A Practice Guide for
School Mental Health Professionals:

School-Based Interventions Related to Student Cannabis Use

School Mental Health Ontario
Santé mentale en milieu scolaire Ontario

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Introduction

The legalization of recreational cannabis for adults who are 19 or older has prompted greater discussion about this substance in schools and in our communities. This increased discussion may result in more youth, parents/guardians and school staff approaching school mental health professionals (SMH professionals) with questions and disclosures about cannabis use. SMH professionals play a critical role in helping school staff, students and their families understand the effects of cannabis (psychoeducation). Given that youth are most likely to receive mental health services at school[1-3], SMH professionals are in an ideal position to engage in promotion, prevention, and early identification services related to mental health and substance use[4, 5]. SMH professionals are well-positioned to **identify and respond** to possible adverse consequences of substance use; **engage with students in evidence-informed discussions** related to personal decision-making about substance use, and; help students to **explore and navigate pathways** for more intensive treatment. Overall, work by SMH professionals is a complement to whole school interventions which take a universal approach to substance use by: promoting well-being, creating welcoming environments, and integrating effective programs[6].

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Purpose of this Resource

SMH professionals already engage and support youth who present with concerns related to mental health and substance use. This resource was developed in response to the needs identified by SMH professionals for more specific strategies to identify, respond to, and support students struggling with substance use.

In April 2019, a Substance Use Prevention and Intervention Survey was sent to SMH professionals across all Ontario school boards (see Appendix A for the full report). Of the 294 respondents, 92% indicated they would use a print/on-line resource related to cannabis and other substances and there was strong endorsement for the need for a resource, alongside training, to provide information regarding:

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

The **Practice Guide for School Mental Health Professionals: School-Based Interventions Related to Cannabis Use** focuses on cannabis, but can be applied to other substances, and includes an overview of cannabis specific research with implications for focused interventions by SMH professionals. Each section provides a “Highlights” section that summarizes important evidence-informed points to consider in your discussions with youth, staff, and families.

3

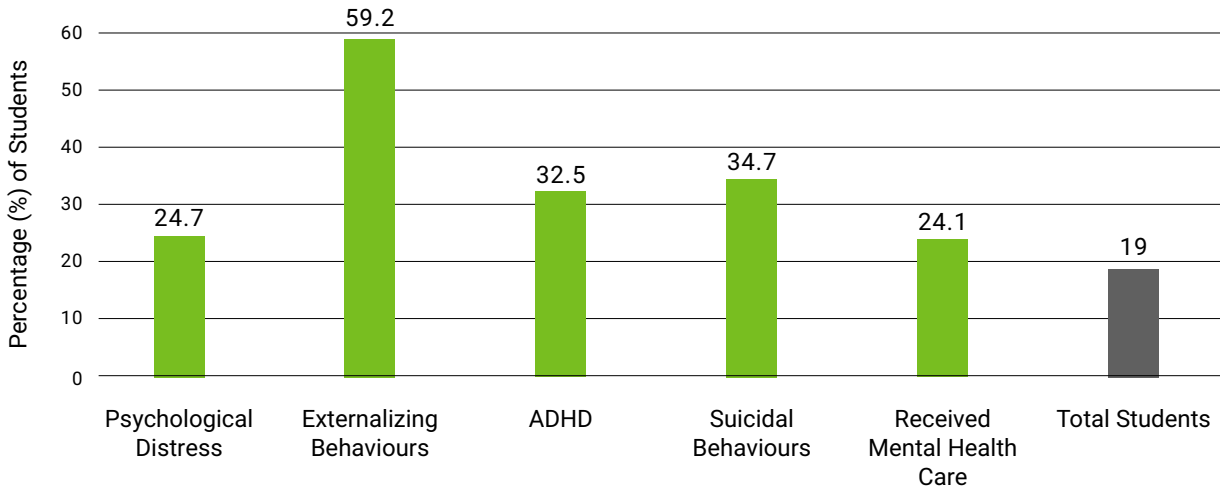
Background Information

3.1 How many youth use cannabis?

Cannabis is one of the most commonly used psychoactive substances[7]. Canadian youth report the highest rates of use compared to other young people in the developed world[8,9], with recent increases in use beginning pre-national legalization[10]. Specific to students in Ontario, in 2017, 19% of Ontario students in grades 7 to 12 said they had used cannabis in the past year (with older students reporting more use)[11]. In recent years, there has been a reduction in the perceived risks associated with using cannabis (both occasionally and regularly) and an increase in the perceived social acceptability of using cannabis[12-15]. This shift in attitudes related to cannabis may influence youth decisions about use, as well as their ability to recognize when to seek help.

Youth may not be aware of the relationship between their mental health and cannabis use. In general, individuals who have a mental health disorder are **twice as likely** to experience substance use problems, compared to individuals who do not experience mental health disorders[16]. This co-occurrence of substance use and mental health concerns is highest among older adolescents[16]. Specific to cannabis, adults with a mental health disorder are almost 10 times as likely to use cannabis at least weekly compared to those without a mental health disorder[17]. This is also seen in youth in Ontario. Youth reporting higher cannabis use is seen among Ontario students who also report high symptoms of: psychological distress, externalizing behaviours (i.e. antisocial behaviours such as stealing, fighting, running away, vandalizing, etc.), attention deficit hyperactivity disorder (ADHD), suicidal thoughts or attempts, and who have received mental health services in the past year (see Figure 1)[11]. Further, students reporting high mental health symptomatology also use cannabis more frequently than students without symptoms of mental health concerns (see Appendix B for specifics on measures and frequency of use). Overall, this Ontario data reinforces the importance of a concurrent focus on mental health and cannabis use.

Figure 1. Percentage of Ontario Students Grades 7–12 Reporting Past Year Cannabis Use in General and Across Subgroups of Students with Mental Health Symptomatology. Data comes from the Ontario Student Drug Use and Health Survey 2017 (OSDUHS)[11].



This chart demonstrates that in the total grade 7-12 student population, 19% of students report using cannabis within the past year. Among students with high levels of mental health symptomatology, the prevalence of past year use is higher. For example, of students reporting high levels externalizing behaviours, 59.2% reported past year cannabis use.

3.1 Highlights:

- Cannabis use is common among youth, **about 1 in 5** report past-year use.
- Youth with mental health concerns are **more likely to use** cannabis and **to use cannabis frequently**.
- The co-occurrence of cannabis use and mental health concerns highlights the need to address these concerns at the same time.

3.2 What is cannabis?[18, 19]

Cannabis is a plant made up of over 500 different compounds including a group of chemicals called cannabinoids[20]. Cannabinoids act on our body's natural **endocannabinoid system (ECS)**, leading to a broad range of physical and psychological effects[21]. Δ-**9-tetrahydrocannabinol (THC)** and **Cannabidiol (CBD)** are the most commonly studied cannabinoids at this time that are thought to have psychological effects[20]. Unlike THC, CBD does not produce a high or intoxication.

"Cannabis" is an overarching term for a lot of different varieties or species. These cannabis varieties (commonly called "strains") have historically been divided into three main categories: *sativas* (thought to be 'energizing' cannabis), *indicas* (thought to be 'calming' cannabis), and hybrids[22]. However, given how cannabis strains have been interbred, it is now understood that this distinction is likely inaccurate, despite the acceptance of this categorization by many individuals who use cannabis. Further, these strains of cannabis often do not have universally consistent effects, and the effects of particular strains of cannabis appear to be very person-specific[23, 24].

The classification of cannabis is becoming more complex and refined in order to capture the many combinations of cannabinoids and the ingredients that can be in cannabis (i.e. over 500 compounds in various combinations that are not consistent across all products). As knowledge about cannabis becomes more sophisticated, students may talk about the varied ***terpenes*** (i.e. volatile plant oils that give cannabis its smell/taste) and ***flavonoids*** (i.e. compounds that affect its smell/taste/colour)[25], but this research is in its' infancy and there is little evidence that chemovars, terpenes, or flavonoids impact cannabis effects.

Much of the pre-existing research on the effects of cannabis among youth – both general population and clinical populations – focuses only on THC and CBD and does not ask about other ingredients. Usually, we measure cannabis use by asking about **any** cannabis/marijuana use – not capturing composition. Therefore, pre-existing research on nonmedicinal (recreational) cannabis use is commonly evaluating the *average recreational cannabis product* that is typically a high THC and low in CBD.

Cannabis can be used in different ways including[11, 19, 26]**:**

- Smoked as a cigarette, called a joint (rolled in light transulcent papers) or a blunt (rolled in tobacco paper).
- Smoked or vaporized (called vaping) through a pipe, bong or an e-cigarette.
- Mixed into a drink or food, such as tea, brownies, gummies and candies (i.e. edibles).
- Consumed as a tincture (alcohol-based extract) on its own or added to food or drinks.
- Heated and inhaled (called dabbing) as oil, wax, or in a form called shatter that is made from cannabis resin or hashish. These resins can have up to 80% THC.
- There are also synthetic cannabinoids (often called K2 or spice). These products are manufactured in laboratories and have no relationship to the compounds in the cannabis plant.

Terms youth may use for cannabis

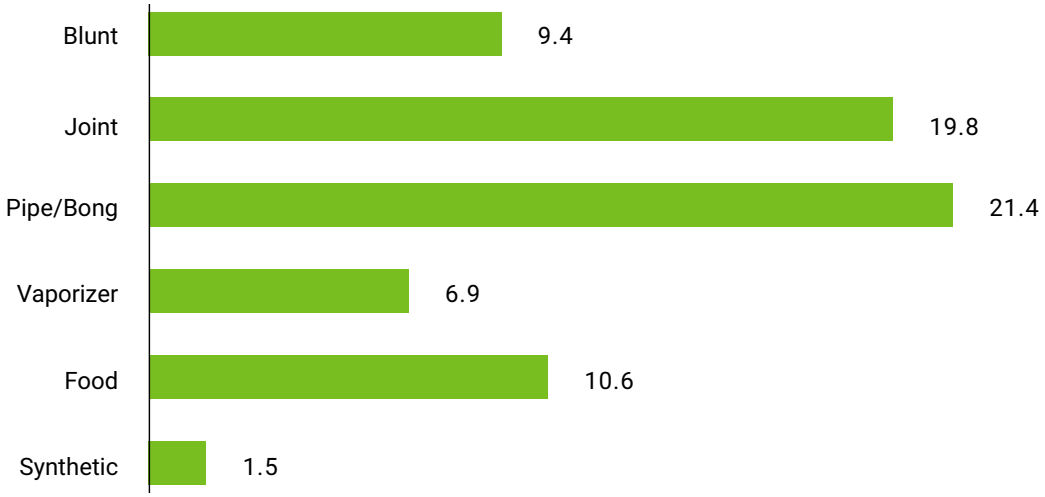
Marijuana, bud, blunt, chronic, dab, dope, ganja, grass, green, hash, herb, joint, loud, mary jane, mj, pot, reefer, sinsemilla, skunk, smoke, trees, wax, weed.

What is the "high" of cannabis use?

The THC component of cannabis is thought to be responsible for the "high," and cannabis products with higher THC are referred to as more potent. In the short-term, THC makes people feel "high" which commonly refers to:

- Altered and enhanced senses
- Altered sense of time
- Changes in mood
- Impairments in body movement and coordination
- Difficulty thinking and problem-solving
- Impaired memory
- Hallucinations, delusions, and psychosis (when taken in high doses)

Figure 2. **Percent of Grade 9 to 12 Students in Ontario reporting different methods of Cannabis Use (OSDUHS, 2017)**



Different ways of using cannabis produce different "highs." The timing an intensity of these intoxicating effects depend on different rates of absorption, distribution, and metabolism of THC and other cannabinoids. Using cannabis through vaporizing and smoking have similar effects that begin quickly after inhalation, have strong "highs" (depending on the THC content), and short durations[27]. This is largely due to rapid absorption and distribution of THC to the brain when cannabis is inhaled. The high from edible products takes longer to be felt, is of a lower intensity, but lasts much longer[21]. Delayed onset and reduced intensity with edibles are due to slower absorption and extensive metabolism of THC that occurs via the gastrointestinal tract. Educating youth about these differences is crucial, as individuals may misinterpret delayed onset of effects when consuming edibles and increase the amount that they take. This increases the risk of adverse effects and potentially cannabis overdose. We do not know if these methods have different long-term mental health effects.

When youth mix cannabis and tobacco together (and inhale it at the same time) it is "often" referred to a as a **popper** (if using a bong) or a **spliff** (if using a cannabis cigarette). This is important to take note of, as combining cannabis with tobacco increases the risks associated with use (including increasing the risk of dependence and difficulty reducing or stopping).

3.2 Highlights

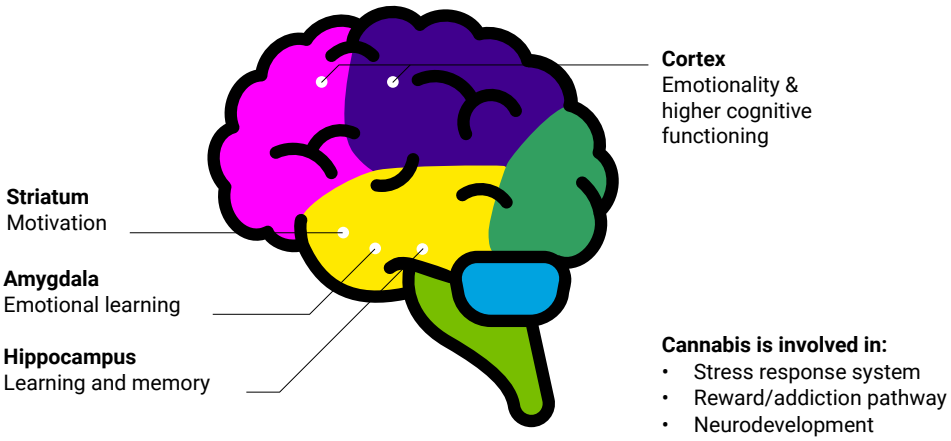
- Not all cannabis is the same. The cannabis plant is a complex and contains hundreds of different chemical components.
- Most research that has found links between cannabis use and harm or consequences has been done on THC-dominant cannabis products (which is the type most often used recreationally).
- Although particular strains (which may be categorized by labelling terpenes) are often marketed as having specific effects, there is no existing research to support these claims.
- There is a lot of variability in the potency of cannabis (THC level) and the other ingredients present.
- The method of use of cannabis substantially impacts how quickly youth will feel effects and how long effects last.

3.3 How does cannabis work in the brain & how might it be linked to mental health concerns?[18]

Most of the psychological effects of cannabis are thought to be due to THC acting on Cannabinoid 1 Receptors (CB1Rs) in the brain[21, 28-30]. CB1Rs are mostly found in areas of the brain including the[28, 30]:

- hippocampus (learning and memory)
- striatum (motivation)
- cortex (emotionality and higher cognitive function)
- amygdala (emotional learning)

Figure 3. Where cannabis acts in the brain



The endocannabinoid system (ECS) plays a key role in the stress response, reward/addiction pathways in the brain, and in brain development[21, 28-30]. Our body creates its' own natural endocannabinoids that act on CB1Rs, but these are tightly regulated by our body and are created and destroyed on demand[28, 30]. Cannabinoids not made by our body, like **THC**, bind much more strongly to CB1Rs and last much longer[21], which can overstimulate the system. This can lead to a new "normal" in the brain, which may change how the system functions putting people at a greater risk for alterations in functioning in all those parts of the brain – putting people at risk for impairments associated with executive functioning, substance use dependence, and mental health problems[30, 31].

The effects of cannabis on the ECS are particularly prominent among youth. This is because the brain is still developing until about mid-20s and the ECS plays a critical role in healthy brain development[32]. The prefrontal cortex is the last area of the brain to mature developmentally and is related to **executive functioning**, which is influenced by cannabis.

It is important to note that in the short term – prior to the brain adapting and changing in response to ongoing cannabis use – cannabis will likely produce desired short-terms positive effects on mood and anxiety. Often, youth will say, *"when I started using cannabis, it helped my mood/anxiety."*

At first, cannabis provides a desired effect – but with repeated and ongoing use, it can change how the brain is structured and functions leading to more problems, not less.

When cannabis use is initiated before the brain is fully developed, lasting cognitive impairments (problems with memory, attention, long-term school and work performance)[33] can occur. In adults, these cognitive deficits seem to be reversible after one month of discontinuation – but this may not be true for youth[34]. Although the effect *may* be reversible, *while a youth is actively* using cannabis they are likely to experience issues with learning, memory, attention, and academic performance and achievement[34]. Also, research indicates that the ECS develops and acts differently in biological females compared to biological males[18]. Furthermore, there is emerging evidence suggesting that cannabis use among females is more strongly linked to mental health concerns then for males[35].

The association between cannabis and mental health concerns appears may be related to the amount of THC and CBD in the cannabis product[21, 36].

- Higher levels of THC are associated with increased risk of problems.
- CBD may dampen some of the psychoactive effects of THC.
- More research is needed to identify how individual characteristics (e.g., genetic, biological, environmental) interact with various cannabis products to increase susceptibility to mental health concerns such as psychosis and schizophrenia.

It is important to note that the potency of THC in typical cannabis products has been dramatically increasing in recent years. Conversely, CBD (the part of cannabis that dampens the potency and may have benefits) has been decreasing[37, 38, 39]. In 2016, the 12 most popular cannabis products in Toronto were tested and found to have **average THC levels of 20%** and **no CBD at all**[39], compared to average levels in 1995 being 4% for THC and 0.5% for CBD. In 2018, with national legalization, the Ontario Cannabis Store began selling products 0 to 27% THC and 0 to 18% CBD[40].

Regulations, tests, and labelling related to legally purchased cannabis *may* provide opportunities for psycho-education and harm-reduction, allowing individuals to make more informed decisions regarding THC and CBD content (although, even with labelling there is a chance of inaccuracies). However, the same opportunities and confidence in quality and composition of the product cannot be extended to cannabis which is illegally acquired (such as obtained from a dealer or friends), that is usually the case for youth.

3.3 Highlights

- Cannabis may initially result in desired effects related to anxiety and mood, but repeated use may lead to structural and functional changes to the brain making problems worse.
- Higher potency (i.e., THC) cannabis may lead to more psychological effects, cognitive effects, and brain changes.
- Cannabis today is higher in potency than it was in the past.

3.4 Clinical concerns related to cannabis use

In the general population of youth…

Youth are particularly vulnerable to the effects of cannabis use and other substance use – even if not meeting criteria for a substance use disorder – given ongoing brain development[30, 41]. Regular use of cannabis, particularly during adolescence while the brain is still developing, may negatively impact healthy brain development, especially in areas of the brain associated with cognition and emotions[18, 34, 42]. Regular cannabis use among youth has been associated with and increased likelihood of:

- Mild cognitive impairments including:
    - Difficulties with short term learning, memory and attention[34, 42]
    - Lack of motivation[42]
    - Poor academic performance and dropping out of school[33]
- Mental health concerns including:
    - Depression, anxiety, and suicide-related outcomes[18, 43]
    - ADHD[44, 45]
    - Externalizing disorders and aggressive behaviour[46]
    - Symptoms of psychosis and the development of psychotic disorders, especially with pre-existing genetic risk factors[34, 42, 47]
    - Developing an addiction to cannabis (i.e. 30% of individuals who used cannabis experience symptoms of cannabis use disorder[48], and the likelihood of developing and addiction is at least four times higher for people who begin using before 18 years of age[49])
    - Developing other addictions (including food and other substance addictions)[18]

At this time it is not yet clear whether cannabis is a cause, consequence, or correlate of cognitive and mental health problems, however these concerns consistently co-occur with cannabis and are important considerations when working with youth. The co-occurrence of cannabis use and mental health concerns may be more pronounced among youth who:

1. Initiate use at an earlier age, use more frequently, and for a longer duration[18, 49, 50] *(consistent evidence)*
2. Have poor distress tolerance and/or report using cannabis (and other substances) for coping purposes[51-53] *(emerging evidence)*
3. Are female – even though males may be more likely to use a substance and experience a substance use disorder, females who are using substances are more likely to experience concurrent mental health concerns[53-57] *(emerging evidence)*

Social context also seems to matter. More peer use, sibling or parental use, and using cannabis for socialization purposes is associated with higher frequency of use and more related problems[58]. However, solitary cannabis use has also been associated with more use and problems among adolescents[58].

In a clinical population of youth…

Only about **15%** of youth with a substance use disorder access professional services for their substance use[59]. However, as indicated above, many youth who present to other mental health services will have co-occurring cannabis and/or other substance use that may be playing an important role in their current symptoms, treatment engagement, and prognosis. At a systems level, among the top priorities identified by stakeholders for projects related to drug treatment in Ontario, was increased collaboration in addiction and mental health services[60].

There is *some* evidence suggesting that individuals with a mental health disorder who also use cannabis (even if not at the level of a cannabis use disorder) may experience:

- more severe symptoms[61]
- worse prognosis[61]
- improvements in treatment outcomes when they reduce their cannabis use[62, 63, 64]

It is possible that individuals with mental health disorders may experience increased risk of cannabis dependence (See Appendix C for Cannabis Use Disorder Criteria and Cannabis Withdrawal Symptoms). For SMH professionals, this possibility underscores the relevance of a concurrent approach to screening, assessment, counselling and referral. Use of other substances have similar clinical implications for those with mental health disorders[35]. The Canadian Centre on Substance Abuse [65] indicated a need for improved care and treatment of concurrent mental health and substance use concerns including improving detection, diagnosis, and concurrent treatment of (or awareness of) both problems. This document acknowledged a lack of evidence regarding treatment options and best practices for co-occurring concerns, although stated that **treating both problems simultaneously is preferential to treating them separately.**

Young people may experience symptoms of psychosis related to mental health disorders and substance use[47, 66]. When working with students who use cannabis, SMH professionals are encouraged to inquire about the effects experienced and consider symptoms of psychosis[67] (See Appendix D for a brief tool to screen for symptoms of psychosis among youth). It is important to note that although there can be a connection between psychosis and substance use, not all symptoms of psychosis among youth are substance-related. Psychotic-like symptoms can occur without substance use and can be a symptom of a mental or physical illness[66]. Therefore, if/when a youth presents with symptoms of psychosis, a referral to a medical professional for assessment is advised.

When working with students who experience psychosis, SMH professionals can access helpful resources provided by EPION (Early Psychosis Intervention Ontario Network) included in the Resources section of this guide.

3.4 Highlights

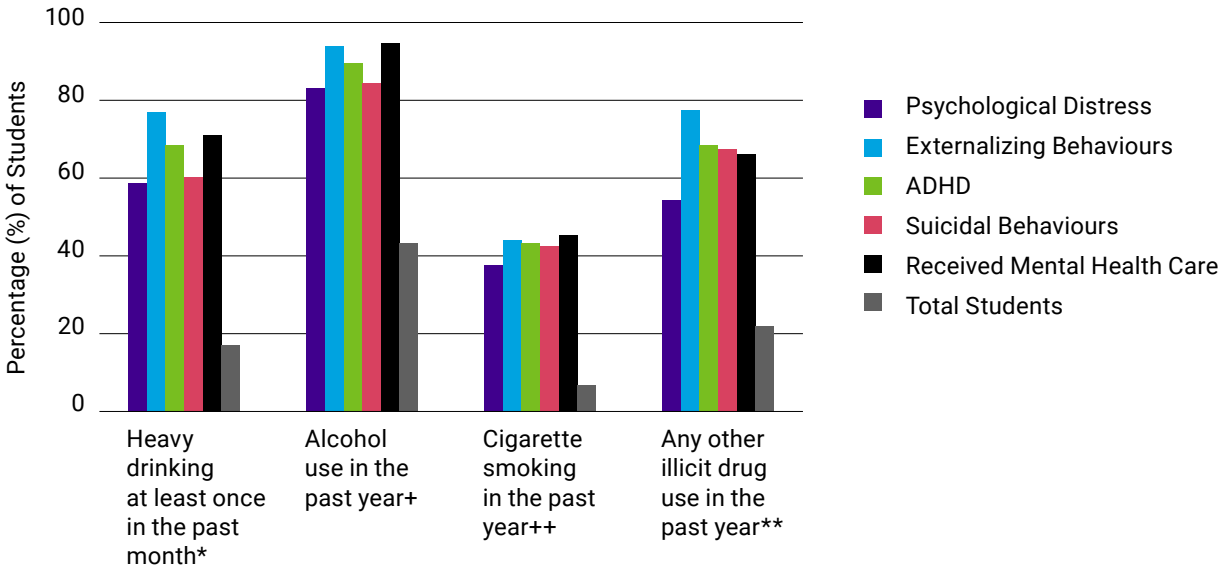
- Cannabis use is associated with cognitive and mental health concerns among general population and clinical samples.
- The potential for problems related to cannabis use seem to be increased when youth initiate use at a young age, use frequently, and use for coping purposes.
- Cannabis use among those with mental health problems appears to intensify symptoms and negatively impact prognosis.

3.5 Cannabis and other substances

Cannabis use rarely occurs in isolation, especially among youth with mental health concerns. Some research suggests that cannabis use precedes the initiation of other "harder" illicit drugs and acts as a "gateway drug." The gateway hypothesis, that is, that substance use occurs in a particular sequence beginning with alcohol and tobacco, proceeding to cannabis and then on to other illicit drugs, has been heavily debated since at least the 1970s[68]. In brief, the theoretical rationale for this sequencing of substances stems from both neurobiological and social sciences. When focusing specifically on cannabis, THC may prime the brain, making it more susceptible to developing other addictions[28, 69, 70]. However, it is not only neurobiological vulnerability driving this proposed sequencing, but rather a series of steps increasing in risk from legal and more socially acceptable substances (i.e. alcohol, tobacco, and now cannabis) to illegal and more stigmatized substances (i.e. "hard" illicit drugs). This being said, evidence for the gateway hypothesis is inconsistent and more refuted than supported.

Regardless of the sequencing, cannabis is moderately correlated with other substance use and may increase the likelihood that individuals will use (or do use) other illegal drugs. Using data from Ontario students, we can see that students who use cannabis commonly use other substances like alcohol, heavy drinking, cigarettes, and other drugs; co-use of other substances is higher among students who are experiencing symptoms of mental health concerns (Figure 4). Labelling cannabis as a "gateway drug" may impede the ability to engage in a discussion about use with a student. However, eliciting a student's opinions about how their use of cannabis and other substances may be connected can be a helpful way to engage in discussion and explore ideas about use (Refer to section on Motivational Interviewing and the Transtheoretical Model in this resource for more information).

Figure 4. The percentage of other substance use among grade 7 to 12 students who reported using cannabis at least once per month.



Notes: *drinking five or more drinks on one occasion at least once in the past month; + excludes a few sips just to try it; ++ excludes a few puffs just to try it; ** among high school students only (G9-G12) and includes nonmedical use of prescription drugs

As an example, this graph shows that among all grade 7 to 12 students who have used cannabis in the past month, less than 20% reported heavy drinking in the past month. However, among students who used cannabis in the past month and also scored high on psychological distress, almost 60% of these students engaged in heavy drinking.

3.5 Highlights

- Evidence indicates that students who use cannabis have higher rates of use of other substances than those who do not use cannabis.
- If students are using cannabis, SMH professionals are encouraged to screen/inquire about other substances they are using to identify opportunities for intervention.

3.6 Cannabis for medicinal purposes

In Canada, cannabis use for medical purposes has been legally available since 1999, with the most recent changes in this legislation occurring in 2016 for the current regulations called "Access to Cannabis for Medical Purpose Regulations (ACMPR)[71]." There are over 340,000 registered Canadians accessing cannabis for medicinal purposes[72]. Cannabis for medicinal purposes can be prescribed for upwards of 30 conditions (both physical and psychological disorders), however, there is a recognized need for greater research related to evidence of therapeutic benefit across all such conditions and the related risks[73].

Current recommendations for prescribing cannabis for medicinal purposes discourage use by smoking and suggest that **medicinal cannabis is not appropriate treatment for individuals under 25 years of age**, or for those who have a personal or family history of serious mental disorders (i.e. schizophrenia, psychosis, depression, or bipolar disorder) or substance use problems[74].

SMH professionals may work with students who live with family members who use cannabis medicinally. It is also possible that some students may have been prescribed medicinal cannabis for particular conditions[75]. When working with youth, exploring their beliefs about how their use of cannabis interacts with their mental health symptoms can provide important insight and opportunity for engagement. Despite a lack of evidence, young people may report using cannabis to ameliorate symptoms of their mental illness[44]. Further research is required to determine if there is potential for a specific component or type of cannabis to be beneficial for mental health concerns due to the action on the ECS. However, there is currently no evidence or guidelines which suggest that medicinal cannabis should be used among youth to treat mental health symptoms or disorders. SMH professionals are encouraged to use a motivational interviewing approach to explore the topic of medicinal cannabis when it is raised by students.

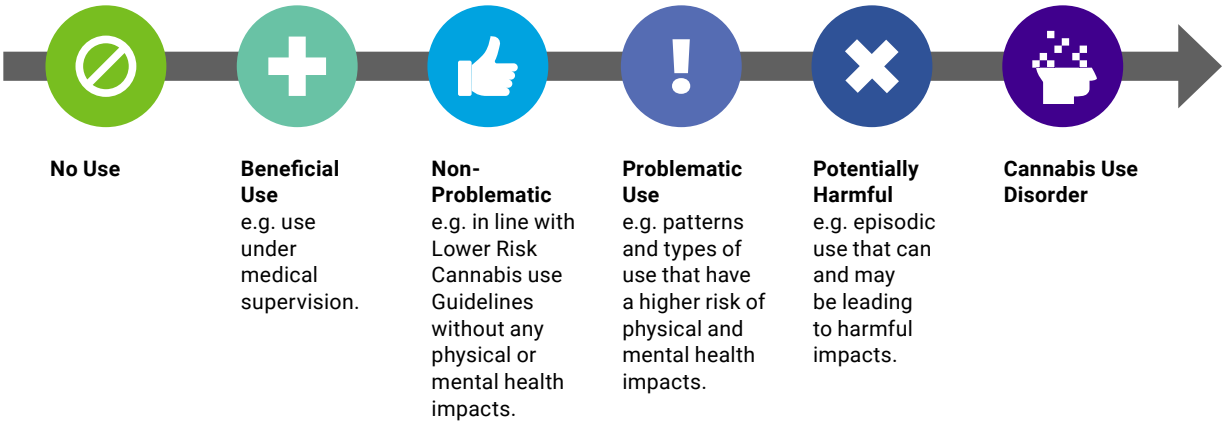
3.6 Highlights

- Adults can legally obtain cannabis for medical purposes for a wide range of physical and psychological health conditions.
- The evidence on therapeutic effectiveness for most conditions is inconclusive.
- Recognizing that students may be using or exposed to medicinal cannabis, a non-judgemental approach to exploring risks and benefits can reduce stigma and promote engagement.

3.7 Cannabis use continuum

Many youth treatment agencies use the concept of a substance use continuum to assist in the consideration of potential harm of use and as a tool for engagement with youth related to their substance use. The Ministry of Health and Long-Term Care developed a Substance Use Prevention and Harm Reduction Guideline (2018)[76]. Within this guideline, they indicate that substance use occurs along a spectrum ranging from no use at all to experiencing a substance use disorder. Figure 5. presents a Cannabis Use Continuum, informed by this spectrum of substance use.

Figure 5. Cannabis Use Continuum



Youth involvement with cannabis can be considered along this continuum:

1. **No use.** A youth has not yet initiated use and therefore is not experiencing use related problems. The youth may or may not be considering using cannabis.
2. **Beneficial use.** Youth may be using cannabis for medicinal purposes prescribed by a physician that may be providing them with some physical or psychological benefits. It is also important to note that youth may report experiencing benefits such as enhancing social relationships or a sense of belonging related to their use of cannabis.
3. **Non-problematic use.** Youth may be using cannabis in a way that is not leading to problems. However, given the neurodevelopmental vulnerability of youth to the potential negative effects of cannabis on long-term health and well-being, any use among youth may pose some degree of "problems."
4. **Problematic use.** Youth who use cannabis are at an increased risk of adverse outcome due to their neurodevelopmental vulnerability – since their brains are not yet fully developed. Youth may also be using in a "riskier" way, i.e. not in accordance with other Lower Risk Use guideline suggestions. However, this "problematic" use may not be related to current impairment.
5. **Potentially harmful use.** Youth may be using cannabis in a way that is causing them problems, but not yet experience all the symptoms associated with a cannabis use disorder.
6. **Cannabis use disorder.** Youth can develop symptoms which are classified as clinical diagnosis of a cannabis use disorder.

3.8 Lower risk cannabis use guidelines

Lower Risk Cannabis Use Guidelines are available as one of the tools to support individuals who choose to use cannabis in reducing the risks they may incur as a result. A harm reduction approach acknowledges the reality that some people will use, and are using, and that providing information and support to reduce harms related to use promotes healthier outcomes.

SMH professionals can use the information in this resource to support students who are currently using cannabis in reducing cannabis-related harms, recognizing that not all young people will have a goal of abstinence. Overall, it is important that there are different ways of using cannabis and some are **safer** than others. The following are a summary of key recommendations from Canada's Lower Risk Cannabis Use Guidelines, provided by the Centre for Addiction and Mental Health. These recommendations are not an exhaustive list and should be considered alongside other evidence (such as that presented in this document) and clinical expertise:

1. Encourage **less risky use**. Encourage youth to try to choose:
    a. Products with low THC content, or higher CBD compared to THC content.
    b. Natural cannabis products and avoid synthetic cannabinoids.

2. Communicate that cannabis is a higher risk for **certain people**. Encourage youth to:
    a. Try to delay using cannabis until they are older to lower the risks.
    b. Avoid using cannabis if they are pregnant or breastfeeding.
    c. Avoid using cannabis if they have a personal or family history of psychosis or substance use disorder.
    d. Ensure they never drive or get into a car with a driver who is under the influence of cannabis

3. If youth do decide to use cannabis, encourage them to:
    a. Limit their use, such as using only on weekends or once a week.
    b. Wait at least six hours before driving or operating machinery after using. If they plan on driving, encourage them to not use cannabis, alcohol or other drugs.
    c. Try to avoid deeply inhaling or holding your breath if deciding to smoke cannabis.
    d. Start low and go slow – encourage youth to begin with low doses and wait to feel the effects before choosing to consume more (especially with edibles that have delayed onsets of effects).

The website for the complete Lower Risk Cannabis Use Guidelines for youth are provided in the Resources section of this guide.

4

Clinical Assessment and Interventions

Many of the assessment and intervention strategies used already by SMH professionals working with students in areas unrelated to substance use will also be effective for addressing cannabis and other substance use. The following information is intended to offer clinical strategies to support engagement with youth related to cannabis, recognizing that many of the skills SMH professionals already possess and use to engage youth and develop caring relationships, explore concerns, and set goals are essential.

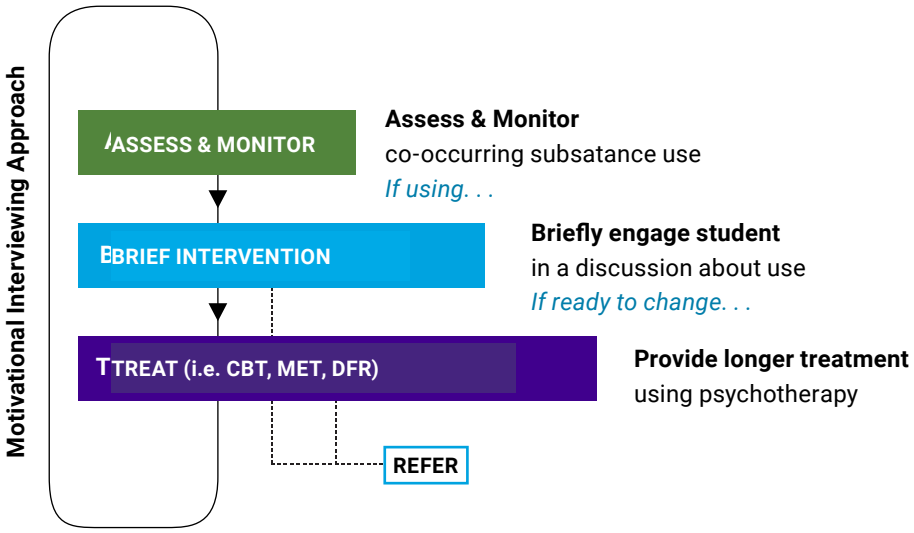
The most important knowledge and skills when working with youth who are using substances include: taking a nonjudgmental stance, learning about how youth understand what is happening in their lives, and collaborative goal-setting.

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

The National Institute on Drug Abuse[77] and UpToDate[78] (a summary clinical text) recommend psychotherapy, including **Motivational Enhancement Therapy (MET), Cognitive Behavioural Therapy (CBT)**, and/or a combination of these psychosocial interventions to treat cannabis problems (conditional recommendation). Currently, MET or other Motivational Interviewing (MI) strategies have the most evidence for the treatment of cannabis related problems. Recognizing readiness to change and viewing change as a process is a key element of interventions for cannabis use. **The Transtheoretical Model** provides a recognition of the stages of change that we move through as we increase our readiness for behavioural change. It is also important to note that CBT is also suggested as the first line psychotherapy treatment for anxiety and depressive disorders among youth. These disorders commonly co-occur alongside cannabis use problems[79, 80]. If individuals do not respond to CBT or MET, it is recommended to add on Contingency Management (CM) strategies. Related to CM, there is emerging interest in the utility of drug-free reinforcing activities (referred to as DFR in this guide) or alternative activities as a way to approach substance use treatment[81].

The Cannabis Use Continuum (Figure 5), illustrates the need for a stepped care approach to addressing cannabis use and other substance use concerns among youth. Figure 6 reflects a stepped care approach to assessing and addressing cannabis and other substance use concerns among youth who present to SMH professions. In brief, in addition to supporting mental health promotion and prevention efforts related to substance use more broadly, it is recommended that SMH professionals engage in early identification and intervention beginning with assessing and monitoring concurrent cannabis use among students presenting for help. If a student is using substances, the SMH professionals should briefly engage the student about their use. If the student is experiencing problems and is ready to change their substance use, SMH professionals can use strategies such as CBT, MET, and/or other drug free reinforcement address cannabis use concerns.

Figure 6. Stepped Care for Assessing and Addressing Cannabis and other Substance Use for Students Presenting to SMH Professionals.



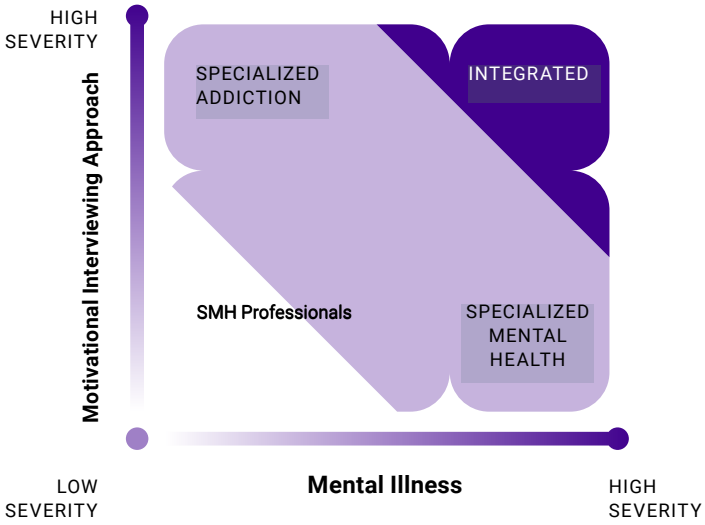
Note. CBT=Cognitive Behavioural Therapy; MI=Motivational Interviewing; DFR=Drug Free Reinforcement

Shown in Figure 6, referral may be indicated depending on the severity of the students' presentation and co-occurring problems. The Centre for Addiction and Mental Health has proposed a 4-quadrant model that captures both the severity of the presenting mental health concern and substance use problem (See Figure 7). When both occur simultaneously, this is referred to as a concurrent disorder. The greater the severity, the more specialized the services need to be (as is the same for other mental health concerns). The following sections discuss interventions SMH professionals can use to address co-occurring substance use among students, but it is important to also recognize when to refer students to specialized community services. Indicators that a student may required more specialized services include:

- Ongoing cannabis use causing severe impairment that is not improving with motivational and cognitive behavioural interventions delivered in the school setting.
- Disclosure from student, family and/or school staff that indicates increased severity of mental health concerns related to substance use (e.g. experiencing psychosis during or after use; engaging in self-harm or risk of suicide during or after use).
- Regular use of other illicit drugs (such as opioids).
- Daily alcohol use showing symptoms of alcohol use disorder (withdrawal from alcohol use can be life threatening and reductions/cessation of this use should be monitored by a medical professional).

When you are referring students to other services, it is still important to continue care and support for that student within the limits of your expertise and time. This may include facilitating the student's transition to the specialized services and supporting their re-entry back to school.

Figure 7. Adapted 4-Quadrant Model of Concurrent Disorders for SMH Professionals [82]



The following sections will guide you through how SMH professionals can implement evidence-informed strategies for brief interventions and treatment related to youth substance use concerns. This section will include an overview of each of these recommended approaches and consideration of how this relates to the Brief Intervention for School Clinicians (BRISC).

Introduction, setting the tone, and checking in.

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

> *"Our time together today is an opportunity to talk about how your mental health may be impacting your life and your ability to succeed at school. I also often ask students I see about their substance use. Sometimes substance use can also impact your life and if you are using substance, it may be related to how you are feeling or functioning."*
>
> *"My job is not to tell you what to do. I want this time we have together to be an opportunity for an open conversation. How, when, why, or if you decide to make any changes in your life is completely up to you."*
>
> *"How does that sound? What do you think?"*

Students may be accustomed to cannabis related discussions with adults turning into debates.

Canadian resources which provide tips about talking with youth about cannabis and recommended language for responding to questions and statements about cannabis use are included in the Resources section of this guide. These resources were developed with youth consultation and use a motivational enhancement approach to supporting well-informed, open dialogue.

Confidentiality

At the beginning of any session with a student, regardless of the reason for referral, SMH professionals review privacy and limits of confidentiality. This discussion may also include specific school and school board policies.

Students may be concerned about their substance use being reported to school administration, parents/guardians and other community agencies depending on their personal situations (for example if they have involvement with Probation Services or Children's Aid Society). It is important to be clear about if and when others will be informed about what the student says.

Clarity around how information about limits to confidentiality specific to cannabis use and other substances is important for the development of a clinical relationship.

4.0 Highlights:

- It is important to simultaneously assess and treat youth for mental health and substance use concerns.
- Approach your discussions in a non-judgmental manner.
- Discuss privacy and confidentiality – what information will and will not go to others?
- You have the skills to be able to engage in these conversations.

4.1 Alignment with the Brief Intervention for School Clinicians

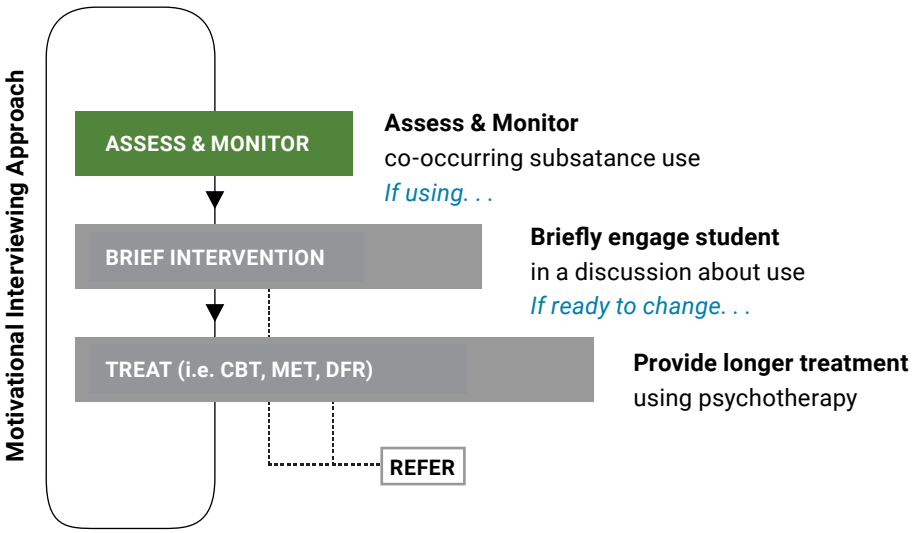
Increasingly, SMH professionals in Ontario are applying the **Brief Intervention for School Clinicians (BRISC)** in their practice. This student-led, time-limited intervention provides a structured approach, which focuses on effective problem-solving and skill-building. Interventions for cannabis use can be aligned with the BRISC in the following ways:

- **In General**
    - A stepped care approach to problem solving that includes cannabis use would include strategies to reduce harm as described in this resource.
    - The guiding questions in the BRISC intervention align with motivational interviewing strategies (an evidence-based approach to increasing readiness to change with respect to substance use).
- **In Session 1:**
    - Monitoring cannabis use as a primary behaviour to focus on, or as an aspect of when a problem occurs (e.g. cannabis use may be a related factor in relational concerns, in managing stress, etc.).
    - The monitoring process is particularly complementary to readiness for change (refer to the Transtheoretical Model in this resource).
    - Open discussion about substance use and how it may impact mood and various areas of school and personal life provides an opportunity for students to consider how their use may be impacting their presenting concerns (this could be prompted by consideration of results of PHQ9, GAD7 and self report of academic functioning and how cannabis use may relate to the items endorsed as concerns).
- **In Session 2:**
    - Students may identify cannabis use as a presenting problem in their problem list.
    - Identification of stressors and strategies for managing stress may include a disclosure of cannabis or other substance use.
    - Identifying benefits and barriers to taking small steps for change can assist in resolving the ambivalence students are likely to experience related to their substance use.

- **In Session 3:**
  - Students may choose to focus on cannabis use as a problem after monitoring.
  - The discussion of stressors related to cannabis use can relate to the process of resolving ambivalence and enhancing readiness to change.
  - In considering a problem-solving plan, if reducing cannabis use or harm reduction is presented as a student goal, refer to the information in this resource about harm reduction.
  - Small steps (experimenting with change) could include CBT strategies including recognizing automatic thoughts about use (e.g. using cannabis after a stressful event).
- **In Session 4**
  - In this session, SMH professionals are recognizing what the student has accomplished so far, even if it's a small step, and determining next steps. This is essential to harm reduction as it recognizes small changes around cannabis use (e.g. using one less time in the week, reducing the amount).
  - Strategies for managing stress and mood can assist with managing urges to use substances such as cannabis and strengthening coping strategies.
  - Regular substance use can increase vulnerability to stress, which can be addressed in session.
  - Taking positive action by recognizing mood, thoughts and altering behaviour reflects the CBT approach.

4.2 Essential factors in the assessment of cannabis use

Figure 8.



Even when substance use is not mentioned in a referral, it is recommended that SMH professionals assess for current and previous use of cannabis and other substances (this is also recommended for other health and mental health care providers[18]). Asking a youth about their substance use does not encourage them to use. SMH teams may consider some of the following tools to assist with screening and assessment, but the first recommendation is to ask youth in a non-judgmental manner about substance use.

Your school board mental health team may decide to incorporate a specific screening tool into your assessment process. There are a number of validated screening and assessment tools specifically for cannabis use, with the best performing tools including: the Cannabis Use Disorder Identification Test (CUDIT)[83], Cannabis Abuse Screening Test (CAST)[84], Drug Use Disorder Identification Test (DUDIT)[85], and Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)[86]. The CUDIT and CAST are cannabis specific, whereas the DUDIT and ASSIST are for general substance use. The CUDIT is a self-administered screening tool which is in the public domain and available for use by SMH professionals (See Appendix F for CUDIT).

As depicted in Figure 9, any student who presents to SMH professionals should be assessed for current and previous cannabis use and other substance use prior to planning your treatment approach. SMH professionals should continue to monitor for cannabis use and other substance use during treatment (even if a youth initially is not using, or not using in a way that is related to problems). If a student is not responding to treatment, it is important to re-evaluate the potential co-occurrence of substance use related problems that may be complicating the students' presentation and slowing progress.

> I ask all students I see about substance use. Are you using any substances these days? What about alcohol, cannabis, etc...

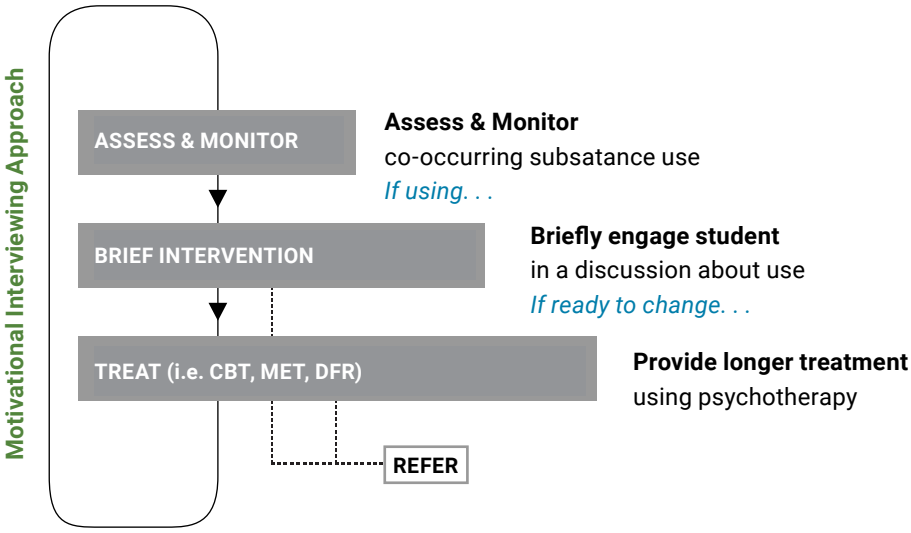
Figure 9. **Assessment and Monitoring of Co-occurring Substance Use**

4.2 Highlights

- Assessing for past and current substance use is important, especially among youth coming to see SMH professionals.
- Brief standardized tools — which have been validated for use with youth — can be used in school-based interventions.
- The CUDIT is a self-administered screening tool that is in the public domain and available for use by SMH professionals.

4.3 Motivational Interviewing and Transtheoretical Model

Figure 10.



Motivational Interviewing (MI) approaches are grounded in a non-judgmental communicative approach that has the goal of enhancing and eliciting motivation to change and subsequent behaviour change (see Appendix H for a Motivational Interviewing Tip Sheet). MI does this by resolving ambivalence and by building intrinsic motivation for change, rather than focusing on external motivation (such as punishments, consequences or rewards from family, school or justice system) [87]. The **principles** of MI are defined by the mnemonic, RULE [88]:

RULE

- **R**ecognize and resist the urge to correct or inform (the righting reflex, or our innate urge to correct clients and prescribe solutions)
- **U**nderstand the perspective of the student
- **L**isten reflectively to the student's experience of their use
- **E**mpower the client to explore change

Clinicians operating under an MI approach use **skills** defined by the pneumonic, OARS [88]:

OARS

- **O**pen ended questions
- **A**ffirmations (acknowledge their current skills or steps towards making a change)
- **R**eflections (accurate empathy and reflecting what they have said and/or what they may be experiencing – even if they have not vocalized it)
- **S**ummaries (help organize thoughts and highlight "change talk")

MI focuses on evoking "change talk" statements from the client that reflect their internal motivation for and commitment to change including vocalized actionable steps to change. MI strategies work within the context of a supportive clinical relationship[89].

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

In MI, you will hear the term *"roll with resistance,"* which is an encouragement to recognize someone's stage of readiness to change rather than wrestling with a person to convince them to change. The goal of MI is to create a collaborative partnership that facilities a shared exploration of change. This is a natural connection to using the BRISC and the Transtheoretical Model of Change.

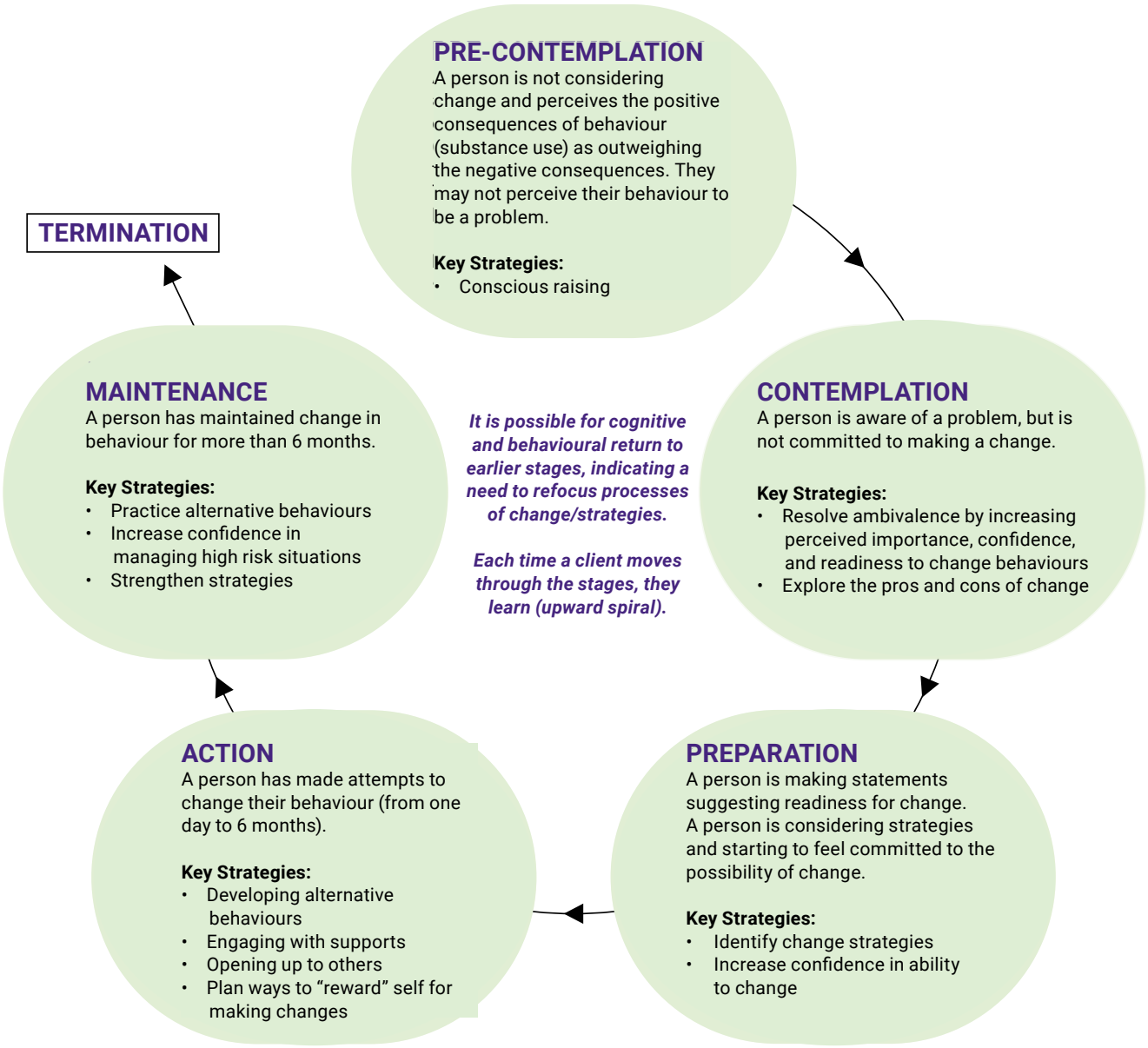
4.3.1 Transtheoretical Model of Change

A vital step in working with someone related to their substance use is understanding their **readiness to change**. Too often, we assume that a person who is using substances will want to set a goal of abstinence and may implement an intervention that does not match their experience or goal[90]. Equally problematic is the assumption that if a person does not yet want to change their substance use, there is no work that can be done. The myth surrounding someone having to "admit they have a problem" with substance use prior to assistance being provided can negatively impacted our ability to engage with substance users.

The Transtheoretical Model of Change (also called the Stages of Change) Model is widely accepted as a helpful guiding approach in the addictions field[91]. This model entails gaining an understanding of how ready a person may be to consider changing their behaviour and identifies the focus area for each stage of readiness. This model can be used for other behaviour changes as well and is a complement to the Cognitive Behaviour Therapy (CBT) and Motivational Interviewing (MI) strategies, which will be discussed in this resource. Understanding the stage of change of a student related to a problem behaviour such as substance use will assist a SMH professional in determining how to use CBT and MI strategies.

The Transtheoretical Model of Change explains change as occurring through 6 stages: ***precontemplation, contemplation, preparation, action, maintenance,*** and ***termination***[91] (See Figure 11). It is important to recognize that this is not a linear process and individuals will often move back to earlier stages (as indicated in the image below) [91]. It is important to note that individuals can be at a different stage of change for different behaviours (and substances). Thus, a student may be in *Precontemplation* around their use of cannabis and in *Preparation* related to their use of alcohol. For each stage of change, different intervention strategies are considered effective to support a person in progressing to the next stage of change (See Appendices F, G and H) It is also important to note that behaviour change related to substance use may not be focused on a goal of abstinence.

Figure 11. Adapted Stages of Change Model

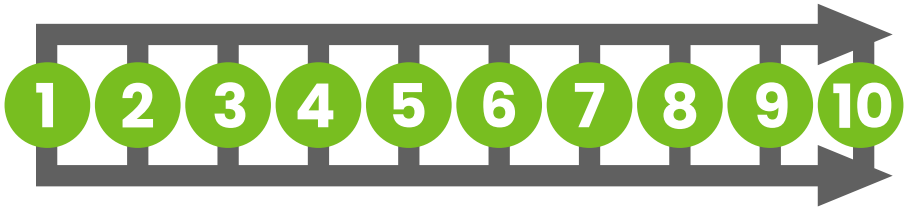


You can assess a students' readiness to change using your clinical judgement through your conversations with the student and the amount of:

CHANGE TALK		SUSTAIN TALK
e.g. I'd like to… I could… It is important because… I have to… I will…I'm ready…I've tried… I am doing…")	**Versus**	e.g. You don't understand… I am not ready…I tried that before and it didn't work…I don't see the point… There is no reason…

You can also directly ask the student how important they believe changing their use is, how ready they are to make a change, and how confident they are in their ability to change. You can directly ask students these questions by using Readiness Rulers[88] (See G for a Readiness Ruler Worksheet):

Figure 12. Readiness Ruler



After a student provides their answer on the ruler, it can be helpful to discuss the rationale for their self-assessment. After assessing readiness to change, it is important to align your approach to match their stage of change, or "meet the student where they are at" (see Appendix I for more details on tailoring approaches to stage of change).

1. How **important** is changing your cannabis use to you right now?
2. How **ready** are you to change your cannabis use right now?
3. How **confident** are you about making a change in your cannabis use?

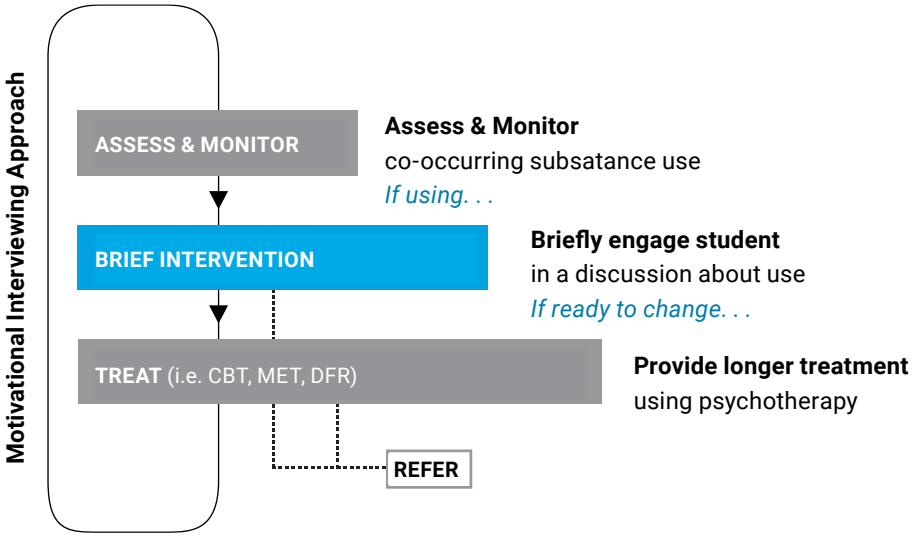
You said your confidence is 3 out of 10. What makes you 3 instead of a 0?...What do you think would need to happen for you to feel like a it is a 10?

4.3 Highlights

- Using motivational interviewing in working with students who are using cannabis demonstrates empathy and recognizes individual autonomy in goal-setting.
- Approach your conversations non-judgmentally and with curiosity.
- You can assess a students readiness to change by determining the amount of change talk relative to sustain talk and/or by directly asking the student their readiness to change (such as by using the readiness rulers).
- As you engage with a student to explore the possibility of change there will be opportunities to: (1) evoke and reflect back change talk, and (2) ask for permissions to offer information, feedback and advice that is appropriate to the student's stage of change related to their substance use.

4.4 Brief motivational interventions

Figure 13.



A brief intervention is often defined as an intervention that lasts 1-2 sessions. Most current brief interventions for cannabis use among youth are single session, in-person interventions, often delivered in schools that utilize MI or motivational enhancement therapy (MET) approaches. These brief interventions have demonstrated small but significant reductions in symptoms of cannabis use disorder and increased abstinence at short term follow-up[92]. This demonstrates that **SMH professionals can help students who are using cannabis use, even within time constraints.**

4.4.1 Exploring the Pros and Cons of Use

Exploring the **pros and cons** of use, often referred to as a Decisional Balance Exercise, involves discussing the pros and cons of both using cannabis, as well as changing cannabis use. In general, this discussion involves working through the following matrix:

Good things about using	**Not so good things about using**
Costs of changing	**Benefits of changing**

SMH professionals are encouraged to work through the quadrants of this matrix by exploring first the benefits of use (or "good things"), and then exploring the costs of use (the "not so good things"). This can be produced as a worksheet (Appendix J), or it can also be drawn and completed with a student while meeting together. Completing this tool together allows for the opportunity to discuss the function of the cannabis use by inquiring about the benefits experienced. This discussion also enables a SMH professional to consider ways to enhance motivation to consider change by enabling the student to envision the costs of their use in more clear terms. When examining the cons, probe further and try to elicit more cons than stated probes from the client.

Too often, we focus on how much better things will be if a person changes (reduces or abstains from) their substance use. This tool encourages a transparent discussion about the perceived costs of changing which is essential work in the contemplative stage. The perceived costs of changing can reveal areas of focus for skill development using CBT strategies. If a person is *pre-contemplative*, it is suggested to only focus on the pros and cons of using and not discuss the costs/benefits of changing (since they are not in a place of considering change, and will likely have a difficult time identifying any benefits of changing, even with prompts – and increase resistance). Additionally, individuals in later stages of change may not need to work through this matrix at all (since they are already ready to change).

Example:

Good things about using	**Not so good things about using**
Social	Money
It is what my friends do	Arguments at home
Relaxes me	
Helps me sleep	
Costs of changing	**Benefits of changing**
I might lose friends	More money – to…get license, go out more, etc
Difficulty sleeping	Old friends I could see more often (they don't use as much)
Fitting in	Remember more at school & attend more often

Work out how much money it is costing and add to matrix

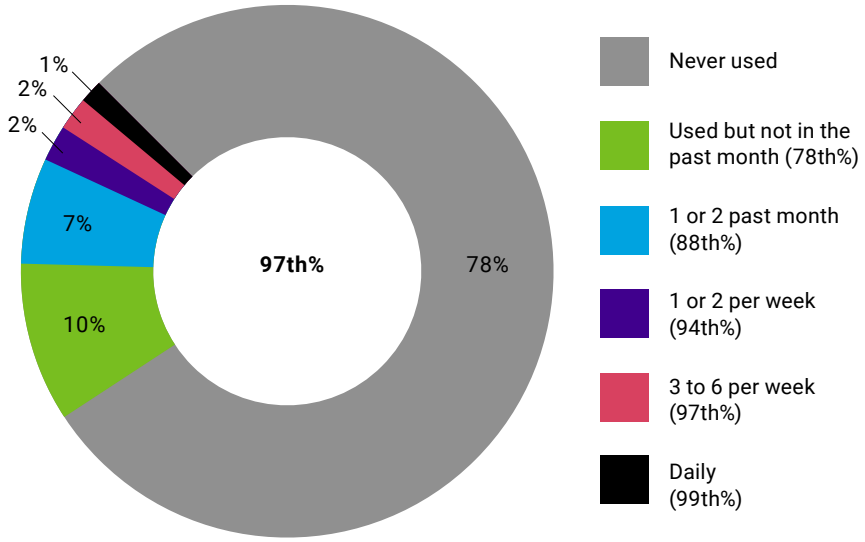
Inquire about this – impact, relationships, etc

Note: If necessary, due to time constraints of meeting with students in school, this can be provided as an out of session task which can be explored further at a next session.

4.4.2 Providing Normative Feedback

Information and personalized feedback can include **norm referencing** where a SMH professional provides information that can put the student's use in context with their peers. This can assist a person in moving from pre-contemplation to contemplative thinking. Specific to cannabis, providing data about peer use can help to dispel the belief that "everyone is using" which can help contribute to the consciousness raising process (See Figure 14 for an example and Appendix K for grade and gender matched norm-data[11]).

Figure 14. Example Normative Feedback. "You said you use cannabis about 4 time a week. This puts you in the orange group. This means that, compared to all grade 7 to 12 students across Ontario, you use cannabis more often then 97% of other students"



4.4.3 Engaging in Goal Setting

Before engaging in **goal setting**, it is helpful to assess the students' readiness to change using the Readiness Rulers and "meet the student where they are at". After providing a brief summary of your discussion with the student (re: pros and cons, normative feedback), you may wish to ask the student:

> Right now, where are you with your cannabis use? Do you think you want to make any changes, or are you okay with where you are right now?

It can be helpful to discuss the Lower Risk Cannabis Use Guidelines. The MI approach suggests asking a student about sharing information rather than proceeding without gaining interest or permission to provide information. If the student expresses desire to make changes, their substance use can become a target for ongoing treatment. If the student states they do not wish to make changes at this time, it may be helpful to ask:

"at what point might you want to make a change?"

or

"what would be a sign for you that changing your use might be something you want to consider?" (examples could include getting into university, if they start missing school, if they start having problems with their friends because of their cannabis use, etc.).

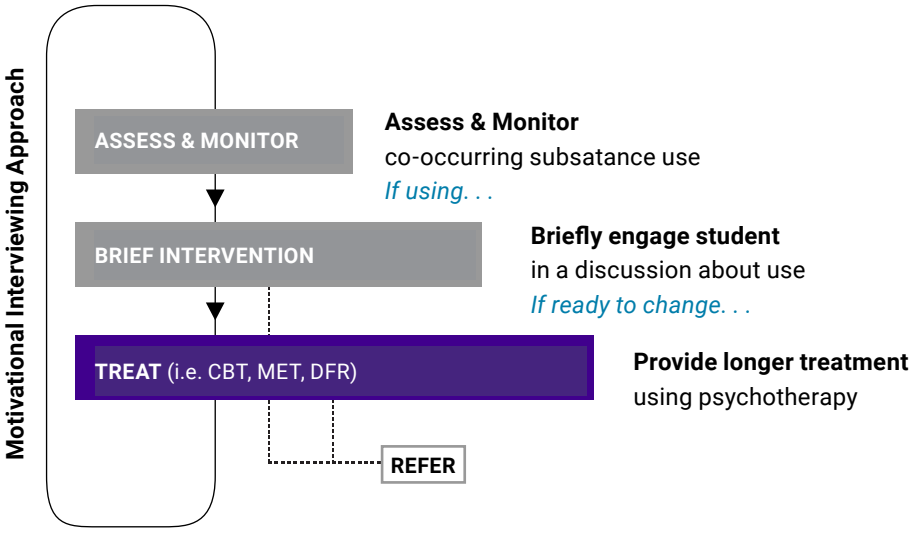
If you are meeting with a student over time, it may be helpful to revisit how the student perceives the importance of changing their cannabis use and their readiness and confidence in making small steps. There may be movement in either direction. The goal of motivational interviewing is to increase the ***perceived importance of changing*** (through psycho-education and highlighting the impact of use); increase the ***readiness to change*** (through highlighting their "change talk" statements and point out discordance in what they say they want and their current behaviours, e.g. I want to be closer with my parents…but my cannabis use causes problems with my parents), and; increase the ***perceived self-efficacy*** for changing (through increasing coping and providing positive reinforcement/affirmation of abilities to change).

4.4 Highlights

- SMH professionals can briefly engage the student in a non-judgemental conversation about their use.
- Strategies include exploring pros and cons of using, providing and discussing normative feedback, and engaging in specific goal setting.
- These approaches, although brief, can facilitate risk reduction and improvements in students cannabis use and related concerns.
- The MI approach/spirit can be used throughout all treatment for both substance use and other mental health concerns related to behaviour change.

4.5 Using CBT in schools to address cannabis use and other mental health concerns

Figure 15.



"Your emotions follow your thoughts just as surely as baby ducks follow their mother. But the fact that the baby ducks follow faithfully along doesn't prove that the mother knows where she is going." -David Burns

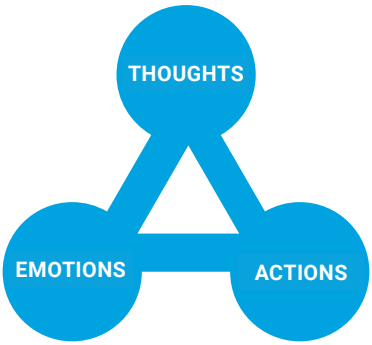
The World Health Organization provides specific questions to help guide the creation of specific substance use goals including:

1. How often will you be using?
2. How much will you have on using days?
3. How many cannabis free days will you have per week or per month?
4. How much will you use in a week or month?
5. What are your high risk situations where you'll avoid using?
6. How will you administer/ deliver cannabis (i.e. smoking, edibles, etc.)?
7. How will you reduce the risk of harm?

Full guide here: https://www.who.int/substance_abuse/activities/en/Draft_Substance_Use_Guide.pdf

Cognitive Behaviour Therapy (CBT) is an evidence-based therapeutic intervention, which focuses on thoughts, emotions, and actions that are interconnected and related to problematic behaviours (See Figure 16 for the "TEA Triangle") [93, 94]. Using CBT, SMH professions can support students in learning how to recognize, explore and change the thoughts, attitudes, beliefs and assumptions related to their substance use and other problematic reactions to specific situations [95]. In the context of substance use, beginning with the action of using a substance can be a natural place to start in the triangle.

Figure 16. **CBT Triangle**



If already using CBT, SMH professionals can include a focus on substance use in several ways. Substance use involves automatic thoughts that may not be self-evident. Working with a student to help them identify the situations or emotions which occur before their use provides an opportunity to help them explore the thoughts that may trigger their use. This can be particularly helpful in working with students who are in preparation about changing their use, have increased the amount they are using, are using in higher risk ways, or have used substances that they previously would have avoided.

If a student appears ready to reduce/change their cannabis use, CBT strategies may be a good approach to assist with their exploration. These strategies will be described in the next section.

Prompting questions for identifying **thoughts**:

- *What was going through your mind just before you began using cannabis?*
- *What were you telling yourself when you used cannabis?*
- *What does using cannabis mean about you? Your life? Your future?*
- *What are you afraid might happen? What is the worst thing that could happen if this is true?*

Prompting questions for identifying **emotions**:

- *How can you best describe the mood you were feeling before you used cannabis* ***only one word?***
- *How intensely did you experience this mood/emotion/feeling?*

Prompting questions for identifying **actions**:

- *What would I see you doing if I watched you on video?*
- *Who were you with? What type of cannabis were you using? What time of day was it? Where were you?*

Why CBT?

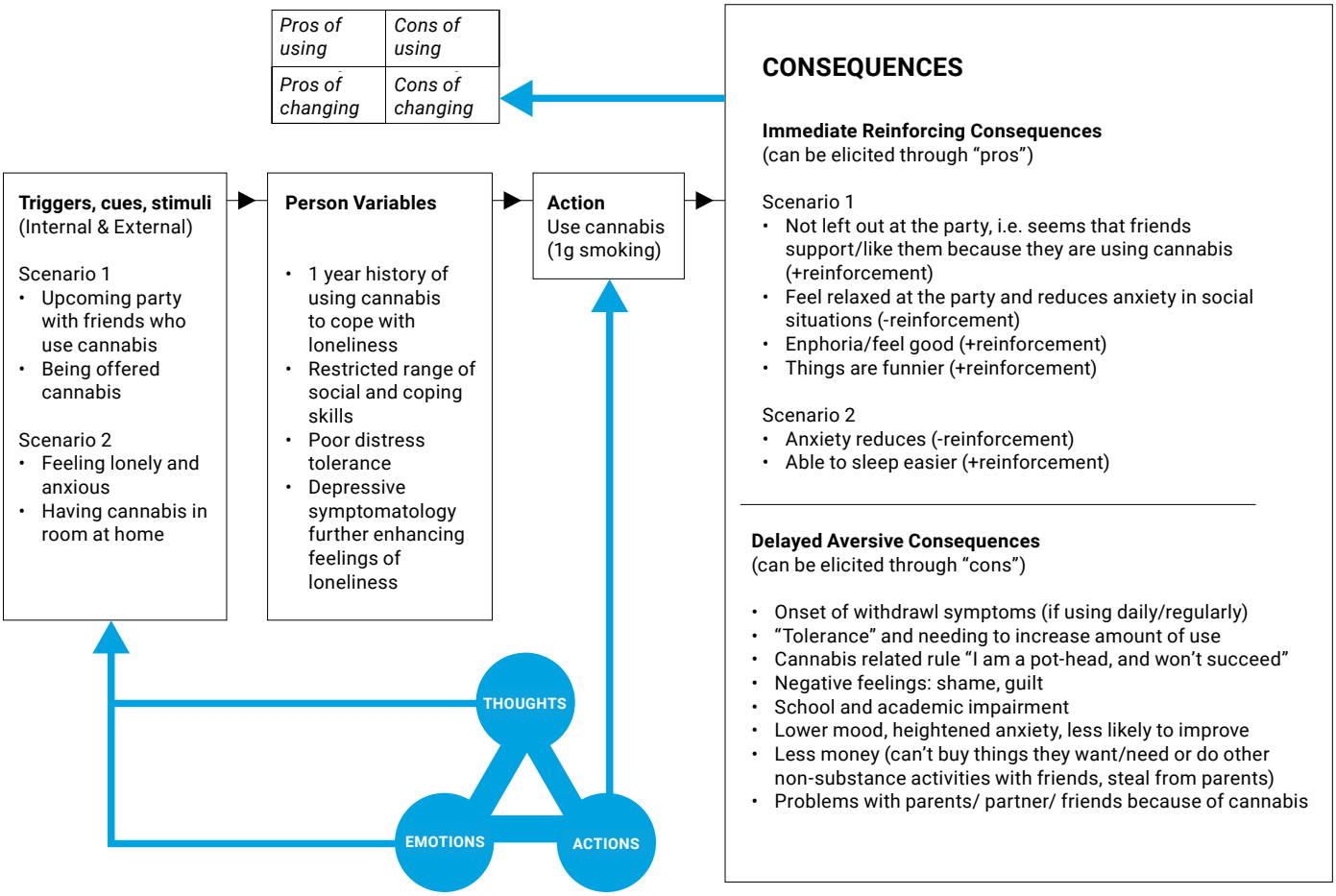
- CBT is structured
- CBT is time-limited
- CBT is problem-focused and goal-oriented
- CBT teaches strategies and skills
- CBT is based on a proactive, shared therapeutic relationship between therapist and client

4.5.1 Functional analysis of cannabis use

SMH professionals can explore what substances are being used, how they are being used, and learn with the student about where, when, and why they use. This can include creating a functional analysis of the students' substance use that focuses on:

- Triggers, cues, stimuli (internal and external) that precede their cannabis use.
- Personal socio-demographic and environmental characteristics that increase their vulnerability to use cannabis.
- Immediate reinforcing consequences of using cannabis (can be elicited through "pros").
- Delayed aversive consequences of using cannabis (can be elicited through "cons").

Figure 17. Example Functional Analysis



Example prompts for **antecedents of use/triggers**[96]:

- "When, or in what situations, do you use cannabis?"
- "What is happening right before you use cannabis?"
- "If you think back to the last time that you used cannabis, what was going on then?"
- "Does this usually happen when you are around other people or by yourself?"
- "Before using cannabis, do you usually have certain thoughts or feelings?"
- "Before you us cannabis, do you have any thoughts about what might happen if you use?"

Note: this can help students recognize high-risk situations for use which can then be used for goal setting and identifying strategies to deal with or avoid triggers.

Example prompts for **consequences** of cannabis use (both pros and cons)[96]:

- "What happens right after you use cannabis?"
- "What do you get from using cannabis?"
- "When you use cannabis, are you aware of any changes in how you feel?"
- "If you use with other people, how do they respond when you use?"
- "Are there times when you do not use? If so, what is going on then and how is it different?"
- "Are there things that happen later on because you used cannabis?"

Note: This can be done in the context of exploring pros and cons described above using an MI approach.

See Appendix L for a Functional Analysis Worksheet.

4.5.2 Identify thought distortions related to cannabis use

Similar to other behaviours, thoughts related to substance use can also be linked to unhelpful rules/assumptions, or cognitive/thought distortions, which can increase the likelihood of using substances. SMH professionals can help a student identify and challenge these distortions in their thinking. Part of the functional analysis described above is identifying potential thoughts related to cannabis use. As with CBT for other behaviours, SMH professionals can help students identify and challenge cannabis-related thought distortions. See below for example thought monitoring form and Appendix M for a worksheet.

Example Thought Monitoring Form				
Situation in which a student used cannabis	**Emotion & Intensity (0-100)**	**Thoughts, beliefs, and interpretations**	**Alternative Thoughts ("facts")**	**Balanced Thoughts**
Example. At a party with friends	Nervous/worried (70%)	People won't like me if I don't use cannabis (black & white thinking).	My friends still hang out with me when I am not using cannabis, Some of my friends don't use cannabis and are still in the friend group.	I may not spend as much time with my friends who are using cannabis at the party tonight, but they will still be my friends and hang out with me when they are done.

4.5.3 Teach strategies to cope with thoughts and emotions that may trigger use

After identifying particular thoughts and emotions that are related to the students' cannabis use, SMH professionals can identify targets for treatment and/or psycho-educational teaching opportunities. As similarly described in MI, it can be helpful to elicit if and what students have done currently or in the past to change their cannabis use. This can also be applied to assessing their current coping strategies related to specific triggers pertaining to their use identified through a functional analysis or thought record.

Example prompts for evaluating effectiveness of **coping strategies**[96]:

- "Have you ever tried to reduce or stop using cannabis before? If so, what have you tried to reduce or stop using cannabis? How did that work?"
- "How do you cope with difficult situations? When you do that, does it help? Does that way of coping cause other problems?"

From this, the SMH profession can reinforce and affirm their current skills and abilities (MI approach) and then help facilitate further skill development (with permission, using an MI approach). This may include practicing strategies for leaving a situation or refusing use.

4.5.4 Create opportunities for alternative activities

Students may identify activities that trigger use – such as going to a party. Consistent with the emerging evidence related to examining drug-free reinforcing alternative activities, SMH professionals can help the students identify and create opportunities for activities other than substance use.

"..treatments should go beyond a focus on reducing or eliminating substance use to target greater access to and more time spent in experiences that will be enjoyable or otherwise rewarding to clients."
–McKay, 2017 Addiction[81]

These alternative activities should provide rewards and/or enjoyable experiences. Facilitating and/or highlighting these alternative activities, may help the youth have long lasting reductions in their substance use – we can help the youth find natural reinforcers to reducing or stopping their use. Some of these alternative activities may include:

- **Developing and maintaining healthy social networks.**
- **Engaging in substance-free recreational activities (e.g. exercise, creative activities, clubs).**
- **Experiencing academic (and later occupational) success.**

4.5 Highlights

- Like other actions, cannabis use is connected to thoughts and emotions.
- Strategies to explore the connection between thoughts, emotions, and actions related to cannabis use include:
    - **Functional analyses**, which can be used to understand the who, what, when, where, and why of cannabis use.
    - **Thought monitoring** and challenging.
    - **Teaching coping skills** for thoughts and emotional triggers.
    - Exploring **alternative activities**.

4.6 Contingency management, alternative activities, & values exploration

The most well-researched drug-free reinforcement strategy is **contingency management**. Contingency management typically provides monetary incentives for sustained abstinence (usually confirmed with objective measures, like a urine test). Current best evidence suggests that if an individual experiencing cannabis use related problems is not responding to MI/MET and/or CBT, that contingency management should be considered [77 78]. Contingency management has been shown to increase short term and sustained abstinence among youth in several trials[97]. However, providing monetary reinforcement is not a practical strategy for SMH professionals and less commonly done in Canada (most of these interventions are in the US). Despite this, **finding ways to positively reinforce reduction or abstinence from substance use** can still be found using alternative, more practical, means.

As described above, SMH professionals can help students identify and engage in alternative drug-free activities. These activities can provide positive reinforcement to the students' by providing fun ways to spend their time and engage with others that does not require substances. Additionally, SMH professionals can provide affirmations or verbal praise for the steps students are taking (or have taken) to reduce their use.

Additionally, it can be helpful to support youth to **identify and live in alignment with their interests, values, and life goals**. There is emerging work suggesting that identifying values and goals and steps to reach their goals can help youth reduce substance use[98, 99]. Often these strategies are included within brief motivational interventions (i.e. 68% of the brief motivational interventions in a recent systematic review included some form of values exploration)[92]. Exploration and discussion of values is also included as part of the BRISC that SMH professionals utilize for other difficulties. To further connect values and life goals to substance use, it can be helpful to ask youth *"How does your substance use affect your values/goals, if at all?"* and *"If you decided to reduce or stop using, how might that impact your ability to live in alignment with your values and reach your goals?"*

4.6 Highlights

SMH Professionals can use contingency management strategies including:

- Finding ways to positively reinforce reduction or abstinence from substance use.
- Helping the student to identify and live in alignment with their interests, values, and life goals.

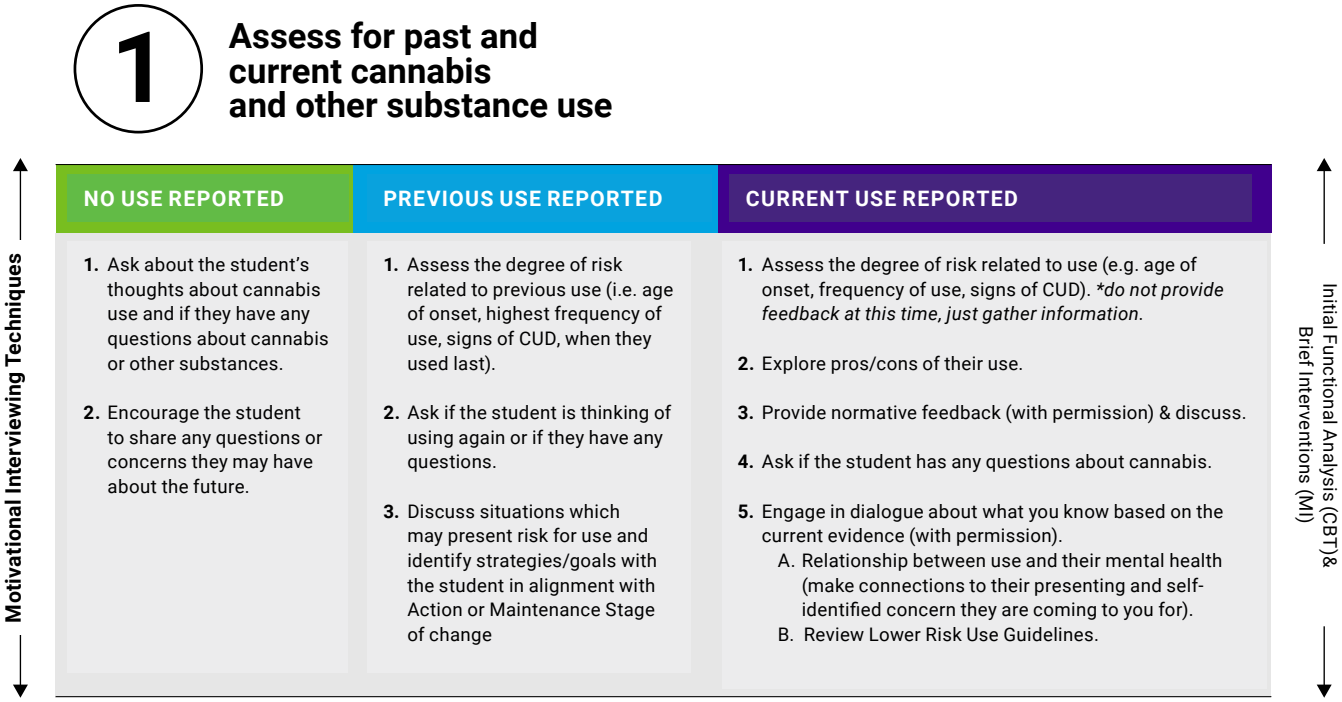
5

Summary & Clinical Flow Chart

SMH professionals will often see students who are using cannabis (and other substances). Among youth, substance use is related to mental health concerns and problems with healthy development and functioning. Co-occurring substance use may be related to poor treatment response from the students seen by SMH professionals.

This guide provides actionable information and tools for SMH professionals to: (1) assess and monitor for co-occurring substance use and substance use problems; (2) engage in psycho-education and motivational interviewing techniques for all students who report using substances (brief intervention); (3) concurrently treat substance use problems alongside mental health concerns with existing tools and techniques used by SMH professionals (i.e. motivational interviewing or enhancement and cognitive behavioural therapy approaches); and (4) identify youth at high risk and facilitate referral to the appropriate services. See Figure 18 for a clinical flow chart to help SMH professionals navigate how to assess and address student substance use.

Figure 18. Clinical Flow Chart



For helpful discussion points and skills to address students reporting no use or previous use, refer to the following sections of the guide: Background Information & Motivational Interviewing and the Transtheoretical Model.

For helpful discussion points and skills/techniques to facilitate the conversation with students reporting current use, please refer to the following sections of the guide: Background Information, Essential Factors in Assessment of Cannabis Use, and Brief Motivational Interventions. Prompting statements from the Functional Analysis within CBT may also be helpful.

2 Assess Importance,Confidence, and Readiness to Change

Refer to the **Transtheoretical Model of Change**

Motivational Interviewing Techniques

PRE-CONTEMPLATION	CONTEMPLATION	PREPARATION	ACTION
1. Summarize discussion (re: preliminary functional analysis and readiness to change). 2. Ask the youth if there is anything that may indicate to them that they want to change in the future. 3. Ask permission to check in with them about their use again at a later session. 4. Provide information in a non-judgmental manner about use and possible connection to other presenting issues (e.g. anxiety). 5. When providing treatment and skills related to other concerns, provide examples of how it may apply to substance use generally.	1. Summarize discussion (re: preliminary functional analysis and readiness to change). 2. Ask the youth if there is anything that may indicate to them that they want to change in the future. 3. Let the youth know that strategies to help them with their cannabis use (or other substance use) are similar to strategies they are already learning within your sessions. If and when they decide they are ready to make changes, you can start actively discussing cannabis during the sessions alongside other concerns. • Suggest self monitoring or self assessment tools (if deemed clinically appropriate). • Suggest alternative activities or drug free reinforcement strategies (if deemed clinically appropriate). 4. Ask permission to check in with them about their use again at a later session. 5. When providing treatment and skills related to other concerns, provide examples of how it may apply to their substance use.		1. Summarize discussion (re: preliminary functional analysis and readiness to change). 2. Let the youth know that strategies to help them with their cannabis use (or other substance use) are similar to strategies they are already learning within your sessions. Ask permission to include cannabis use (and/or other substance use) in future discussion and skills. • Suggest self monitoring or workbooks. • Suggest alternative activities or drug free reinforcement strategies.

3 Incorporate Cannabis (and/or substance use) into subsequent treatment for those in Action Stage.

Refer to **Using CBT in schools** and/or **Contingency Management**. Note: Motivational Interviewing strategies are used throughout assessment & interventions

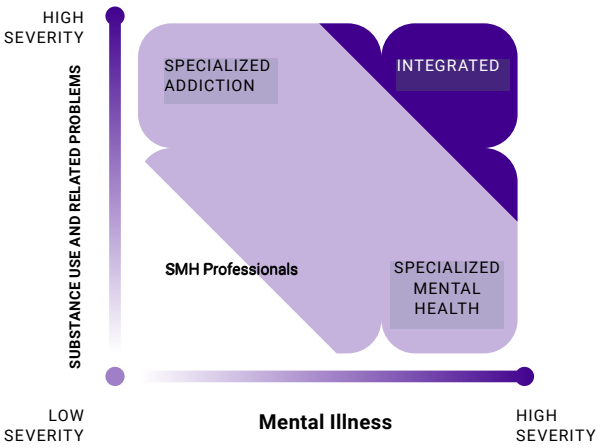
4 Consider referral to a specialized community medical providers and/or concurrent disorders treatment programs.

Refer to **Navigating Referrals**

Indications a student may require referral:

- Ongoing cannabis use is causing severe impairment that is not improving with motivational and cognitive behavioural interventions able to be delivered in the school setting.
- Disclosure from student, family and/or school staff indicates increased severity of mental health concerns related to substance use (e.g. experiencing psychosis during or after use; engaging in self-harm or risk of suicide during or after use).
- Regular use of other illicit drugs (such as opioids)
- Daily alcohol use showing symptoms of alcohol use disorder (withdrawal from alcohol use can be life threatening and reductions/cessation of this use should be monitored with a medical professional).

continue supporting the student within constraints related to your time and expertise when referring out



6

Navigating Referrals

Referral resources may vary by region and board mental health teams often create linkages and partnership agreements with community partners to support better pathways to care. The School Mental Health Ontario Circle of Support Resource Document is a guide for mental health leadership teams to support a coordinated approach to developing referral plans that reflect each board's local resources and opportunities.

As detailed in this guide, students will often receive counselling regarding their cannabis use related to other presenting concerns. Many community addictions services (non-residential/outpatient) will support youth who do not have a defined goal of reduction or abstinence and will use the Transtheoretical Model of Change in their approach to supporting a student in considering, preparing for and making changes in their cannabis use.

Consider referral to local community medical services and/or specialized substance use or concurrent disorders treatment programs when:

- Ongoing cannabis use is causing severe impairment that is not improving with motivational and cognitive behavioural interventions able to be delivered in the school setting.
- Disclosure from student, family and/or school staff indicates increased severity of mental health concerns related to substance use (e.g. experiencing psychosis during or after use; engaging in self-harm or risk of suicide during or after use).
- Regular use of other illicit drugs (such as opioids).
- Daily alcohol use showing symptoms of alcohol use disorder (withdrawal from alcohol use can be life threatening and reductions/cessation of this use should be monitored with a medical professional).

SMH professionals can access community-based details about:

- **treatment services**
- **crisis lines**
- **self-help groups**
- **distress centres, and**
- **family services, through:**

ConnexOntario
https://www.connexontario.ca/
1-866-531-2600

Board mental health leadership teams are encouraged to engage with community resources that provide substance use /addictions counselling for youth for potential consultation, referrals and collaboration.

7

Acknowledgements

7.1 Acknowledging the limitations of the evidence

Cannabis is complicated. Much of the current research on the potential of harms and correlates of cannabis use are based on use of **any cannabis** – not considering the composition, age of onset, patterns through the day, method of delivery, etc. Therefore, most of the potential "risks" are based on research on typical cannabis products used by the general population (and are not person specific). Similarly, there is little research done on particular treatments for cannabis problems, especially when considering specific sub-populations (for example, youth with co-occurring cannabis use, ADHD, and depression). This guide is based on the best **available** research – but it is important to acknowledge the limitations of this literature. However, due to legalization and increased public health and government interests into the effects of cannabis use (both benefits and harms) and treatment of related problems, it is anticipated that ***more and better research is coming.***

7.2 Document consultation team

This Practice Guide was created by Allison Potts, MSW, RSW and Jillian Halladay, BScN, RN, MSc, in collaboration and consultation with provincial partners and key stakeholders.

We are grateful for collaboration and consultation with: clinicians and researchers affiliated with the Centre for Addiction and Mental Health (CAMH); Dr. Catharine Munn, the lead psychiatrist at the McMaster University Student Wellness Centre and Mental Health Strategy Lead at McMaster University; Dr. James MacKillop and Dr. Michael Amlung at the Peter Boris Centre for Addictions Research and the Michael G. DeGroote Centre for Medicinal Cannabis Research at McMaster University; Dr Angie Kirby, Clinical Coordinator at Pinewood Health Centre of Lakeridge Health; a key informant team of Mental Health Leaders (Patrick Carney, Petra Duschner, Jenny Marino, Michelle Neville), and; Ontario SMH Professionals through survey feedback.

8

Key resources

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

Further professional development related to cannabis and substance use:

- The Centre for Addiction and Mental Health (CAMH) offers various professional development opportunities and resources including an on-line course called The Fundamentals of Addiction. The course description states that this course aims to help learners further their understanding of addictive behaviour, which in the current Diagnostic and Statistical Manual includes both substances use issues and problem gambling. The course uses a biopsychosocial plus (BPS+) model of addiction, which provides a multidimensional way of understanding this complex field. Information about this and other CAMH resources can be found at: https://www.camh.ca

  Information about the Fundamentals of Addiction course can be found at this link: https://www.camh.ca/en/education/continuing-education/continuing-education-programs-and-courses/fundamentals-of-addiction-online-course

- The Peter Boris Centre for Addictions Research, the Michael G. DeGroote Centre for Medicinal Cannabis Research, and McMaster Continuing Education offer a program for further education called The Science of Cannabis program. It is an on-line program that focuses on the study of cannabis from a scientific and research-based perspective. Information about this program can be found at: https://mcmastercce.ca/the-science-of-cannabis-program?

Resources providing cannabis specific information (Canadian content):

- Information for health professionals from Health Canada: https://www.canada.ca/content/dam/hc-sc/documents/services/drugs-medication/cannabis/information-medical-practitioners/information-health-care-professionals-cannabis-cannabinoids-eng.pdf
- Information on cannabis from the Canadian Centre for Substance Use and Addiction (CCSA) – Clearing the Smoke on Cannabis: http://www.ccsa.ca/Resource%20Library/CCSA-Clearing-the-Smoke-on-Cannabis-Highlights-2016-en.pdf
- Information resource from the Children's Hospital of Eastern Ontario (CHEO) includes links to other useful documents: *Clearing the Air: Informing conversations about cannabis for child and youth mental health and addictions professionals*: http://www.excellenceforchildandyouth.ca/resource-hub/clearing-air-informing-conversations-about-cannabis-child-and-youth-mental-health-and
- Ophea listing of teaching tools and related resources for educators: https://teachingtools.ophea.net/supplements/cannabis-education-resources/substance-use-addictions-and-related-behaviours

Resources that provide youth-specific recommendations for talking about cannabis

- From Drug Free Kids Canada, a *Cannabis Talk Kit* provides information for parents about how to talk with teens about cannabis: https://www.drugfreekidscanada.org/wp-content/uploads/pdf/Cannabis-Talk-Kit_EN.pdf
- The Canadian Centre for Substance Use and Addiction provides a guide for youth allies about engaging in conversations around cannabis called *Talking pot with youth:* https://www.ccsa.ca/talking-pot-youth-cannabis-communication-guide-youth-allies
- Canadian Students for Sensible Drug Policy created a resource which makes recommendations about cannabis called *Sensible Cannabis Education: A Toolkit for Educating Youth:* https://cssdp.org/uploads/2018/04/Sensible-Cannabis-Education-A-Toolkit-for-Educating-Youth.pdf

Resources to support youth in self-monitoring their use of cannabis

- What's With Weed: http://whatswithweed.ca
- Self Monitoring/Substance use workbook: http://www.who.int/substance_abuse/activities/en/Draft_Substance_Use_Guide.pdf
- Lower Risk Cannabis Use Guidelines (CAMH resources: one which is youth specific and one for general population):

  https://www.camh.ca/-/media/images/all-other-images/research-lrcug-for-youth/lrcug_for_youth-eng-pdf.pdf?

  https://www.camh.ca/-/media/files/pdfs---reports-and-books---research/canadas-lower-risk-guidelines-cannabis-pdf.pdf

Resources about psychosis and cannabis for youth, families and educators

- EPION (Early Psychosis Intervention Ontario Network) information about cannabis: http://mycannabisiq.ca
- EPION also provides a useful infographic resource to support educators in responding to possible symptoms of psychosis: http://help4psychosis.ca/wp-content/uploads/2016/03/What-can-Educators-Do_infographicSept2015-FINAL-1.pdf

Resources to support whole school and targeted prevention initiatives

District and school level mental health teams are encouraged to use the decision support tools provided by School Mental Health Ontario to guide the selection of awareness and prevention activities.

- The Public Health Agency of Canada partnered with Western University to develop educational resources for Canadian school stakeholders. The purpose of the project is to promote school-based initiatives that enhance positive youth development as a means of addressing problematic substance use and other adverse outcomes among youth. Resources include an infographic, research briefs and whiteboard videos, and are available in English and French: https://www.canada.ca/en/public-health/services/beyond-health-education-preventing-substance-use-enhancing-students-well-being.html
- The Western University Centre for School Mental Health provides further information on their website related to preventing problematic substance use through positive youth development at their website: https://www.csmh.uwo.ca/research/positive-youth-development.html
- OPHEA provides a resource database and cannabis education resources for educators: https://teachingtools.ophea.net/supplements/cannabis-education-resources
- For further guidance related to supporting collaborative partnerships between school boards, schools and boards of health, the Ministry of Health and Long Term Care created a School Health Guideline (2018) to provide direction to boards of health on required approaches to developing and implementing programs and services: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/School_Health_Guideline_2018.pdf
- In planning awareness and prevention activities, teams can access resources provided by the Canadian Centre on Substance Use and Addiction: https://www.ccsa.ca
- Health Canada provides several links related to cannabis including laws and regulations, health risks (including risks related to pregnancy) and information about recalls and adverse reactions at: https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis.html

9

References

Document References

1. Costello EJ, He JP, Sampson NA, Kessler RC, Merikangas KR. Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey-Adolescent. *Psychiatric Services*. 2014;65(3):359-66. Available from: doi: 10.1176/appi.ps.201100518.
2. Merikangas KR, He JP, Burstein M, Swendsen J, Avenevoli S, Case B, et al. Service utilization for lifetime mental disorders in U.S. adolescents: results of the National Comorbidity Survey-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry.* 2011;50(1):32-45. Available from: https://doi.org/10.1016/j.jaac.2010.10.006.
3. Ryan SM, Toumbourou JW, Jorm AF. Factors associated with service use for young adolescents with mental health problems: Findings from an Australian longitudinal study. *SAGE open*. 2014;4(4). Available from: https://doi.org/10.1177/2158244014556286.
4. Ministry of Health and Long Term Care. *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy 2011.* Available from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf. [Accessed 21st June 2019].
5. Mental Health Commission of Canada. *Changing directions changing lifes: the mental health strategy for Canada*. Calgary, AB. Available from: https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf [Accessed 21st June 2019].
6. Public Health Agency of Canada. *Promoting Well-Being: Promoting students' well-being can reduce their risk of problematic substance use*. Available from: https://www.csmh.uwo.ca/docs/EN-BLAM1-Final-Web.pdf. [Accessed 21st June 2019].
7. National Institute on Drug Abuse. *Most commonly used addictive drugs*. Available from: https://www.drugabuse.gov/publications/media-guide/most-commonly-used-addictive-drugs. [Accessed 21st June 2019].
8. Currie C, Zanotti, C., Morgan, A., Currie, D., de Looze, M., Roberts, C., et al. Social determinants of health and well-being among young people. *Health Behaviour in School-aged Children (HBSC) study: international report from the 2009/2010 survey.* Copenhagen: World Health Organization; 2012.
9. UNICEF Office of Research. Child Well-being in Rich Countries: A comparative overview. *Innocenti Report Card 11*, UNICEF Office of Research, Florence; 2013.
10. Zuckermann AME, Battista K, de Groh M, Jiang Y, Leatherdale ST. Prelegalisation patterns and trends of cannabis use among Canadian youth: results from the COMPASS prospective cohort study. *BMJ Open.* 2019;9(3):e026515. Available from: doi:10.1136/ bmjopen-2018-026515.
11. Boak A, Hamilton HA, Adlaf EM, Mann RE. *Drug use among Ontario students, 1977-2017: Detailed Findings from the Ontario Student Drug Use and Health Survey (OSDUHS) (CAMH Research Document Series No. 46).* Toronto, ON: Centre for Addiction and Mental Health; 2017.
12. Okaneku J, Vearrier D, McKeever RG, LaSala GS, Greenberg MI. Change in perceived risk associated with marijuana use in the United States from 2002 to 2012. *Clinical Toxicology.* 2015;53(3):151-5. Available from: https://doi.org/10.3109/15563650.2015.1004581.

13. Berg CJ, Stratton E, Schauer GL, Lewis M, Wang Y, Windle M, Kegler M. Perceived harm, addictiveness, and social acceptability of tobacco products and marijuana among young adults: marijuana, hookah, and electronic cigarettes win. *Substance use & misuse.* 2015 Jan 2;50(1):79-89. Available from: https://doi.org/10.3109/10826084.2014.958857.

14. Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE, Miech RA. *Monitoring the Future national survey results on drug use, 1975–2014: Volume 2, College students and adults ages 19–55.* Ann Arbor, MI: Institute for Social Research, University of Michigan; 2015.

15. Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed tables.* Rockville, MD: US Department of Health and Human Services, Office of Applied Studies; 2014. Available from: https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2013.pdf. [Accessed 21st June 2019].

16. Rush B, Urbanoski K, Bassani D, Castel S, Wild TC, Strike C, et al. Prevalence of co-occurring substance use and other mental disorders in the Canadian population. *Canadian Journal of Psychiatry.* 2008;53(12):800-9. Available from: https://doi.org/10.1177/070674370805301206.

17. Lev-Ran S, Le Foll B, McKenzie K, George TP, Rehm J. Cannabis use and cannabis use disorders among individuals with mental illness. *Comprehensive Psychiatry.* 2013;54(6):589-98. Available from: https://doi.org/10.1016/j.comppsych.2012.12.021.

18. Halladay J, MacKillop J, Munn C, Jack SM, Georgiades K. Cannabis Use as a Risk Factor for Depression, Anxiety and Suicidality: Epidemiological Associations and Implications for Nurses. *Journal of Addictions Nursing.* In press.

19. National Institute on Drug Abuse. *Marijuana.* Available from: https://www.drugabuse.gov/publications/drugfacts/marijuana. [Accessed 21st June 2019].

20. ElSohly MA, Radwan MM, Gul W, Chandra S, Galal A. Phytochemistry of Cannabis sativa L. *Progress in the Chemistry of Organic Natural Products.* 2017;103:1-36. Available from: doi: 10.1007/978-3-319-45541-9_1.

21. Health Canada. *Information for heath care professional: cannabis (marihuana, marijuana) and the cannabinoids 2013.* Available from: http://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/marihuana/med/infoprof-eng.pdf. [Accessed 21st June 2019].

22. Canadian Students for Sensible Drug Policy. *Sensible Cannabis Education: A Toolkit for Educating Youth.* Available from: https://cssdp.org/uploads/2018/04/Sensible-Cannabis-Education-A-Toolkit-for-Educating-Youth.pdf. [Accessed 21st June 2019].

23. Ormiston S. What's in your weed: Why cannabis strains don't all live up to their billing. *CBC News;* 2018. Available from: https://www.cbc.ca/news/thenational/ormiston-pot-marijuana-cannabis-weed-genetics-1.4489974. [Accessed 21st June 2019].

24. Cain P. Why the labels 'sativa' and 'indica' tell you very little about your pot. *Global News;* 2018. Available from: https://globalnews.ca/news/4678421/labels-sativa-indica-pot/. [Accessed 21st June 2019].

25. Hazekamp A, Tejkalová K, Papadimitriou S. Cannabis: from cultivar to chemovar II—a metabolomics approach to Cannabis classification. *Cannabis and Cannabinoid Research.* 2016;1(1):202-15. Available from: https://doi.org/10.1089/can.2016.0017.

26. School Mental Health Assist. *Cannabis: What Parents/Guardians and Caregivers Need to Know.* Available from: https://smh-assist.ca/wp-content/uploads/Cannabis-Parent-Infosheet.pdf. [Accessed 21st June 2019].

27. Abrams DI, Vizoso HP, Shade SB, Jay C, Kelly ME, Benowitz NL. Vaporization as a smokeless cannabis delivery system: a pilot study. *Clinical Pharmacology and Therapeutics.* 2007;82(5):572-8. Available from: https://doi.org/10.1038/sj.clpt.6100200.

28. Solinas M, Tanda G, Wertheim CE, Goldberg SR. Dopaminergic augmentation of delta-9-tetrahydrocannabinol (THC) discrimination: possible involvement of D(2)-induced formation of anandamide. *Psychopharmacology.* 2010;209(2):191-202. Available from: doi: 10.1007/s00213-010-1789-8.

29. Colizzi M, McGuire P, Pertwee RG, Bhattacharyya S. Effect of cannabis on glutamate signalling in the brain: A systematic review of human and animal evidence. *Neuroscience and Biobehavioral Reviews.* 2016;64:359-81. Available from: doi: 10.1016/j.neubiorev.2016.03.010.

30. Volkow ND, Hampson AJ, Baler RD. Don't Worry, Be Happy: Endocannabinoids and Cannabis at the Intersection of Stress and Reward. *Annual Review of Pharmacology and Toxicology.* 2017;57:285-308. Available from: doi: 10.1146/annurev-pharmtox-010716-104615.

31. Tambaro S, Tomasi ML, Bortolato M. Long-term CB(1) receptor blockade enhances vulnerability to anxiogenic-like effects of cannabinoids. *Neuropharmacology.* 2013;70:268-77. Available from: doi: 10.1016/j.neuropharm.2013.02.009.

32. Gavin L, MacKay AP, Brown K, et al. Sexual and Reproductive Health of Persons Aged 10–24 Years — United States, 2002–2007. *MMWR Surveillance Summaries*. 2009;58(SS06):1-58. Available from: https://www.cdc.gov/mmwr/preview/mmwrhtml/ss5806a1.htm. [Accessed 21st June 2019].

33. Volkow ND, Compton WM, Weiss SR. Adverse health effects of marijuana use. *New England Journal of Medicine.* 2014;371(9):879. Available from: doi: 10.1056/NEJMra1402309.

34. McInnes OA, Porath-Waller A. Clearing the Smoke on Cannabis Chronic Use and Cognitive Functioning and Mental Health – An Update. *Canadian Centre on Susbtance Use and Addiction.* Available from: https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Cannabis-Use-Cognitive-Effects-Report-2019-en.pdf. [Accessed 21st June 2019].

35. Halladay JE, Boyle MH, Munn C, Jack SM, Georgiades K. Sex Differences in the Association Between Cannabis Use and Suicidal Ideation and Attempts, Depression, and Psychological Distress Among Canadians. *Canadian Journal of Psychiatry.* 2018;64(5):345-350. Available from: doi: 10.1177/0706743718804542.

36. Atakan Z, Bhattacharyya S, Allen P, Martin-Santos R, Crippa J, Borgwardt S, et al. Cannabis affects people differently: Inter-subject variation in the psychotogenic effects of DELTA9-tetrahydrocannabinol: A functional magnetic resonance imaging study with healthy volunteers. *Psychological Medicine.* 2013;43(6):1255-67. Available from: doi: 10.1017/S0033291712001924.

37. Cascini F, Aiello C, Di Tanna G. Increasing delta-9-tetrahydrocannabinol (Delta-9-THC) content in herbal cannabis over time: systematic review and meta-analysis. *Current Drug Abuse Reviews.* 2012;5(1):32-40. Available from: doi: 10.2174/1874473711205010032.

38. ElSohly MA, Mehmedic Z, Foster S, Gon C, Chandra S, Church JC. Changes in Cannabis Potency Over the Last 2 Decades (1995-2014): Analysis of Current Data in the United States. *Biological Psychiatry.* 2016;79(7):613-9. Available from: doi: 10.1016/j.biopsych.2016.01.004.

39. CBC Marketplace. *What's really in your weed?* Available from: https://www.cbc.ca/news/canada/what-s-really-in-your-weed-1.3866482. [Accessed 21st June 2019].

40. Ontario Cannabis Store. 2019. Available from: https://ocs.ca/. [Accessed 21st June 2019].

41. National Institute on Drug Abuse. *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide*. Available from: https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide. [Accessed 21st June 2019].

42. Volkow ND, Swanson JM, Evins AE, DeLisi LE, Meier MH, Gonzalez R, et al. Effects of cannabis use on human behavior, including cognition, motivation, and psychosis: a review. *JAMA Psychiatry.* 2016;73(3):292-7. Available from: doi:10.1001/jamapsychiatry.2015.3278.

43. Gobbi G AT, Zytynski T, et al. Association of Cannabis Use in Adolescence and Risk of Depression, Anxiety, and Suicidality in Young Adulthood: A Systematic Review and Meta-analysis. *JAMA Psychiatry.* 2019; 76(4):426-434. Available from: doi:10.1001/jamapsychiatry.2018.4500.

44. Mitchell JT, Sweitzer MM, Tunno AM, Kollins SH, McClernon FJ. "I Use Weed for My ADHD": A Qualitative Analysis of Online Forum Discussions on Cannabis Use and ADHD. *PloS one.* 2016;11(5):e0156614. Available from: doi: 10.1371/journal.pone.0156614.

45. Lee SS, Humphreys KL, Flory K, Liu R, Glass K. Prospective association of childhood attention-deficit/hyperactivity disorder (ADHD) and substance use and abuse/dependence: a meta-analytic review. *Clinical Psychology Review.* 2011;31(3):328-41. Available from: doi: 10.1016/j.cpr.2011.01.006.

46. Farmer RF, Seeley JR, Kosty DB, Gau JM, Duncan SC, Lynskey MT, et al. Internalizing and externalizing psychopathology as predictors of cannabis use disorder onset during adolescence and early adulthood. *Psychology of Addictive Behaviors.* 2015;29(3):541. Available from: doi: 10.1037/adb0000059.

47. Mustonen A, Niemelä S, Nordström T, Murray GK, Mäki P, Jääskeläinen E, et al. Adolescent cannabis use, baseline prodromal symptoms and the risk of psychosis. *The British Journal of Psychiatry.* 2018;212(4):227-33. Available from: doi: https://doi.org/10.1192/bjp.2017.52.

48. Hasin DS, Saha TD, Kerridge BT, Goldstein RB, Chou SP, Zhang H, et al. Prevalence of marijuana use disorders in the United States between 2001-2002 and 2012-2013. *JAMA Psychiatry.* 2015;72(12):1235-42. Available from: doi:10.1001/jamapsychiatry.2015.1858.

49. Winters KC, Lee C-YS. Likelihood of developing an alcohol and cannabis use disorder during youth: association with recent use and age. *Drug and Alcohol Dependence.* 2008;92(1-3):239-47. Available from: doi: 10.1016/j.drugalcdep.2007.08.005.

50. Fischer B, Russell C, Sabioni P, van den Brink W, Le Foll B, Hall W, et al. Lower-Risk Cannabis Use Guidelines: A Comprehensive Update of Evidence and Recommendations. *American Journal of Public Health.* 2017;107(8):e1-e12. Available from: doi: 10.2105/AJPH.2017.303818.

51. Fox CL, Towe SL, Stephens RS, Walker DD, Roffman RA. Motives for cannabis use in high-risk adolescent users. *Psychology of Addictive Behaviors*. 2011;25(3):492-500. Available from: doi: 10.1037/a0024331.

52. van der Pol P, Liebregts N, de Graaf R, Korf DJ, van den Brink W, van Laar M. Predicting the transition from frequent cannabis use to cannabis dependence: A three-year prospective study. *Drug and Alcohol Dependence*. 2013;133(2):352-9. Available from: doi: 10.1016/j.drugalcdep.2013.06.009.

53. Bujarski SJ, Norberg MM, Copeland J. The association between distress tolerance and cannabis use-related problems: The mediating and moderating roles of coping motives and gender. *Addictive Behaviors*. 2012;37(10):1181-4. Available from: doi: 10.1016/j.addbeh.2012.05.014

54. du Roscoat E, Legleye S, Guignard R, Husky M, Beck F. Risk factors for suicide attempts and hospitalizations in a sample of 39,542 French adolescents. *Journal of Affective Disorders*. 2016;190:517-21. Available from: doi: 10.1016/j.jad.2015.10.049.

55. Foster KT, Li N, McClure EA, Sonne SC, Gray KM. Gender differences in internalizing symptoms and suicide risk among men and women seeking treatment for cannabis use disorder from late adolescence to middle adulthood. *Journal of Substance Abuse Treatment*. 2016;66:16-22. Available from: doi: 10.1016/j.jsat.2016.01.012.

56. Danielsson A-K, Lundin A, Allebeck P, Agardh E. Cannabis use and psychological distress: An 8-year prospective population-based study among Swedish men and women. *Addictive Behaviors.* 2016;59:18-23. Available from: doi: 10.1016/j.addbeh.2016.03.005.

57. Dawson DA, Goldstein RB, Moss HB, Li TK, Grant BF. Gender differences in the relationship of internalizing and externalizing psychopathology to alcohol dependence: likelihood, expression and course. *Drug and Alcohol Dependence*. 2010;112(1-2):9-17. Available from: doi: 10.1016/j.drugalcdep.2010.04.019.

58. Courtney KE, Mejia MH, Jacobus J. Longitudinal Studies on the Etiology of Cannabis Use Disorder: A Review. *Current Addiction Reports*. 2017;4(2):43-52. Available from: doi: 10.1007/s40429-017-0133-3.

59. Gulliver A, Griffiths KM, Christensen H. Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry.* 2010;10:113. Available from: https://doi.org/10.1186/1471-244X-10-113.

60. Urbanoski K. *Strengthening Performance Measurement for Mental Health and Addiction in Ontario.* Center for Addiction and Mental Health; 2017. Available from: https://eenet.ca/sites/default/files/pdfs/DTFP-ON_Performance%20Measurement%20for%20MHA_FINAL.pdf. [Accessed 21st June 2019].

61. Mammen G, Rueda S, Roerecke M, Bonato S, Lev-Ran S, Rehm J. Association of Cannabis With Long-Term Clinical Symptoms in Anxiety and Mood Disorders: A Systematic Review of Prospective Studies. *Journal of Clinical Psychiatry.* 2018;79(4). Available from: doi: 10.4088/JCP.17r11839.

62. Moitra E, Anderson BJ, Stein MD. Reductions in cannabis use are associated with mood improvement in female emerging adults. *Depression and Anxiety.* 2016;33(4):332-8. Available from: https://doi.org/10.1002/da.22460.

63. Hser Y-I, Mooney LJ, Huang D, Zhu Y, Tomko RL, McClure E, et al. Reductions in cannabis use are associated with improvements in anxiety, depression, and sleep quality, but not quality of life. *Journal of Substance Abuse Treatment*. 2017;81:53-8. Available from: doi: 10.1016/j.jsat.2017.07.012.

64. Jacobus J, Squeglia LM, Escobar S, McKenna BM, Hernandez MM, Bagot KS, et al. Changes in marijuana use symptoms and emotional functioning over 28-days of monitored abstinence in adolescent marijuana users. *Psychopharmacology.* 2017;234(23):3431-42. Available from: doi: 10.1007/s00213-017-4725-3.

65. Canadian Centre on Substance Abuse. *Substance abuse in Canada: Concurrent disorders.* Ottawa, ON: Canadian Centre on Substance Abuse; 2009.

66. Stevens JR, Prince JB, Prager LM, Stern TA. Psychotic disorders in children and adolescents: a primer on contemporary evaluation and management. *Primary Care Companion for CNS Disorders.* 2014;16(2). Available from: doi: 10.4088/PCC.13f01514.

67. Bourque J, Afzali MH, O'Leary-Barrett M, Conrod P. Cannabis use and psychotic-like experiences trajectories during early adolescence: the coevolution and potential mediators. *Journal of Child Psychology and Psychiatry.* 2017;58(12):1360-9. Available from: https://doi.org/10.1111/jcpp.12765.

68. Kandel D. Stages in adolescent involvement in drug use. *Science.* 1975;190(4217):912-4. Available from: doi: 10.1126/science.1188374.

69. Cheer JF, Wassum KM, Sombers LA, Heien ML, Ariansen JL, Aragona BJ, et al. Phasic dopamine release evoked by abused substances requires cannabinoid receptor activation. *Journal of Neuroscience.* 2007;27(4):791-5. Available from: https://doi.org/10.1523/JNEUROSCI.4152-06.2007.

70. Fox HC, Tuit KL, Sinha R. Stress system changes associated with marijuana dependence may increase craving for alcohol and cocaine. *Human Psychopharmacology: Clinical and Experimental.* 2013;28(1):40-53. Available from: doi: 10.1002/hup.2280.

71. Health Canada. *Understanding the New Access to Cannabis for Medical Purposes Regulations.* Available from: https://www.canada.ca/en/health-canada/services/publications/drugs-health-products/understanding-new-access-to-cannabis-for-medical-purposes-regulations.html. [Accessed 21st June 2019].

72. Government of Canada. *ARCHIVED – Market data under the Access to Cannabis for Medical Purposes Regulations.* Available from: https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/licensed-producers/market-data.html. [Accessed 21st June 2019].

73. Abrams DI. The therapeutic effects of Cannabis and cannabinoids: An update from the National Academies of Sciences, Engineering and Medicine report. *European Journal of Internal Medicine.* 2018;49:7-11. Available from: doi: 10.1016/j.ejim.2018.01.003.

74. Health Canada. *Consumer Information – Cannabis (Marihuana, marijuana).* Available from: https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/licensed-producers/consumer-information-cannabis.html. [Accessed 21st June 2019].

75. Rieder MJ. Is the medical use of cannabis a therapeutic option for children? *Paediatrics & Child Health.* 2016;21(1):31-4.

76. Ministry of Health and Long-Term Care. *Substance Use Prevention and Harm Reduction Guideline, 2018.* Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Substance_Use_Prevention_and_Harm_Reduction_Guideline_2018_en.pdf. [Accessed 21st June 2019].

77. National Institute on Drug Abuse. *Available Treatments for Marijuana Use Disorders*. Available from: https://www.drugabuse.gov/publications/research-reports/marijuana/available-treatments-marijuana-use-disorders. [Accessed 21st June 2019].

78. Gorelick DA, Saxon AJ, Hermann R. Treatment of cannabis use disorder. *UpToDate*; 2018.

79. Pan L, Brent DA. *BMJ Best Practice: Depression in children*. 2018.

80. Creswell C, Waite P, Cooper PJ. Assessment and management of anxiety disorders in children and adolescents. *Arch Dis Child.* 2014;99(7):674-8. Available from: http://dx.doi.org/10.1136/archdischild-2013-303768.

81. McKay JR. Making the hard work of recovery more attractive for those with substance use disorders. *Addiction*. 2017;112(5):751-7. Available from: doi: 10.1111/add.13502.

82. O'Grady CP, Skinner WWJ. A family guide to concurrent disorders. *Centre for Addiction and Mental Health*. Available from: https://www.camh.ca/-/media/files/guides-and-publications/partnering-with-families-guide.pdf. [Accessed 21st June 2019].

83. Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, et al. An improved brief measure of cannabis misuse: The Cannabis Use Disorders Identification Test-Revised (CUDIT-R). *Drug and Alcohol Dependence.* 2010;110(1-2):137-43. Available from: https://doi.org/10.1016/j.drugalcdep.2010.02.017.

84. Legleye S, Karila L, Beck F, Reynaud M. Validation of the CAST, a general population Cannabis Abuse Screening Test. *Journal of Substance Use*. 2007;12:233–42. Available from: https://doi.org/10.1080/14659890701476532

85. Berman A, Bergman H, Palmstierna T, Schlyter F. *Drug Use Disorders Identification Test manual*. Stockholm, Sweden: Karolinska Institutet.; 2005. Available from: https://paihdelinkki.fi/sites/default/files/duditmanual.pdf. [Accessed 21st June 2019].

86. WHO ASSIST Working Group. The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): development, reliability and feasibility. *Addiction*. 2002;97(9):1183-94. Available from: https://doi.org/10.1046/j.1360-0443.2002.00185.x.

87. CAMH. *Motivational interviewing*. Available from: https://www.porticonetwork.ca/treatments/treatment-methods/motivational-interviewing. [Accessed 21st June 2019].

88. Miller WR, Rollnick S. *Motivational interviewing: Helping people change (applications of motivational interviewing).* New York: Guilford. 2012.

89. Herman KC, Reinke WM, Frey A, Shepard S. *Motivational interviewing in schools: Strategies for engaging parents, teachers, and students.* Springer Publishing Company; 2013.

90. DiClemente CC. *Motivation for change: Implications for substance abuse treatment.* Psychological Science. 1999;10(3):209-13.

91. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: applications to addictive behaviors. *American Psychologist*. 1992;47(9):1102. Available from: http://dx.doi.org/10.1037/0003-066X.47.9.1102.

92. Halladay J, Petker T, Fein A, Munn C, MacKillop J. Brief interventions for cannabis use in emerging adults: protocol for a systematic review, meta-analysis, and evidence map. Systematic reviews. 2018 Dec;7(1):106. Available from: https://doi.org/10.1186/s13643-018-0772-z.

93. Beck JS. *Cognitive behavior therapy: Basics and beyond.* Guilford press; 2011.

94. CAMH. *What is Cognitive Behavioural Therapy?* Available from: https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/cognitive-behavioural-therapy. [Accessed 21st June 2019].

95. Rector N. *Cognitive Behavioural Therapy: An Information Guide.* Available from: https://www.camh.ca/-/media/files/guides-and-publications/cbt-guide-en.pdf. [Accessed 21st June 2019].

96. Farmer RF, Chapman AL. *Behavioral interventions in Cognitive Behavior Therapy: Practical guidance for putting theory into action*. American Psychological Association; 2016.

97. Copeland J, Swift W. Cannabis use disorder: Epidemiology and management. *International Review of Psychiatry.* 2009;21(2):96-103. Available from: https://doi.org/10.1080/09540260902782745.

98. Murphy JG, Dennhardt AA, Martens MP, Borsari B, Witkiewitz K, Meshesha LZ. A randomized clinical trial evaluating the efficacy of a brief alcohol intervention supplemented with a substance-free activity session or relaxation training. *Journal of Consulting and Clinical Psychology.* 2019. Available from: doi: 10.1037/ccp0000412.

99. Murphy JG, Dennhardt AA, Skidmore JR, Borsari B, Barnett NP, Colby SM, et al. A randomized controlled trial of a behavioral economic supplement to brief motivational interventions for college drinking. *Journal of Consulting and Clinical Psychology.* 2012;80(5):876-86. Available from: doi: 10.1037/a0028763.

100. American Psychological Association. *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub; 2013.

101. Kahan M, Watts K. *Influencing motivation to change*. Portico, Canada's Mental Health and Addiction Network. Available from: https://www.porticonetwork.ca/web/fundamentals-addiction-toolkit/motivation-change/influencing-change. [Accessed 21st June 2019].

102. LaMorte W. *The Transtheoretical Model (Stages of Change)*. Boston University School of Public Health. Available from: http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories6.html. [Accessed 21st June 2019].

Appendix A.

Substance Use Prevention and Intervention Survey for SMH Professionals Summary Report

Substance Use Prevention and Intervention Survey for SMH Professionals: Summary Report

- Report prepared: April 29, 2019
- Number of Responses: 294

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

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

How many years have you worked in school mental health?

Answer	%	Count
0-5 years	39%	116
6-10 years	25%	73
11-20 years	22%	64
More than 20 years	14%	41
Total	**100%**	**294**

Experiences with substance use prevention and intervention:

Please choose how strongly you agree with each statement using the following scale from strongly disagree to strongly agree.

Statement	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree		Mean	ST DEV	Total
	%	#	%	#	%	#	%	#	%	#			
1. Cannabis is commonly raised as a concern in the schools/ board I support.	3%	8	15%	43	16%	44	44%	123	22%	61	3.67	1.07	**279**
2. A resource that includes information on screening and assessment for substance use concerns would support me in my role.	1%	2	4%	11	16%	44	54%	153	25%	71	4.00	0.79	**281**
3. A resource that focuses on early intervention to prevent consequences of cannabis use would help me in my role.	1%	2	2%	6	11%	31	52%	147	34%	95	4.16	0.76	**281**
4. I require information on pathways and referrals for students who require more intensive treatment related to their substance use.	4%	12	16%	45	20%	57	34%	94	26%	72	3.60	1.15	**280**
5. I need more information about the effects of cannabis to provide timely and accurate information to students.	4%	11	14%	40	17%	47	46%	130	19%	53	3.62	1.06	**281**
6. I would like substance use prevention and intervention efforts to include other substances in addition to cannabis.	1%	4	1%	2	6%	18	48%	134	44%	123	4.32	0.75	**281**
7. I am confident in my ability to discuss substance use with parents/guardians, when appropriate in my role.	1%	4	10%	29	20%	56	47%	132	21%	57	3.75	0.94	**278**
8. I would like more information to support other staff (eg. educators, administrators, clinical staff) related to prevention and early intervention for substance use.	2%	6	2%	6	12%	35	53%	150	30%	84	4.07	0.83	**281**
9. I would use a print/on-line resource related to cannabis and other substances.	1%	3	2%	5	6%	16	57%	159	35%	97	4.22	0.72	**280**
10. 1I would use training/consultation related to cannabis and other substances.	1%	2	3%	9	12%	33	52%	146	32%	89	4.11	0.79	**279**
11. I am knowledgeable about ways to reduce harm of cannabis use for current users.	3%	8	26%	72	26%	72	39%	110	7%	19	3.21	0.99	**281**
12. I know the pathways to access services in my community for students requiring referrals for substance use.	3%	9	11%	32	15%	43	54%	151	16%	46	3.69	0.98	**281**
13. Service limitations in my area impact my ability to make referrals for substance use concerns.	4%	10	20%	55	29%	81	29%	81	18%	50	3.38	1.10	**277**

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

Answer	%	Count
Yes	16%	45
Unsure	74%	207
No	10%	27
Total	**100%**	**279**

What are some core elements that should be included in a substance use prevention and intervention practice guide that will help you to support students, staff, and parents/guardians?

Themed Responses Analysis:
Information to include:
Information about substances:
Types of substances (i.e. cannabis, vaping, alcohol, methamphetamine, Fentanyl, tobacco, heroin, cocaine)
Levels of THC in modern day cannabis
Methods of usage (e.g. injections, ingestion, inhalation)
Info on drug paraphernalia
Continuum of substance use/misuse/abuse (i.e. Medical use of cannabis)
Stats re: usage by age, gender; risk factors; protective factors
Links to curriculum:
Highlight areas of curriculum that relate to substance use (i.e. link to lesson plans)
Effects:
Facts about health effects (i.e. dispelling the myth that cannabis is benign/healthy, immediate and long term effects, first episode psychosis, physical health effects, dangers of use, effects on developing brain, signs/effects of addiction, brain scans of healthy brains/cannabis use, impact on motivation levels, clarify different effects based on consumption method)
Co-morbidity:
Co-morbidity info for substance use/abuse (i.e. learning/intellectual disabilities, ADHD, mental illness)
Intervention / Support / Pathways:
Harm reduction/early intervention model of intervention (i.e. evidence-based practice, safe partying)
Legal info (i.e. role of police, DUI & Cannabis, legal obligations for schools to report misuse)
Pathways for treatment (i.e. where to obtain intervention support, school-based and community-based pathways, referral criteria)
Best practices for Parent support (i.e. role of parents, open communication with child, how to have conversations about substance use/addiction with child, building trusting relationship with child, getting to know who their friends are, supervision accountability, warning signs to recognize a problem, parent resources, framing message to youth for parents who use cannabis for medically/recreationally)
Student-centered approaches (i.e. ways to support students to reduce or quit use, encourage students to make good choices, suggestions for how to deal with peer pressure, assertive communication)
Coping skills/strategies
Community supports (i.e. self-monitoring support)
Goal setting skills
Healthy living strategies (i.e. sleep, eating, reduce screen time)
Info for educators (i.e. tips/scripts on how to engage in classroom conversations about substance use/misuse/abuse prevention and intervention, how to recognize signs of misuse/abuse, knowledge and professional learning for educators)
Info about available school board supports (i.e. MHLs, addictions specialist)
Stages of/readiness to change model

Themed Responses Analysis (continued):
Stigma reduction
Reporting guidelines
Info on therapeutic treatment (i.e. motivational interviewing, DBT, mindfulness)
Recommended evidence-based school-based programs/practices (i.e. information on effective versus ineffective programs/ practices, guidelines for schools on how to deal with “high” students)
Information on issues of confidentiality
Relapse prevention
Assessment / Fidelity:
List of suggested assessment/screening tools (i.e. Burns Depression index, use/misuse/abuse measure)
Ways to present information:
Present material in a youth-friendly, engaging way (i.e. not condescending, non-judgmental, non-fear-based, boring, picture book, video clips – “Safety Rhymes” and “Chugging on Clouds”, sample PA announcements)
Create interactive electronic resources (i.e. app, online quiz, game)
Information should be AODA compliant (i.e. read-to-me feature)
Ensure information is accurate and current
Flow chart that guides practitioners on what to do given the scenario
Create tip sheets for parents / students
Make the guide brief
Make resource available simultaneously in English and French
Embed case stories to provide “real-life” examples of incidents of substance use/misuse/abuse
Standardized training (ASIST equivalent for substance use such as the Core Addiction Practice)
Consider Indigenous perspective (i.e. natural provider by Creator versus “mind changer”)
How to present information at the elementary school level
Resources:
WHO School and Youth Health promotion report: https://www.who.int/school_youth_health/en/ (this report states that mental health promotion education can prevent health risks in youth)
CAMH – has info on up to date information re cannabis use, dangers, and supports (i.e. Blunt Truth resource)
Health Canada – has info on up to date information re cannabis use, dangers, and supports

Appendix B.

Frequency of Past Month Cannabis Use Among Grade 7 to 12 Ontario Students[11]

Split by Sex, Gender, and Grade

Definition of sex and gender sub-groups:

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

By Grade

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

	Grades 7-8 (all students)	Grade 9-10 (all students)	Grade 11-12 (all students)	**Total Students (grades 7-12)**
Never used in lifetime	97.4	82.6	61.4	**78.2**
Used, but not in the past month	1.7	8.4	16.2	**9.7**
Once or twice in the past month	suppressed	4.5	12.0	**6.4**
1 or 2 times a week	suppressed	2.1	3.8	**2.2**
3 to 6 times a week	suppressed	1.4	3.8	**2.0**
Daily	suppressed	1.0	2.7	**1.4**

Significant grade difference, p<.001

By Sex & Grade

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

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

Significant sex difference, p<.01

By Gender & Grade

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

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

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

Split by Mental Health Symptomatology

Definition of sub-groups:

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

Percentage (%) of students with mental health problem reporting frequency of cannabis use in the past month

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

	Psychological distress	Externalizing Behaviours	ADHD	Suicidal Behaviours	Received Mental Health Care	**Total Students**
Never used in lifetime	70.1	34.5	63.6	60.4	72.6	**78.2**
Used, but not in the past month	12.6	16.2	12.3	14.0	12.3	**9.7**
Once or twice in the past month	8.9	17.3	11.7	12.0	6.5	**6.4**
1 or 2 times a week	3.0	7.5	4.0	3.6	2.2	**2.2**
3 to 6 times a week	3.8	17.8	6.4	suppressed	4.3	**2.0**
Daily	1.7	6.7	2.0	2.6	2.0	**1.4**

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

	Psychological distress	Externalizing Behaviours	ADHD	Suicidal Behaviours	Received Mental Health Care	**Total Students**
NO cannabis use in the past year	75.7	40.8	67.5	65.3	75.9	**81.0**
Used cannabis in the past year	24.7	59.2	32.5	34.7	24.1	**19.0**

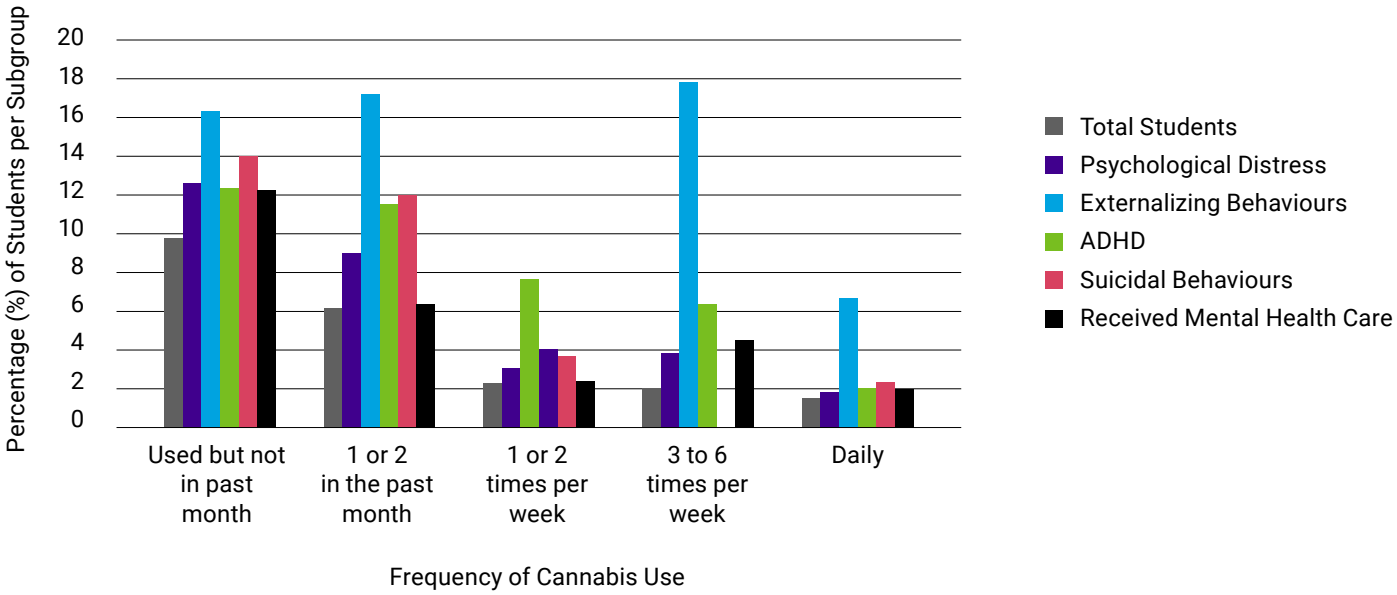
Percentage (%) of students with mental health problem and who also used cannabis in the past month reporting other substance use

The prevalence of other substance use for students endorsing using cannabis at least one per month.

	Psychological distress	Externalizing Behaviours	ADHD	Suicidal Behaviours	Received Mental Health Care	**Total Students**
Heavy drinking at least once in the past month*	58.7	76.2	69.1	60.1	71.9	**16.9**
Alcohol use in the past year+	82.9	93.4	89.0	84.2	94.1	**42.5**
Cigarette smoking in the past year++	37.1	43.2	42.6	41.8	44.5	**7.0**
Any other illicit drug use in past year**	53.4	77.7	67.2	66.2	64.8	**21.8**

*drinking five or more drinks on one occasion at least once in the past month; + excludes a few sips just to try it; ++ excludes a few puffs just to try it; ** among high school students only (G9-G12) and includes nonmedical use of prescription drugs

Prevalence of Cannabis Use Across Subgroups of Students with Mental Health Symptomatology



Appendix C.

Diagnostic Symptoms of Cannabis Use Disorder and Withdrawal Symptoms

Cannabis Use Disorder

The Diagnostic Statistical Manual 5[100] defines **Cannabis Use Disorder** as a problematic pattern of cannabis use that leads to clinically significant impairments or distress, as evident by experience at least two of the following within a 12-month period:

1. Cannabis is often taken in larger amounts or over a longer period than was intended.
2. A persistent desire or unsuccessful effort to cut down or control cannabis use.
3. A great deal of time spent on obtaining, using, or recovering from cannabis.
4. Craving, or a strong desire or urge to use cannabis.
5. Recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of cannabis use.
7. Giving up or reducing involvement in important social, occupational, or recreational activities because of cannabis use.
8. Recurrent cannabis use in situations in which it is physically hazardous.
9. Continued cannabis use despite knowledge of having persistent or recurrent physical or psychological problems that is likely to have been caused or exacerbated by cannabis.
10. Experiencing tolerance as defined by either of the following:
    - **i.** A need for increased amounts of cannabis to feel “high” or the desired effect.
    - **ii.** A lower magnitude of effects or “high” with continued use of the same amount of cannabis.

11. Experiencing withdrawal as defined by either of the following:

i. Experiencing 3 or more of the following signs/symptoms within 1 week of stopping heavy or prolonged cannabis use that causes clinically significant distress or impairment in social, occupational or other important areas of functioning (that cannot be attributed to another substance or medical concern):

a. Irritability, anger, aggression

b. Nervousness or anxiety

c. Sleep difficult (i.e. insomnia or disturbing dreams)

d. Decreased appetite or weight loss

e. Restlessness

f. Depressed mood

g. At least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills or headache

ii. Cannabis (or a closely related substance) taken to relieve or avoid withdrawal symptoms.

These signs and symptoms are similar for all substance use disorders and are categorized by severity including:

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 or more symptoms

Appendix D.

Screener for Symptoms of Psychosis[67]

The next items ask about thoughts or beliefs that you could have had DURING THE PAST 12 months				
		Not True (0)	**Somewhat True (1)**	**Certainly True (2)**
1	Some people believe that their thoughts can be read. Have other people ever read your thoughts?			
2	Have you ever believed that you were being sent special messages through the television?			
3	Have you ever thought that you were being followed or spied upon?			
4	Have you ever heard voices that other people cannot hear?			
5	Have you ever felt as though your body had been changed in some way that you could not understand?			
6	Have you ever felt that you were under the control of some special power?			
7	Have you ever known what another person was thinking even though that person wasn't speaking?			
8	Do you any some special powers that other people do not have?			
9	Have you ever seen something or someone that other people could not see?			

Appendix E.

Self-Reflection Tool for SMH Professionals

SMH professionals can use this reflection tool individually, in team discussions or as an aid for clinical supervision.

Reflection Questions to assist in engaging with youth about cannabis use:

Personal History	Think about your own adolescence and your personal history with substance use
• How might your early life experience with substances such as cannabis impact how you view substance use? • Do you have current personal and/or professional experience with cannabis that may influence your approach to interventions related to this substance?	

Beliefs about Cannabis	Think about what you know about cannabis
• What are your views on cannabis use and on legalization? Why do you think you hold these views? • Are you concerned about youth cannabis use? Why or Why not? • Do you feel informed about cannabis and cannabis use?	

Current approach to substance use	Reflect on how you currently view substance use
• Do you use substances such as alcohol, tobacco and/or caffeine? • What is your relationship with these and other substances? • When you talk about cannabis use, do you use first-person language? *Consider how terms used may impact the approach taken to discuss cannabis use. Referring to someone as a "drug user" or "addict" can limit our view of a person to be encompassed by their substance use.*	

Questions were adapted from an exercise included in the Cannabis Communication Guide for Youth Allies: Fleming, K., & McKiernan, A. (2018). Cannabis Communication Guide for Youth Allies. Ottawa, Ont.: Canadian Centre on Substance Use and Addiction.

Appendix F.

Cannabis Use Disorder Identification Test (CUDIT-R) – Screening Tool

Have you used any cannabis over the past six months? YES/NO

If YES, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use *over the past six months*.

1	**How often do you use cannabis?**				
	Never **0**	Monthly or less **1**	2-4 times a month **2**	2-3 times a week **3**	4 or more times a week **4**
2	**How many hours were you "stoned" on a typical day when had been using cannabis?**				
	Less than 1 **0**	1 or 2 **1**	3 or 4 **2**	5 or 6 **3**	7 or more **4**
3	**How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?**				
	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
4	**How often in the past 6 months did you fail to do what was normally expected from you because of using cannabis?**				
	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
5	**How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?**				
	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
6	**How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?**				
	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
7	**How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children?**				
	Never **0**	Less than monthly **1**	Monthly **2**	Weekly **3**	Daily or almost daily **4**
8	**Have you ever thought about cutting down, or stopping, your use of cannabis?**				
	Never **0**		Yes, but not in the past 6 months **2**		Yes, during the past 6 months **4**

This scale is in the public domain and is free to use with appropriate citation: Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, and Sellman JD. (2010). An Improvised Brief Measure of Cannabis Misuse. The Cannabis Use Disorders Identification Test – Revised (CUDIT-R). *Drug and Alcohol Dependence* 110:137-143.

This questionnaire was designed for self administration and is scored by adding each of the 8 items: **Question 1-7 are scored on a 0-4 scale. Question 8 is scored 0, 2 or 4.** Scores of 8 or more indicate hazardous cannabis use, while scores of 12 or more indicate a possible cannabis use disorder for which further intervention may be required.

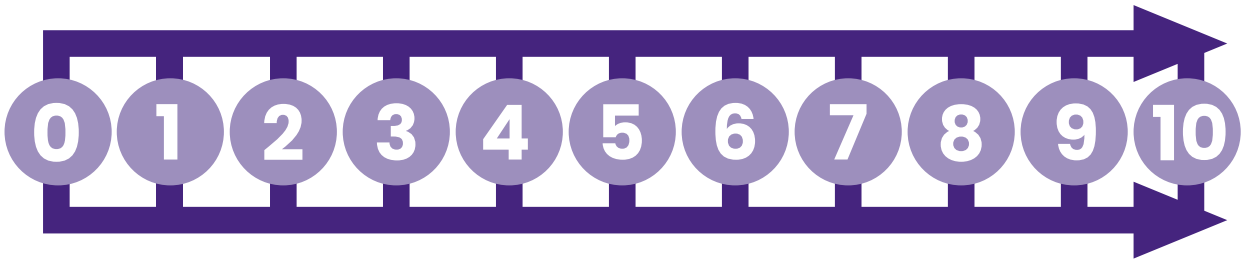
Appendix G.

Readiness Ruler Worksheet

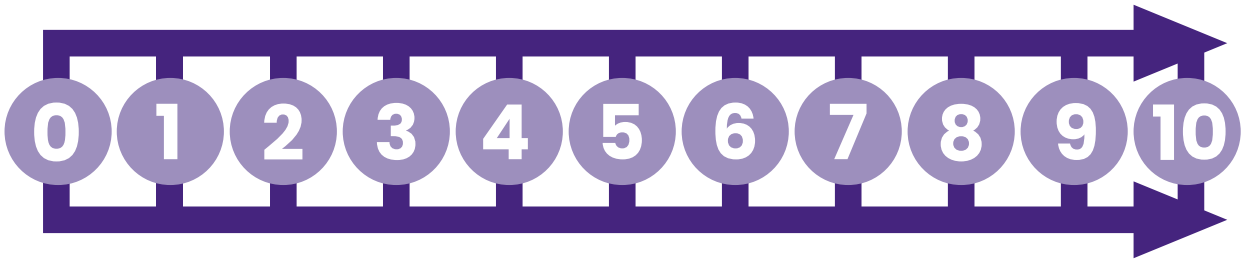
Readiness Rulers

On a scale of 0 to 10, where 0 is not at all…

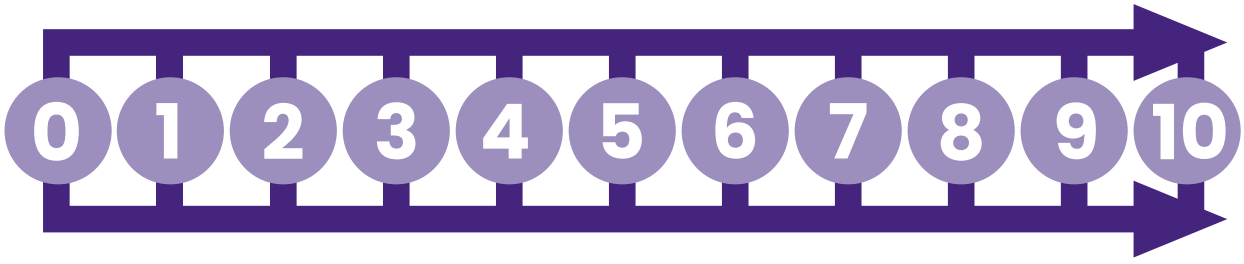
How ***important*** is changing your cannabis use to you right now?



How ***ready*** are you to change your cannabis use right now?



How ***confident*** are you about making a change in your cannabis use?



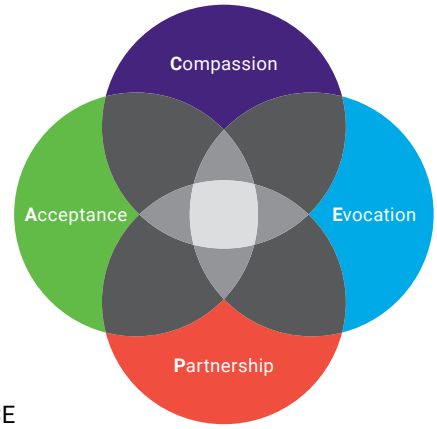
Appendix H.

Motivational Interviewing Tip-sheet for SMH Professionals

Motivational Interviewing (MI) Basics

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

Spirit of MI: PACE	Principles of MI: RULE
Partnership **A**cceptance **C**ompassion **E**vocation * Also known as PACE	**Resist the "righting reflex"** The urge to "fix" the student. Arguing for change can have a paradoxical effect. **Understand your student** The student's reasons for change are most important because these will most likely trigger behaviour change. **Listen to your student** MI involves as much listening as informing. **Empower your student** Convey hope around the possibility of change and support students' choice and autonomy re: change goals.



Foundational Skills in Motivational Interviewing: OARS

OPEN-ENDED questions encourage elaboration.

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

RELECTIONS: the skill of accurate empathy:

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

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

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

MI Quick Tips

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

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

Readiness Rulers

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

1 2 3 4 5 6 7 8 9 10

Low importantance/confidence **Extremely important/confident**

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

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

AGENDA MAPPING

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

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

Appendix I.

Matching Interventions to the Stages of Change[77, 101, 102]

Precontemplation

- Use of Motivational Interviewing Strategies
- Consciousness Raising: increasing self-awareness and consideration of current behaviour in context of personal values
- Increase awareness of risk related to use, provide information non-judgmentally
- Build hope in consideration of options while validating current lack of readiness to change

Contemplation

- Use of Motivational Interviewing Strategies
- Evoke reasons to change and impact of not changing – discuss the pros and cons
- Consciousness Raising: increasing self-awareness and consideration of current behaviour in context of personal values
- Self reappraisal to consider the current behaviour in the context of who they want to be
- Environmental Re-evaluation – Social reappraisal to realize how the behavior affects others
- Build confidence in ability to make change – increase self-efficacy

Preparation

- Explore alternative options to substance use
- Identify and lower barriers to change
- Further explore pros and cons of changing behaviour
- Use of Cognitive Behaviour Therapy strategies
- Help identify sources of social support

Action (change in behaviour from one day – six months)

- Use of Cognitive Behaviour Therapy strategies
- Support a realistic view of change that recognizes the importance of small steps
- Identify and support the engagement in alternative behaviors and thoughts
- Identify ways to create personal rewards for changed behaviour
- Identify high risk situations and coping strategies
- Engage with sources of support

Maintenance (behaviour change is sustained beyond 6 months)

- Continue to recognize high risk situations/triggers
- Develop and practice alternative behaviours
- Recognize the possibility of returning to previous behaviours or thinking and strategies for self-care
- Maintain sources of support

Appendix J.

Decision Balance Matrix Worksheet

Decisional Balancing Worksheet

Benefits “good things” about using	Costs “Not so good” things about using
Costs of changing	**Benefits of changing**

Appendix K.

Normative Comparison Data

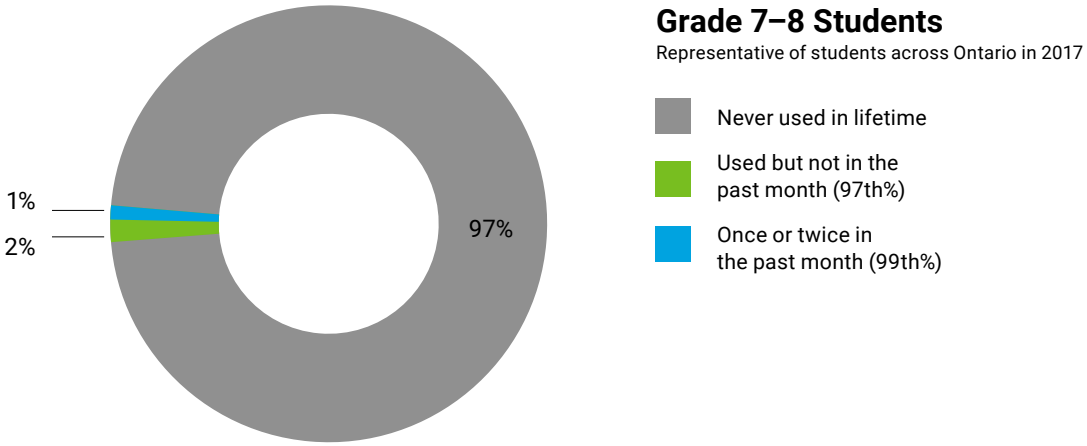
When providing normative feedback, it is helpful to provide the closest peer-matched data possible. Based on your clinical judgment you can provide peer-matched normative data for sex, self-identified binary gender (for high-school students), or simply by grade. The following sheets provide normative reference data for grade only, and gender by grade for high-school students).

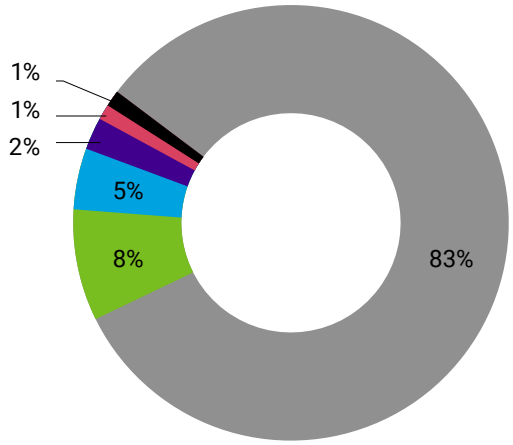
Example Language when reviewing this normative feedback is:

> "You said you use cannabis about [insert amount endorsed by student]. Compared to other grade 7-8 students across Ontario, you use more than [insert percentile related to their use] percent of other students. What are your thoughts about this?"

You may be met with some resistance. Students may question the validity of the data.

- You can inform the students that this information comes from the Ontario Student Drug Use and Health Survey that asks students across Ontario about their drug use every 2 years.
- You can also validate their resistance – stating that many students believe that other students are using more often than they actually are. It can sometimes feel like "**everyone** is using cannabis." Although a lot of students are using (refer to the graph), a majority of students have never used cannabis or are not actively using cannabis (refer to graph).
- Engage the student in a further discussion about this information.
- Try to "roll with resistance" when discussing this information.

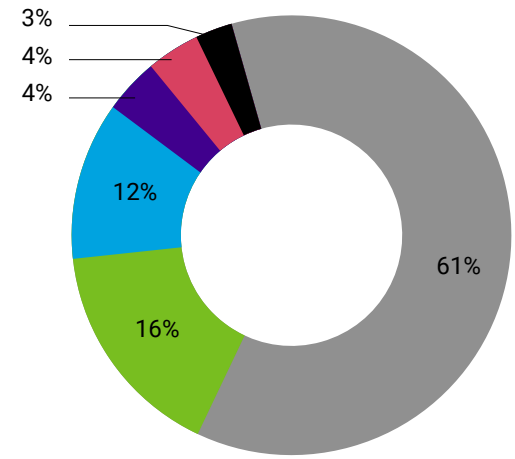




Grade 9–10 Students

Representative of students across Ontario in 2017

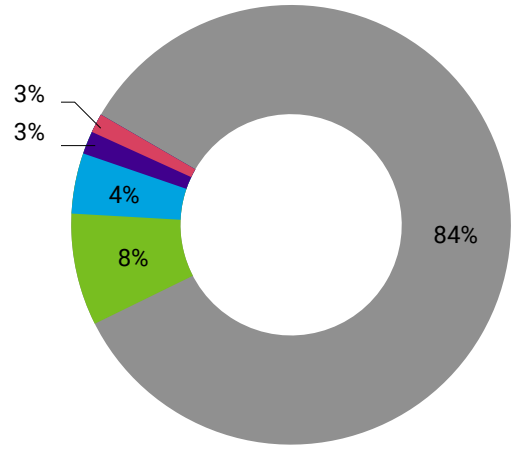
- Never used in lifetime
- Used but not in the past month (83rd%)
- Once or twice in the past month (91st%)
- 1 or 2 times a week (96th%)
- 3 to 6 times a week (98th%)
- Daily (99th%)



Grade 11–12 Students

Representative of students across Ontario in 2017

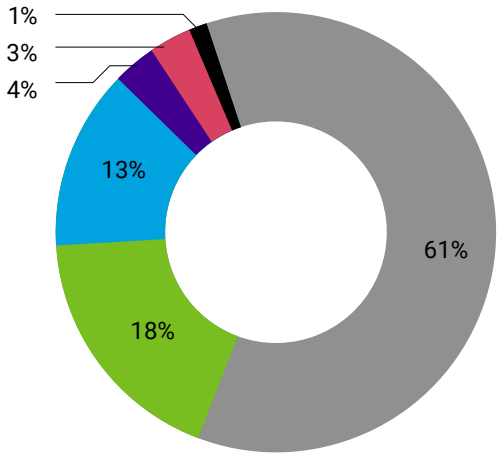
- Never used in lifetime
- Used but not in the past month (61st%)
- Once or twice in the past month (78th%)
- 1 or 2 times a week (90th%)
- 3 to 6 times a week (93rd%)
- Daily (97th%)



Grade 9–10 Students (Female Gender)

Representative of students across Ontario in 2017

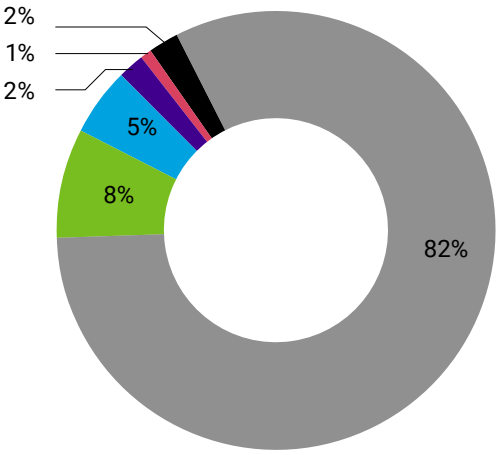
- Never used in lifetime
- Used but not in the past month (84th%)
- Once or twice in the past month (93rd%)
- 1 or 2 times a week (97th%)
- 3 to 6 times a week (99th%)



Grade 11–12 Students (Female Gender)

Representative of students across Ontario in 2017

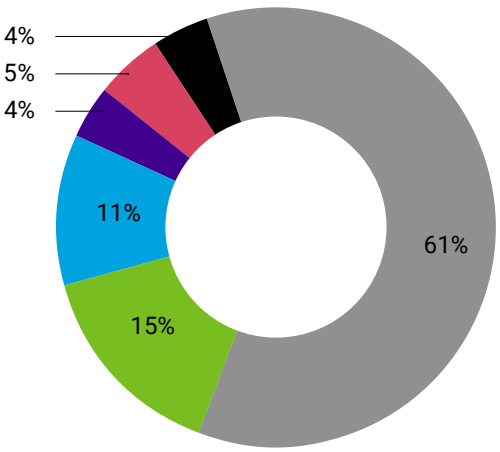
- Never used in lifetime
- Used but not in the past month (61st%)
- Once or twice in the past month (79th%)
- 1 or 2 times a week (92nd%)
- 3 to 6 times a week (96th%)
- Daily (99th%)



Grade 9–10 Students (Male Gender)

Representative of students across Ontario in 2017

- Never used in lifetime
- Used but not in the past month (82nd%)
- Once or twice in the past month (90th%)
- 1 or 2 times a week (95th%)
- 3 to 6 times a week (97th%)
- Daily (98th%)



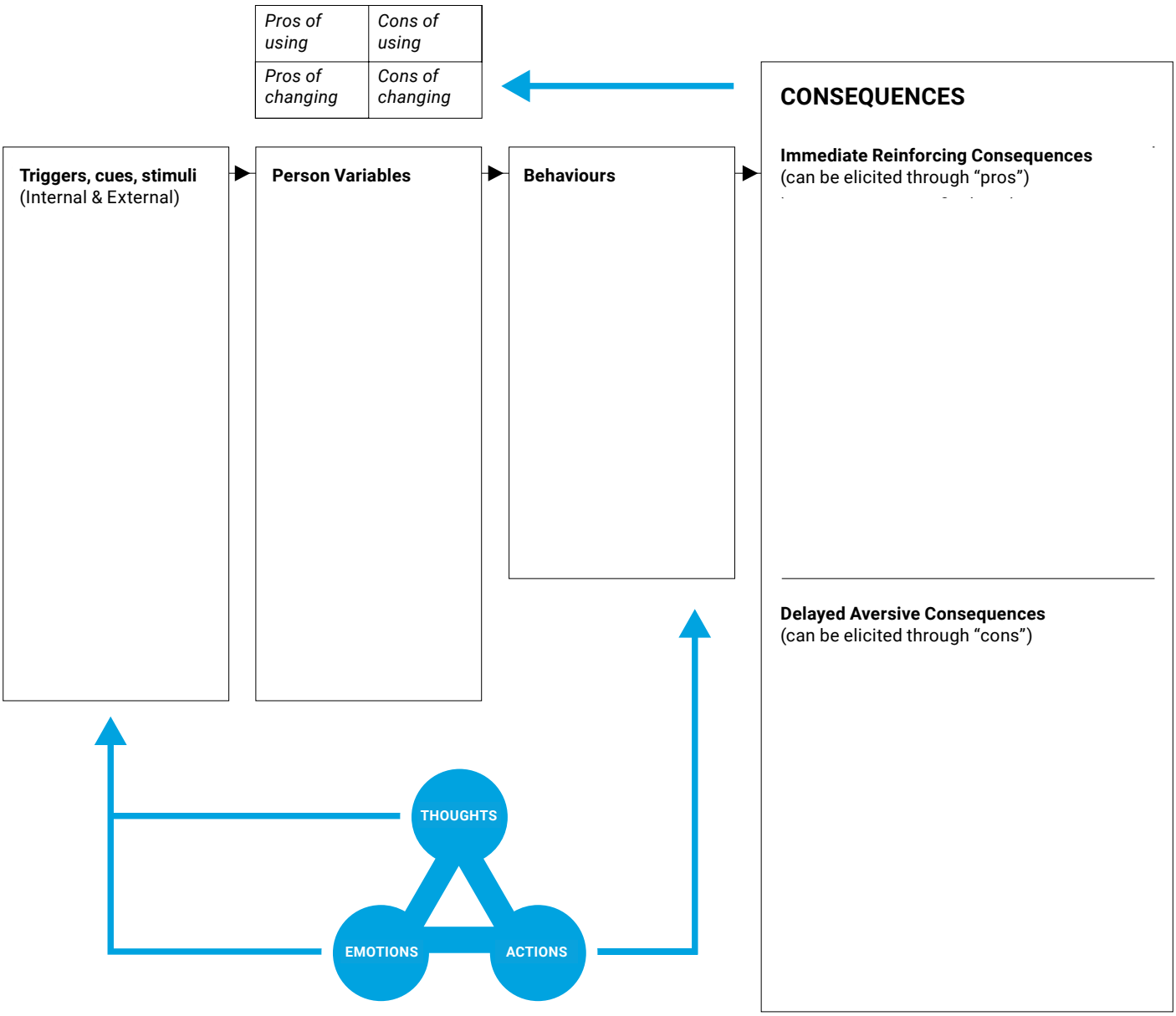
Grade 11–12 Students (Male Gender)

Representative of students across Ontario in 2017

- Never used in lifetime
- Used but not in the past month (61st%)
- Once or twice in the past month (76th%)
- 1 or 2 times a week (87th%)
- 3 to 6 times a week (91st%)
- Daily (96th%)

Appendix L.

Functional Analysis Worksheet



Appendix M.

Thought Monitoring Worksheet

Situation	Emotion & Intensity (0-100)	Thoughts, beliefs, and interpretations	Alternative Thoughts ("facts")	Balanced Thoughts

We work together with Ontario school districts to support student mental health

School
Mental Health
Ontario

Santé mentale
en milieu scolaire
Ontario

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School Mental Health Ontario

Santé mentale en milieu scolaire Ontario