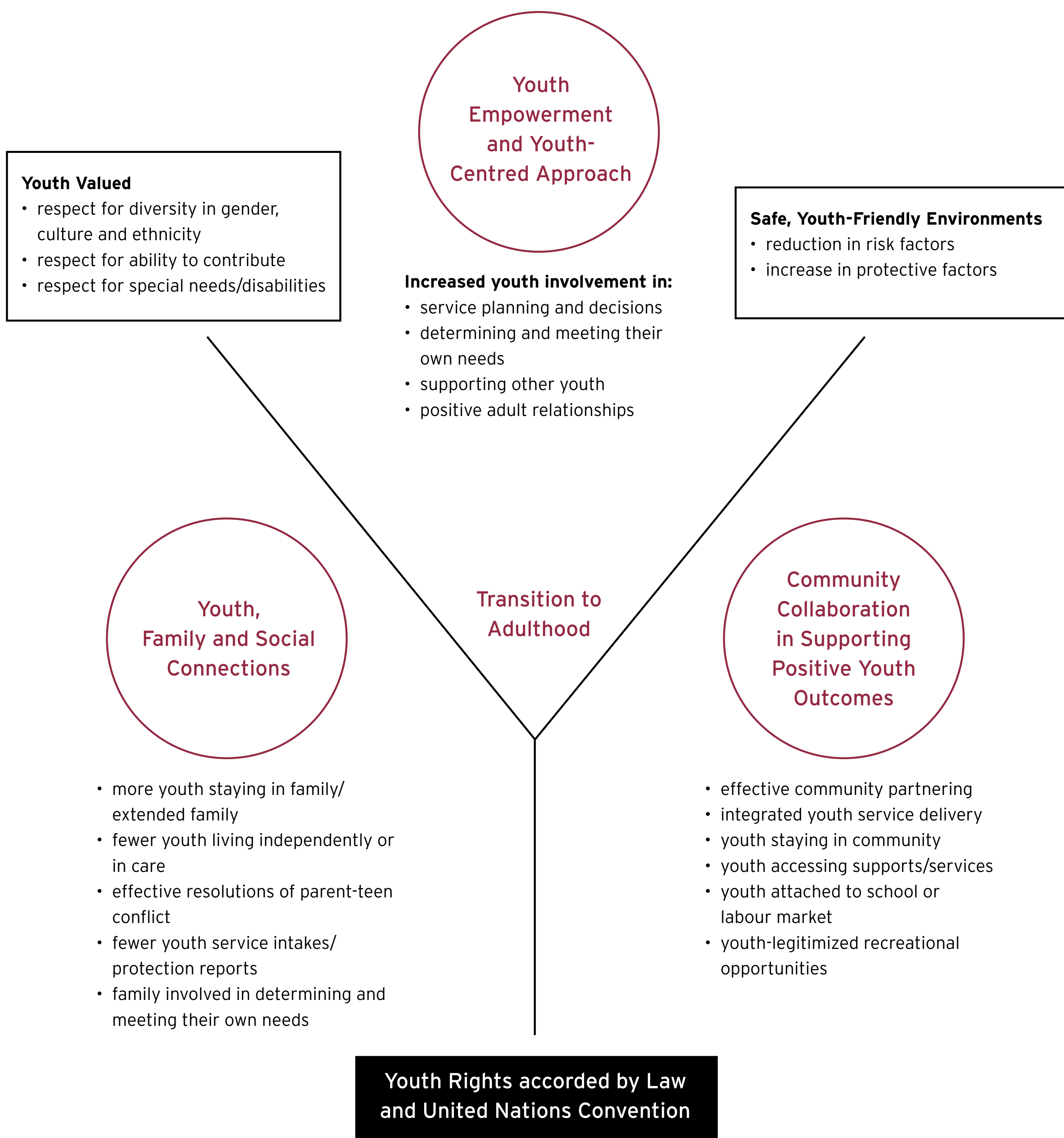
- Service approaches are based on promoting development and enhancing resiliency with a context that focuses on the assets inherent in our youth
- A youth centred approach is best served through quality relationships with people who are skilled and trained and able to maintain connections for the long term
- Youth are supported to make choices and to deal with the consequences of their choices
- The role of advocacy is supported
- Youth are involved in designing, developing, delivering and evaluating policies, programs and practices affecting their lives and the lives of other young people
- Given the multi-service needs of many youth, partnerships among youth, family and service providers are facilitated whenever possible

2) Family and Social Connections

- The family, in its diverse forms, is central in the provision of affection, care and support to youth
- Throughout the entire span of involvement with a youth, the family is viewed as the preferred environment whenever possible. Where not possible, youth are supported in a plan that promotes their independence while maintaining family connections
- If, with available support services, a family can provide a safe and nurturing environment for a youth, there is a shared responsibility between government, regional authorities, community and contracted agencies to strengthen the capacity of youth and family to provide for themselves
- Youth and their families are informed of the range of services and options available to them
- Whenever feasible, recognition is given to the capacity of the individual youth and/or their families to determine and meet their own needs
- The influence of positive peer mentoring (i.e., teens helping teens) promotes healthy lifestyle choices

3) Community Collaboration in Supporting Positive Youth Outcomes

- The community has a responsibility to support youth and to strengthen the capacity of youth and families to provide for themselves
- Building formal and informal relationships with all youth-connected and youth-serving agencies promotes seamless services, effective supportive and follow-up services, and is instrumental in leveraging more resources
- The development of community resources and capacity to address youth needs and issues are most effective through community partnerships involving both the public and private sectors
- Providing opportunities for youth to contribute to their communities helps to demonstrate that youth are valued citizens who have something substantial to contribute to society while instilling respect for themselves, others and the world around them
- Integrating youth services on site (school, community centre or street) where youth are more likely to congregate assists in achieving positive youth-centered outcomes
- Ensure that information about all existing programs/services for youth is readily available and understandable



Key Influences on Youth Health and Development – Guidelines for the Provision of Youth Services

Attitudes and Biases

The attitude with which one approaches any job has an influence on the outcome and success of the work. Often attitudes influence what behaviour we get in return. This could not be truer when talking about working with youth. In its work on best practices for the treatment of youth with substance use problems, Health Canada (2001) found that specific staff characteristics were a significant factor related to treatment and outcome. In terms of attitude, the most effective therapists were able to:

- Show respect and trust
- Minimize the hierarchical power structure and work collaboratively with youth
- Build and maintain a positive and supportive relationship with clients
- Accept relapse and not define it as failure
- Help youth redefine themselves in new, more positive ways
- Model a positive, healthy lifestyle
- Engage with clients
- Be relaxed and caring
- Be spontaneous
- Be objective
- Show a sense of humour
- Be encouraging and reinforce positive behaviour
- Not be confrontational or directive

Therefore, it is important to look at what we believe about adolescents, adolescent substance use and how people change in general, so we can rework many of our own attitudes that might cause us trouble in working with youth. There are a number of factors that can influence our work:

- Your own history of alcohol and drug use, and family history of alcohol and drug use
- Do some teenagers intimidate you because they are loud, aggressive and rude?
  Do some teenagers tick you off?
- With some youth, you might feel protective or get more involved than you should. Beware of looking forward to seeing your 'best' client – it might mean you're taking their treatment personally
- Watch out for the trap of feeling like you know the 'right' way, or what's 'best' for your client.
  Your job is to be the 'guide on the side'
- Know that we all make assumptions about clients the minute they walk in the door, but don't treat them as fact – you need to check them out
- Do you think that adolescents are too young to be 'hooked' on alcohol and drugs? Examine why you think this way, as it runs counter to real-life experiences
- What's your belief about how people change? And what's your belief about your role in that change?

- Does your lack of personal experience with alcohol and drugs in your youth make you worry that you can't connect with the adolescent clients? What can you do to make yourself more effective? Is a past problem the only way you can connect with a youthful client?

It is important to seek out support from your colleagues, especially if you are feeling like you are not connecting with a young client or if you are feeling uncomfortable, over-involved, etc. An objective second opinion and support may be helpful in finding ways to approach the client in a different, more therapeutic way.

Sometimes our negative attitudes and biases stem from a lack of knowledge. Staff knowledge is another factor related to treatment outcome and success when working with youth experiencing substance use problems. Health Canada (2001) found that the most effective practitioners:

- Speak with familiarity (and experience) to issues of importance to youth
- Show direct familiarity with different cultures and issues related to sexual orientation
- Understand conceptual tools such as the "stages of change" model and motivational interviewing
- Are trained and qualified
- Understand youth developmental issues and changes.

Barriers to Treatment

In their work on identifying best practices for treating youth with substance use problems, Health Canada (2001) identified three main types of barriers that affect or limit youth access to treatment:

- Personal Barriers – related to the youth's perception of self, lack of knowledge or presence of co-existing personal problems;
- Barriers related to family and peer relationships;
- Structural or program-related barriers.

The following chart summarizes the most common of each of the three barriers:

Primary Personal Barriers	Primary Family-Related Barriers	Primary Structural/ Program Barriers
• Denial/lack of recognition of problem • Peer values and group membership normalize use • Personal issues which mitigate against access (self-esteem, mental health and cognitive problems) • Lack of awareness of treatment options	• Parental abuse • Parental substance use problems • Lack of parent support/existence of denial • Family breakdown	• Lack of youth-oriented programming • Long waiting lists • Lack of accessibility to existing programs • Lack of workers skilled in counselling youth • Poor outreach information • Lack of specialized residential treatment

BARRIERS TO TREATMENT FOR SPECIFIC GROUPS

Specific groups of youth also experience barriers that are unique to them. The following chart summarized these unique barriers (Health Canada 2001).

Group	Personal Barriers	Family/Community	Program/Structure
Street-involved youth	• Don't self-refer • Multiple problems • Distrust of mainstream system • Don't understand access points	• Lack of support from family and significant others to access and use treatment	• Lack of effective outreach programs • Lack of service flexibility • Restrictive treatment entry • Lack of adjunctive services (e.g., housing) which support treatment
Youth with Concurrent substance use and mental health disorders	• No consensus	• No consensus	• Lack of planning, coordination and understanding between mental health and substance abuse treatment systems • Inadequate early diagnoses or capacity to provide them • Insufficient number of programs to handle specific needs of clients • Lack of trained staff who can treat both types of problems
Youth who inject drugs	• Multiple barriers • Isolation and marginalization from society • Distrust/ hostility toward mainstream system	• General isolation and lack of supportive relationships	• Inadequate/inaccessible methadone maintenance treatment • Lack of understanding of special needs • Need to have practical needs addressed prior to and concurrently with substance abuse treatment needs

Group	Personal Barriers	Family/Community	Program/Structure
Ethno-cultural minority youth	• Cultural beliefs strengthen denial and avoidance of problems • Greater stigma attached to drug/ alcohol problems	• Families may deny problems • May not support treatment/look to internal problem solving in own community • Inter-generational misunderstanding and conflict	• Lack of culturally appropriate outreach • Language barriers, especially parental language barriers • Lack of worker sensitivity or cross-cultural skills and training
Aboriginal Youth	• No consensus	• High level of substance use in some Aboriginal communities • Youth treatment may not be supported/ seen as appropriate • Families do not request assistance	• Language barriers (including parental language barriers) • Lack of culturally appropriate programs
Youth involved with justice system	• Resistance to mandated treatment • Peer culture	• Often no support from family	• Lack of correctional programs addressing substance use problems • Barriers to accessing community programs • Group work difficult with offenders • Corrections staff lack knowledge of substance abuse treatment system – often don't refer youth with substance use problems

Outreach, Contact and Engagement

A number of best practices related to the outreach, contact and engagement of youth in treatment have been described in the literature and can be categorized into four general areas:

Location and Physical Accessibility of Treatment

- Direct staff outreach to youth-defined venues
- Develop long term, highly supportive staff-client relationships
- Support program/school relationships
- Provide immediate (24 hours) access to youth
- Use community prevention programs as building block to access
- Low threshold to access (few entry criteria)

Outreach

- Drop in component to support access
- Maintain extensive referral networks
- Train referral sources
- Involve family members prior to contact with youth, if desired

Program Approach and Philosophy

- Respectful and non-judgmental staff
- Familiarity with youth reality and language
- Client centered treatment
- Establish safe, secure, comfortable treatment environment

Program Structure and Content

- Include recreational activities (fun and non-threatening)
- School and community-based prevention activities

Health Canada, 2001

For more information on creating a client-directed environment and inviting clients into a collaborative relationship, refer to Module IV in the *Core Addictions Practice Guide*.

Initial Contact – Risk Assessment and Crisis Intervention

As discussed in the *Core Addictions Practice* course, intake "screens and assesses individuals promptly and responsively to efficiently determine the urgency of the need" (COA 2006). The following things are determined:

- If the client is in the right place;
- If the client is in imminent danger;
- Potential lethality including harm to one's self or others;
- Client's emotional status and imminent psychosocial needs;
- Client's strengths and available coping mechanisms;
- Resources that can increase service participation and success; and
- The most appropriate and least restrictive service alternative for the client.

(COA 2006)

Right Place for Right Service

As it is discussed what services can be offered and what the client is looking for, it may appear that the services are not what the youth wants or needs. If this is the case, other options in the community should be suggested and the youth should be assisted to find what they need in the most accessible and appropriate place possible.

Urgent and/ or Immediate Needs

It is important to be aware that a youth may present with some needs which will require immediate and prompt action. Situations which may require crisis intervention include:

- The person seems to be currently withdrawing from a substance
- The person is in need of protection
- The person is a danger to him/herself or others

Referral to a Physician

In order to determine whether a youth needs to be referred to a physician, the Youth Medical Needs (Triggers) Screening Tool (MTST) can be administered to a youth upon initial contact.

Youth Medical Needs (Triggers) Screening Tool (MTST)

Description:

The Youth Medical Needs (Triggers) Screening Tool (MTST) was developed for use in addiction services outpatient treatment agencies. The tool is designed to identify youth (clients under 19 years of age) that may require a referral to a physician for a comprehensive assessment of physical health status. The 11 questions on the MTST are intended to screen for health conditions and circumstances that potentially require medical assessment or intervention.

Target Population:

The MTST is appropriate for all youth clients in the outpatient setting who present with substance misuse/affected or problem gambling/affected issues. Physicians routinely assess clients attending withdrawal management services or other residential treatment facilities and different scales are used to evaluate and monitor medical symptoms.

Administration:
The MTST is designed to be administered in an interview format and takes 5 to 10 minutes to complete. Counsellors should ask clients about each of the 11 items on the form, and circle the appropriate box. If the client is misusing a prescription drug, record the name of the drug(s) beside that item.

The Screening Tool form should not be given to the client to fill out. Questions are not to be read verbatim; rather the information is to be arrived at with language and questions suitable to the client's level of understanding.

Scoring & Interpretation:
The number of positive items is summed to a total score. (Count the total number of shaded boxes circled). *Consultation with, or referral to, a physician is recommended If the MTST score is **one** or greater*. If a program does not have access to sessional physician services, then consultation with the client's own primary care physician should occur. A copy of the MTST screening form should accompany the referral to the physician. Agencies **must** obtain client consent prior to contacting the physician.

Clients with positive triggers for suicide risk and/or pregnancy should be considered in urgent need of attention.

It is recognized that several of the questions are of a sensitive nature; therefore it may take longer than one interview/session to complete the MTST screen.

Youth Medical Needs (Triggers) Screening Tool

QUESTIONS	CIRCLE RESPONSE	
1. Does the client have any current medical concerns?	YES	NO
2. Does the client need to obtain his/her own primary care physician?	YES	NO
3. If the client has a primary care physician, is that physician aware of his/her substance use problem?	YES	NO
4. Is the client misusing her/his own or someone else's prescription medication? Name: ____________	YES	NO
5. Does the client need withdrawal management services?	YES	NO
6. Does the client have a history of seizures?	YES	NO
7. Has the client missed one or more periods in the last six months or is she known to be pregnant?	YES	NO
8. Does the client have a history of a serious co-existent medical or mental health condition, e.g., diabetes, anorexia/bulimia, hepatitis, HIV, attention deficit hyperactivity disorder (ADHD), fetal alcohol syndrome/fetal alcohol effects (FAS/FAE)?	YES	NO
9. Is the client at risk for suicide, e.g., persistent thoughts, planning, attempts?	YES	NO
10. Has the client ever injected drugs?	YES	NO
11. Does the client engage in sexual activity which is high risk for the transmission of disease, e.g., gonorrhea, HIV?	YES	NO
TOTAL SCORE:		

- Some of the answers, due to particular circumstances, may require more than one client/counsellor discussion to obtain.
- It is recommended that all youth clients have a primary care physician.
- The goal of these prompts is to increase counsellor's awareness of clients' medical issues and to encourage referral to a physician, where appropriate.
- The above screen is considered positive if one or more shaded areas are marked.

Name of Client: ____________ Date: ____________

Family Doctor (if known): ____________

Action Taken: ____________

Outcome: ____________

OTHER INFORMATION TO BE GATHERED AT INITIAL CONTACT

Some basic demographic information should be gathered and recorded during the initial contact, including:

- Identifying information, including name, date of birth and social insurance number (if available)
- Current residence
- Emergency health needs
- Emergency contacts
- Safety, imminent danger or risk of future harm, as applicable
- Legal status

COA, 2006

The Screening Process

As discussed in greater detail in the *Core Addictions Training* course, screening is a brief process that is used to help a counsellor determine the probability that a problem exists, substantiate that there is a need for concern, or ascertain that further evaluation is warranted. The screening process also helps determine eligibility and appropriateness for services provided by addiction services. If, based on the initial screening, it appears that the services offered are appropriate, a more comprehensive assessment is then completed in order to formulate a treatment plan.

Anyone who comes in contact with youth, in particular those at high risk, should be trained to screen for addictions issues including child and youth mental health clinicians, youth probation officers, school counsellors, youth workers, shelter workers and those working at youth drop-in centres.

NB: Given the high incidence of mental illness concurrent with substance use in youth, Health Canada (2002) recommends that all individuals seeking help from the mental health system be screened for co-occurring substance use and that all youth seeking services from the addictions system be screened for co-occurring mental illness in order to ensure that youth are welcome wherever and whenever they enter the system and receive timely and seamless access to services. Not screening for both disorders may result in misdiagnosis, over treatment with psychiatric medication, the neglect of appropriate interventions and interference with a client's ability to carry through with the treatment plan. Identifying the problem early and intervening early, increases the chances for positive treatment outcomes which is particularly important for youth with concurrent disorders since they are at even higher risk for poor outcomes such as higher rates of relapse and hospitalization; exacerbated symptoms of mental illness; unstable living arrangements and homelessness; greater depression and suicidality; violence; noncompliance and reduced/exaggerated effects of medication; familial problems; loss of support networks; increased vulnerability to HIV infection; contact with criminal justice system; poor physical health; disruptive motivation; poor self care (Mueser et al., 1997; McDermott and Pyett, 1993; and Lehman and Dixon, 1995; Cuffel 1996; Hegner 1998; Cupitt, Morgan and Chalkley 1999; Lindsay and McDermott 2000; Hall, Lynskey and Teeson 2001).

Screening usually involves an informal interview and perhaps a brief standardized screening tool. The informal interview gives counsellors the opportunity to establish rapport with the youth, and begin to build trust and engage a young person in the treatment process. Using motivational interviewing will help a counsellor gather information in a non-judgmental way and understand the youth's view of their situation.

For more detailed information on the screening process, please refer to the section on Screening in Module IV of the *Core Addictions Practice Participant's Manual*.

FORMAL SCREENING TOOLS

There are a number of formal screening tools that have been developed in the addiction field. Screening tools differ in many ways including what they screen for (only alcohol, alcohol and other drugs, other problematic areas), the timeframe the questions refer to and their complexity. Some screening tools are simple and free and can be used by anyone whereas others must be purchased or require training and have restrictions on who can purchase, administer or interpret the results. Screening tools should only be used as one piece of the screening process and counsellors should only choose the tools they are qualified and trained to administer and that are appropriate for their client (e.g., developed for youth, culturally and developmentally appropriate).

Some common youth screening tools include the Global Appraisal of Individual Needs (GAIN SS), Personal Experience Screening Questionnaire (PESQ), the Substance Abuse Subtle Assessment Inventory (SASSI), the Adolescent Drinking Index (ADI), Teen Addiction Severity Index (T-ASI). The GAIN is a 20 item disorder screener examining the emotional, behavioural and substance use disorders and involvement in crime and violence. The Personal Experience Screening Questionnaire (40 questions) examines adolescent drug use history, problem severity in addition to psychosocial indicators including psychological distress, thinking problems, physical and sexual abuse. The SASSI (80 questions) measures five areas including alcohol, drugs, obvious attributes, subtle attributes and defensivness. The ADI (24 questions) only screens for alcohol use problems. The T-ASI uses a multidimensional approach of assessment as an age-appropriate modification of the Addiction Severity Index and yields ratings in seven domains: chemical (substance) use, school status, employment/support status, family relations, peer/social relationships, legal status and psychiatric status.

SCREENING FOR OTHER ISSUES

CONCURRENT DISORDERS

As previously mentioned, there is a high incidence of mental illness concurrent with substance use in youth. Therefore, all youth seeking services from the addictions system should be screened for mental disorders and vice versa. There are a number of formal screening tools used in the child and youth mental health field. Like screening tools for addictions, screening tools for mental disorders differ in many ways including what they screen for (several disorders, only one type of disorder), whether they are dimensional (measure quantity, degree or frequency of a parameter) or diagnostic (map onto diagnostic criteria of the DSM-IV and indicate whether a psychiatric disorder is likely to be present or absent), the timeframe the questions refer to and their complexity. Some screening tools are simple and can be used by anyone whereas others require training and have restrictions on who can purchase, administer or interpret the results (e.g., only a registered psychologist or psychiatrist).

Screening tools should only be used as one piece of the screening process and clinicians should only choose the tools they are qualified and trained to administer and that are appropriate for their client (e.g., developed for youth, culturally and developmentally appropriate).

Some common youth screening tools for mental disorders include the Mental Status Checklist – Adolescent, the Personal Problems Checklist – Adolescent, Problem Behavior Inventory – Adolescent, Reynolds Adolescent Adjustment Screening Inventory, Brief Symptom Inventory (BSI), Holden Psychological Screening Inventory (HPSI), Mental Status Exam (MSE), Beck Depression Inventory (BDI), Brief Psychiatric Rating Scale for Children (BPRS-C).

NEXT STEPS

In addition to the information gathered in the screening process and where the youth's drug use may lie on the continuum, the decision on what to do next will also be influenced by the youth's:

- level of involvement in substance use
- risk of increased involvement in substance use
- risk of experiencing harmful consequences from substance use
- stage of change
- motivation for change.

(Tupker, 2004)

In consultation with the youth, the counsellor can choose to act in five ways:

- Continue to monitor the young person over time
- Work on drug use prevention which develops attitudes and behaviours incompatible with drug use
- Provide some information and education about the drug use and various risks, general well-being and mental health
- Provide support and assistance to reduce the harmful effects of substance use without requiring abstinence
- Move toward completing a more detailed and comprehensive assessment with the young person

RECOMMENDING A POTENTIAL GOAL & ACTION

Different levels of involvement in the Continuum of Alcohol and Drug Choices and different levels of risk largely determine what the goals and action might be. The following chart outlines these options:

Stage of Substance Use Involvement	Goal	Potential Action
Non-Use	• Prevent initiation of substance use	• Reinforce choice • Education & prevention • Monitor
Experimental	• Enhance motivation for change • Prevent further involvement in substance use • Reverse involvement in substance use • Reduce harm from substance use	• Education & prevention • Harm reduction • Monitor
Occasional	• Enhance motivation for change • Prevent further involvement in substance use • Reverse involvement in substance use • Reduce harm from substance use	• Education & prevention • Harm Reduction • Monitor
Regular	• Enhance motivation for change • Prevent further involvement in substance use • Reverse involvement in substance use • Reduce harm from substance use	• Education & prevention • Harm reduction • Monitor • Assessment
Abuse/Problematic	• Enhance motivation for change • Reverse involvement in substance use • Reduce harm from substance use	• Harm reduction • Assessment • Treatment
Dependent	• Enhance motivation for change • Reverse involvement in substance use • Reduce harm from substance use	• Harm reduction • Assessment • Treatment (possibly including detox)

Adapted from Tupker, 2004

Assessment

If, upon completion of the screening process, it is determined that a youth has developed or is at risk of developing a substance use problem and that the services offered can be tailored to meet the wants and needs of the client, the next step is a comprehensive assessment. Assessments are used "to fit services to the individual based on an ongoing assessment of that person's needs and level of functioning" (Miller, Mee-Lee, Plum and Hubble, 2005). Health Canada (2002) states that assessment "is seen as intimately linking to treatment planning and the delivery of quality services." Two aspects of assessment were identified by Health Canada (2001) as best practices which support the retention of youth in treatment:

- The importance of (early stage) client/treatment matching, which considers and tries to match client readiness with treatment objectives and methods. The "stages of change" model is recommended as a tool to assist with client/ treatment matching
- The importance of making available, both to the client and family, at intake, detailed information about the program, presented in creative and interesting ways

For more information on the purpose and dimensions of a comprehensive assessment, refer to Module IV in the *Core Addictions Practice Guide*.

Depending on the youth's unique situation, a practitioner may be able to complete a comprehensive assessment on their own. Alternatively, collaboration with other service providers, such as those in child and youth mental health, may be necessary.

THE ASSESSMENT PROCESS WITH ADOLESCENTS

There are a number of considerations to be aware of when doing an assessment with adolescents. Keeping these in mind will increase the chances of success in connecting with and working with a youth with alcohol/drug and other issues.

Many adolescents feel uncomfortable talking about their experiences and feelings in groups, at least initially. If your program is a group-based program, it is important to provide sufficient one-to-one opportunities for the adolescent to be able to connect with you and to establish a basis of trust.

It is important to be clear with adolescent clients the limits of consent and confidentiality. Inform them about the situations in which you would be required to break confidentiality (threats of harm to self and others, physical or sexual abuse, and court-ordered disclosures).

Using questionnaires can provide a familiar and structured way of gathering information from the young person, especially from non-verbal adolescents. Questionnaires are sometimes seen as less threatening ways of getting information. One caution: check out the client's reading and writing ability before asking the young person to do a questionnaire on her own. Using computer-based assessment questions can tap into most adolescent's comfort with computer technology.

Besides using questionnaires to gather information, the most important tool with adolescents is to talk with them face-to-face. Between meetings, youth clients can be asked to work on assignments such as daily diaries (written,

pictures, tape) that describe a typical day for them. These tools can provide the adolescent with opportunities to begin reflecting about how their life is going.

Find out who is important in the young person's life and could potentially be supportive to the young person if they choose to make any changes. The youth would need to consent to involving these people, but their input and support in change can be invaluable. The counsellor needs to assess who might be in the supportive category and who might be contributing to the client's problems. If other agencies and counsellors are involved, it is important that they be consulted as part of the process so that a consistent approach to assessment and treatment is attained.

BEFORE STARTING THE ASSESSMENT PROCESS WITH YOUTH

Before beginning the actual assessment, several steps should be taken in order to try and enhance a youth's motivation and engage him/her in the assessment process through the fostering of a client-directed collaborative relationship.

1. **Orientation to the Assessment Process**

   For many adolescents, this may be their first encounter with a process like assessment, so they may have no idea what to expect. The counsellor should introduce him/herself and explain who they are and what they do. The counsellor should let the youth know what work they will be doing together during assessment and what the point of the whole process is, i.e. to gather information about the youth to get a more accurate picture of what is going on not only with the drug use, but with their life, explore what strengths and supports the youth has, what changes the youth might be interested in making, and possible treatment options. The counsellor should let the youth know that their involvement and participation is crucial, and that the counsellor's role is as a guide to the process. The possibility of family involvement in the assessment process and the issue of consent should also be discussed. Information on how long the process will take, and what may come after the assessment is completed should be provided. Any expectations or preconceived ideas the youth might have about assessment or treatment should be explored and the counsellor should respond to any questions or concerns that the adolescent may have.

   In an ideal world, the young person should refrain from using drugs for 12 - 24 hours prior to the appointment in order for the counsellor to get an "un-drug distorted" view of the client. Inability to do so may indicate the need for detoxification prior to the assessment process. The counsellor should also let the client know other expectations they have in working with them; i.e., follow-up on 'no show' appointments, acceptable behaviour, etc.

2. **Checking In with Your Client**

   A first priority for the counsellor is to find out whether there are any crisis issues that are occupying the youth's emotional or physical attention. These issues need to be dealt with before the assessment process can continue. The counsellor should explore what has brought the youth here, i.e., self-referred, coerced, or referred by another agency and how the youth feels about how they came to see the counsellor. The counsellor should empathetically acknowledge the youth's feelings as appropriate, and either discuss with them at that point, or agree to discuss with them at a later, mutually agreeable time. The counsellor should also aim to find out what the youth's current perspective is about drug use generally.

3. **Remember the Principles of Motivational Interviewing**
   Many youth are in the pre-contemplative or contemplative stages of change when arriving for an assessment, so the counsellor should remember to meet the youth where they are at and not try and move too quickly into the assessment. The youth should determine the pace and the counsellor should focus on building a rapport with the client. It is important for the counsellor to remember to "roll with resistance" and avoid getting into arguments with the youth. If the counsellor remains empathic, hopeful and connected with the youth it will strengthen the assessment process.

STANDARDIZED TOOLS

Standardized tools can assist in the assessment process. As with standardized screening tools, assessment tools differ in what they assess and what training or qualifications a person should have in order to administer and interpret them. Standardized assessment tools should be used only as one piece of the assessment process and practitioners should only choose the tools they are qualified and trained to administer or partner with other agencies to conduct this piece of the assessment.

Some common youth assessment tools include the Adolescent Drug Abuse Diagnosis (ADAD), Adverse Consequences of Use, Personal Experience Inventory (PEI), Adolescent Self-Assessment Profile (ASAP), Psychoactive Drug History Questionnaire (DHQ), Teen Addiction Severity Index (T-ASI) and Global Appraisal of Individual Needs (GAIN).

ASSESSING STAGE OF CHANGE

When assessing for stage of change, the question(s) you ask should be:

- Accurate
- Non-leading
- Non-judgmental
- Respectful

To assess stage of change:

- Ask initial question
- Listen carefully and assess
- If necessary, ask follow-up question and reassess

Sample initial questions:

- How do you feel about your [behaviour]?
- What do you think about your [behaviour]?
- How does [behaviour] fit into your life?

Sample follow-up questions:

- So, are you saying that you're thinking of [changing] soon, or not really?
- I'm confused. Are you saying that you're ready to [change], or is this a bad time?

REVIEWING THE ASSESSMENT

The young person's assessment should be reviewed at regular intervals to ensure that the treatment plan is still meeting the needs of the youth and that it takes into account any changing needs and circumstances. Reviews should include the following components:

- Areas of achievement for the young person
- The progress that has been made towards meeting the desired outcomes
- Changes in drug-taking behaviour
- Deterioration or improvements in health
- Compliance with treatment programme
- Change in circumstances, including possible child protection concerns
- Young person's view about the treatment
- New or unmet needs
- Improvements in health, family and social functioning
- Reduction in criminal behaviour
- Improvements in self-esteem and motivation
- Movement towards employability

(EIU 2004)

ADDITIONAL RESOURCES

Additional resources on screening and assessment standardized tools:

AADAC (2004). A review of addictions related screening and assessment tools: Measuring the Measurements.
http://www.aadac.com/documents/review_of_assessments.pdf

Substance Use Screening and Assessment Instruments Database.
http://lib.abai.washington.edu/instrumentsearch.htm

Treatment Planning

Once the assessment is complete, the counsellor and the client will have a more complete picture of the adolescent's drug use and what their issues and strengths are in all areas of their life. The counsellor and client will also be able to identify which areas are priority and require immediate attention and which areas can wait. The next step is the development of a highly individualized service delivery plan, "a written summary, or a snapshot, of the alliance between a client and therapist (or treatment system) at any given point in time" (Miller, Mee-Lee, Plum and Hubble, 2005) as discussed in Module IV of the *Core Addictions Practice Training Guide*. Some clients will see their lives and their problems in a different light, and begin thinking about different ways of doing and being. The counsellor's role is to provide feedback based on the data gathered and observations of the client, and to help the

adolescent make connections between what is going on for them, and the role which drugs may be playing. The adolescent can be asked to rank the various problems (drug and life) in terms of urgency. Preliminary goals for change and treatment can then be developed. Sometimes adolescents find it hard to talk about what their goals for change might be. Questions to guide their thinking can help: How would they like to be, to see themselves or to feel in a month or a few months? How would they be in their ideal world? Often these pictures don't involve alcohol or drug use, and can help the client see beyond their current situation and reality.

The most relevant resources available are matched to the needs of the youth. In some areas, this may mean a referral to other sources of help, or it may mean the original counsellor continues this function themselves. All services within the addictions continuum of care should be considered as well as those in other systems of care as applicable and shared goals need to be collaboratively developed, as discussed in Module IV of the *Core Addictions Practice Training Guide*. Treatment interventions fall along a continuum that ranges from minimal outpatient contact to long-term residential treatment and services should be matched to the needs of the youth.

However, as discussed in *Substance Abuse in Canada: Youth in Focus*:

> Addressing youth substance abuse presents many challenges. There are few standards and little evidence underpinning some prevention and treatment services. Program evaluations are rare, staff training is often inadequate, and there is a lack of knowledge and guidance when it comes to choosing prevention and treatment programs. These limitations contribute to discrepancies in the quality of services delivered to youth, and delivery of ineffective services wastes resources and fails to achieve our prevention and treatment goals. (CCSA, 2007).

Therefore, addictions practitioners need to be aware not only of the services within the addictions continuum of care so that they can match the intensity and length of service to the needs of the youth, but also be aware and supportive of the important role that accreditation and program evaluation can play in the development of effective treatment programs.

Treatment Principles and Values

The following are 15 philosophical principles that have been identified as underlying successful youth treatment:

1) Treatment planning and delivery should be highly individualized, client-centred and client-directed. Tools like the "stages of change" model and motivational interviewing support this approach.

2) While there is sometimes a struggle between the "harm reduction" and abstinence models, the harm reduction approach is most effective with and responsive to youth needs and stage of life. Teaching youth to "keep themselves safe" is the "cornerstone" of this approach. In addition, while abstinence is still a useful goal, most youth are unwilling to change their lives fundamentally; therefore, long-term abstinence is likely to be unrealistic. Even when abstinence is a goal, harm minimization strategies are required.

3) Treatment should offer and be based on choice. A multi-dimensional, eclectic model is preferable to one which is based on a uni-dimensional treatment approach.

4) Treatment should be holistic and comprehensive – addressing a variety of problems with a range of strategies.

5) Treatment is a process, not a series of events.

6) Treatment should consider youth within a system – of family, peers, community, and others (school teachers, counsellors, and correctional staff).

7) The climate of treatment should be caring, respectful, safe and open.

8) Wherever feasible, families should play an important part in treatment. If there is no current "stable" family, a family of "significant" adults should be created.

9) Treatment needs to consider the youths' spiritual, mental, emotional, and physical self and needs. Treatment should be based on the developmental stages and needs of the youth.

10) Programs should espouse the principle of "least intrusive treatment" as a first option (based on appropriate assessment and treatment matching).

11) Staff must respect and value youth in treatment, trusting in their basic motivation and value.

12) Wherever possible, learning should be experiential and be conducted in a variety of venues.

13) Treatment should focus on positives, not deficits in the youth's life. The "Resiliency Model" is a useful approach.

14) Treatment should focus on the building of specific skills, which enhance self-esteem.

15) Treatment should be appropriate for youth. Youth needs and experiences differ fundamentally from those of adults. An adult-oriented approach to treatment should be avoided.

(Health Canada, 2001)

Program Philosophy and Approach

Health Canada (2001) found that an understanding/acceptance of relapse and a focus on harm reduction are the optimal approaches to support youth retention in treatment. This approach includes these common elements:

- Acceptance of youth relapse as an inevitable part of recovery;
- Consideration of relapse not as a failure but as an opportunity to learn about substance use triggers and ways of reducing use;
- A need to focus on client life goals and the impact of substance use on these rather than primarily focusing on substance use;
- The development of a long-term supportive client – staff relationship which accepts and explores relapse;
- The presence of program strategies to support youth re-engagement in treatment, if and when relapse has occurred.

(Health Canada, 2001)

In addition, having a client directed, flexible approach where the youth is involved in goal setting and treatment

planning is also important.

Informed Consent and Confidentiality

INFORMED CONSENT

Obtaining informed consent is a critical first step in the counselling relationship.

The *Infants Act* provides the authority for youth to act on their own to provide informed consent to treatment without a parent or guardian's knowledge or approval. Youth are considered to be capable of making decisions to accept or refuse treatment on their own behalf and in their own best interests subject to certain qualifications. The Infants Act does not specify a minimum age at which youth can make decisions for themselves but does define criteria that must be satisfied in order for youth to consent to treatment without parental/guardian involvement. According to section 17(3) of the *Infants Act*, the service provider must explain to the youth and be satisfied that the youth understands the nature and consequences and the reasonably foreseeable benefits and risks of the treatment plan. The service provider must also make reasonable efforts to determine and has concluded that the treatment plan is in the youth's best interests.

As with adults, youth who present to health authority addiction services are considered to have granted implied consent for the purposes of seeking information and/or services pertaining to screening, assessment and referral. Once a treatment plan is negotiated, however, informed written consent is required.

Service providers should invite the youth to discuss the treatment plan with parents/guardians or seek the youth's consent to invite the parents into the treatment process if appropriate. If the youth refuses, the service provider should proceed to obtain informed consent from the youth without further reference to including parents/guardians in that process. Service providers should document their efforts to include parents/guardians and the youth's refusal in the youth's client file.

Once the criteria for informed consent has been met, service providers will obtain the youth's written consent to treatment and will place the consent on the youth's client file, along with notes detailing the process of establishing consent.

CONFIDENTIALITY

Information that a youth tells you about themselves, family members or other people, or even the fact that they are a client, cannot be shared with others without permission of the client or by court order. Permission from the client should be in the form of written consent, which specifies to whom the information can be released, what information can be released, and what the time limits are. A few exceptions to the rules of confidentiality exist, where information may be disclosed without the client's consent. It is important that these exceptions be explained to the client early so they can choose what information they wish to disclose. Exceptions to confidentiality include:

- Reason to believe that someone under the age of 19 years old may need protection from abuse (Child, Family

and Community Service Act, Section 14: Duty to Report);

- Youth expresses intention to harm himself/herself or someone else – Duty to Inform;
- Youth appears unfit to operate a motor vehicle;
- Service provider's records are subpoenaed by the courts;
- Statutes requiring disclosure:
    - Child, Family and Community Service Act
    - Coroners Act
    - Freedom of Information Act
    - Protection of Privacy Act
    - Health Act Communicable Disease Regulation
    - Medical Practitioners Act
    - Workers Compensation Act
    - Valid subpoena, court order or search warrant

Role of Family

The active involvement of the family in treatment of youth experiencing substance use problems has been identified as a best practice, with the engagement of even one family member (e.g., sibling, parent) considered crucial (Health Canada 2001). Families can be a powerful source of strength and information. Families may also need information and support in dealing with their family member's substance use and family counselling may be one component of the youth's treatment plan (Tupker, 2004).

However, there are some situations where family involvement may not be a good idea (e.g. youth has been victimized by a family member). Therefore, it is important to recognize the highly influential role that family's play in an adolescent's life but be sure that involving the family in the youth's treatment is in the best interests of the youth and make this determination only after a thorough family assessment is completed. For more information on working with families, see Module V.

Case Management

Case management is an ongoing role and requires a commitment to be involved with the adolescent and their family, however long that process takes. The case manager maintains contact with the youth and family while he/she is in active treatment and is involved in aftercare planning with the client and any services the client has been involved in.

Case management is critical to working successfully with adolescents and families. They are often reluctant to enter into treatment and counselling in the first place. The case manager plays a vital, ongoing role in seeing the whole picture from start to finish, and helping to motivate the client during the ups and downs that may accompany his/

her treatment process. The case manager does follow-up with the clients on missed appointments or when the clients drop out of treatment to attempt to re-engage and motivate them to try again. The case manager helps the adolescent and family look at other options when the initial plans made don't work out. When there are other professionals involved, the case manager coordinates the plan with them, ensuring that information is exchanged as needed (with the client's consent).

For further information on case management, please refer to Module IV in the *Core Addictions Practice Guide.*

Required Support Services

Successful youth treatment is holistic, eclectic and comprised of a range of associated services. Most critical adjunctive services are:

- Specialized mental health services and connections with clinical therapists and child psychiatrists;
- Health services (to address general physical health issues);
- Education services (full range of educational services and support from school support to home study or tutoring);
- Housing support services to provide safe and secure housing for street-involved youth;
- Recreational services to support skill building;
- Services directly applicable to First Nations and Inuit youth to teach and address language issues, and to facilitate culturally supportive practices and linkages (e.g. spiritual and traditional practices);
- Employment and apprenticeship training.

Health Canada, 2001

A wide variety of services for youth are available in the wider youth system of care. The following is a brief description of some of these services:

CHILD AND YOUTH MENTAL HEALTH

Through the Ministry of Children and Family Development (MCFD), Child and Youth Mental Health (CYMH) provides a wide range of community-based specialized mental health services to mentally ill children, youth and their families and those at risk of or vulnerable to mental illness. Some services are provided by ministry staff, and others are provided by community agencies contracted with the province. Services are for children and youth under the age of 19 on a voluntary basis. Referrals can be made to CYMH by the child or youth themselves, and individuals who are directly involved with the child and youth, such as family members and other agencies or service providers. CYMH staff typically include psychologists, social workers, counsellors with masters degrees and nurses. Services include assessment and planning, treatment, management of community issues and consultation with individuals involved with the client, if the youth gives informed consent to share the information.

Some residential and outreach assessment and treatment options for children and youth with mental illness are

available at the Maples Adolescent Treatment Centre. The Maples provides programs and services to address the needs of youth aged 12 to 17 with significant psychiatric and behavioural problems. All programs and services are holistic in their approach and include participation of the family or alternate caregivers as well as the professionals in their home community. In most programs, both residential and non-residential options are available. These programs provide a period of stabilization and intensive intervention followed by support for families/caregivers to implement a long-term community-based care plan. The programs and services are staffed with a multidisciplinary team of social workers, psychiatrists, psychologists, nurses and child and youth counsellors.

For youth who have become involved with the law, Youth Forensic Psychiatric Services provides a similar range of services (see below).

For more information on CYMH services, see
http://www.mcf.gov.bc.ca/mental_health/pdf/cymh_youth_brochure.pdf
http://www.mcf.gov.bc.ca/mental_health/pdf/what_to_expect_cymh.pdf

CHILD WELFARE

The Ministry of Children and Family Development (MCFD) "promotes and develops the capacity of families and communities to care for and protect vulnerable children and youth, and supports healthy child and family development to maximize the potential of every child in British Columbia" (MCFD Service Plan 2008/09-2010/11). Among many other duties, MCFD has the lead responsibility for responding to suspected child abuse and neglect. Child welfare workers are employed by the Ministry of Children and Family Development (MCFD) or by a Delegated Aboriginal Child and Family Services Agency. Child welfare workers have the authority, under the *Child, Family and Community Service Act* (CFCSA), to help when children and youth are at risk, including responses to suspected child abuse and neglect. The CFCSA is the law in British Columbia that protects children from abuse and neglect in their home. Child welfare workers provide a range of services to families, including child protection, to keep children safe. Child welfare workers often work in partnership with police and people in the justice, health and education systems and other agencies that provide services to children and families.

The CFCSA emphasizes the importance of preserving the cultural identity of Aboriginal children and having Aboriginal people involved in the planning and delivery of services to Aboriginal children and families. In many communities in British Columbia, Delegated Aboriginal Child and Family Services Agencies have been established under formal agreements between MCFD and the Aboriginal community to enable the agency to operate with delegated authority under the CFCSA to provide child welfare services that are culturally-appropriate.

For an up-to-date list of Delegated Aboriginal Child and Family Services Agencies, including contact information and the services they are delegated to provide, go to: www.mcf.gov.bc.ca/about_us/aboriginal/delegated/pdf/agency_list.pdf

Under B.C. law, anyone who has reason to believe a child has been, or is likely to be, abused or neglected has a legal duty to report that concern to a child welfare worker.

For more information on your role and responsibilities as a service provider in helping keep children and youth

safe from neglect and abuse, see *The B.C. Handbook for Action on Child Abuse and Neglect for Service Providers* available at:
http://www.mcf.gov.bc.ca/child_protection/pdf/handbook_action_child_abuse.pdf

YOUTH JUSTICE

MCFD also provides support and services for young people involved in the youth justice system through the provision of community youth justice and youth custody services. The youth justice system in BC deals with youth aged 13 to 17 who have committed various offences. Youth justice services are guided by the federal *Youth Criminal Justice Act*, the *Criminal Code of Canada*, the *Youth Justice Act of BC*, and the *Canadian Charter of Rights and Freedoms*.

In the community, youth involved with the justice system are supervised by probation officers who work in multi-disciplinary teams in various communities across BC. Youth probation officers are officers of the court who supervise youth subject to court orders and agreements. Youth probation officers can refer youth to specific services in the community which are intended to facilitate rehabilitation, healthy growth and pro-social development. These services can include day programs, intensive support and supervision programs, specialized residential programs, community service work, alcohol and drug programs, full and part-time wilderness challenge programs and youth forensic psychiatric services.

Youth can also be ordered by the court to serve a period of time in open or secure custody or be detained in custody pending further courts appearances. There are legally designated facilities to house young offenders in BC: Victoria Youth Custody Services, Burnaby Youth Custody Services and Prince George Youth Custody Services. While in custody, each youth is assigned a probation officer and case manager to work with him/her but the primary responsibility for case management remains with the assigned community probation officer which continues throughout the custody period. While in custody, programs such as education, substance abuse management, life-skills, and anger management are available as well as specialized services for Aboriginal youth, female youth, violent offenders and youth requiring mental health services or alcohol and drug counselling. Reintegration programs are also available to support a youth's return to the community.

YOUTH FORENSIC PSYCHIATRIC SERVICES

Under MCFD, Youth Forensic Psychiatric Services (YFPS) is a provincial program that provides court-ordered and court-related assessment and treatment services for youth in conflict with the law or found unfit to stand trial or not criminally responsible due to a mental disorder. Services are mandated under the authority of the *Youth Criminal Justice Act*, the *Criminal Code of Canada*, the *Mental Health Act (BC)* and other provincial legislation.

Clinical Services are provided either through inpatient or outpatient services through clinics and a network of private contractors around the province. Inpatient services are provided at the Burnaby Inpatient Assessment Unit (IAU) which is a designated mental health facility under the *Mental Health Act* and is a designated place of temporary custody. Services provided include psychiatric and/or psychological assessments of youth remanded into custody by the courts, short-term transitional care and custody for youth not found criminally responsible by reason

of mental disorder and mental health services to youth remanded or to the youth custody centres. Outpatient services provide court-ordered assessments of youth residing in the community, assessments or consultations of youth referred by their probation officer, general and specialized mental health services, and specialized outpatient programs dealing with sexual and violent offences.

YOUTH SERVICES

A wide range of other services are provided by MCFD under "Youth Services" which include services to help young people and their families when they are having difficulties; youth are sexually exploited; youth who have an addiction to drugs or alcohol; youth who are living on the street; youth who have mental health problems; and youth who may have a combination of issues. Youth workers can support youth to access youth agreements, which are a legal agreement between the youth and MCFD to have access to supports and services that will support the youth to live independently. Youth agreements are for youth at risk between the ages of 16 – 18, have no parent or other person willing to take responsibility for them and they cannot return home to their family for reasons of safety. Youth outreach/support workers work with street youth to establish safer lifestyles or encourage those children and youth who are new to the street to reconnect with their families and communities. Workers also address immediate needs, such as food, clothing and shelter, provide short-term crisis support and provide linkages to community services and resources. Safe housing and emergency shelter services for street youth and sexually exploited youth wanting to leave the street are also provided under Youth Services. Youth services also provide parent-teen mediation to mediate and resolve conflicts within the family. The goals of this program are to keep families together or support them to solve problems on their own as well as keep teens out of foster homes.

YOUTH IN CARE ORGANIZATIONS AND SUPPORT GROUPS

The Youth in Care Network provides formal and informal support to youth currently in care or who were formerly in care. The Youth in Care Network also offers experiential viewpoints to increase the awareness of the needs of youth in and from government care on subjects like sexual exploitation, learning difficulties, physical, sexual and emotional abuse, family violence, substance abuse and emotional and behavioural difficulties.

For more information on the Youth in Care Network see:
http://www.youthincare.ca/

YOUTH SERVICES IN COMMUNITY AGENCIES

In most communities there are various other services usually found at community agencies like drop in centres, mentorship, groups for various issues (anger management, parent teen conflict etc.) that youth can access without being involved with MCFD.

HEALTH AUTHORITIES

Regional health authorities also provide many services for youth including public health which provides free and confidential clinics for testing, counselling and education for sexual health (birth control, pregnancy, STD/STIs), nutrition programs, smoking cessation programs, HIV/AIDS focused services, and parenting groups.

Though some variation exists across regions, Health authorities also provide a variety of for youth who are in crisis and/or dealing with an acute psychiatric illness. The Adolescent Crisis Response Program (ACR) serves youth who are in an acute crisis state by providing assessment, short term crisis intervention and short term resource coordination and referral. Adolescent Day Treatment programs provide a wide range of individualized mental health services and educational programming for youth with acute psychiatric illness. Adolescent Psychiatric Units provide assessment, stabilization and initial treatment. The Early Psychosis Intervention (EPI) program is a community based program that links with hospital psychiatry. The EPI program provides a full range of clinical service to adolescents and adults who have recently developed psychosis, and their families as well as providing education to a wide variety of people.

Individualized Service Delivery Plan

As discussed in more detail in the *Core Addictions Practice Participant's Guide*, after the assessment is complete, developing a highly individualized service delivery plan is a key procedure involved in operationalizing client-directed, outcome-informed work. Though it is important to continually review and modify the treatment and service plan with adults, when working with youth it is even more important. Given the possible higher risk and more fluid circumstances surrounding their lives, young people may need to be reviewed more often than adults.

Relapse Prevention

As discussed in the *Core Addictions Practice Guide*, relapse is a common part of the change process of which both the counsellor and client need to be aware. Relapse occurs when, having made progress to later stages of change, the individual resumes old thought patterns and behaviours associated with the problem. Health Canada (2001) found that an understanding/acceptance of relapse was one of the optimal approaches to support youth retention in treatment.

Since relapse is such a common part of the change process, relapse prevention and management is seen as an integral part of treatment. Relapse prevention "is a treatment intervention designed to teach clients a wide range of cognitive and behavioural coping skills to avoid or deal with a brief return to substance use (lapse) or a protracted return to previous levels of use (relapse), following a period of moderation or abstinence" (CCSA, 2007). Six elements of best practice supporting relapse management or prevention with youth were identified:

- A philosophical approach which perceives relapse not as a failure but as likely to occur and an opportunity for client growth and change;
- The development (with the client) of a treatment plan and a set of personal goals, small, short term achievable goals which are visible to the client and which support feelings of success;
- A focus on identifying triggers to substance use and on teaching specific and concrete skills to handle use at

critical times (i.e., what are high-risk situations, triggers, avoidance strategies, environmental supports and plans to handle risk situations)

- The exploration of other issues related to relapse (e.g., handling of stress)
- The development of a system of post-treatment aftercare and program contact. Contact may be required for up to one year or longer in some cases;
- The development of connections for youth in the community (counselling support, recreational and other resources) which can serve as supports and skill building opportunities after treatment has ended.

(Health Canada, 2001)

Coping strategies for relapse prevention and management are discussed in the *Core Addictions Practice Guide.* Relapse prevention services are usually provided by youth addictions practitioners and typically not allied professionals. However, allied professionals can play a supportive role in implementing the relapse prevention plan and assist the youth with their treatment goals (CCSA, 2007).

MODULE V

Specific Treatment Considerations

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Module V: Specific Treatment Considerations

Youth and Mental Health

As previously discussed, experimentation with alcohol and other drugs is common in adolescence, with most youth not progressing to problem use or dependence. However, adolescence is also a period of major risk for the onset of major psychiatric illnesses and research has shown that for those youth who do develop a substance use problem, it is common to also find a mental health problem (CAMH 2002).

Problematic substance use impacts directly and indirectly on the mental health of individuals who use them. Youth experiencing a combination of both substance use and mental health problems are said to be dealing with "concurrent disorders." Concurrent disorders are not a single condition – they include an array of addiction and mental health problems that vary in their cause, symptoms and the effect they have on people's lives.

Youth have been identified as one group that is particularly vulnerable to experiencing concurrent disorders, with those aged 15 to 24 more likely to be affected than any other group. Adolescents with a substance use problem are about three times as likely to have a concurrent mental health concern as youth without a substance use problem. What came first – the substance use problem or the mental health concern – varies and may be difficult to determine. The two are often intertwined and related. It can be very difficult to separate out the symptoms into those caused by mental health problems and those related to substance use.

A 2002 analysis of mental illness prevalence studies concluded that 15% or around 150,000 children and youth in BC, "experience mental disorders causing significant distress and impairing their functioning at home, at school, with peers or in the community" (BC Partners for Mental Health and Addictions Information 2003).

As discussed in the *Core Addictions Practice Participant's Guide*, it is not an expectation that all addictions practitioners be experts in the area of mental health or that they be able to diagnose mental disorders. However, given the high prevalence rate of substance use and concurrent mental health issues, addictions practitioners need to have enough knowledge and training in this area to be able to screen for mental disorders, recognize the general signs or symptoms indicating that a youth may have a substance use problem and/or a mental health concern so that so that appropriate referrals to the mental health system can be made and/or work effectively with individuals with mental health concerns.

COMMON MENTAL HEALTH DISORDERS IN CHILDREN AND YOUTH

The most common mental health disorders in children and youth are anxiety, conduct, attention-deficit, and depressive disorders (BC Partners for Mental Health and Addictions Information 2003).

Mental Health and Mental Disorders Among Canadian Children		
Disorder	**Prevalence (%)**	**Approximate Number in BC**
Any anxiety disorder	6.5	60,900
Conduct disorder	3.3	30,900
Attention-deficit/hyperactivity disorder	3.3	30,900
Any depressive disorder	2.1	19,700
Substance abuse	0.8	7,500
Pervasive development disorder	0.3	2,800
Obsessive-compulsive disorder	0.2	1,900
Schizophrenia	0.1	900
Tourette's disorder	0.1	900
Any eating disorder	0.1	900
Bipolar disorder	<0.1	<900
Any disorder	15	140,500

The approximate number who may be affected is based on a population of 936,500 children and youth in BC (MCFD, 2002)

Source: Mental Health Evaluation and Community Consultation Unit

ANXIETY

Youth with anxiety problems or disorders – at least five percent of whom have significant problems such as panic disorder, generalized anxiety, obsessive-compulsive or post-traumatic stress disorder, social phobia or other phobias or disabling fears – can have varying reactions and social consequences from upset and worry to anger, uncooperative behaviour and even aggression. Left unmanaged, anxiety in young people can worsen and lead to development of other problems such as depression (BC Partners for Mental Health and Addictions Information 2003). Anxiety manifests as school avoidance behaviours, poor self-image, and social isolation.

For more information on anxiety, see:
http://www.mcf.gov.bc.ca/mental_health/mh_publications/Parent_Info_Bro_BC_Anxiety.pdf

Anxiety and Drug Use

When a young person tries alcohol or other drugs the anxiety reducing effect of the substance can promote ongoing use. Youth who self medicate can appear to be functioning reasonable well but as tolerance develops the effects of the drugs diminish and anxiety can be exacerbated. Excessive caffeine or stimulant use by a person with anxiety disorder can mimic symptoms of anxiety and increase insomnia. (Tupker 2004) Youth with a history of anxiety or depressive disorder may be at twice the risk for later drug abuse (Milin, 2006).

DEPRESSION

Depression and suicide are among the most talked about youth mental health issues. In Statistics Canada's 2000/2001 Community Health Survey, 32,000 or about 8% of young people in BC aged 12 to 19 disclosed symptoms consistent with major depression. About 20% of young people admit having considered suicide in the past year, with fewer than 10% having attempted it. Being bullied at school increases the suicide risk about three-fold. That risk drops the more connected the youth is to their school.

Young people with depression are much more likely than other children to have low self-esteem, problems in school, physical ailments, and substance use disorders (BC Partners for Mental Health and Addictions Information 2003). Depression manifests as irritable moods, physical complaints, insomnia, decreased academic functioning, decreased social activities and antisocial behaviour. Rates of depression are especially high among Canadian youth. A nationwide survey conducted by the Canadian Mental Health Association and the Canadian Psychiatric Association found that more than 40% of young people aged 18 to 24 years felt "really depressed" once a month or more (BC Partners for Mental Health and Addictions Information 2003).

For further information on mood disorders, see:
http://www.mcf.gov.bc.ca/mental_health/mh_publications/Parent_Info_Bro_BC_Mood.pdf
http://www.mcf.gov.bc.ca/mental_health/pdf/dwd_printable.pdf

Depression and Drug Use

Researchers have found a strong association between major depression and problematic substance use. It has been found that adolescents and young adults who have a depressive or anxiety problem had double the risk of subsequent problematic substance use. There is a strong entwined relationship between substance use and depression. This relationship has a variety of components:

- It is common for people experiencing depressive symptoms to self-medicate with the use of drugs or alcohol.
- There are certain drugs that by their very nature can create symptoms of depression. Alcohol for example is a central nervous system depressant.
- Depressive symptoms are also common when people are in withdrawal from substance use.
- The other area of interaction between drug use and depression can occur when a person stops using drugs or alcohol completely. Following the acute withdrawal period, there occurs a post-acute withdrawal period, which typically lasts from 6 months to two years, depending on the substance use history and the person's stress level. During this time, the brain is repairing itself from the damage of alcohol or drug use, and oftentimes, symptoms of depression are experienced.

BC Partners for Mental Health and Addictions Information, 2003.

Individuals with onset of alcohol abuse in their adolescence have been found to be 3x more likely to be depressed and 4x more likely to attempt suicide vs. later onset of alcohol abuse and earlier drug use is associated with an increased risk for later depression, alcohol dependence and other SUDs (Milin, 2006). In addition, frequent cannabis use in adolescence increases the risk of depression and anxiety, especially in young women (Milin, 2006).

CONDUCT AND ATTENTION DEFICIT DISORDERS

Conduct and attention deficit disorders, which may include hyperactivity, reduce a youth's ability to direct and control his or her attention. Left untreated, these illnesses can interfere with the learning process and make it difficult for a youth to live in harmony with family and friends (BC Partners for Mental Health and Addictions Information 2003). Conduct disorder shows itself as antisocial behaviours, such as illegal activities and disregard for other people's rights.

For more information on behaviour and attention disorders, see:
http://www.mcf.gov.bc.ca/mental_health/mh_publications/Parent_Info_Bro_BC_Behaviour.pdf
http://www.mcf.gov.bc.ca/mental_health/mh_publications/Parent_Info_Bro_BC_Attention.pdf

Conduct and Attention Deficit Disorders and Substance Use

Youth with conduct and attention deficit disorders are often risk takers and may use multiple substances to enjoy the excitement and rush. ADHD is a significant risk factor for substance use problems. Research suggests that many young people with ADHD use substances to feel better about themselves and to alter their mood in an effort to cope. However, ADHD children had an earlier onset of substance use disorders and more rapid progression of substance use disorders than normal controls (Milin, 2006). Early conduct problems are a strong predictor of substance abuse in those whose substance abuse began in early adolescence and the greater the number of conduct symptoms, the earlier the age of initiation of use and the greater the likelihood of substance abuse (Milin, 2006). Conduct disorder for the most part precedes the substance abuse and appears to be a significant risk factor for early adolescent onset substance abuse and adolescent females with conduct disorder progress more rapidly to alcohol or cannabis abuse/dependence following first use than their male counterparts (Milin, 2006).

EATING DISORDERS

Eating disorders are characterized by severe disturbances in eating behaviours coupled with distortions in the perception of body shape and weight. Eating disorders usually have their onset in adolescence and therefore can have a profound impact on development. The two most common types of eating disorders are anorexia nervosa (individuals are not able to maintain body weight at or above normal weight, intense fear of gaining weight or become fat, even though underweight) and bulimia nervosa (recurrent episodes of binge eating followed by recurrent compensatory behaviour to prevent weight gain, such as self-induced vomiting, misuse of laxatives, fasting, excessive exercise).

Eating Disorders and Substance Use

The likelihood of developing a concurrent substance use problem increases by 12 to 18% among people with anorexia and 30 to 70% among people with bulimia (CAMH, 2002). Youth with eating disorders often use substances such as nicotine or stimulants, to suppress their appetite (Tupker, 2004).

PSYCHOSIS

Psychosis is a serious condition that often strikes young people, and often goes undetected for months and even years. It's characterized by symptoms such as hallucinations, delusions, paranoia, social withdrawal and at its most extreme, loss of contact with reality. The symptoms of psychosis may be related to ongoing illnesses such as schizophrenia, schizoaffective disorder, and some forms of unipolar or bipolar affective disorder. Since early detection of psychosis is associated with a better chance of recovery, it's important to intervene as soon as possible (BC Partners for Mental Health and Addictions Information 2003).

For more information on psychosis, refer to Module V in the *Core Addictions Practice Participant's Guide* or see: http://www.mcf.gov.bc.ca/mental_health/mh_publications/a_care_guide.pdf

Psychosis and Substance Use

The risks associated with drug use are even greater for people who have experienced psychosis. Substance use often precedes the psychotic disorder and imparts a more debilitating course of psychotic illness (Milin, 2006). Psychosis can be induced by drugs or can be "drug assisted." Increasing research evidence has shown that marijuana use can trigger and worsen psychosis in young people who are vulnerable to psychosis and may even cause psychotic illnesses in people who would not otherwise suffer from them (BC Partners for Mental Health and Addictions Information, 2006). Research has also shown that crystal meth can cause psychosis on it's own if used heavily or by someone who has some other risk factors for psychosis. Often, the onset of psychosis occurs gradually with continued crystal meth use but sometimes it can occur suddenly even with very little use. The psychosis may continue on even after the youth has stopped using crystal meth (EPI, 2006).

For more information on Psychosis and Drug Use, refer to Module V in the *Core Addictions Practice Participant's Guide*.

POST TRAUMATIC STRESS DISORDER

Post traumatic Stress Disorder (PTSD) is an anxiety disorder that can develop after exposure to one or more terrifying events in which grave physical harm occurred or was threatened. It is a severe and ongoing emotional reaction to an extreme psychological trauma and is characterized by persistent frightening thoughts and memories of the ordeal. PTSD can manifest through such symptoms as anxiety, depression, self-harming, a preoccupation

with death, suicidal thoughts or gestures and flashbacks. Having been sexually or physically abused increases the incidence of posttraumatic stress in young people (CAMH, 2002).

Post Traumatic Stress Disorder and Substance Use
People experiencing PTSD often use alcohol and other drugs to help numb painful emotions and deal with anger (CAMH, 2002).

WHY FOCUS ON YOUTH WITH CONCURRENT DISORDERS

Any combination of substance use and mental health problems can cause other problems. Youth experiencing concurrent disorders also:

- Have higher rates of hospitalization
- Have increased hallucinations, depressive symptoms and suicidal ideation
- Have higher rates of relapse
- Have reduced compliance with treatment
- Have reduced/exaggerated effects of medication
- Are more stigmatized
- Experience unstable living arrangements and homelessness
- Have poor problem solving skills
- Have more familial problems
- Are socially isolated (loss of support networks)
- Lack educational qualifications
- Are at higher risk for HIV infection and other blood borne viruses
- Increased contact with criminal justice system
- Have poorer physical health
- Fail to develop appropriate social skills
- Disrupted motivation
- Disruptive behaviour and violence
- Poor self care

Source: McDermott and Pyett, 1993; Lehman and Dixon, 1995; Cuffel, 1996; Hegner, 1998; Cupitt, Morgan & Chalkley, 1999; Lindsay & McDermott, 2000; Hall, Lynskey & Teeson, 2001

RECOVERY

As discussed in the *Core Addictions Practice Participant's Guide*, the recovery concept in the mental health field offers clients with mental disorders hope and optimism for the future. This is especially important when working with youth as a diagnosis itself can cause serious problems due to the stigma associated with mental illness. A

recovery focus and fits well with Miller and Duncan's client directed outcome informed approach in that the focus is on supporting the youth to develop the skills and access the resources they need to increase their capacity to live a life that they choose and improve their quality of life. It is important to emphasize with the youth that recovery can occur even though symptoms may reoccur.

Working with Families

Note: For the purposes of this section, family is defined as relatives and/or significant others with whom the youth has a significant ongoing relationship.

As discussed in Module I, a youth's family can influence risk and protective factors, which decrease or increase the likelihood that the young person will develop problems with substance use. For example, a youth who feels emotionally supported in his/her family and has clear boundaries and expectations set by his/her parents is less likely to develop problems with substance use than a youth who is a member of a family where there is a lack of communication or respect between family members and a lack of supervision. Drug use by family members also increases the chances of other family members becoming involved with drugs (Victoria Government Department of Human Services 2000). For youth who develop problematic substance use, often "families may either contribute to the development of adolescent problems or simply not respond adequately to interrupting them. Problems may arise from long-standing family issues, disturbed family function, or difficulty in negotiating the transition of a family member into young adulthood" (Snyder, as quoted in Victoria Government Department of Human Services, 2000).

There is consensus in the literature that actively involving at least one family member in treatment with youth is critical (Health Canada, 2001). In reviewing evidence based literature on working with families, CAMH (2004) found that "research demonstrates that involving families hastens client recovery from mental illness and addiction, lowers the risk of mortality, reduces reliance on health care services, reduces the rate of rehospitalization and relapse, enhances medication compliance and bolsters client interpersonal functioning and family relationships."

REASONS FOR INCLUDING FAMILIES IN TREATMENT

Several convincing reasons have been given for including families in treatment. First, family is likely the most familiar with the youth and can provide intimate, pertinent information that may be important to treatment. The National Center for Mental Health and Juvenile Justice (NCMHJJ) lists the following key areas in which the family can provide essential information:

- The youth's strengths and needs
- The family's capacity to participate in treatment
- Circumstances that affect the youth's well-being
- The youth's treatment history, any diagnoses, including use of medication
- Youth's education history and status
- Ongoing support services in the community
- Family history and context

(as quoted in Brock, Burrell, and Tulipano, 2006)

Secondly, the family is usually a large influence in the environment in which the youth lives. If no changes in the youth's environment are made, a youth is more likely to relapse into old patterns of thinking and behaviour. Working with the family to create as healthy an environment as possible and minimize negative coping behaviours can have a significant influence on a youth's success during/after treatment when the youth may return home to the family environment A youth's involvement with his/her family will likely continue long after treatment with a service provider is completed.

Third, a youth's problematic substance use often creates a great amount of stress and pressure within the family unit and families, both individually and as a family system, resulting in a need to support families to deal with the many negative feelings and emotions that the youth's substance use may have created.

Lastly, for youth who are still pre-contemplative or contemplative about their drug use, supporting the family can be an effective strategy to supporting the youth.

According to the Australian Drug Foundation (2003), family intervention can help both families and their individual members to:

- Deal with alcohol and drug use issues as a family
- Improve the family's awareness and knowledge of the nature and effects of different illicit substances
- Reduce drug-related harms
- Encourage and support individuals through drug treatment programs
- Improve communication and conflict resolution skills within the family
- Prevent younger or non-using siblings in the family from taking up drug use.

PHILOSOPHIES FOR WORKING WITH FAMILIES

With the goal of strengthening the supports it offers to family members of persons with substance use and/or mental health concerns, CAMH (2004) produced a report on involving families in client care and supporting them more generally after reviewing evidence-based best practices in this area. Two main philosophies for working with families were found:

- Family Focused Care – centered on meeting clients' needs within the context of the family
- Family-Centered Care – focuses on meeting the needs of both clients and families by emphasizing relationships and recognizing and building on the strengths and interconnectedness of families

CAMH, 2004

BARRIERS TO FAMILY INVOLVEMENT

Health Canada (2001), in interviews with key experts who work with youth dealing with problematic substance use, identified three main barriers to family involvement in youth's treatment:

- Parents own alcohol/drug problems which affect their ability to support or access treatment for their children
- Parents denial of the extent or severity of their child's substance use

- Family breakdown and/or abuse may result in dysfunctional family relationships where parents lack ability to influence youth decision making.

Other research focusing on examining the ways in which the alcohol and drug system can best work with families in order to engage them effectively in the treatment process of a young person found some different barriers:

- Frustration with aspects of the health care system including: problems in communicating with professionals, including receiving inconsistent information; failure to involve families in treatment planning,
- Lack of information on what is happening and how to behave appropriately to support treatment
- Challenges in locating appropriate support services
- Having to be in crisis in order to get prompt attention/services
- Financial strain
- Feelings of total helplessness, lack of preparation, shock, disbelief
- Involvement discouraged by youth

Summarized from CAMH 2004

ISSUES RELATED TO WORKING WITH FAMILIES

In interviews with service providers, the following key issues emerged with regards to working with families:

- Who is the primary client
- Confidentiality
- Individual client focused models of service
- Client resistance to family involvement
- Family dynamics and conflict
- Broader social and legal context of families
- Culture

APPROACHES TO WORKING WITH FAMILIES

Research has shown that family involvement in a youth's treatment can vary in length, level of intensity and means and include family education, support groups, family counselling and mediation, and family therapy.

FAMILY EDUCATION

Families have expressed a need for information/education on the effects of drug use, addiction, services/ treatment available for their family member, and a clear explanation of the treatment process so they can understand what is happening and what their role is/can be. In consultation on engaging families in treatment, young people expressed concerns about their parents not having the necessary knowledge and understanding needed to adequately support them in treatment (Victoria Government Department of Human Services 2000).

SUPPORT GROUPS

Support groups for family members are another possible way families can be involved with their youth's treatment. These groups can provide emotional support, normalize the families' feelings, and allow for opportunities to share and problem solve with others who may have had similar experiences. Support groups can help alleviate feelings of isolation and loneliness families may be experiencing. Parents Together Services, under the auspices of the Boys and Girls Clubs of British Columbia, is one example of a support group for families (http://pt2.nfshost.com/index.php).

FAMILY GROUP COUNSELLING AND MEDIATION

In family group counselling and mediation, family members work with an independent facilitator to examine issues within the family and support the family to develop a plan for change. Communication between family members takes place in a safe environment within a structured process, guided by the facilitator, for the purposes of defining the conflict and looking at creative ways to problem solve and come to a mutually agreeable resolution to the issue.

FAMILY THERAPY

Family therapy is "a collection of therapeutic approaches that share a belief in the effectiveness of family-level assessment and intervention. Consequently, a change in any part of the system may bring about changes in other parts of the system" (CSAT 2004). Common family therapy models used today in alcohol and drug treatment include the Bowenian, Structural, Strategic, Narrative and multidimensional family therapy. Family therapy requires specialized skills and training and alcohol and drug practitioners should not practice family therapy unless qualified to do so. However, alcohol and drug practitioners should be knowledgeable enough about family therapy in order to be able to discuss the option with a client and recognize when a referral to family therapy may be appropriate.

STRATEGIES TO ENGAGE FAMILIES

The most effective involvement of families usually occurs when the service provider "recognizes the expertise that families have to offer and the importance of working collaboratively to achieve the main outcome goals for working with families, which are to achieve the best outcomes for the client and to ameliorate the distress of the family (CAMH, 2004). Strategies that can be used by practitioners to engage families in a collaborative manner include:

- Listen to families' concerns, needs and questions and understanding the unique issues facing family members as a function of their relationship to the care recipient (e.g., spouse, parent);
- Soliciting their input and feedback particularly because they have intimate knowledge of the client and can shed light on the strengths, interests and competencies of the client as well as the rate and severity of decompensation and substance use;
- Acknowledging strengths, expertise and contributions of family members;
- Exploring families' expectations of the intervention and the client;
- Assessing the capacity of the family to support the client;
- Facilitating the resolution of family conflict by responding thoughtfully to emotional distress;
- Acknowledging and dealing with feelings of loss;
- Working with families to develop a crisis plan;
- Helping improve communication between family members;

- Providing education and training for the family, including structured problem-solving techniques, at suitable times;
- Encouraging family members to expand their support networks;
- Being flexible in meeting the needs of the family;
- Providing resources to facilitate involvement (e.g., childcare);
- Providing the family with easy access to another professional in case current work with the family ceases; and
- Developing strategies far resolving problems related to confidentiality.

CAMH, 2004

Additional Resources

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