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The Adolescent Cannabis Check-Up For Young Offenders

NDARC Technical Report No. 166

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ISBN: 1 877027 54 5

This project was jointly funded by the NSW Attorney General's Department and the Australian Government's National Crime Prevention Program.

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1. INTRODUCTION

1.1 Background

This Technical Report is based on a study examining the efficacy and attractiveness of a brief intervention for cannabis use among young offenders in NSW. The study was conducted as a Capacity Building Project jointly funded by the NSW Attorney General's Department, and the Australian Government's National Crime Prevention program.

It arose from earlier research by the investigators on brief cognitive behavioural and motivational interventions for cannabis use among adults and young people, and from the recognition that drug-related crime underpinned many of the major issues in the crime prevention agenda of the Commonwealth and the States. Drug-related crime is a major issue among young offenders, and level of drug (including cannabis) involvement has been shown to be a major causal risk factor in property crime (see Section1.2).

The aim of this trial was to increase the early intervention options available to young cannabis users in the criminal justice system that were not seeking treatment, to contribute to the evidence base for the efficacy of brief interventions for this group, and inform the development of policy and programs in relation to drug crime diversion for young offenders. It targeted young people who were using cannabis and involved in criminal activity, but not initiating efforts to stop use. The intervention used a "Check-up" approach, based on similar treatments that have been shown to be useful for alcohol and cannabis problems in adults and adolescents (see Section 1.2.3).

Unfortunately the trial was hampered by serious recruitment problems, and data collection was discontinued at the end of December, 2002. During the 18 month recruitment period only 29 young people were randomized to the study. At the request of the NSW Department of Juvenile Justice, the Check-up materials were developed into a training package for their staff, and three workshops were delivered during May, 2003.

While we were unable to complete the trial and evaluate the effectiveness of the Check-up among young offenders who use cannabis, the approach has sound theoretical and empirical justification (Section 1.2.3). While a community-based study using this approach is still underway, we are presenting the consensus Check-up materials developed for this study as an information exercise, and invite the field to consider exploring this approach with young people. We strongly encourage evaluation of this approach as a means of increasing the evidence base for interventions for young people. As an aid in evaluation we have included forms for the evaluation of the Check-up sessions by the young person participating.

This Technical Report presents a review of the literature on adolescent cannabis use and interventions, the consensus treatment manual and associated Check-up materials developed for use with young offenders and a description of the methodology and results of the pilot trial. The consensus materials differ only slightly from those used during the trial. The major differences were (i) that a single assessment is presented in this manual, and (ii) the single cognitive behavioural session delivered during the trial was divided into 2 sessions, to make it more manageable. The essential elements remain unchanged.

1.2 Cannabis use among young people

1.2.1 Epidemiology of use and related problems

Data from the 2001 National Household Survey indicate approximately one third (34.3%) of 14-19 year olds have ever tried cannabis, and approximately one quarter (26.6%) have used in the last year. Thirty five percent of young males and 25% of young females who reported recent use were smoking cannabis at least weekly (Australian Institute of Health and Welfare, 2002). While these latest data appear to reflect a decrease in use among young Australians since the 1998 survey, differences in the survey methodologies make comparisons difficult; in any case, recent cannabis use was more common than tobacco (and other illicit drug) use among this age group (26% vs. 20%) (AIHW, 2002). Data from the 1999 Australian School Student's Alcohol and Drugs Survey confirm the widespread use of cannabis among secondary students, particularly males and older students (White, 2001).

While most cannabis use remains experimental and irregular, the incidence and intensity of use typically increases over the mid to late teens (e.g., Coffey et al, 2000; Perkonnig et al, 1999; Poulton et al, 1997), before a decline in use from the mid 20s (Bachman et al, 1997; Chen and Kandel, 1995). Nevertheless, a minority of young people report use patterns that increase the likelihood of long-term use and dependence, regular use of other drugs, and exposure to cannabis-related harms (e.g., Golub and Johnson, 2001; Johnston et al, 2001; Perkonnig et al, 1999; Poulton et al, 1997).

Numerous factors may modify the natural history of cannabis use (e.g., Hall, Johnston and Donnelly, 1999). Young males typically report more frequent and heavier use than females (Hall, Degenhardt and Lynskey, 2001; von Sydow, Lieb, Pfister, Höfler and Wittchen, 2002), although not all studies have found such gender differences (e.g., Perkonnig et al, 1999). Another common finding is that an earlier age of initiation and frequent cannabis use predict the escalation and persistence of use (e.g., Coffey et al, 2000; DeWit et al, 2000; Perkonnig et al, 1999; Poulton et al, 1997). There is evidence that the age of initiation of cannabis use is decreasing among more recent birth cohorts (Degenhardt, Lynskey and Hall, 2000; Hall and Swift, 2000; von Sydow, Lieb, Pfister, Höfler, Sonntag and Wittchen, 2001). The average age of first use among Australian 14-19 year olds in 2001 was 14.6 years (AIHW, personal communication from Cid Matteo, 2003).

Although experimentation is a normal part of adolescent development, young people that regularly use cannabis may risk negative effects at a time of rapid development and transitions in life roles (e.g., see Hall et al, 2001 for a recent, comprehensive review of the adverse health and psychological consequences of cannabis use). There is evidence that young people (14 to 15 years) may be more likely to suffer the adverse consequences of regular cannabis use than their 20 to 21 year old peers (Fergusson, Horwood and Swain-Campbell, 2002). This may interfere with their options and choices in a range of areas in their lives, now and in the future.

In particular, earlier and/or greater involvement with cannabis is associated with an increased risk of problems such as impaired mental health and psychosocial adjustment, delinquency, lower educational achievement, problematic use of other substances, risky sexual behaviour and criminal offending (e.g., Arsenault, Cannon, Poulton, Murray, Caspi and Moffitt, 2002; Brook et al, 1999; Donovan and Jessor, 1985; Fergusson and Horwood, 1997; 2000a; Fergusson, Horwood and Lynskey, 1994; Fergusson, Horwood

and Swain-Campbell, 2002; Lynskey and Hall, 2000; Lynskey, Health, Bucholz et al, 2003; Patton, Coffey, Carlin, Degenhardt, Lynskey and Hall, 2002). There is no simple cause and effect relationship between the extent of cannabis use and other outcomes. Rather, these associations may primarily arise because of common or overlapping risk factors and life pathways among young people who may be predisposed to cannabis use and those at increased risks of these other outcomes (e.g., Hall, Johnston and Donnelly, 1999; Lynskey et al, 2003; Morral, McCaffrey and Paddock, 2002).

Young people are more likely to develop cannabis dependence than adults, possibly because of an increased susceptibility to the syndrome or the impact of age cohort effects (e.g., Dennis, Babor, Roebuck and Donaldson, 2002; Kandel, Chen, Warner, Kessler, & Grant, 1997; Swift, Hall and Teesson, 2001; Winters, 1999; but see Chen and Anthony, 2003). The population prevalence of cannabis dependence increases throughout adolescence, up to levels of 10% among young adults (e.g., Coffey et al, 2002; Fergusson and Horwood, 2000b; Perkonnig et al, 1999; Poulton et al, 1997). Other studies report substantial proportions (>50%) of young people attending emergency rooms (e.g., Colby, Chung, O'Leary, Spirito, Rohsenow and Monti, 1998) and drug and alcohol treatment services (e.g., Crowley et al, 1998) meet diagnostic criteria for cannabis use disorders. As spontaneous remission of cannabis use may be somewhat rare among adolescent regular cannabis users (Perkonigg et al, 1999; von Sydow et al, 2001), there is a significant group who may benefit from assistance in order to prevent or overcome cannabis-related problems including abuse or dependence.

There is solid evidence for a relationship between cannabis use, antisocial behaviour and criminal behaviour. In addition to the population-based studies linking the early and/or heavy use of cannabis with increased participation in crime (see Hall et al, 2001 for a discussion of this association), surveys of young people in the juvenile justice system report high levels of cannabis use and a relationship between frequent cannabis use and offending behaviour (e.g., Baker, 1998; Dembo, Williams, Schmeidler, Wish, Getreu & Berry, 1991; Golub and Johnson, 2001; Salmelainen, 1995; Stevenson and Forsythe, 1998; for a review see Trimboli and Coumarelos, 1998). For example, the 1996 NSW secondary schools survey found cannabis use predicted criminal involvement, with the odds of participation in assault, malicious damage and acquisitive property crime between two and fives times greater among frequent cannabis users than non-users, after controlling for drug use and developmental factors (Baker, 1998). Salmelainen's (1995) study of 247 juvenile detainees found that those offenders who reported higher levels of cannabis consumption were more likely to be frequent offenders, particularly those in detention for motor vehicle theft and break and enter offences. There is evidence that juveniles resort to income-generating property crime to primarily fund their consumption of cannabis, as well as other drugs (Stevenson & Forsythe, 1998).

1.2.2 Substance use interventions for young people

Currently, few young people who might benefit from professional assistance for their substance use choose to access relevant services. Few adolescents reporting substance use disorder symptoms receive treatment although there have been large increases in those presenting for cannabis related problems in the United States, typically to outpatient settings (Muck, Zempolich, Titus, Fishman, Godley and Schwebel, 2001). In 1998, 74% of young people presenting for treatment did so for cannabis use (Dennis, Titus, Diamond et al, 2002). Self-referral is uncommon, with most referred by family, or the educational or juvenile justice systems; recent trends towards mandating young

people to attend treatment programs largely explain the large increase in demand (e.g., Brody and Waldron, 2000; Webb et al, 2002). The NSW Minimum Data Set indicates that among those aged 19 years or under entering treatment, 29.4% were self-referrals (Copeland, 2003; unpublished data). Rigorous evaluations of the effectiveness of adolescent substance abuse treatments have recently been completed or are currently in progress, with greatly increased attention having been devoted to this population in recent years. In particular, there has been an increased focus on models targeted towards the issues and developmental stage of young people, rather than simply applying (inappropriate) adult programs to this group (for reviews see Muck et al, 2001; Wagner, Brown, Monti, Myers and Waldron, 1999; Williams, Chang and the Addiction Centre Adolescent Research Group, 2000). Manualised therapies are now becoming available for dissemination to the field. Prior to the late 1990s, the conclusions of the few published studies had been limited by methodological problems (Deas & Thomas, 2001).

Outpatient treatments for young people have had mixed success in reducing cannabis use. For example, the Treatment Outcome Prospective Study (TOPS) of 87 adolescents compared daily cannabis use in the year prior to, and the year following, treatment. It found a reduction of 42% for those receiving less than three months of treatment and an increase of 13% among those who received three or more months of treatment (Hubbard, Cavanaugh, Craddock, & Rachel; 1989, 1985a). The Services Research Outcome Study found that cannabis use increased 2-9% among 156 adolescents in the five years after they received any kind of treatment (Office of Applied Studies, 1995). However, two recent studies, reported slight (National Treatment Improvement Evaluation Study) (Gerstein and Johnson, 1999) to moderate (Drug Abuse Treatment Outcome Study (DATOS) – Adolescents) reductions in cannabis use at follow-up. For example, there was up to a 50% reduction in regular cannabis use among participants in the DATOS-A at a 12 month follow-up (Rounds-Bryant and Staab, 2001). The lack of untreated control groups in these studies makes it difficult to evaluate the outcomes. Treatment may be helpful, but relapse rates are high (20-50%), retention in treatment is problematic, and long-term outcomes are unknown (Muck et al, 2001).

Preliminary outcome data from the Cannabis Youth Treatment (CYT) Project , a rigorous, multi-site intervention study of 600 young cannabis users aged between 12 and 18 years, compare favourably with previous studies (Dennis and Babor, 2001; Dennis, Babor, Diamond, Donaldson, Godley and Tims et al., 1998; for a summary of the study and the baseline characteristics of the sample see Dennis, Titus, Diamond et al, 2002; Tims, Dennis, Hamilton, Buchan, Diamond, Funk and Brantley, 2002). Participants were randomised to one of five outpatient interventions of varying type and intensity. A non-treatment control condition was not included in the design. Compared to intake, at six months there was an increase in reported abstinence, and decreases in symptoms of cannabis abuse or dependence and a range of other behaviour problems (e.g., truancy, criminal justice involvement, school problems, family problems, and violence). There was some evidence for differential effectiveness of the five treatments by problem severity, with the briefest treatment being more effective among low severity adolescents, and longer, more intensive interventions most effective with high severity adolescents. Otherwise, little difference was found across the treatment conditions.

While the mandating of young offenders to substance use treatment is increasingly popular, there is little evaluation of the efficacy of these interventions (see Titus and Godley, 1999). A limited examination of young people enrolled in the CYT who were referred by the legal system or who reported recent criminal behaviour found that

manual-guided outpatient therapy was as effective in reducing substance use among these groups as it was in those with no criminal involvement (Webb et al, 2002). Thus, those referred by the legal system reduced their substance use by 32% and substance use problems by 36% during treatment (compared to 34% and 39% respectively, for the non-referred group). Those reporting recent criminal behaviour reduced their substance use frequency by 38% and reported 39% fewer substance use problems (compared to 25% and 32%, respectively, among those not reporting recent criminal behaviour). These reductions were maintained in both groups up to 12 months after entry to treatment. Among criminally involved adolescents in the DATOS-A, reductions in alcohol or cannabis use were significantly related to reductions in the likelihood of committing crime at the 12 month follow-up (Farabee, Shen, Hser, Grella and Anglin, 2001).

While the CYT offers a menu of effective treatments, the results may apply primarily to treatment- seeking adolescents, many of whom may have been coerced into treatment in various ways. Interventions tailored to attract and enhance motivation in non-treatment seeking adolescents have not been developed or studied systematically.

Several recent studies have shown promise utilising brief motivational enhancement treatment (MET) approaches with adolescent substance users (see Monti, Colby and O'Leary, 2001 for a review). Motivational enhancement treatment refers to counselling that incorporates motivational interviewing, defined as "a directive, client-centered counselling style for eliciting behavior change by helping clients to explore and resolve ambivalence" (Rollnick & Miller, 1995). For example, Monti and colleagues (1999) used MET with adolescent drinkers in an emergency room setting and demonstrated reductions in alcohol use, drinking and driving, traffic violations, and alcohol-related injuries and problems. Colby, Monti and colleagues (1998) compared brief advice and brief MET with adolescent tobacco smokers in an emergency room setting. While both groups reduced their days of smoking and levels of nicotine dependence, there were no significant differences between interventions. More research is needed to examine whether MET is more efficacious than standard brief interventions in reducing cannabis and other substance use among adolescents, including those in the juvenile justice system.

1.2.3 The Check-up approach

The Cannabis Check-Up is a brief motivational intervention modelled on the Drinkers' Check-Up for problem drinkers (Miller & Sovereign, 1989). The basic Check-up model comprises a two-session assessment and feedback intervention in which a clinician helps the participant make informed choices regarding their substance use. There is no confrontation regarding use, but the provision of a non-judgmental atmosphere in which questions may be asked. There is no overt attempt to make participants change their use unless requested by them.

In the initial session, assessment data are collected concerning the participant's substance use and its role in their life. This includes areas such as positive and negative consequences of use; the individual's life goals; readiness for change; and support networks. This information is used to prepare a Personalised Feedback Report (PFR) that is reviewed with the participant in the feedback session conducted approximately one week later.

While reviewing the PFR with the participant during the feedback session, the clinician uses MET strategies (e.g., open-ended questions, reflections, reframing, and avoidance of argumentation) to elicit the participant's active and candid involvement in the session (Miller & Rollnick, 1991, Lawendowski, 1998). The general focus is on encouraging the young person to explore the personal meaning and implications of the information in an open and balanced fashion. Expressions of motivation for change are reinforced and resistance is avoided by giving attention to motivation both favouring and opposing change. If participants clearly express a desire to change their cannabis use, the clinician supports their efficacy by discussing various change options, including self-managed change or referrals to local drug treatment providers.

The Check-up approach has shown promise among adolescent cannabis users. In the United States, an exploratory study of a two session intervention recruited 78 young people primarily from schools, 54 of whom completed the assessment and feedback sessions and a three month follow-up interview. This approach was able to recruit and retain young cannabis smokers, many of whom were in Pre- and Contemplation stages of change. The majority (83%) reported having made voluntary reductions (stopping or reducing use) in their cannabis use in the 90 days to follow-up. There were also substantial decreases in consumption in the 30 days prior to follow-up, compared to the 30 days prior to the baseline assessment. Further, 15% (n=8) reported complete abstinence from cannabis in the 30 days prior to their follow-up session (Berguis, Swift, Roffman, Stephens and Copeland, in press). A larger study is currently underway

Preliminary, unpublished results of an ongoing NDARC study of the Check-up among young people in the general community similarly show promise. In addition to the two Check-up sessions, this study included an additional session in which cognitive behavioural techniques were used to help the young person develop skills with which they could make changes to their use. All participants received the assessment and feedback sessions, and those meeting criteria for cannabis abuse or dependence were randomly assigned to receive the third session immediately or wait until the three month follow-up, at which time they would be offered participation. To date, 64 young people have been enrolled. Their mean age is 16.4 years, and they first commenced cannabis use at a mean of 13.4 years. Participants reported using cannabis on a mean of 51 of the last 90 days, with 78% having a history of daily use. Almost all (93%) met criteria for a cannabis use disorder. Over half (53%) had a history of treatment for a psychiatric disorder and more than a third (36%) had supported themselves through illegal activity at some time in the past 3 months.

The rate of treatment completion for the Check-up phase has been very high (of those who completed the baseline assessment, 94.8% returned for the feedback session). Approximately 80% of the sample has been followed up at three and six months. Preliminary analyses (n=58) show a significant mean reduction in cannabis using days from 51 of 90 at baseline to 39/90 at three months and 36/90 at the six month follow-up. The mean quantity of cannabis use in the past 90 days also declined, from 384 cones at baseline to 317 and 262 cones at three and six months respectively. Continuous abstinence was reported by 21% of participants at three months, and was maintained at six months. The proportion of participants meeting DSM-IV criteria for cannabis dependence fell from 86% at baseline to 59% at the three month follow-up. (Martin, Copeland, Swift and Roffman, 2003).

The Check-up approach has been well received among the US and NDARC samples. Nearly all participants felt their counsellor listened to them, was helpful and was non-judgmental of them and their attitudes about their cannabis use. Most also reported that receiving feedback about their cannabis use was moderately to extremely helpful, and at least a half of the participants reported they would be interested in attending additional sessions to discuss their cannabis use, if offered.

2. THE CANNABIS CHECK-UP

2.1 The Cannabis Check-Up and when to use it

The Cannabis Check-up (CCU) is based on cognitive behaviour therapy and is modeled after the Drinkers' Check-Up for problem drinkers (Miller & Sovereign, 1989). It utilizes motivational enhancement techniques (also known as motivational interviewing). It is suited to young people who use cannabis excessively but are not necessarily interested in change. The Check-up comprises a series of individual, face-to-face sessions which aim to provide objective feedback on cannabis use and the opportunity to develop skills for change. There is no confrontation regarding use, but the provision of a non-judgmental atmosphere in which questions may be asked. There is no overt attempt to get participants to change their cannabis use unless requested by them.

The Check-up is designed for clinicians trained in psychological interventions for substance use problems and is appropriate when cannabis use has been identified as an issue worth addressing. It may be useful as a one-off intervention, or delivered as one of a range of services, depending on the nature and severity of the issues involved.

Clients should ideally (but not necessarily) be fluent in English, be fully cognisant, have no serious comorbidity that would compromise their ability to participate and display a willingness to examine their cannabis use. The CCU is not targeted towards individuals with a history of severe poly-drug use.

This style of intervention requires that the young person engages voluntarily. The Check-up should occur in a non judgmental atmosphere, should be informative and non directive.

2.2 Aims and objectives

The specific objectives of the Cannabis Check-up are to:

- provide the young person with a chance to receive objective feedback on their cannabis use in a non-judgmental environment;
- increase the young person's awareness of their cannabis use and how it is related to their current life situation, including criminal behaviour if relevant;
- educate the young person about the associated risks and harms of cannabis use; and
- help them identify high risk situations and introduce strategies for change.

2.3 The format of the Cannabis Check-Up sessions

The Cannabis Check-up comprises 2-4 sessions, matched to the young person's Readiness to Change. Sessions 1 and 2 are the assessment and feedback components which form the core of the Check-up model. These 2 sessions should be delivered to **all** participants, even if they are in Pre-Contemplation. Session 3 is a skills-based session targeted towards young people in the Preparation and Action stages. By matching the level of involvement in the intervention to the participant's stage of change, the clinician will have a better chance of achieving the desired outcome, which is to shift the young person from one stage to the next. It assumes that any knowledge gained will increase the young person's chance of moving to the next stage of change and will help the participant make informed choices regarding their cannabis use.

	Stage of Change
Session 1 - Assessment and further plan -	Pre - or Contemplation
Session 2 - Feedback	Contemplation
i.e. all participants	
ADD ON Session 3 if appropriate	
i.e. if young person is in	Preparation
ADD ON Session 4 if appropriate	
i.e. if young person is in	Action

Session 1: This is a detailed assessment of the young person's cannabis and other drug use, attitudes, behaviours and experiences. This includes measures of the young person's patterns of cannabis use and dependence, use of alcohol and other drugs, their views concerning positive and negative consequences associated with use, their "Stage of Change", perceived obstacles to initiating and maintaining changes, short and long term goals and other pertinent attitudes and beliefs. This session is an important way of engaging the young person and explaining the purpose and course of the Check-up. The young person receives a booklet containing accurate and current information on the effects of cannabis (e.g., *What's the Deal on Grass: Cannabis Facts for Young People*).

Session 2*:* About one week later, the young person returns for the feedback session. The clinician will have prepared a written Personal Feedback Report, and this is discussed and a decision is made on the next step.

Session 3*:* This session is held approximately one week following Session 2, and focuses on preparing the young person for change. It provides strategies for quitting/change, including goal setting, coping with craving and withdrawal and behavioural self-management. The young person is given a workbook they **complete during the session** and take with them.

Session 4: Focuses on additional issues for young people who are ready and willing to commit to change. It deals with the practical issues of their future, setting a specific date to change, self monitoring and relapse prevention. The young person is given a second workbook during this session.

NB: Some of the young people for whom the Check-up may be suitable may have difficulties in reading and writing and may find it difficult to complete a session in one meeting. If necessary, individual sessions could be conducted over two meetings.

3. SESSION ONE: ASSESSMENT

Approximate length: 60-120 minutes

What you will need for this session:

- Young person's assessment (Appendix A).
- *What's the deal on grass? Cannabis facts for young people (optional)*

3.1 How to do it

1). WELCOME THEM. Take a few moments to establish rapport, check how they're feeling about the session and answer any brief questions they might have.

2). EXPLAIN that today you will be asking them to answer questions and to complete questionnaires to help you find out more about them, such as their concerns and attitudes about their cannabis use and life in general. It will take about 60-90 minutes and they don't have to answer any questions they do not want to answer. Offer to read any materials to the young person to give poor readers an easy opportunity not to have to say they can't read something.

3). EXPLAIN that you would like to arrange another meeting in about 1 week to review a feedback form created specifically for them based on the information they provide today. That meeting will last about 1 hour and there will be more discussion in that meeting. Organise a time and place for the feedback session now.

4). ADMINISTER THE ASSESSMENT (Appendix A). Follow the order of questions presented in the assessment. You may wish to ask the questions verbatim (some basic scripts are written) or you may choose to use your own words; however the essence of the questions should be maintained. At all times remain objective and non-judgmental.

The assessment is basically interviewer-administered, except for the following (unless the young person would like you to read them): Risk Perception Questionnaire (Question 4b); Cannabis Problems Questionnaire (Question 4d), Severity of Dependence Scale (Question 4e); and the Costs and Benefits Scale (Question 5a). As the assessment forms the basis of all further sessions, it is important the young person understands the questions and as much accurate information as possible is recorded. Probe where necessary and be aware of major inconsistencies between answers and gross exaggerations.

5). AFTER THE ASSESSMENT has been completed, answer any questions they may have, thank them for their involvement and provide them with the booklet on *Cannabis facts for young people*. Please reiterate the time and location of the feedback session. If relevant, you may wish to make a reminder call regarding the feedback session in the following week.

4. SESSION TWO: PERSONALISED FEEDBACK

Approximate length: 60-120 minutes

What you will need for this session:

- Completed assessment
- 2 copies of the Personalised Feedback Report (PFR) (Appendix B)
- A copy of the age-appropriate prevalence data for comparing use patterns (Appendix C)
- A copy of the young person's evaluation form (Appendix F) (optional, but recommended)

4.1 Introduction and overview of feedback session

This session aims to provide the young person with feedback regarding their cannabis use which will hopefully increase their chance for change to the next stage. It builds rapport and allows the young person to think about and express their beliefs about cannabis use and the possibility/desirability of change. The content of the feedback session is based on the young person's responses in the assessment (Session 1). All components of the assessment can be addressed in some way during this session. The PERSONALISED FEEDBACK REPORT (PFR) is a tool which the clinician and young person can work through together. It is compiled by the clinician from answers the young person provides in the assessment, under the appropriate headings. The template for the PFR is presented in Appendix B – it is then simply a matter of inserting the information for each individual under the standard headings. The order of the assessment items mirrors the order in which issues are raised in the feedback, making it straightforward to refer back to when compiling the Report. The bulk of the PFR is filled out before the feedback session, with other items completed during the session.

MOTIVATIONAL INTERVIEWING (MI) is an empathic, reflective therapeutic style designed to elicit self-motivation to change from the concerned participant. This interviewing technique is most appropriate with clients who are ambivalent, who are primarily in Contemplation and those who vacillate between Contemplation and Preparation. The five general strategies of MI are: i) express empathy, ii) develop discrepancy, iii) avoid argumentation, iv) roll with resistance, and v) support self-efficacy.

THE GOAL OF MI is to develop discrepancy between present behaviour and important personal goals endorsed by the participant in order to motivate change. In the Personalised Feedback, however, it is important that the participant present the reasons for change. Arguments with the participant over the need to change are assumed to be counterproductive and participant resistance becomes a signal to the counsellor to change strategies.

THE COUNSELLOR uses reflective listening to express empathy regarding the participant's ambivalence rather than confront them with the need to change. The assumptions are that acceptance facilitates change and that ambivalence is normal.

From a STAGES-OF CHANGE perspective, the MI approach addresses where the participant currently is in the cycle of change and assists the person in moving through the stages toward successful sustained change.
When a client is resistant to change**,** there is a need to ROLL WITH RESISTANCE. This refers to reframing a participant's ambivalence, turning the question or problem back to the participant, and allowing the participant to accept what they want from the interaction.

The counsellor also works to SUPPORT the participant's perception that they are capable of making changes in their behaviour. Self-efficacy is fostered through the counsellor's optimism and confidence in the participant.

MI skills include the use of a number of IMPORTANT COUNSELLING STRATEGIES:

- open-ended questions
- reflective listening
- affirmation of the participant
- periodic summaries of the pros and cons of change expressed by the participant
- elicitation of self-motivational statements
- recognising and dealing with resistance
- recognising readiness for change
- providing information and advice

As the participant expresses increasing interest in modifying his or her use, the counsellor works carefully to SUPPORT EFFICACY for making a change without prescribing the change and engaging resistance. If and when the participant clearly expresses a commitment to change, the counsellor asks the participant about the steps or methods they might use in making the change.

4.2 How to do it

1). HAVE 2 COPIES OF COMPLETED PFR (one for young person and one for you) and some referral information in case it is needed (a template is presented in Appendix B).
2). Begin by spending some time BUILDING RAPPORT and engaging the young person. This is a critical aspect of the session and will be aided by an approach that uses positive connotation, empathy, humour, use of self, and some familiarity with street language. The goal is to assist the young person to feel safe and supported. Start by welcoming them back and affirming their choice to continue with the Check-up - for example:

"It's good to see you, I'm glad you could make it".

Initiate some casual conversation and take sufficient time to allow them to settle in and feel at ease. Encourage them to talk about what they have been doing and what is currently of interest. Inquire about their response to the assessment session

"What did you think about the assessment last week?"

and discuss any concerns or questions they have.
3). EXPLAIN THE PURPOSE of the current session - for example:

"Do you know what we're going to do today? If it's okay with you, today we're going to. ... Do you have any feelings about doing this?"

Explore their feelings and reflect. Clarify the purpose of the session in response to feelings the young person just shared. Reiterate the confidentiality of the session.
4). GIVE A BRIEF STEP-BY-STEP PREVIEW of the PFR before going through each section.
5). Go through EACH SECTION of the PFR and seek elaboration ("Tell me more about this…")
6). USE PARAPHRASING REFLECTIONS so they know that you are listening
7). Listen for expressions of MOTIVATION TO CHANGE and feed them back to the young person. This is reinforcing to them.
8). BE OPEN and don't be too quick to form an opinion concerning where the participant is at regarding their cannabis use and motivation to change (assume they have some ambivalence even if not expressed directly at first).
9). IF YOU WISH TO EVALUATE THIS SESSION, ask the young person to complete the evaluation form (Appendix F) at the completion of the session.

General Reminders
1). TAKE NOTES as you go to help you summarise key information later in the session. Use the outline of the PFR to put notes on (see attached). Let the young person know that you will take some notes, if that's okay, because you don't want to forget important information.
2). WATCH THE PACE. Push gently if they're going too slowly, but don't rush, and slow the person down if they're going too fast.
3). KEEP IN MIND the young person's comments and other information from their assessment that will be useful in the session.
4). AIM for about a 3: I proportion of reflections to questions

4.2.1 Stage of change

Based on **Question 1 (p. 1)** of assessment **Item 1** on Personalised Feedback Report

Aim:
To set up the session by recapping and clarifying where the young person is at with their cannabis use.

Function:
Allows the young person to have their current perception of their cannabis use (their stage of change) discussed and accepted without confrontation. Their motivation for attending (e.g. voluntary/coerced, seeking information/assistance) and expectations can also be explored.

How to do it:
1). FEED BACK the young person's stage of change. Ask if this is an accurate reflection of where they are with their smoking – for example:

> *"you said during the assessment that ….. [insert]. Is this how you feel now? Can you tell me a bit more about that?"*

Document this response on both copies of the PFR.
2). Reflect back and explore their reasons for attending and their expectations. Affirm their effort in agreeing to participate.

Reminder:
Take note of any problem recognition or motivation to change statements and feed these back.

4.2.2. Good things about cannabis use

Based on **Question 2 (p. 2)** of assessment
Item 2 on Personalised Feedback Report

Aim:
To explore the young person's positive feelings about cannabis use without imposing on them any assumptions about it being a "problem."

Function:
This is a useful way to start the session because it allows an exploration of cannabis smoking in a non-threatening manner, it builds rapport and understanding of the context of the behaviour, and it minimises resistance because you're talking about positive things first.

How to do it:
1). REVIEW the good things the young person identified about cannabis use, using the actual responses that they provided.
2). INQUIRE about which of these good things are important reasons to smoke.
3). INQUIRE about any other important good things that are not of the list. Document any other reasons generated on both copies of the PFR.
4). USE lots of reflective listening and summarise periodically. Offer a summary reflection as succinctly as possible – for example:
"So smoking cannabis helps you..."
5). You may also want to EXPLORE some reasons – for example:
"What is it that you like about this?~ "Tell me more about this?"

Reminder
Don't spend too much time on the positives, particularly if the assessment session indicates that some ambivalence is already present. Once rapport is established and you have a good sense of the positives, move on to the next section.

4.2.3 Cannabis use and other drug use patterns

Cannabis use: based on **Questions 3a-3d (pp.2-4)** on assessment
Other drug use: based on **Question 3c (p.5)** on assessment
Item 3 on Personalised Feedback Report

Aim:
To review the young person's pattern of cannabis, alcohol, and other drug use. This includes comparisons of their use with other young Australians, using prevalence data from the 2001 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2002) (Appendix C).

Function:
It allows the young person to get an overall picture of their substance use. It also provides information that can highlight discrepancy between the young person's use and that of other young people, which may generate a sense of discomfort that often precedes a decision to make a change.

How to do it:
1). REVIEW the young person's recent pattern of cannabis use by going through the use statements ("Recent cannabis use" on PFR: quantity and frequency of use in the last 3 months, last use, duration of this use pattern, context of use and amount spent on cannabis). Inquire about accuracy and their reaction - for example:

> *"How does that look to you? ...Does that look pretty accurate? ...How did your cannabis use change over time? ...Tell me about your early experiences with cannabis."*

2). REVIEW their cannabis use relative to other young people their age using the population prevalence data provided ("Comparing with other people" on PFR). These data come from the 2001 Australian National Household Survey and are broken down by male and female, for the age groups 14-15, 16-17 and 18-19. They provide selected information on young people's use of cannabis (ever use, use in last 12 months, use in last month, frequency of use in last 12 months and age of initiation) as well as basic information on their use of other illicit drugs, alcohol and tobacco. For example, only 6% of 14-15 year old Australian males have used cannabis in the last month. If the young person has used cannabis in this time, you can tell them that they used more recently than most (94%) other young males their age. Further, only 16% of 14-15 year old males have ever tried cannabis. Use the data in a similar way when considering frequency of use and age of initiation. Inquire – for example:

> *"What do you make of this? What do you think about that? What's going through your mind after seeing this?*

Then paraphrase the individual's response.
3). REVIEW the young person's history of cannabis use, any attempts at quitting or cutting down on their use and any successes or failures ("Summary of cannabis use" on PFR).
4). BRIEFLY REVIEW their alcohol, tobacco and other illicit drug use and compare it to other young people their age and gender using the prevalence data provided ("Other drug use" on PFR). Again, inquire – for example:

> *"What do you make of this? What do you think about that? What's going through your mind after seeing this?*

Then paraphrase the individual's response. Document additional responses on both copies of the PFR.

Reminders:
1). Let the young person sit with their feelings and reactions to the comparisons. Don't "hammer" them with the statistics or "rescue" them from their discomfort - it's part of the process.
2). Don't argue over the accuracy of the statistics. Reflect their feelings about seeing comparisons.

4.2.4 Less/not-so-good things about cannabis use

Based on **Questions 4a-4g (pp. 6-18)** of assessment **Item 4** on Personalised Feedback Report

Aim:
To explore the "less good things" about cannabis use for the young person without imposing on them any assumptions about it being a "problem." They, rather than you, identify problem areas or reasons for concern or change.

Function:
This is a useful way to continue the session because you have already explored the "good things" and it minimises the resistance because you're talking about "less good things" rather than "problems" or "concerns". This allows the young person to identify problem areas without feeling labeled.

How to do it:
1). REVIEW the "less good" things the young person identified about cannabis use (Item 4 on PFR), using their actual responses as a guide – for example:

> *"We've talked about the things you like about cannabis smoking. Now I'd like to talk about the other side: the not-so-good things about your cannabis use. Here's what you indicated in the assessment session."*

Go through and inquire about each item, encouraging the young person to elaborate on each.
2). INQUIRE about which of these "less-good" things are important drawbacks or reasons to not smoke.
3). INQUIRE about any other important "less good" things that are not on the list – for example:

> *"What other things about your cannabis use have you, or people close to you, feeling worried? ...What else have you noticed?"*

Document any other reasons generated on your copy of PFR.
4). OFFER A SUMMARY REFLECTION as succinctly as possible. For example:

> *"So smoking cannabis makes you..."*

5). EXPLORE any other issues arising from items 4b to 4g that may also be relevant when considering the "less good" things about cannabis use. This additional information may be useful in developing discrepancies between their behaviour and their goals. As

there are several areas covered, choose only those you feel most pertinent, preferably those not already discussed. Before the feedback session, note these in the appropriate space on your copy of the PFR (under the heading "Any others?"). During the session, note down a summary of the young person's response on their copy of the PFR. The areas covered are: (4b) attitudes about cannabis risk expressed in the Risk Perception questionnaire; (4c) legal issues that may be associated with their cannabis use; (4d) items endorsed on the Cannabis Problems Questionnaire; (4e) their feelings about cannabis measured on the Severity of Dependence Scale (SDS)*; (4f) health-related issues and 4(g) social and environmental issues. Be careful not to couch these issues as problems but rather as opportunities to explore what has been said. Raise each issue in neutral terms and ask the young person to explore it, so they can make their own decision about whether it really is a "less good" thing. For example, they may endorse items on the Cannabis Problems Questionnaire indicating they had felt paranoid after a smoking session, or had been in an argument with their parents after smoking. Say to the young person something like:

> *"you said last week that you had felt paranoid after a smoking session, can you tell me a bit more about this?"* rather than *"you said you had problems with paranoia after you'd been smoking".*

6). PROVIDE AN INTEGRATIVE SUMMARY of positive (Item 2) and negative (Item 4) things about cannabis smoking for the young person – for example:

> *"So, smoking cannabis helps you relax...you enjoy smoking with friends, and it seems to help when you're feeling fed up. On the other hand, you feel less motivated, you sometimes say things you don't mean after smoking, and you're having a hard time concentrating which has contributed to lowering your marks at school."*

Document any additional responses on both copies of the PFR.

Reminders:

1). Avoid using words like "problem" or "concern" unless the client does.
Don't assume that a "less good" thing is a concern for the young person.
2). Keep to the task at hand, and avoid raising new topics or ideas of your own.

* Note on the SDS: The SDS can be used in two ways: (i) answers to the individual questions can be used as indicators of the level of concern the young person displays towards their cannabis use; (ii) the total scale score can be used as an indicator of level of dependence. The SDS score has a range of 0-15, with a score of 3 or more indicative of cannabis dependence. The higher the score, the more likely they are to be concerned about their use and be dependent. For the purposes of the feedback session the first method may be most useful, while the information gained from the SDS score is used in the Strategies 1 session.

4.*2.5 Anticipated consequences of reducing (and increasing) use*

Based on **Questions 5a-b (pp.19-22)** of assessment
Item 5 on Personalised Feedback Report

Aim:
To explore the young person's anticipated costs and benefits of reducing and increasing their cannabis use.

Function:
To facilitate exploration of what's attractive and unattractive to them about reducing use and increasing use. It allows them to compare the costs and benefits of making changes in their use.

How to do it:
1). INTRODUCE the topic of reducing use – for example:

> *"When I asked you to think about what might happen if you decided to reduce your cannabis use, you identified some costs/negative things and some benefits/positive things you thought might happen. Here's what you said…."*

2). SUMMARISE AND EXPLORE the costs and benefits of reducing use, again using actual responses collected during the assessment phase.
3). INTRODUCE the topic of increasing use in the same manner.
4). SUMMARISE AND EXPLORE the costs and benefits of increasing use.
5). COMPARE the costs and benefits of reducing and increasing use. Document any additional responses on both copies of the PFR.

Reminders:
1). Be aware of potential approach-avoidance conflict: when the weight begins to shift one way, the person tends to focus on and shifts weight to the opposite side.
2). Use MI to explore ambivalence, to clarify competing motivational factors, and to encourage the young person to consider the possibility of change.
3). Don't oversimplify or rush through the process. The pros and cons often do not add up in a simple fashion and their value may shift over time. Participants may or may not be aware of the balancing process going on for them; their pros and cons may be contradictory; and their ambivalence can be confusing and difficult to understand. Persist with the ambivalence (and their discomfort), however, because it is often the heart of the problem. Be patient and explore the complexity of the person and their situation.

4.2.6. Goals and aspirations

Based on **Question 6 (pp. 23-25)** of assessment
Item 6 on Personalised Feedback Report

Aim:
To look at the young person's goals for the future and the role of cannabis use in reaching those goals.

Function:
This is a useful way to explore the young person's goals for the future, their confidence/self-efficacy and involvement in reaching their goals (which may relate to their confidence in following a change plan), and how increasing and decreasing their cannabis use might affect the likelihood they will reach their goals (which may provide information that is useful in developing discrepancy).

How to do it:
I). REVIEW their top 3 goals, confidence in reaching goals, involvement in goals, and their likelihood of reaching each goal if they increase and reduce use. For example, for each goal:

> *"Last week you told me about some of your goals for the next 3 years. You said [goal] was an important goal for you, that you feel confident you can reach that goal, and that you are actively involved in working towards that goal. You also said that, if you increased your cannabis use, you would be [more/less] likely to reach your goal of [goal]. If you reduced your cannabis use, you thought you would be [more/less] likely to reach the same goal)".*

2). EXPLORE their goals and how they are working to reach them. This will provide information about how they go about making plans to reach goals.

Reminders:
Look for goals that may enhance motivation to change.

4.2.7 Your relationships

Based on **Question 7 (p. 26)** of assessment
Item 7 on Personalised Feedback Report

Aim:
To identify some important people in the young person's life - people they feel they can trust and count on when having a problem, and to get a snapshot of how cannabis use is related to important relationships.

Function:
This is a useful way to identify key people in the young person's life and find out whether or not they know about their cannabis use and their feelings (or expected feelings) about their cannabis use. This provides information that may be helpful in building discrepancies and identifying people who might support or not support the young person if they decide to make changes in use.

How to do it:
I). REVIEW the names of important people, their relationship to the young person, whether or not they know about the young person's cannabis use, and their reactions or potential reactions - for example:

> *"Now I'd like to talk with you a bit about some important people in your life. In our first session, you mentioned that [person] is important to you. How? ... You also said that [person] knows (doesn't know) about your cannabis use and that they think (or would think) [what they would think] about it."*

2). EXPLORE these issues with the participant, going through each important person mentioned.

Reminders:
Keep in mind important referents for the strategies session.

4.2.8 So what now? Summarising and exploring immediate goals regarding cannabis

Based on Feedback session so far and **Question 8 (p. 27)** of assessment
Item 8 on Personalised Feedback Report

Aim:
To review what has been covered and explore where the young person is at regarding their cannabis use. Also, to help them decide what to do if they have expressed a desire to make a decision to change or asks, "What should I do?"

Function:
This is a way to pull together everything that has been covered and provide a setting in which the young person can talk about what they would like to do (e.g., make a change, get more information, think things over).

How to do it:
1). SUMMARISE the key information that you have covered - for example:

> *"We've learned a lot about you and your cannabis smoking over the last 2 sessions. Where are you at with this information?"*

2). CHECK for reactions and feelings at this point - for example:

> *"What does this mean about your cannabis smoking? What are some reasons why you should continue smoking cannabis the way you have been? And, what about the reasons you think it's time to change? ..If you decide to make a change, what are your hopes for the future?"*

3). FIND OUT where the young person is regarding immediate cannabis goals (Item 8 on PFR).
4). INQUIRE AND INVITE the young person to talk about change - for example:

"What do you think you will do? ..It sounds like a part of you would really like to make some changes. Would you like to talk about that? ...Would it be helpful to talk about some things you might consider"?

Go through options of i) no change, ii) stop use, iii) reduce use, and iv) stop for a while to get practice saying "no " and not using, then revisit the issue (more effective for most people than just trying to reduce their use).

Then ask:

"Do any of these options seem attractive to you?"

5). If the young person desires to make a change EXPLORE THE DETAILS of their decision. If not, don't push them, move on to Section 9a: The "How would you know?" question.

Reminders:
1). Try to elicit problem recognition, concern, and intention to change statements.
2). There are different kinds of decisions:

- w*hether* to do something
- *what* to do (goals, targets), and
- *how* to do it (ways of achieving a goal).

This strategy can be useful with any of these kinds of decisions.
3). Don't rush a person into premature decision-making. If you get stuck, the person may not be ready to make a decision. Ask if this is so. It can be useful to go back to ambivalence-exploring strategies, or to give the person some time to consider and make a plan for that.

4.2.9(a) The "How would you know?" question.

Item 9 on Personalised Feedback Report
(This question is intended for those people who don't see their current level of cannabis use as problematic. For those who do, go to 9b: The "how do you know?" question.)

Aim:
To help the young person think through and articulate indicators that would tell them they are smoking too much cannabis.

Function:
This primes the young person to recognise the need for change at a later date. By identifying and explicitly stating criteria for recognising "too much" use, the young person will be more likely to register it should they reach that point and will therefore be more likely to initiate change efforts.

How to do it:

1). MOVE ON to this question once you have established that the young person is comfortable with their use and is clearly not interested in making or discussing any changes.

2). FIRST, make sure you have clearly and fully restated and validated their position.

3). LET THEM KNOW that you are at this point interested in making sure that they are able to successfully keep using without unacceptable consequences.

4). EXPLAIN that in order to make sure that their use stays within a range that is appropriate to them it is important to identify how they could clearly identify it if their use were to become unacceptably harmful or excessive.

5). AT THIS POINT ASK the question:

"How would you know if you were using too much?"

6). PUSH FOR DETAILS. The more concrete examples or signs the young person can generate the better – for example, if they say:

"If I started smoking too often" ask *"How often is too often?"*

If they say:

"If my grades drop" ask "*Below what, "B" average, "C" average?*" Encourage them to identify amount, frequency, effects and consequence indicators.

7). WORK WITH THE YOUNG PERSON to put together the information they give to form a specific description of signs they are smoking too much. Ask what they think their reaction would be if they recognised that they were in that situation.

8). WRITE A STATEMENT summarizing their position under Item 9 on both copies of the PFR.

Reminders:

1). For the young person who indeed is using without what they consider to be significant harm, this process should help them think about the effects and characteristics of a level of use they would not be comfortable with. By thinking it through ahead of time, they should be more likely to recognise that stage of use if they should reach it.

2). The core of this step is in helping the young person think through the signs of overuse.

3). Young people should be more open to this step if it is framed clearly as a way to support their acceptable level of use. It is important to avoid the implication that you expect them to reach this point. Instead, emphasise that this is a precaution to help them guard against the types of problems they have successfully avoided so far.

4). Some young people may clearly not be interested in discussing how they would know if their use was becoming excessive or problematic. If gentle prodding is not effective at facilitating a discussion on this matter, it may be best to just summarise where you think they are at on this matter and see how they respond. Then, if it's still clear they are not interested, thank them and move on to wrap up the feedback session.

4.2.9(b) The "How do you know" question.

Item 9 on Personalised Feedback Report
(This question is intended for those people who currently do see their cannabis use a problematic. For those who don't, go to 9a: The "how would you know?" question.)

Aim:
To help the young person think through and clearly articulate the reasons they perceive their current level of cannabis use to be too much.

Function:
Helps the young person recognise and focus on the signs of their overuse, as they see them. Makes explicit key motivators for changing cannabis use.

How to do it:
1). MOVE ON to this question once you have established that the young person considers their current use problematic, and is interested in making or discussing changes.
2). WORK WITH the young person to put together the information they give to form a specific description of signs they are smoking too much.
3). EXPLORE each of the signs – for example:

"how is that a problem for you?"

and reflect.
4). PROVIDE A SUMMARY of the signs of overuse and ask if it is accurate
5). ASK THE YOUNG PERSON whether they have plans to change and, if so, how they might go about it. Support their self-efficacy for change - for example:

"You managed to give up the cigarettes, which is great - a lot of people find that really hard, so you've shown that you can make tough changes. I think you can change your cannabis smoking as well if that's what you want. What do you think?"

6). WRITE A STATEMENT summarising their position under Item 9 on both copies of the PFR.
7). OFFER participation in, and provide a brief outline of, Sessions 3 and 4, or discuss referral options if that is indicated.

4.2.10. Wrap-up

Item 10 on Personalised Feedback Report

How to do it:
Following the Feedback component….
1). AFFIRM their effort and willingness to take the time to look at their cannabis use and to decide to make any changes they have indicated. Ask if they have any further questions or comments.
2). EXPLORE the level of interest in continuing with another session. If the young person is interested in learning more about ways in which they can control their use, schedule the strategies session for a time in approximately one week. At this session they are provided with practical skills aimed to help them reduce/quit their use and minimise the harmful consequences of their use. They are given a personalised booklet of these strategies to keep.
3). FINALLY, WRITE THE OUTCOME of the session under Item 10 on the PFR – e.g., "I plan to participate in the strategies session", "I am not planning on doing anything about my cannabis use right now".

5. SESSION THREE: STRATEGIES PART 1

Approximate length: 60-120 minutes, depending on how much is relevant to the young person and the number of sessions you choose to deliver the material

What you will need for these sessions:

- Young person's assessment and Personalised Feedback Report
- Young person's strategies workbook – Part 1 (Appendix D)

5.1 Overview

Session 3 is for young people who are interested in change. It aims to build motivation to change their smoking, help the young person think about their reasons for change, recognise actions and situations that lead to smoking, set goals and plan for change, cope better with craving and manage any withdrawal symptoms.

The session is based on cognitive behavioural therapy (CBT) principles and deal with the person's thoughts, feelings, and behaviours related to their cannabis smoking. The intervention focuses on the context within which the individual's cannabis use typically occurs, and assists the person to develop strategies and skills for changing problematic thoughts and behaviours that perpetuate cannabis use.

The session includes a workbook for the young person to keep, designed as a collaborative exercise between the young person and clinician. It aims to assist the young person to plan and develop a complete set of strategies for changing their cannabis use and maintaining the change in the long term.

5.2 How to do it

Prior to introducing the intervention, time should be spent building rapport with the young person and assisting them to feel comfortable.

Give the young person a brief outline of the rationale of the session. It should be explained that the session involves the learning of specific skills or techniques that will assist them in making changes to their cannabis use and maintaining those changes over time. It is about learning new skills and unlearning some old ones. The young person should be made aware that the treatment is not an easy "magic bullet" but will require them to do some work in order to change their cannabis use. The work they put in, however, will be rewarded. Emphasise that change is possible.

Indicate that the intervention involves a simultaneous emphasis on the young person's thoughts and actions (or behaviour), and the inter-relationship between these factors.

Outline the specific components of the intervention that will be covered in the session, and indicate how these will assist the young person in changing their cannabis use. These components are:

- building motivation to change their smoking;
- thinking about their reasons for changing their smoking;

- recognising actions and situations that lead them to smoke;
- setting goals and plan for change;
- managing any withdrawal symptoms;
- coping better with "hanging out" (craving); and
- managing withdrawal symptoms

Wherever possible the specific strategies discussed during the session should be illustrated with concrete examples based on material provided by the young person. Throughout the session feedback should be sought from the young person regarding their thoughts, feelings, and understanding of the ideas discussed.

5.2.1 Level and pattern of cannabis use

Aim:
To provide the young person with a profile of his or her cannabis use, level of dependence, and re-examine reasons for use and change.

How to do it:
1). INTRODUCE the concept of dependence, and the fact that it can have both physical and psychological aspects to it. Make clear what is meant by dependence with a brief overview of each of the diagnostic criteria:

- tolerance;
- withdrawal symptoms;
- using more cannabis than you planned;
- cravings to use cannabis, or not being able to control your use;
- spending a lot of time getting, using, and recovering from cannabis use;
- giving up or cutting down on important activities; and
- continuing to use cannabis even if it is causing you physical or psychological problems.

If a person experiences any three of these symptoms in a defined time period, they are considered to be dependent.

2). DISCUSS the fact the dependence is a continuum, not an all-or-nothing category. Give feedback on the young person's level of dependence using the Severity of Dependence Scale data collected in the assessment. The SDS total score has a range of 0-15, with a score of 3 or more indicative of cannabis dependence. The higher the score, the more likely they are to be concerned about their use and be dependent. Ask for the young person's response to this - how does that look to them, is it an accurate reflection of their situation?

5.2.2 Triggers and high risk situations

Aim:
To introduce the young person to the concept of high risk situations and help them identify personal situations and triggers that may increase their risk of smoking.

How to do it:
1). INTRODUCE the concept of high risk situations and provide some examples. Point out that smoking often occurs as part of a pattern of behaviour that is reasonably consistent – (e.g., in certain places, with particular people). Go on to discuss personal triggers and how these may be external (e.g., being offered a smoke, payday) or internal (e.g., boredom, stress). Be aware that some young people may be less confident in labeling their feelings than some adults, so it may be necessary to provide examples of feelings that other young people have found to be internal triggers. Explain how triggers promote thoughts of smoking and so often lead to increased desires or urges.
2). ELICIT the young person's experience of high risk situations and their concern about these.
3). HELP the young person compile a list of their high risk situations and triggers, being as specific as possible. Point out that knowing what their high risk situations and triggers are is an important first step in being able to deal with them. Dealing with high risk situations can be briefly introduced at this point, but will be covered in more detail later in the session.

5.2.3 "It's Just Habit"

Aim:
To provide an understanding of Seemingly Irrelevant Decisions and their relationship to high risk situations. To identify examples in the young persons life, and encourage the young person to think through each decision they make and where it may lead them.

How to do it:
1). "It's just habit" is used to provide a simple way of conveying "seemingly irrelevant decisions". Avoid using this latter term as it is quite convoluted, and "It's just habit" expresses the same concept more easily. EXPLAIN that this concept refers to those decisions that move a person closer to, or into, high risk situations. Cannabis smoking can, over time, become over-learned and automatic; smoking can occur without any real higher conscious effort. Some people may find themselves repeating old behavioural patterns without realising that they are putting themselves in danger of a high risk situation. Becoming more aware of the implications of the decisions they make on the likelihood of smoking will assist the young person to avoid high risk situations or prepare for them. The following outline may be useful to introduce the idea to the young person (it is also written in their workbook):

> *"Having a smoke can happen so often that it can seem to just happen without any real effort or thought. There are lots of steps that lead you to having a smoke. Some of the obvious ones are:*
>
> - *getting out the stash;*
> - *mulling up; and*
> - *packing a cone or rolling a joint.*
>
> *But there are lots of other little steps that lead up this point. They may be things like:*
>
> - *making time to prepare for having a session;*

- *sitting down in a certain room; and*
- *being with certain people.*

Sometimes these steps start happening hours before you actually have a smoke. Without thinking, many people make decisions or plans that lead them to a high risk situation, and then to a smoke. That is, through a series of small decisions you may gradually work your way closer to the point at which smoking becomes very likely".

2). ASK the young person whether they have ever tried to avoid smoking only to find that they ended up in a situation where it was impossible to resist. They may have been tempted by other people, or they may have unintentionally exposed themselves to internal triggers such as boredom or stress, which set off a chain of events that led to smoking.

5.2.4 Be aware of where your choices/ decisions may lead you

Aim:
To help the young person become aware of the choices they have in decision-making, and the impact of their decisions on the likelihood of cannabis use.

How to do it:
1). Being aware of the impact of decisions, even if they don't seem important, is crucial. POINT OUT that if the young person can get into the habit of recognising all the small decisions they make every day, and thinking through the safe versus risky consequences of those decisions, they will be less vulnerable to high risk situations. Trying to minimize temptations well before they grow into high risk situations will help the young person achieve their goals.
2). When making decisions, whether large or small, SUGGEST that the young person do the following:

- consider the choices they have;
- think ahead to the possible outcomes of each choice. What positive or negative things might happen? What are the risks that their choice will lead to them smoking?;
- select one of the options. Choose one that will make them less likely to smoke. If they make a choice that makes them more likely to smoke, plan how they could protect themselves while in the high risk situation; and
- watch for "red flag" thinking – thoughts like: "I have to…." (do something, go somewhere, see someone) *or* "I can handle…." (a certain high risk situation) *or* "It doesn't really matter….." (if I just have a puff).

3). ASK the young person to make a list of decisions they know they have made in the past. Also ask them to think of a few likely decisions that they could see themselves making in the future.

5.2.5 Decisional balance: Why smoke and why change

Aim:
To help the young person weigh up the pros and cons of smoking, and the pros and cons of change. This provides an opportunity to explore any ambivalence about smoking and change.

How to do it:
1). BEGIN the discussion of reasons for smoking with an acknowledgment that there are positive aspects to smoking. Emphasise the importance of the young person giving careful consideration to their own reasons for smoking. Point out that although these questions were looked at in the feedback session it is worth considering them further. Refer back to the assessment and feedback sessions to get the young person's verbatim responses to the questions of what the "good" and "less good" things are – for example:

> *"To keep it fresh in our minds, we will have another look at the good and less good things about your smoking that we talked about last time".*

Ask the young person to complete the list in their workbook.
2).ASK if the young person has anything they would like to add to the list, or any other changes they would like to make. Note any changes. Use Motivational Interviewing principles in exploring the issues, i.e. express empathy; develop discrepancy; avoid argumentation; roll with resistance; support self-efficacy.
3). As in the feedback session, DISCUSS the good things with the young person and determine the importance of each. Summarise the good things and feed this information back. Have the young person rate each item (0-10) in terms of importance to them.
4). TURN NEXT to the "less good" things. Again, ask the young person to complete the list. Discuss each one in turn and ask the young person the importance of each – for example:

> *"Is that a problem for you", "does that bother you sometimes?"*

Have them rate each item. Summarise and feed back the not-so-good things that the young person considers important.
5). EXAMINE the total ratings of the good and less good things, and discuss the decisional balance. Explore any ambivalence.
6). AGAIN, REFER BACK to the assessment and feedback sessions to get the young person's verbatim responses regarding the good and "less good" things about change, i.e. the young person cutting down their smoking, or quitting. Ask the young person to complete the list, and if there are any changes they would like to make. Discuss each item in turn and, as above, have the young person rate the importance of each.

Reminder:
The time spent re-examining the good and not so good things about cannabis smoking will vary according to the young person's stage of change. For those who are clearly in the determination or action stages a brief reiteration will suffice before moving on to a discussion of practical strategies. For those who remain ambivalent about change, some further exploration of their ambivalence may be required.

5.2.6 Strategies for change

Aim:
To generate a personalised list of strategies that may be of assistance to the young person in changing and maintaining the change.

How to do it:
1). INTRODUCE the discussion of strategies for change by pointing out that change is an individual process, and the types of strategies successfully used by one person will not necessarily suit another. Different strategies may also be useful in one situation but not another. Some flexibility and experimentation may be required for the young person to find what is right for them.
2). EMPHASISE that preparation and planning are key elements of successful change. Thinking in advance about how to handle problems will make dealing with them easier when they actually arise.
3). ASK the young person to think back to the positive things about smoking for them. The benefits that they currently see themselves gaining from smoking will need to be addressed in order to change successfully. That is, the young person will need new skills to replace the role that cannabis formerly played in their life. For example, if they use cannabis as a way to relieve boredom or depression, they will need to work out other ways to manage these feelings when they change their cannabis use.
4) BUILDING ON PREVIOUS EXPERIENCE is useful. Refer back to the assessment data to find if the young person has attempted to quit or cut down before, and if so, how they went about it. Discuss any previous attempts to change and how successful they were. Note down any strategies the young person found helpful in the "My Own Strategies" section of the booklet.
5). PRESENT the following list of strategy suggestions and briefly discuss them. Work with the young person to compile a list of as many strategies as possible.

- Before you smoke – think about it – practice distracting yourself (that is, focusing on something else) and delaying the time until you smoke
- Plan ahead: think about what you will do instead of smoking
- Remind yourself of why you want to change
- Remind yourself of the benefits of not smoking
- Do enjoyable things that don't involve smoking
- Ask a friend or relative for help
- Avoid high risk situations and people who smoke
- Practice urge management skills
- Spend more time with people who don't smoke.

5.2.7 Increasing enjoyable activities

Aim:
To generate a list of activities that will be rewarding for the young person. These will provide alternative activities to smoking, and assist the young person in coping with craving and boredom.

How to do it:
1). POINT OUT that the number of enjoyable activities a person engages in is directly related to the number of positive feelings they have. This means that enjoyable leisure activities may be a very useful tool for controlling negative feelings such as boredom and loneliness. Everyone wants and needs enjoyable activities in their life. For many people, a lot of time is spent meeting obligations that need to be done but aren't necessarily pleasant (e.g. housework etc). These are things we "should" do rather than "want to" do.
2). EXPLAIN that one of the common effects of cannabis dependence is a narrowing of focus of activities. That is, the person's involvement in activities other than smoking tends to decrease as their cannabis use increases.
3). ASSIST the young person to compile a list of activities that they find enjoyable, or have previously found enjoyable, or they would like to get involved in. Encourage them to generate as many ideas as they can. This list can be referred back to later in the session to provide concrete examples of activities that the young person could participate in as alternatives to smoking.

5.2.8 Dealing with high risk situations

Aim:
To raise the young person's awareness of high risk situations and personal triggers, and generate strategies to cope with them.

How to do it"
1). REVIEW the young person's high risk situations identified earlier, and reiterate the role that these situations play in eliciting urges to smoke.
2). EXPLAIN to the young person that, given the strong cravings associated with high risk situations, one of the best ways to deal with them is to avoid them; particularly in the first few weeks after they have quit or cut down. For example, advise them to avoid visiting friends that they know will be smoking at the time. Temptation is almost certain to arise, and it can be very difficult to deal with in the early stages. Explain that this doesn't mean permanently cutting ties with their smoking friends, just avoiding a high risk situation while they are particularly vulnerable.
4). ACKNOWLEDGE that not all high risk situations can be anticipated or avoided (e.g., time of the week; certain mood states). Remind the young person that planning and being prepared for these situations will help them deal with them, if it is not possible to avoid them. For example, boredom can be dealt with by having a plan of activities to do when the feeling arises.
5). Go through the young person's list of high risk situations and assist them to GENERATE A LIST OF STRATEGIES to deal with each of them. Write these in the young person's booklet.

6). It is also USEFUL for the young person to have an "all-purpose" plan for dealing with unexpected or especially difficult situations. Present the following as an outline of an all-purpose emergency plan.

1. I will leave or change the situation or environment
2. I will put off the decision to smoke for 30 minutes. (I know that cravings are short term. I'll wait it out.)
3. I will change my thoughts about smoking (do I really need a smoke)
4. I will think of something unrelated to smoking
5. I will remind myself of my success to this point
6. I will call someone I trust and talk about it.

5.2.9 Cravings: Urges to smoke

Aim:
To educate the young person on the origin and time course of craving, and to work with them to prepare coping strategies.

How to do it:
1). BEGIN this section with an overview of cannabis craving. Prompt the young person to recall their past experiences of cravings and how they build up over time. Indicate that cravings are reinforced by the effects of the drug on the reward centres of the brain. Cravings are triggered by cues for drug administration; remind the young person of his or her personal triggers, and discuss how these will tend to induce cravings.
2). EMPHASISE that cravings are normal in people who are quitting or cutting down their smoking. Cravings do go away, but they may be quite strong for a while immediately after quitting or cutting down. To explain the time limited nature of cravings, convey the following to the young person:

> *"Cravings to have a smoke rarely last very long. In fact, they almost never last more than about 30 minutes. This is true for everybody, but few people give themselves the chance to prove it."*

3). ASK the young person whether they have ever had a strong craving, but were for some reason unable to smoke. Next ask about whether the craving passed (most will have had this experience). This is intended to improve the young person's self efficacy for riding out cravings, and allows them to identify waiting-it-out as a useful strategy that they can use. The main message is that cravings do not have to be acted upon.

4). INTRODUCE the following methods of handling cravings/urges:
(i) "Urge surfing" and non-reinforcement of cravings.
Introduce the young person to the analogy that cravings/urges are like waves - they reach peak intensity then subside. For example:

> *"Cravings or urges usually come and go in waves. So, if they are feeling intense, try to distract yourself for a while and soon you will notice that the worst part has passed. Imagine the wave rising up to its peak level, and then it will pass you by, leaving you feeling more comfortable and no longer in need of a smoke. This is called "urge surfing". You will feel good when the urge wave has passed and you didn't have to act on it by smoking."*

Urges are continually being reinforced when cannabis is smoked in reaction to them. Resisting smoking in the presence of a craving will help to weaken the craving via the process of extinction.

(ii) Distracting

Distracting works on the principle that cravings are thoughts, and thoughts can be changed. The easiest way to change thoughts is to change the behaviour that is currently occurring. By getting involved in some activity that is unrelated to smoking the young person's thoughts will be removed from smoking and focused on the new activity. Suggest that the young person might try: taking a walk, phoning a friend, or engaging in one of the enjoyable activities they listed earlier. This will help pass the short time during which the craving is active.

(iii) Delaying

Delaying is related to distraction and works on the assumption that cravings are time-limited and they will disappear over time if not acted upon. Advise the young person that if they are about to give in to an episode of serious craving, they should check the time and make a personal commitment not to smoke for at least half an hour. During this time, ask the young person to engage in distraction. After the half hour is up they should decide whether having a smoke still seems necessary. It will usually be the case that having a smoke will not be as important as it was earlier.

(iv) Keeping the craving in perspective

This term is used in the workbook instead of the more commonly used term "decatastrophising". Explain that in this context, we simply mean keeping the experience of craving in perspective. Ask the young person to think about the feeling of craving and compare that to other uncomfortable feelings, such as a bad case of sunburn or severe anxiety. Suggest that the young person avoid becoming overwhelmed by craving by reminding themselves that cravings are not unbearable, just temporarily uncomfortable. Encourage the young person to ask such questions as: "is the craving really unbearable", "is it the worst thing that could be happening", "how does it compare to bad sunburn", before they act on the craving and have a smoke.

(v) Recalling the negative consequences of smoking

Often when experiencing craving people tend to remember only the positive effects of smoking; they often forget the negative consequences. It can be effective for them to remind themselves of the negative effects of smoking and the benefits of not smoking.

(vi) Avoiding

Remind the young person that avoiding (or leaving) situations with strong personal triggers is a useful way to minimise craving. If they persist in sitting in front of the TV, surrounded by people smoking, or other strong personal triggers, they will only increase the effect of those triggers on their craving.

5). REITERATE that cravings diminish over time. "You win every time you beat your craving. It makes the craving weaker next time and makes you more confident you can resist a smoke".

5.2.10 Withdrawal Symptoms

Aim:
To provide an outline of the type, intensity, and longevity of withdrawal symptoms that may occur, and give advice on how to cope with them.

How to do it:
1). BEGIN by pointing out that although not everyone experiences them, there can be some withdrawal symptoms associated with the cessation or reduction of cannabis use. Although these may be uncomfortable for a while, they are not dangerous.
2). REFRAME the withdrawal symptoms in a positive light - point out the symptoms are actually signs that the body is recovering and adapting to being without cannabis. So, they can be seen as positive signs of progress toward recovery.
3). BRIEFLY REVIEW commonly reported withdrawal symptoms (e.g., irritability, insomnia, trouble concentrating, restlessness etc.), and emphasise the short term and relatively minor nature of these symptoms. Point out that the symptoms do not last very long – for example:

"Don't worry, these symptoms are usually quite mild, and only last a week or so."

4). ADVISE the young person to look after their general health during the withdrawal period (if any). That is, try to eat well, drink plenty of water, get some exercise, and try to establish regular sleeping patterns.
5). SUGGEST the techniques of distraction, delaying, keeping it in perspective, and de-stressing as helpful ways of dealing with symptoms.

6. SESSION FOUR: STRATEGIES PART 2

Approximate length: 60-120 minutes, depending on how much is relevant to the young person and the number of sessions you choose to deliver the material

What you will need for these sessions:

- Young person's assessment and Personalised Feedback Report
- Young person's strategies workbook – Part 2 (Appendix E)

6.1 How to do it

Session 4 is for those young people who wish to go further in developing strategies for change. This session covers future goals, planning a method and a date for change, monitoring your progress, rewards for success and dealing with slips and relapses.

As with Session 3, start by establishing rapport and making the young person feel comfortable. Outline the specific components of the intervention that will be covered in the session, and indicate how these will assist the young person in changing their cannabis use. These components are:

- considering goals for the future;
- planning a method and a date for change;
- monitoring progress;
- remembering to reward for success; and
- dealing with slips and relapses

Again, wherever possible the specific strategies discussed during the session should be illustrated with concrete examples based on material provided by the young person. Throughout the session feedback should be sought from the young person regarding their thoughts, feelings, and understanding of the ideas discussed.

6.1.1 The future

Aim:

To explore the young person's goals and aspirations and place their cannabis use within the context of these larger life goals.

How to do it:

1). ASK the young person to think back to your earlier session when you looked at their goals and plans for the future. Have them consider the things they want to achieve and what they would like to change or improve. Note the top 3 goals, including any changes they make, in the young person's workbook.

2). ASK about the role they see that smoking has, or does not have, in helping them achieve their goals. Note these next to each goal in the workbook. Suggest that looking at the changes in their smoking habits in the larger context of what they want to do can help reinforce the desire to change or maintain any changes they have already made.

3). POINT OUT that the young person is fully capable of achieving their goal of change if they wish. Tell them that when they have succeeded in changing their smoking the possibilities of new opportunities and a new lifestyle will be there for them.

6.1.2 Doing it:

Aim:
To negotiate a specific goal for change and have the young person commit to a date for change.
NB: The booklet specifies only the goal of quitting, but you may wish to discuss cutting down if appropriate.

How to do it:
1). SET A CHANGE GOAL. Having discussed various strategies for change and skills for coping, the young person should now be asked to make some decisions about short-term goals for changing their cannabis use.
Ask the young person what their immediate goal for change is. Do they intend to quit or cut down to a set level or pattern of use? Advise the young person that even if they choose to cut down in the long-term, it can be useful to have a period of non-use before attempting controlled use. Give reassurance that stopping smoking is never as difficult as it seems at the beginning. Support a goal of abstinence but don't try to impose it.
2). Have the young person WRITE DOWN their goal for change (i.e. abstinence or controlled/recreational use). If controlled use is the preferred goal, ensure that the details of what this will mean are clearly spelt out – e.g., to smoke no more than once per week and to smoke only when offered; or strictly Friday nights only.
3). SELECT A METHOD FOR CHANGE. Whether the young person should opt for sudden or gradual change will depend largely on their motivation and level of dependence. If their level of dependence is severe, they might want to consider cutting down first over a few days prior to stopping completely. For those who want to taper their use suggest that they gradually delay the time of day of have their first smoke by 4 – 6 hours each day, and count the number of cones they use and reduce this by 20% each day. For young people with low to moderate dependence, suggest that quitting "cold turkey" might be the best option. This means they can get on with it immediately and avoid the hassle of working out how to gradually reduce their use.
4). ADVISE the young person to use their own experience as a guide. If they have had some success before with one method, try using that again.
5). SELECT A CHANGE DATE. It is important that the young person nominate a specific date for change. Ask the young person to choose, and commit to, the date that they are going to make their change. Point out that if they don't set a specific date they may never get started. Write down the young person's change date in their workbook.

6). DISCUSS some of the issues that need to be considered when changing their cannabis use:

(i) Preparing mentally
Indicate that while changing cannabis smoking habits may not be easy, it is certainly not impossible. Being aware of trouble spots and planning ahead will make it easier. Remind the young person that people who have changed their use often say that it was not as bad as they thought it would be. It is the belief that it is going to be really hard that puts people off and makes the job harder. Ask the young person for any comments they have about the process of change, and evince confidence in their ability to succeed.

(ii) Rationalisations

Rationalisations are an important potential relapse precipitant that often arise as a result of negative, irrational thoughts. They may result from old automatic thought processes, and the young person needs to be aware of them to be able to deal with them effectively. Convey the following idea to the young person:

> *"You may find sometimes that your mind seems to "play tricks" on you; it's almost like it's trying to get you to have a smoke. These thoughts are rationalisations, and they seem to automatically make excuses for having a smoke immediately. These can be a real threat if you don't recognise them. Common ones include:*
>
> > *"it's a special occasion";*
> > *"I've had a really hard week"; and*
> > *"just one last smoke".*
>
> *You can probably think of a few others".*

Prompt the young person for their experience of rationalisations. Indicate that rationalisations are a common means by which relapse can occur, and being able to recognise them is important for dealing with them. Advise the young person that if they notice they are beginning to rationalise, they should clearly acknowledge it (i.e. "I am rationalising"). This should be followed by a strong positive statement, affirming their decision to change and the importance of their desire to be successful.

(iii) Separation loss or anxiety

It is common for people giving up smoking to say that it feels like they are losing a good friend. It may be like this for the young person. If cannabis has been a big part of their life, they may feel that there is a gap once they have stopped using. Seek feedback from the young person about this, and explore possibilities for alternatives to fill the role cannabis currently plays in their life. Provide reassurance that these feelings do pass, although it takes time. Encourage the young person to focus on thinking positively about the future. They will discover new possibilities and opportunities over time as they focus less on smoking.

(iv) Self Rewards

Often people feel that they deserve a reward for the hard work of changing their cannabis smoking, and the best reward is, of course, a smoke. Advise the young person to be aware of this temptation because it is a <u>major</u> pitfall. Help the young person generate a list of alternative rewards (e.g. spending some of the money saved from not buying cannabis). Having options for alternative rewards ready in advance will help short-circuit the processes of automatically thinking of (and having) a smoke.

6.1.3 Self monitoring

<u>Aim:</u>

To provide an effective way for the young person to maintain their focus on change, and slow down the sometimes "automatic" nature of the processes that lead to having a smoke.

<u>How to do it:</u>

1). ADVISE the young person that self monitoring will help keep track of their commitment to change, and will show up any patterns of problems they may have with cravings, situations, and smoking.

2). SHOW the young person the self monitoring form and suggest that each day the young person fill it in with ratings of the strength of any cravings they experienced; the situation these occurred in; moods or feelings that accompanied the craving; the outcome and the amount smoked. Explain the "mastery rating" - i.e. it refers to how successful they felt in handling the situation. It is rated from 0 ("not at all successful") to 10 ("completely successful")".
3). AT THE END OF THE WEEK the young person should check back over the form to see how they did. This will allow them to identify problem situations, thoughts, or feelings. It will also provide evidence of their successes in dealing with difficult situations.
4). POINT OUT that if the young person made mistakes or had problems, this is not a disaster; they should stay positive. Advise them to look at the mistakes and learn from them. It might be necessary for them to try different strategies to avoid making the same mistakes again next time.

6.1.4 Relapse Prevention

Aim:
To discuss common pitfalls that may lead to relapse and suggest ways to deal with them effectively.

How to do it:
1). INTRODUCE the distinction between a "relapse" and a "slip". A "relapse" is a return to previous levels of cannabis use, a "slip" is an isolated case of having a smoke, which does not necessarily have to lead to a full relapse.
2). POINT OUT that it is quite common for people to make mistakes when they start out learning a new skill. Changing cannabis use is no different, and occasional mistakes may be made. It is important that the young person knows that if they do have a slip this doesn't mean they have failed, or are unable to change, or must have a full relapse. Emphasise that catastrophising over a slip (e.g., "I had a smoke, I can't stop, I'll never be able to give up") can itself lead to relapse. What is important to long term success is how the young person handles the slip. How to handle it will depend on how and why it happened. The slip may have been intentional or unintentional.
3.) DISCUSS INTENTIONAL SLIPS. Tell the young person that slips can happen "on purpose" for a couple of reasons. They may tell themselves that they are tired of sticking to their plan and want a night off. Or they may decide that they deserve a reward (a smoke) for working so hard. If the young person does slip purposely they should think carefully about their reasons for wanting to change, and how important these are to them. Advise them that, if they do slip in this way, each slip will reduce their chances of long term success. It will result in their craving returning more strongly, which means more hard work.
4). DISCUSS UNINTENTIONAL SLIPS. Slips may occur despite the young person's best intentions, because they found themselves in a high risk or tempting situation with their guard down. If so, they should look at their strategies to see what can be improved.

- Did they just "slip" into an old habit again without thinking?
- Are they finding some high risk situations too hard right now?
- Is there a better way of dealing with them?

Thinking about what happened and why will make it easier to avoid the same mistake next time. Tell the young person that the best thing is to get back on track as soon as possible, and stay positive about their ability to handle it in the future.

5). DEVELOP A PLAN for dealing with a slip. A slip can feel like a crisis, and it's useful to have a pre-prepared plan for coping if one occurs. Go through the plan below with the young person, and remind them that a slip is only a set-back, it doesn't mean failure.

If I have a slip:
(i) I will get rid of the cannabis and get away from the situation where I smoked.
(ii) I will remind myself that one smoke or even a day of smoking doesn't have to result in a full blown relapse.
(iii) I will not give in to guilt or blame myself because these feelings will pass.
(iv) I will call for help from someone I trust.
(v) I will look at the slip to see what triggers there were and my reaction to them.
(vi) I will think about what I expected cannabis to change or provide.
(vii)I will set up a plan for coping with similar situations in the future.

7. GENERAL ISSUES

7.1 Referral issues

All clinicians should have a current list of referral sources, which can be used at any time throughout the Check-up.

Please refer if the participant requests it, or if you feel they need to talk to someone about issues beyond the scope of the Check-up.

7.2 Mandatory reporting issues

You could obtain knowledge of child abuse or other risk of harm, or plans by the young person to seriously hurt self or others during the sessions. The assessment does not specifically enquire about child abuse. However, the Cannabis Problems Questionnaire (pp. 13-14) and the mental health questions (p. 17) may indicate intentions to hurt self or others, or other clinical symptoms.

In these cases the risk to self or others needs to be further evaluated. This is particularly the case if answers indicating suicidality or homicidality are reported.

Staff should comply with Departmental reporting procedures and provide additional assistance and referral in the event child abuse or intentions to hurt self or others is disclosed. All clinicians should be aware of what is reportable and the reporting and referral procedures for the disclosures. Any incidents (whether reportable or of concern) should be reported according to departmental procedures, at the time they occur if necessary.

If the young person discloses details of a serious crime, this will have to be reported to your supervisor in the first instance, and where relevant, to appropriate authorities.

<u>Suggestion for how to deal with the disclosure of child abuse or other risk of harm during the session</u>

You are required by law to make a report to the Department of Community Services (DOCS) when you suspect, on reasonable grounds, that a young person is at risk of harm.

According to the Children and Young Persons (Care and Protection) Act 1998, a young person is "at risk of harm" when they experience the following or when it is likely that one of these things will happen to them:

- their basic needs are not met (e.g., food, shelter, clothing);
- their psychological needs are not met or they are being treated in a way that could lead to psychological damage;
- they do not have access to required medical care;
- they are experiencing physical or sexual abuse or ill-treatment;
- there is domestic violence at home that could result in physical or psychological damage to the young person; and
- they are homeless and this has put them at risk

1). If child abuse or other "at risk of harm" information is revealed, stop the session and inform the young person that this issue will be discussed further after the session. If the discussion cannot wait, the session will be discontinued at that point.
2). Prior to further discussion of this issue, inform the young person that you are required to make a report to the Department of Community Services.
3). Also inform them that another option would be for them to call DOCS themselves and make the report. If they choose to call, it will be done at that time. You will then complete the session, if it was interrupted, provided they are able and willing to do so.

Suggestion for how to deal with the disclosure of plans to seriously hurt self or others
1). If information is revealed to you that a young person has plans to seriously hurt themselves, stop the session and inform them that this is an important issue that you need to discuss further. Tell them that you may call a crisis clinic, a mental health professional or other authorities, as needed or required by law.
2). If a young person's answers indicate significant depressive symptoms, discuss, immediately if possible, your concerns and get more information from them.
3). In either of these cases, a clinician should evaluate the seriousness of the young person's plans to determine the most appropriate action to take. This may include making referrals and calling a crisis clinic, a mental health professional, or other authorities as necessary to protect the participant and/or other individuals.
4). Have the young person complete the session, if it was interrupted, provided they are able and willing to do so.

Contact your supervisor/manager should these situations arise.

8. THE CANNABIS CHECK-UP TRIAL FOR YOUNG OFFENDERS

This chapter describes the pilot trial of the Cannabis Check-up among a non-custodial young offender group in NSW.

8.1 Aims

The specific objectives of this innovative intervention were:

- to test the effectiveness of a 3 session "Cannabis Check-up Plus " intervention, compared to a single "Cannabis Check-up" control intervention, in the reduction of drug-related criminal activity, cannabis use and cannabis-related health and psychosocial problems among adolescent offenders who came to the notice of the NSW criminal justice system;
- to assist the families of young people to learn how to effectively communicate their concerns and encourage the young person to make changes in problematic cannabis use;
- to assess the attractiveness and appropriateness of the intervention for culturally diverse groups of young offenders;
- to identify, and where appropriate intervene with, risk and protective factors within the family; and
- to inform the implementation of similar interventions in other jurisdictions within Australia

8.2 Design

The study was a randomised controlled trial, where eligible adolescents were randomised to one of two interventions: a brief, one session control intervention called the Cannabis Check-up (CU), and a three session motivational intervention called the Cannabis Check-up Plus (CU+). The target sample size was n=460, comprising n=230 in each condition.

8.3 The Interventions

The Cannabis Check-up (CU) and the Cannabis Check-up Plus (CU+) are briefly described below. Please note that the intervention described in the treatment manual (Sections 2 to 7 and Appendix A) differs slightly from those used in the trial as it represents the consensus instrument developed with key stakeholders.

8.3.1 Intervention 1 - The Cannabis Check-up (CU)

It was considered unethical to randomise young people to a no-treatment control group, so the control condition comprised a thorough assessment and brief personalised feedback in a single session of approximately 60-90 minutes duration. There is evidence that a thorough assessment may be beneficial in reducing substance use (see Richmond, Heather, Wodak, Kehoe and Webster, 1995).

The structured assessment addressed the young person's patterns and context of cannabis use and cannabis abuse and dependence, their "Stage of Change" and aims concerning cannabis use, use of alcohol and other drugs, patterns of criminal offending, health and social issues and standard demographic information. The session was concluded with a focused feedback of the issues addressed in the assessment. The young person was asked to provide a urine sample for the measurement of cannabinoid levels to assess against the findings at follow-up. In order to differentiate the control condition

from the CU+, there were no questions assessing motivational themes (e.g., expectancies concerning change) in the assessment and the associated feedback.

Detailed information on cannabis use in the past 3 months was obtained using the Timeline Followback method (Sobell, Sobell, Leo and Cancilla, 1988). Approximations to DSM-IV cannabis abuse and dependence diagnoses were obtained using items from the assessment used in the Cannabis Youth Treatment (CYT) Project (Dennis, Titus, Diamond et al, 2002). An additional measure of cannabis dependence was the five-item Severity of Dependence Scale (Gossop, Griffiths, Powis and Strang, 1992), which has been found to be a useful indicator of cannabis dependence among adult cannabis users (Swift, Copeland and Hall, 1998). Cannabis related problems were measured with the adolescent version of the Cannabis Problems Questionnaire, developed by the authors; it is currently undergoing psychometric evaluation. The 12-item version of the Family Assessment Device (Byles, Byrne, Boyle and Offord, 1988), was used to measure family functioning. Suicidal and homicidal ideation and conduct disorder were assessed using items from the CYTP assessment, and current general psychological health was assessed by the 53-item Brief Symptom Inventory (Derogatis, 1993).

8.3.2 Intervention 2 - The Cannabis Check-up Plus (CU+)

The Check-up Plus intervention comprised 3 sessions - the first two sessions were the basic Check-up model, while the third session was an additional skills session based on cognitive behaviour therapy (CBT). There is extensive evidence for the effectiveness of CBT with a variety of substance use problems (Miller and Heather, 1998), including cannabis among adults (e.g., Copeland, Swift, Roffman and Stephens, 2001) and adolescents (e.g., Dennis et al, 1998).

Session 1: The CU+ assessment consisted of the CU assessment plus several items addressing motivational themes that were to be used in the feedback session. Additional items addressed the pros and cons of use, the pros and cons of change, expectancies about change, risk perception, the relationship of cannabis to their goals, and important people in their life. As before, a urine sample was also requested.

Time was spent engaging the young person and explaining the purpose and course of the Check-up. The young person was given a booklet containing information on cannabis (*What's the deal on grass: Cannabis facts for young people*).

Session 2: The feedback session was scheduled for one week later. In the meantime the clinician had prepared a written Personal Feedback Report, and the participants in this session together reviewed the report using the techniques described earlier (section 1.2.3). At the end of the session the young person was asked to complete a confidential evaluation form, on which they rated the content and delivery of the feedback session.

Session 3: This session was held approximately one week following Session 2 and focused on providing strategies for quitting and reducing use, including goal setting, coping with craving and withdrawal and behavioural self-management. The young person was given a workbook which they completed during the session with the clinician and could take with them for future reference. As for Session 2, a confidential evaluation form of the skills session was completed.

Young people randomised to the CU+ had the option of involving a Concerned Other (e.g., a parent) in the Check-up. If a Concerned Other was interested they could also

attend a session with the clinician in which they could discuss their concerns about the young person's cannabis use, receive current information on cannabis and learn ways to communicate their concerns more effectively (this session is described in the treatment manual).

8.4 Eligibility criteria

To be eligible to participate, adolescents were required to meet legal and research requirements:

Legal

In the last 6 months the adolescent must:

- have appeared before a NSW Children's Court; **or**
- have a guilty plea entered and accepted; **or**
- have been eligible for a non-custodial sentence; **or**
- a "Griffiths Bond" under s33(1) (c2) of the Children (Criminal Proceedings) Act may be utilized where appropriate; **or**
- if relevant, have been eligible to receive a recommendation for drug counselling treatment as part of their sentence; **or**
- have participated in the Youth Justice Conferencing Scheme; **or**
- have received a police caution for an offence; **or**
- have been the subject of an apprehended violence order (AVO)application

Research

The adolescent must:

- be aged 14-19 years
- have smoked cannabis regularly (at least weekly) in the last 3 months
- have no other significant drug problem (i.e., not injecting more than weekly, not using other illicit drug on more than 3 days per week or drinking more than 80gms of alcohol (8 standard drinks) per day
- speak English
- be able to read printed material
- have no significant cognitive impairments such as profound intellectual disability or organic brain syndrome, or be currently experiencing severe psychotic symptoms
- have not received treatment for cannabis-related problems in the last 3 months

8.5 Recruitment

Recruitment relied on someone's awareness that cannabis use was an issue for the young person, and then the young person being encouraged to participate. It was not possible to make participation in the Check-up mandatory, so young people could not be ordered to attend the Check-up against their will and had to provide voluntary, written informed consent. Thus, recruitment efforts stressed the potential two-fold benefit of participation: (i) it may be beneficial for their cannabis use and (ii) participation may contribute to a more beneficial judicial outcome – e.g., be considered when delivering a sentence.

The four main recruitment sources were:

1. NSW Department of Juvenile Justice – Juvenile Justice Community Services (JJCS) and Youth Justice Conferencing (YJC)
2. NSW Children's Courts – Bidura and Lidcombe Children's Courts
3. NSW Police Cautioning scheme
4. Community legal defence teams

Recruitment to the study was also "piggy-backed" on to recruitment efforts for a parallel study of the Check-up approach for young cannabis users in the general community. Thus, if a young person was referred to the community Check-up but met eligibility for the juvenile justice study, they were referred to the latter.

8.6 Procedure

Prior to recruitment, ethics approval to conduct this study was obtained from the Human Research Ethics Committee at the University of NSW, and the Collaborative Research Unit at the NSW Department of Juvenile Justice. The Director General of the Department also provided written support for the study. Permission was also obtained from the NSW Chief Children's Magistrate to recruit young people from the NSW Children's Court, and from the NSW Police Service to recruit young people participating in the police cautioning scheme.

Juvenile justice personnel from each referral source were provided with a list of eligibility criteria for the study. When they identified an eligible young person that was interested in participating they would refer the young person to the study according to the referral procedure established with the clinician. An appointment was made, at which the young person was screened by the project clinician to confirm their eligibility for the study. If eligible, the study was clearly explained to them, any questions answered and written informed consent was obtained. The young person was then randomised to the CU or CU+ conditions. If allocated to the CU, the session was conducted immediately and contact details were collected to allow for a follow-up interview in six months time. If allocated to the CU+ the first session was conducted, contact details collected and an appointment made for session 2. All participants but one were seen by the same clinician.

Six months after the final session was attended the young person was to be followed up by a research assistant, who would not know which intervention the young person received. The interview would be used to gather outcome data on all the relevant aspects of the study including patterns of cannabis and other drug use, stage of change, family relationships, measures of psychosocial functioning, involvement in crime, urinary cannabinoid levels, and treatment satisfaction.

8.7 Sample characteristics

For the recruitment period August 1, 2001 to December 31, 2002, only 29 eligible young people were randomised to the study. One Concerned Other (a parent) participated in the study, and attended a session with the clinician.

Given the small sample size, inferential statistical analyses were not conducted, and the following data are descriptive only. For continuous variables, the mean, standard deviation and range are reported if the data are normally distributed (e.g., age), and the median and range if the data are skewed (e.g., consumption measures). For categorical data, the number and percentage in each category are reported. All n=29 unless otherwise stated.

8.7.1 Source of participants

The majority of the sample (n=26; 89.7%) was recruited from the NSW Department of Juvenile Justice. Of these, 25 young people were recruited from Community Services and one was recruited from Youth Justice Conferencing. The remainder were recruited from Bidura (n=1) and Lidcombe Children's Courts (n=2: one from the magistrate, and one from defence counsel).

8.7.2 Compliance

Just under a half of the sample (n=12; 41.4%) was randomised to the single session Check-up (CU) condition, with the remainder (n=17; 58.6%) allocated to receive the three Check-up Plus (CU+) sessions.

By definition, there was 100% compliance among the young people allocated to the CU, although three did not complete the session. Of those allocated to the CU+ more than half (n=10; 58.8%) completed all three sessions, two (11.8%) completed the assessment and feedback sessions, and five attended only the assessment session (29.4%; one person did not complete the session). Thus, the majority of those in CU+ (12/17: 70.6%) received the assessment and feedback components which are the core of the Check-up model.

8.7.3 Demographics

The main demographic characteristics of the sample, all of which was male, are listed in Table 1. On average, participants were 16 years old (mean=16.1, sd=1.3, range=14-19). The majority of participants was Australian-born and English speaking, and lived at home with their parent(s). Few (n=5; 18.5%) were still at school or studying, the remainder typically having been expelled or left because they were bored or did not enjoy school. Of those not studying, almost one half (n=13; 48.1%) were unemployed.

Table 1: Demographic characteristics of the sample

	n (%)
Country of birth	
Australia, non-indigenous	22 (75.9)
Australia, indigenous	2 (6.9)
overseas (Korea, Lebanon, NZ, Thailand, Vietnam)	5 (17.2)
Main language spoken	
English	25 (86.2)
other (Arabic, Thai, Vietnamese)	4 (13.8)
Living situation	
parent(s)	25 (86.2)
other relatives	2 (6.9)
friends	2 (6.9)
Education*	
still at school	2 (7.4)
studying elsewhere	3 (11.1)
Employment*	
full-time employment	4 (14.8)
part-time/casual employment	5 (18.6)
unemployed	13 (48.1)

*n=27

8.7.4 Cannabis use

The average age of first cannabis use was 12.7 years (sd=1.7; range=9-16 yrs). All participants had used on a daily or near daily basis, commencing such use on average two years later (mean =14.5; sd=1.3; range=11-17).

Recent and current cannabis use patterns are summarised in Table 2. Participants were typically daily or near daily cannabis smokers (median=86/90 days; range=7-90), consuming approximately 60 cones a week (median=62.3; range= 3.7-324.2). All but one young person had smoked cannabis in the past two days. Most (89.7%) obtained their supply from a street dealer, spending a median of $80 (range: $10-$500) per week.

Most participants (65.5%) were in Pre-contemplation or Contemplation Stages of Change, although one third said they were preparing to make changes to their use, were currently doing so or had recently done so. When asked to state their current aims regarding their cannabis use, the ratings of the sample (on a scale of 0-10) reflected ambivalence. Thus, they believed that continuing their current level of use was "somewhat important". However, they were "somewhat" interested in reducing or stopping use, believed it was "somewhat important" to do so, and were "somewhat confident" they could do so today if they tried (all medians=5).
Indeed, more than three quarters (79.3%) claimed to have stopped or decreased their use at some point, a median of twice. Forty percent of these had done so recently, a median of once; however, the longest median period of reduced use or cessation was only 14 days. Two reported treatment episodes in the past 90 days, although these were one-off sessions and it is not clear what issues were addressed.

Table 2: Recent and current cannabis use patterns

	n (%)
Use in last 90 days*	
daily	9 (32.1)
3-6 times/wk	17 (60.7)
< 3 times/wk	2 (7.1)
Use in last 30 days	
daily	9 (31.0)
3-6 times/wk	16 (55.2)
< 3 times/wk	4 (13.8)
Source	
grow own	1 (3.4)
street dealer	26 (89.7)
friend/acquaintance	7 (24.1)
parent	1 (3.4)
sibling	1 (3.4)
Stage of Change	
Pre-Contemplation	12 (41.4)
Contemplation	7 (24.1)
Preparation	4 (13.8)
Action	4 (13.8)
Maintenance	2 (6.9)
Quitting/reducing use	
ever	23 (79.3)
last 3 mths (n=20)	8 (40.0)

*n=28

8.7.5 Cannabis dependence and problems

The majority received DSM-IV cannabis dependence (86.2%) or abuse (3.4%) diagnoses on the brief dependence measure (see Table 3). An average of 4/7 (sd=1.9; range=0-7) dependence criteria and 2.1/4 (sd=1.3; range=0-4) abuse criteria were reported. The average score on the Severity of Dependence Scale was 5 (sd=3.3; range=0-12), indicating these young people were somewhat concerned about their use in the last three months. This measure also classified the majority of young people as cannabis dependent (Swift et al, 1998).

At least a half of participants reported the following experiences, which can be commonly associated with cannabis use, in the previous 3 months: spending more time with smoking friends than other kinds of friends (82.8%), feeling paranoid or antisocial after a smoking session (67.9%), losing weight without trying to (65.5%), having less energy than usual (62.1%), smoking more on their own than they used to (62.1%), feeling less able to concentrate than usual (58.6%), worrying about the amount of money they were spending on cannabis (55.2%), being in trouble with the police due to their cannabis use (55.2%), concern over a lack of motivation (55.2%), driving while stoned (51.7%), and having a persistent chest infection or cough (50%).

For those who had lived with their parent(s) in the past three months (n=25/29), at least half reported their parents had complained about their cannabis use (80.0%), had argued with them about their smoking (56.0%) and had tried to stop them smoking (52.0%). Similarly, of the 10 young people with partners (only 30% of whom smoked cannabis),

most reported their partners complained (80.0%) and argued with them (60.0%) about their smoking, while 60% avoided their partner after a smoking session.

Table 3: Cannabis dependence and abuse

	n (%)
DSM-IV diagnosis	
dependence (3+ criteria)	25 (86.2)
abuse (1+ criteria)	1 (3.4)
no diagnosis	3 (10.3)
Severity of Dependence Scale	
In the last 3 months …	
1. Thought their use was out of control (at least sometimes)	19 (65.5)
2. Anxious at thought of missing a smoke (at least sometimes)	20 (69.0)
3. Worried about their cannabis use (at least a little)	18 (62.1)
4. Wished they could stop (at least sometimes)	19 (65.5)
5. Difficulty in stopping/going without (at least quite difficult)	20 (69.0)
Dependent (Score of 3+)*	22 (75.9)

*The cut-off score of 3+ was derived from a sample of long-term using adults (Swift et al, 1998), so may not apply to this group. Treat this as an estimate only.

Of the 12 young people who had been employed, 80% claimed to have gone to work stoned in the past three months, but less than half reported any other consequences. However, of the five participants who had attended school during this time, the majority reported being stoned at school, less interested in study, a decreased ability to concentrate, decreased grades, and complaints from teachers about their work (although these were not all necessarily related to their cannabis use)

8.7.6 Other drug use

Other than cannabis, alcohol and tobacco were most commonly used among this group (see Table 4). Tobacco was typically smoked daily (17 out of 22 smokers). While alcohol was usually consumed between two and three days a week, binge drinking was common, with an average of 9.7 (sd=7.1; range=1-25) drinks consumed on each drinking occasion. Apart from amphetamine and ecstasy, these young people were not likely to use other illicit drugs and if they did so, use was typically less than weekly. .

Table 4: Other drug use in the past 90 days

	n (%)
alcohol	24 (82.8)
tobacco	22 (75.9)
opiates	1 (3.4)
amphetamine	10 (34.5)
cocaine	5 (17.2)
benzodiazepines	1 (3.4)
hallucinogens	1 (3.4)
ecstasy	11 (37.9)
inhalants	1 (3.4)

8.7.7 Legal issues

This group had extensive histories of criminal involvement, much of it recent. The median age of first criminal activity was 12 years, which is equivalent to the age of first cannabis use (12.7 years). They were first arrested for an offence at a mean of 13.3 years (sd=1.8; range=8-16), while their last offence was typically committed in the last 6 months (mean=15.9 years; sd=1.4; range=13-18). In the past 90 days nearly two thirds (n=16/26; 61.5%) had engaged in, and nearly one half (n=12/27; 44.4%) had supported themselves from, illegal activities. Approximately one third (n=10/27; 37.0%) had been in detention in the past year, typically (6/10) in the past 6 months.

Lifetime and recent criminal involvement are outlined below (see Table 5). Cannabis was most commonly provided as the main reason for recent episodes of break and enter (4/7 participants), whereas other reasons were typically provided as the main reason for the commission of shoplifting, car theft, robbery and fraud.

Table 5: Number (%) of young people reporting criminal involvement in lifetime and last 6 months*

	Lifetime	Last 6 months
Shoplifting	23 (85.2)	10 (37.0)
Break and enter	13 (48.1)	7 (25.9)
Car theft	18 (66.7)	10 (37.0)
Robbery	14 (51.9)	5 (18.5)
Fraud	8 (29.6)	4 (14.8)
Other theft	7 (25.9)	1 (3.7)
Assault	21 (80.8)	12 (46.2)
Cannabis dealing	10 (37.0)	6 (22.2)
Cannabis growing	13 (48.1)	6 (22.2)
Making other drugs	0	0
Vandalism	14 (51.9)	8 (29.6)
Other crime	3 (11.1)	3 (11.1)

*n=27 for all, except assault (n=26)

Other indices of criminal involvement are presented below (Table 6).

Table 6: Number (%) of young people reporting other indices of criminal involvement

	Lifetime	Last 6 months
Received fine	21 (84.0)	15 (60.0%)
Received supervised order	19 (76.0)	15 (60.0)
Sentenced to detention*	5 (20.0)	3 (12.0)
Been to court	23 (92.0)	18 (72.0)
Given a community service order	12 (48.0)	9 (36.0)
Hassled by police	20 (80.0)	17 (68.0)
Crime has hurt chance of good education#	11 (50.0)	7 (31.8)

All n=25; except #n=22;*discrepancies between these figures for detention and those reported earlier may represent some young people being on remand.

8.7.8 Health

When asked to provide a self-rating of their health in the last three months, the majority of young people reported they were in good or fair health (both 42.9%) (Table 7). Approximately one third (32.1%) had been recently bothered by health problems, typically respiratory, but these had rarely prevented them from meeting their responsibilities. A similar proportion reported consulting a medical practitioner in this time (37.0%).

A minority (22.2%) claimed to have received medication or been treated for a mental health issue, two of these currently. One quarter said they had been told they had attention deficit hyperactivity disorder (ADHD) by a doctor or mental health professional. Not surprisingly, almost one half (48%) received a proxy diagnosis of conduct disorder.

It is of concern that more than one third (38.5%) reported recent thoughts of killing or hurting others. Three young people reported suicidal ideation, with one making a recent suicide attempt. Issues of self-harm and harming others were explored with the clinician if they arose, and appropriate action was taken where required. Unfortunately, scores on the Brief Symptom Index, a global mental health screener, were highly skewed, so cannot be standardised to the available adolescent norms. However, only three participants had scores on the Global Severity Index summary subscale which exceeded the cut-off for psychiatric dysfunction (Derogatis, 1993).

Table 7: Physical and mental health status of participants

	n (%)
Self-rating of health in last 3 months*	
excellent	0
very good	1 (3.6)
good	12 (42.9)
fair	12 (42.9)
poor	3 (10.7)
Bothered by medical problems in last 3 months*	9 (32.1)
Saw doctor/nurse in last 3 months#	10 (37.0)
Ever received treatment/medication for psychological problem#	6 (22.2)
Ever been told they had ADHD+	7 (26.9)
Thought of killing/hurting others+	10 (38.5)
Thought of committing suicide+	3 (11.5)
Proxy conduct disorder diagnosis^	12 (48.0)

*n=28; #n=27; +n=26; ^n=25

8.7.9 Social/family issues

The average score on the Family Assessment Device was 2.2 (n=24; sd=0.68, range=0.67-3.75). As scores on this instrument can range from 1 (healthy functioning) to 4 (unhealthy functioning), this group reported quite a healthy relationship with their immediate family. Nevertheless, recent conflict was not uncommon, with half (n=14/27; 51.9%) reporting verbal abuse, serious argument or violence with their relatives at least "sometimes" in the last three months. Four out of the seven participants with partners reported such conflict with them, but it was less commonly reported at work or school (4 out of 13 reporting conflict in these environments at least "sometimes" in the last three months).

Two thirds (n=18/27; 66.7%) of participants reported having had money problems, including arguing about money or not having enough for food or housing, at least "sometimes" in the last three months. While one in three (n=9/26; 34.6%) young people reported having lived at least "some of the time" with an illicit drug user in the last three months, almost two thirds (n=17/26; 65.4%) spent an equal proportion of time with non-drug using friends .

8.8 Outcome at six month follow-up

Attempts were made to contact all 29 of the participants. While locating these young people was not necessarily difficult (many were still living in the same place or had contact with a relative we were able to speak to) only seven follow-up interviews were conducted at the conclusion of the project. These were all overdue due to difficulty in scheduling appointments. The mean length to follow-up was 278 days (sd=36.8; range=216-314). One young person was deceased.

Given the limited follow-up sample size and the difficulties in obtaining follow-up consumption data, it was not possible to conduct inferential statistics. Thus, descriptive information on main variables of interest for the three young people on whom these data could be obtained follows.

Six of the seven young people had consumed cannabis in the period between their involvement in the Check-up and the follow-up interview. One had been completely abstinent. When asked why he had quit, he said that he found it slowed him down, that he had not been a heavy user anyway (although he met criteria for cannabis dependence) and that he and his friends had all stopped together. He claimed to feel much better and able to think more quickly since he had stopped – however, he reported daily amphetamine use at follow-up, when he had not previously reported any such use (he appeared to be "speeding" during the interview). He reported no current interest in using cannabis and no criminal activity in the time to follow-up (although he reported very limited involvement at baseline).

Of the other two young people from whom consumption data could be obtained, one appeared to have dramatically increased his use (from 39/90 days at baseline to 75/90 days at follow-up), although he claimed to have decreased his use in that time. His Stage of Change reflects these conflicting data: while in Pre-contemplation at baseline, he reported having reduced his use at follow-up (Action) and to be in Contemplation for further reductions in use. However, his spending on cannabis had increased from $50 to $100 per week, and he continued to be dependent on cannabis. Nevertheless, he claimed to have stopped once and reduced his use twice in this period, for a maximum of one week. He may have slightly increased his criminal activity, reporting participation in break and enter offences, assault and cultivation of cannabis, when he had only reported the latter at baseline.

The other young person had slightly decreased his use – smoking less frequently and a lesser amount at follow-up (decreased from 76/90 to 66/90 days and decreased from the equivalent of 59 cones a week to 30 cones per week). This included a three to four week period of abstinence. He had changed from smoking "bongs" to joints, and found it easier to obtain his enjoyment from smoking with friends while smoking less – he also felt it was "better for me". His Stage of Change scores confirm this report, representing

a move from Pre-contemplation at baseline to Maintenance at follow-up, and Contemplation of further reductions. He had slightly increased his weekly expenditure on cannabis from $50 to $65. While no longer qualifying for a dependence diagnosis, he met criteria for cannabis abuse; interestingly, his concern over his cannabis use appeared to have slightly increased. His acquisitive criminal activity appeared to have stopped, and he claimed it was no longer necessary as he was working and no longer needed the income. Nevertheless, he reported committing an assault and cultivating cannabis in the time to follow-up.

8.9 Acceptability of Adolescent Cannabis Check-up

The Check-up was very well received by the CU+ group (the CU session was not evaluated). Confidential reports completed following the second (feedback) and third (strategies) sessions confirmed the non-judgmental nature of the intervention and the perceived value of discussing cannabis use, receiving feedback on use and learning skills to assist moderate use or cessation.

Table 9 illustrates some of the positive ratings received from the 10 young people who participated in the feedback session and also completed the evaluation forms. Similar ratings were provided by the participants in the strategies session.

Table 9: Young person's evaluation of the feedback session (n (%))*

	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
I felt comfortable talking with my counsellor	6 (60.0)	4 (40.0)	0	0	0
The session gave me a new way of looking at my cannabis use	2 (20.0)	7 (70.0)	1 (10.0)	0	0
My counsellor understood me and my feelings about my cannabis use	2 (20.0)	6 (60.0)	2 (20.0)	0	0
The counsellor genuinely cared about me as a person	3 (30.0)	7 (70.0)	0	0	0
The counsellor appreciated my coming in for the session	4 (40.0)	6 (60.0)	0	0	0
The counsellor listened to what I had to say	6 (60.0)	4 (40.0)	0	0	0
The counsellor tried to convince me to quit using cannabis	2 (20.0)	1 (10.0)	3 (30.0)	4 (40.0)	0
The counsellor was judgmental of me and my attitudes towards my use of cannabis	0	0	2 (20.0)	6 (60.0)	2 (20.0)
My meeting with the counsellor was a waste of time	0	0	1 (10.0)	6 (60.0)	3 (30.0)

*n=10

In addition, there was almost universal satisfaction with other aspects of the feedback session, including the length of the session (90% satisfied, 10% neutral), the clinician (100% satisfied; 100% believed she was helpful), receiving feedback on their cannabis use

and its consequences (90% believed it was helpful; 10% neutral) and completing the assessment (100% believed it was helpful). Interestingly, virtually all (90%) said they would be interested in more meetings about their cannabis use.

Similarly, there was no dissatisfaction reported by those attending the strategies session. All were satisfied with the length of the session. They also reported that completing the workbook, and the discussion of issues such as cannabis dependence, the pros and cons of use, high risk situations, strategies for change, cravings, withdrawal, setting goals and planning for slips and relapses, was moderately to extremely helpful.

Only three of the seven young people interviewed at follow-up completed satisfaction ratings, typically because they claimed they could not remember much about the Check-up. One young person was neutral in his feelings, although claimed he would have been interested in returning for further sessions. The remaining two reported being moderately satisfied with the Check-up and found their participation to be moderately helpful.

In summary, the Check-up approach appeared to be well received by this group of young people. Unfortunately, given the small sample recruited and followed up, it is not possible to assess the success of the Check-up with the target group. Consumption data were only available for four participants at follow-up, and indicate mixed results. While one young person was completely abstinent and one had decreased his use slightly, the other had an apparent dramatic increase in use. While some of these findings are encouraging, clearly further work is required on a larger group.

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10. APPENDICES

APPENDIX A – CANNABIS CHECK-UP ASSESSMENT

CLIENT ID: _____ DATE: _____

CANNABIS CHECK-UP ASSESSMENT

This session will take about an hour. During this time I would like to ask you some questions about your cannabis use and how it fits into your life. I will ask you most of the questions but I also need you to fill out some questionnaires yourself. Is this OK? Please feel free to ask me any questions or for any help you might need. Do your best and try hard to remember when the questions ask about what happened a while ago. Everything you tell me is confidential.

1. STAGE OF CHANGE

Okay, I'm going to read you a list of statements, and I want you to tell me which one best represents how you feel right now about your cannabis use.

___ (1) I'm basically satisfied with my use of cannabis and do not plan to change it *(Precontemplation)*
___ (2) I'm thinking about stopping or reducing my use of cannabis, but I don't think I'll begin doing that in the next 30 days *(Contemplation)*
___ (3) I think I will stop or reduce my use of cannabis sometime in the next 30 days *(Preparation)*
___ (4) Sometime within the past 6 months I stopped or reduced my level of cannabis use and I've not returned to my previous level of use *(Action)*
___ (5) More than 6 months ago, I stopped or reduced my level of cannabis use and I've not returned to my previous level of use *(Maintenance)*

[IF ANSWER IS STATEMENT 1, 2, OR 3, GO TO QUESTION 2]
[IF ANSWER IS STATEMENT 4 OR 5, ASK THE FOLLOWING]

Which of the following statements best represents how you have felt about your cannabis use in the past 30 days?

___ (1) I've been basically satisfied with my use of cannabis and do not plan to change it *(Precontemplation)*
___ (2) I've thought about stopping or reducing my use of cannabis, but I don't think I'll begin doing that in the next 30 days *(Contemplation)*
___ (3) I think I will stop or reduce my use of cannabis sometime in the next 30 days *(Preparation)*

2. GOOD THINGS ABOUT USE

I'd like to find out from you what are some of the <u>good things</u> you like about using cannabis?

_____

_____

_____

_____

_____

_____

3. CANNABIS AND OTHER DRUG USE

I'm going to ask you some questions about your use of cannabis and other drugs. Let's concentrate on the past 3 months. That is since _____

<u>3a. Cannabis Use Patterns -</u>

(i) Generally speaking, during the past 3 months, how often did you smoke cannabis? _____

[Assist by probing the number of times per week].

(ii) On average, how many cones/joints did you have on those days?

_____

(iii) How long have you been smoking this way?

_____

(iv) What about before that?

_____

[probe for any differences in use patterns – e.g., increases or decreases etc.]

(v) When was the last time you smoked cannabis? _____ days ago

(vi) During the past 3 months, when did you typically use cannabis on <u>weekdays?</u> (tick whichever are applicable)

__ Early mornings (before school/work)
__ Mornings to mid-afternoons (during school/work)
__ Mid-to late afternoons (after school/work until 6 pm)
__ Evenings/Nights (6 pm – 4 am)
__ Didn't smoke cannabis on weekdays

(vii) During the past 3 months, when did you typically use cannabis on <u>weekends</u>? (tick whichever are applicable)

__ Early mornings (4 am to 8 am)
__ Mid-mornings to mid-afternoons (8 am to 3 pm)
__ Mid- to late- afternoons (3 pm to 6 pm)
__ Evenings/Nights (6 pm to 4 am)
__ Didn't use cannabis on weekends

(viii) Where have you usually used? (tick whichever are applicable)

__ at home
__ other person's home
__ work/school
__ public place
__ in a car

(ix) With whom have you usually used? (tick whichever are applicable)

__ alone
__ partner
__ friends
__ relatives
__ strangers

(x) What kind have you usually used? (tick whichever are applicable)

__ heads
__ leaf
__ mixture of heads and leaf
__ hydroponic

(xi) Where do you usually get your cannabis from? (tick whichever are applicable)

__ grow my own
__ street dealer
__ friends
__ brother/sister/parent/partner
__ other relative
__ steal it

(xii) On average, how much do you spend on cannabis a week?

$_____/wk

(xiii) How old were you the first time you used cannabis? _____ yrs

3b. Quitting/Moderating

(i) Have you <u>ever</u> chosen to stop using cannabis, or significantly reduce your cannabis use for a period of time?

Yes/No [IF EVER **YES**, ASK]

How many times have you chosen to stop or reduce your use?

_____ times

(ii) What's the longest period of time you purposefully chose to stop using cannabis or significantly reduced your cannabis use?

_____ days

(iii) When was the last time you did that? _____

(iv) Think of a time when you reduced your use <u>for the longest period</u>. How did you go about it?

_____

(v) Why did you want to stop or cut down ?

_____

(vi) How successful were you at stopping or cutting down?

_____

(vii) Have you received any treatment or attended any self-help groups, such as AA or NA related to your cannabis or other drug use?

Yes/No [get details] _____

(viii) Why did you stop treatment? [related to relapse prevention]

_____

3c. Other Alcohol Or Drug History

OK, now let's talk about alcohol and other drugs.

(i) Have you ever consumed alcohol Yes/No

(ii) How old were you when you first had a drink of alcohol?_____ yrs

(iii) During the past 3 months, how many days did you drink alcohol?
[Assist to calculate this: e.g., probe the number of times per week.]

_____

(iv) On average, how many drinks did you have on those days when you were drinking? _____
[Get drink type (e.g., glasses of wine, middies/schooners of beer) so can convert to standard drinks]

(v) How many cigarettes did you usually smoke a day? _____

(vi) During the past 3 months, did you use any illicit drugs other than cannabis?

Yes /No

[IF **YES**, FOR EACH DRUG BELOW, ASK:]

How many days on average have you used them? [frequency]
How old were you when you first used [drug]? [first use]

	Frequency	First Use
heroin	_____	___
amphetamine	_____	___
cocaine	_____	___
benzodiazepines	_____	___
hallucinogens	_____	___
ecstasy	_____	___
inhalants	_____	___
other, specify	_____	___

[IF **YES** TO ANY ALCOHOL AND/OR DRUG USE ASK:]

(vii) Did you use (list alcohol or drug) with cannabis? Yes/No

(viii) What effect did this have?

_____
[Probe for effects on amount of cannabis used and impact on the effects of cannabis e.g., increased or decreased stone]

4. Less Good Things About Cannabis Use

4a. "Less Good" Things About Use

You've told me some of the good things about smoking cannabis. What, if anything, are the less good or not so good things about smoking cannabis?

_____

_____

_____

_____

_____

_____

4b. Risk Perception

These next questions are about your attitudes towards the risks associated with cannabis use.

What does the term 'taking a risk' mean to you? What does it mean to say "someone is taking a risk"?

_____

_____

[CLINICIAN: Give the young person the following pages on risk perception and ask them to complete the questions by placing a cross in the box corresponding to their response.]

How much do you think people risk harming themselves physically or in other ways if they use cannabis **occasionally** (once per month)?

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

How much do you think people risk harming themselves physically or in other ways if they use cannabis **regularly** (once per week - once per fortnight)?

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

How much do you think people risk harming themselves physically or in other ways if they use cannabis **every day**?

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

How much do you think people risk harming themselves physically or in other ways if they use cannabis the way **you** currently use it?

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

If you have answered slight, moderate or great risk to any of the last four questions about cannabis, what do you think the risks are to them or you?

_____

_____

What sort of person is most at risk of experiencing the problems you mentioned?

_____

_____

How much do you think people risk harming themselves physically if they use **tobacco / cigarettes** every day?

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

How much do you think people risk harming themselves physically or in other ways if they **drink alcohol** every day?

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

How much do you think people risk harming themselves physically or in other ways if they use **cannabis together with other drugs such as alcohol or heroin?**

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

How much risk is there of you harming **yourself** physically or in other ways if you use cannabis at the frequency **you** currently use it?

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

How often have you worried about any risks that might be associated with your cannabis use?

Never	Rarely	Often	A lot
1	2	3	4

How much do you think people of your age risk having **legal problems or risk getting into trouble with the police** if they use cannabis at least 2-3 times per week?

No risk	Slight risk	Moderate risk	Great risk
1	2	3	4

How much do you think people of your age risk having **financial/money problems** if they use cannabis at least 2-3 times per week?

No risk	Slight risk	Moderate risk	Great risk
1	2	3	4

How much do you think people of your age risk having **physical health problems** if they use cannabis at least 2-3 times per week?

No risk	Slight risk	Moderate risk	Great risk
1	2	3	4

How much do you think people of your age risk having **emotional/ mood problems** if they use cannabis at least 2-3 times per week?

No risk	Slight risk	Moderate risk	Great risk
1	2	3	4

How much do you think people of your age risk becoming **physically addicted or physically dependent** on cannabis if they use cannabis at least 2-3 times per week?

No risk	Slight risk	Moderate risk	Great risk
1	2	3	4

How much do you think people of your age risk finding it **hard to stop using** cannabis if they use cannabis at least 2-3 times per week?

No risk	Slight risk	Moderate risk	Great risk
1	2	3	4

How much do you think people of your age risk having **a lack of motivation** if they use cannabis at least 2-3 times per week?

No risk	Slight risk	Moderate risk	Great risk
1	2	3	4

How much do you think people of your age risk having **problems with their relationships** (friends, parents, partners) if they use cannabis at least 2-3 times per week?

No risk	Slight risk	Moderate risk	Great risk
1	2	3	4

How much do you think people of your age risk **performing worse than they would otherwise at school or work** if they use cannabis at least 2-3 times per week?

No risk	Slight risk	Moderate risk	Great risk
1	2	3	4

How much do you think people of your age risk **starting to use drugs such as speed, heroin and cocaine regularly** if they use cannabis at least 2-3 times per week?

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

How much do you think people of your age risk having **accidents when they are stoned** that they may not have had otherwise, if they use cannabis at least 2-3 times per week?

No risk 1	Slight risk 2	Moderate risk 3	Great risk 4

Please choose the three most important risks for you by placing a tick next to 3 risks below.

- ❑ Financial / money problems
- ❑ Legal / police problems
- ❑ Physical health problems
- ❑ Emotional / mood problems
- ❑ Physically addicted / physically dependent
- ❑ Finding it hard to stop using
- ❑ Lack of motivation
- ❑ Problems with relationships
- ❑ Impact on school / work performance
- ❑ Starting to use drugs such as ecstasy and cocaine regularly

4c. Legal

(i) During the past 3 months, on how many days were you involved in any activities you thought might get you into trouble with the police or be against the law? _____ days

(ii) During the past 3 months, on how many days did you support yourself financially from activities that you thought might get you into trouble or be against the law? _____ days

(iii) In the last 12 months have you spent any time locked up in a detention centre? Yes/No

[IF **YES**] **For how long?** _____ days

Did this occur in the last 3 months? Yes/No

For how long? _____ days

(iv) Have you ever committed a crime… (tick whichever are applicable)

____ to get money for cannabis, alcohol or other drugs?

____ when you were under the influence of alcohol or other drugs?

[IF **YES**] **Which substance(s)?** _____

(v) How old were you when you first committed an offence? _____ yrs

(vi) Has/have…(tick whichever are applicable)

____ your crime hurt your chances of getting an education?

____ you been hassled by the police?

____ your crime hurt your chances of getting a good job?

(vii) Have you ever physically assaulted someone? Yes/No

[IF **YES**]

What happened?

_____

_____

4d. Cannabis Problems Questionnaire

[ASK THE YOUNG PERSON TO COMPLETE THE FOLLOWING QUESTIONS – READ THEM IF NECESSARY]

- We would like to find out if you have experienced any of the difficulties that other people who use cannabis sometimes complain of.
- Below you will find a list of questions that we would like you to answer.
- Read each question carefully and answer either YES or NO by putting a mark in the appropriate spot.
- Some questions specifically ask about problems associated with using cannabis, while others ask about general problems that may have occurred.
-

Please answer all the questions that apply to you. All the questions apply to your experiences in the LAST 3 MONTHS.

In the last 3 months:	**Y**	**N**
1. Have you tended to smoke more on your own than you used to?	□	□
2. Have you worried about meeting people you don't know when you are stoned?	□	□
3. Have you spent more time with smoking friends than other kinds of friends?	□	□
4. Have your friends criticised you for smoking too much?	□	□
5. Have you had any debts?	□	□
6. Have you pawned any of your belongings to buy cannabis?	□	□
7. Have you found yourself making excuses about money?	□	□
8. Have you found yourself worried about the amount of money you have been spending on cannabis?	□	□
9. Have you been caught out lying about money?	□	□
10. Have you been in trouble with the police due to your smoking?	□	□
11. Have you been in juvenile detention or prison?	□	□
12. Have you been physically sick after smoking?	□	□
13. Have you passed out after a smoking session?	□	□
14. Have you had pains in your chest or lungs after a smoking session?	□	□
15. Have you had a persistent chest infection or cough?	□	□
16. Have you felt paranoid or antisocial after a smoking session?	□	□
17. Have you had any accidents requiring hospital admission after smoking?	□	□
18. Have you lost any weight without trying to?	□	□
19. Have you been neglecting yourself physically?	□	□
20. Have you felt depressed for more than a week?	□	□
21. Have you felt so depressed you felt like doing away with yourself?	□	□
22. Have you given up any activities you once enjoyed because of smoking?	□	□
23. Have you had less energy than usual?	□	□
24. Have you found it hard to get the same enjoyment from your usual interests?	□	□
25. Has your general health been poorer than usual?	□	□
26. Have you driven while stoned?	□	□
27. Have you worried about getting out of touch with friends or family?	□	□
28. Have you been concerned about a lack of motivation?	□	□
29. Have you felt less able to concentrate than usual?	□	□
30. Have you worried about feelings of personal isolation or detachment?	□	□

IF YOU HAVE LIVED WITH A PARENT (OR GUARDIAN) IN THE PAST 3 MONTHS, ANSWER THESE QUESTIONS. *OTHERWISE, GO TO QUESTION 36*	**Y**	**N**
31. Do your parent(s) use cannabis on a regular basis?	□	□
32. Have your parent(s) complained about you smoking?	□	□
33. Have your parent(s) tried to stop you from having a smoke?	□	□
34. Have you argued with them about your smoking?	□	□
35. Have you tried to avoid your parents(s) after you have been smoking?	□	□
IF YOU HAVE HAD A REGULAR PARTNER IN THE PAST 3 MONTHS, ANSWER THESE QUESTIONS. *OTHERWISE, GO TO QUESTION 41.*		
36. Does he/she use cannabis on a regular basis?	□	□
37. Has he/she complained about your smoking?	□	□
38. Have you argued with him/her about smoking?	□	□
39. Has he/she threatened to leave you because of your smoking?	□	□
40. Have you avoided him/her after you have been smoking?	□	□

IF YOU HAVE BEEN ENROLLED IN SCHOOL, TAFE OR ANY COURSES OF STUDY IN THE LAST 3 MONTHS, ANSWER THESE QUESTIONS. *OTHERWISE, GO TO QUESTION 50*.	**Y**	**N**
41. Have you been less interested or motivated in schoolwork / study?	□	□
42. Have you been unable to attend classes because of smoking?	□	□
43. Have your school / course marks dropped?	□	□
44. Have you gone to classes stoned?	□	□
45. Have you been less able to concentrate on your schoolwork / study?	□	□
46. Have you smoked on school premises?	□	□
47. Have you been unable to complete homework because of your smoking?	□	□
48. Have you had complaints from teachers about your work?	□	□
49. Have you been disciplined or suspended from school because of cannabis?	□	□
IF YOU HAVE BEEN EMPLOYED, EITHER PART-TIME OR FULL-TIME, IN THE PAST 3 MONTHS, ANSWER THESE QUESTIONS.		
50. Have you found your work less interesting than you used to?	□	□
51. Have you been unable to arrive on time for work due to your smoking?	□	□
52. Have you missed a whole day at work after a smoking session?	□	□
53. Have you been less able to do your job because of smoking?	□	□
54. Have you gone to work stoned?	□	□
55. Has anyone at work complained about you being late or absent?	□	□
56. Have you had any formal warnings from your employers?	□	□
57. Have you been suspended or dismissed from work?	□	□
58. Have you had any accidents at work after smoking?	□	□

4e. SDS

[ASK THE YOUNG PERSON TO COMPLETE THE FOLLOWING QUESTIONS]

Please complete the next 5 questions. They refer to THE LAST 3 MONTHS.

Over the last 3 months:

a. Did you ever think your use of cannabis was out of control?

Never or almost never	☐	0
Sometimes	☐	1
Often	☐	2
Always or nearly always	☐	3

b. Did the prospect of missing a smoke make you very anxious or worried?

Never or almost never	☐	0
Sometimes	☐	1
Often	☐	2
Always or nearly always	☐	3

c. Did you worry about your use of cannabis?

Not at all	☐	0
A little	☐	1
Quite a lot	☐	2
A great deal	☐	3

d. Did you wish you could stop?

Never or almost never	☐	0
Sometimes	☐	1
Often	☐	2
Always or nearly always	☐	3

e. How difficult would you find it to stop or go without?

Not difficult	☐	0
Quite difficult	☐	1
Very difficult	☐	2
Impossible	☐	3

SDS SCORE __/15

4f. Health

I would like to find out a little bit about your health.

(i) During the past 3 months, would you say your health in general was:

__ excellent
__ very good
__ good
__ fair
__ poor

(ii) Do you think there are any benefits to a person's health from using marijuana?

Yes/No

[IF **YES**] **What are they?**

_____

_____

(iii) Do you think there are any health problems associated with using marijuana?

Yes/No

[IF **YES**] **What are they?**

_____

_____

(iv) Do you think cannabis has had any effect on your health in the last 3 months? Yes/No

[IF **YES**] **How?**

_____

(v) Have you ever received medication or been treated for a mental, emotional, behavioural or psychological problem? Yes/No

[IF YES**]** Are you being treated now?

_____

The next questions are about common mental, or psychological problems that many people have. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from doing stuff you want or need to do, or they make you feel like you cannot go on. [NB: If participant answers **YES** to any item in (vi) the presence of suicidal/homicidal tendencies must be further evaluated (see Mandatory Reporting Issues in manual.]]

(vi) During the past 3 months, have you:

a) Thought about killing or hurting someone? Yes/No
b) Thought about ending your life or committing suicide? Yes/No
[IF **NO**, GO TO vii]
c) Had a plan to commit suicide? Yes/No
d) Gotten a gun, pills or other things to carry out your plan? Yes/No
e) Attempted to commit suicide? Yes/No

(vii) In the past 3 months, have you done the following things two or more times? [NB: Suspected conduct disorder if at least 3 symptoms reported below]

(a) Been a bully or threatened older/other people? Yes/No
(b) Started fights with other people? Yes/No
(c) Used a weapon in fights? Yes/No
(d) Been physically cruel to other people? Yes/No
(e) Been physically cruel to animals? Yes/No
(f) Taken a purse/money or other things from another person by force? Yes/No
(g) Forced someone to have sex with you when they did not want to? Yes/No
(h) Set fires? Yes/No
(i) Broken windows or destroyed property? Yes/No
(j) Taken money or things from a house, building or car? Yes/No
(k) Lied or conned to get things you wanted? Yes/No
(l) Lied to avoid having to something? Yes/No
(o) Taken things from a store or written bad checks to buy things? Yes/No
(p) Stayed out at night later than your parent or partner wanted? Yes/No
(q) Run away from home overnight? Yes/No
(r) Skipped school? Yes/No

4g. Environment

The following questions concern the social aspects of your life over the last 3 months, (things like money, job, friends, etc.).

(i) How often in the last 3 months have you had any money problems, including arguing about money or not having enough for food and stuff?

__ never or almost never
__ sometimes
__ often
__ always or nearly always

(ii) How often in the last 3 months have you had conflict with your girlfriend or boyfriend? By conflict, I mean verbal abuse, serious argument, or violence, not a routine difference of opinion.

__ never or almost never
__ sometimes
__ often
__ always or nearly always
__ not applicable (i.e., no partner)

(iii) How often in the last 3 months have you had conflict with your relatives?

__ never or almost never
__ sometimes
__ often
__ always or nearly always
__ no contact with relatives

(iv) How often in the last 3 months have you had conflict with your employer or school?

__ never or almost never
__ sometimes
__ often
__ always or nearly always
__ not applicable

(v) How much of the time over the last 3 months have you lived with an illicit drug user?

__ none of the time
__ some of the time
__ a lot of the time
__ all or nearly all of the time

(vi) How much of the time over the last 3 months have you spent with non-drug using friends?

__ none of the time
__ some of the time
__ a lot of the time
__ all or nearly all of the time

5. ANTICIPATED CONSEQUENCES OF REDUCING (AND INCREASING) USE

5a. Reducing Use
[ASK THE YOUNG PERSON TO COMPLETE THE FOLLOWING QUESTIONS]

Listed below are a number of situations which people sometimes report happen to them when they stop using cannabis or substantially reduce the amount of cannabis they use.

Indicate how strongly you agree or disagree that each of the following situations or things would happen to you if you stopped using cannabis or if you substantially reduced the amount you use. ***Circle the number that corresponds to how strongly you believe each outcome would occur.***

If I stopped or cut back on my cannabis use I would . . .	Strongly disagree	Some-what disagree	Don't know	Some-what agree	Strongly agree
1. Expect to be able to think more clearly.	1	2	3	4	5
2. Expect urges to use when I see cannabis or think about cannabis	1	2	3	4	5
3. Expect to be healthier.	1	2	3	4	5
4. Expect to be happier.	1	2	3	4	5
5. Expect to be moody.	1	2	3	4	5
6. Expect to feel lonely.	1	2	3	4	5
7. Expect to use alcohol or other drugs more often.	1	2	3	4	5
8. Expect to miss feeling high/stoned.	1	2	3	4	5
9. Expect to feel more tense or anxious.	1	2	3	4	5

If I stopped or cut back on my cannabis use I would . . .	Strongly disagree	Some-what disagree	Don't know	Some-what agree	Strongly agree
10. Expect it to be more difficult to sleep well.	1	2	3	4	5
11. Expect to be more productive.	1	2	3	4	5
12. Expect to feel more depressed.	1	2	3	4	5
13. Expect to have more difficulty controlling my temper.	1	2	3	4	5
14. Expect to be bored more often.	1	2	3	4	5
15. Expect my memory to improve.	1	2	3	4	5
16. Expect to do better at work or school.	1	2	3	4	5
17. Expect to have more energy to do things.	1	2	3	4	5
18. Expect to have better relationships with others.	1	2	3	4	5
19. Expect to have more money.	1	2	3	4	5
20. Expect to feel pressured by friends to use.	1	2	3	4	5
21. Expect to be less creative.	1	2	3	4	5
22. Expect to worry less about getting caught.	1	2	3	4	5

(i) Are there other costs or not so good things you think would happen if you were to substantially reduce or stop your cannabis use? If so, please list them below.

_____

_____

_____

_____

(ii) Are there other benefits or good things you think would happen if you were to substantially reduce or stop your cannabis use? If so, please list them below.

_____

_____

_____

_____

5b. Increasing Use

You've just considered the potential costs and benefits of reducing or stopping your cannabis use. Now, imagine that you could see into the future.

What do you think would happen if you decided to increase your cannabis use?

Please write down the costs (the not so good things) and the benefits (the good things) you expect might happen if you increased your cannabis use.

COSTS	***BENEFITS***

6. IMPORTANT GOALS

Now I'm going to ask you about your plans in life for the next 3 years, basically your goals, aspirations, what you hope to do in some different areas of your life. Here are some examples of goals that someone might have: "I want to improve my marks", " I want to graduate from high school", "I want to go to university", "I want to get a job", "I want to save up some money", " I want to get my own apartment", "I want a better relationship with my family", "I want to develop more close friendships", and "I want to become more assertive". Do any of these fit for you? What are some of the things you plan to accomplish or work towards in the next 3 years?

List of top 5 goals:	Confidence:	Involvement:	Likelihood to achieve if increase use:	Likelihood to achieve if reduce use:
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

[INTERVIEWER: **FOR EACH GOAL, ONE AT A TIME**, ASK ABOUT CONFIDENCE, INVOLVEMENT, AND HOW GOAL WOULD BE AFFECTED IF INCREASES CANNABIS USE AND REDUCES CANNABIS USE. THEN GO THROUGH SAME SERIES OF QUESTIONS FOR NEXT GOAL, AND SO ON. WHEN THIS IS DONE, HAVE PARTICIPANT COMPLETE "IMMEDIATE GOALS REGARDING CANNABIS" ITEMS.]

Using Response Card B

a. Now I'd like you to tell me how <u>confident</u> you feel in your ability to reach each goal using this rating scale. [SHOW Response Card B WITH SCALE ON IT AND RECORD PARTICIPANT'S RATINGS ABOVE FOR EACH GOAL]

b. Now I'd like you to tell me what specifically you are doing to reach this goal. So, how actively <u>involved</u> are you in working toward this goal? Please use this scale to rate your level of involvement. [SHOW RESPONSE CARD B WITH SCALE ON IT AND RECORD PARTICIPANT'S RATINGS ABOVE FOR EACH GOAL]

[INTERVIEWER: ASK FOLLOWING QUESTIONS SEPARATELY FOR "INCREASED USE" AND "REDUCED USE". INTERVIEWER WILL CHECK APPROPRIATE BOXES]

c. Now I'd like to ask you to think about these goals in relation to your cannabis use. I'd you to imagine that you decided to increase your cannabis use. Look at each goal, and think about how <u>increasing your cannabis use would affect</u> this goal. [SHOW PAPER WITH RESPONSE OPTIONS]

d. Now I'd you to imagine that you decided to reduce your cannabis use. Look at each goal, and think about how <u>reducing your cannabis use would impact or affect</u> this goal. [SHOW PAPER WITH RESPONSE OPTIONS]

RESPONSE CARD B

Confidence in reaching this goal (how sure you are that you can achieve this goal):

0	1	2	3	4	5	6	7	8	9	10
Not at all confident					Somewhat confident					Very confident

Involvement in working toward this goal (how actively you are working toward this goal):

0	1	2	3	4	5	6	7	8	9	10
Not at all involved					Somewhat involved					Very involved

If I **increased** my cannabis use, I would be (how likely to achieve this goal)…

0	1	2	3	4	5	6	7	8	9	10
Not at all likely					Somewhat likely					Very likely

If I **reduced** my cannabis use, I would be (how likely to achieve this goal)…

0	1	2	3	4	5	6	7	8	9	10
Not at all likely					Somewhat likely					Very likely

7. YOUR RELATIONSHIPS

Now I'd like you to think about some people in your life who mean a lot to you and that are especially important to you, people you could turn to for help or emotional support, people you respect, or whose respect is important to you.

[CLINICIAN: For each person named ask and record: 1) name of person and relationship to young person, 2) whether or not this person knows about young person's cannabis use, and 3) how this person feels, or would feel (if they knew) about the young person's cannabis use.]

Important people in your life	Does this person know you use cannabis?	How does (or would) this person feel about your cannabis use?

8. IMMEDIATE GOALS REGARDING CANNABIS

I would like you to answer the following questions on a scale of 1 – 10.

(i) In general, **how important is it for you to continue your current level of cannabis use**, where 0 = not at all important, 5 = somewhat important, and 10 = very important? (CIRCLE RESPONSE)

0	1	2	3	4	5	6	7	8	9	10
Not at all important					**Somewhat important**					**Very important**

(ii) **How interested are you in reducing or stopping your cannabis use <u>right now</u>** , on a scale from 0 to 10, where 0 = not at all , 5 = somewhat, and 10 = very much? (CIRCLE RESPONSE)

0	1	2	3	4	5	6	7	8	9	10
Not at all					**Somewhat**					**Very much**

(iii) In general, **how important is it for you to reduce or stop using cannabis**, on a scale from 0 to 10, where 0 = not at all important, 5 = somewhat important, and 10 = very important? (CIRCLE RESPONSE)

0	1	2	3	4	5	6	7	8	9	10
Not at all important					**Somewhat important**					**Very important**

(iv) **How confident are you that you'd be able to reduce or stop your cannabis use today if you tried**, on a scale from 0 to 10, where 0 = not at all confident, 5 = somewhat confident, and 10 = very confident? (CIRCLE RESPONSE)

0	1	2	3	4	5	6	7	8	9	10
Not at all confident					**Somewhat confident**					**Very confident**

THANKYOU!!

APPENDIX B – PERSONALISED FEEDBACK REPORT

APPENDIX C – POPULATION PREVALENCE DATA FOR 14-19 YEAR OLDS

(Source: Australian Institute of Health and Welfare, 2002)

APPENDIX D – STRATEGIES WORKBOOK 1

APPENDIX E – STRATEGIES WORKBOOK 2

APPENDIX F – ASSESSMENT OF PERSONALISED FEEDBACK SESSION

DATE: _____

YOUNG PERSON'S ASSESSMENT OF PERSONALISED FEEDBACK SESSION

We would like to get your impression of the feedback meeting you just had with your counsellor. Please answer each question by circling the number that indicates your response or by filling in the requested information. Your answers are anonymous – you do not have to fill in your name on this form. Do you have any questions?

Please circle your response for each statement	Strongly Agree 1	Agree 2	Don't Know 3	Disagree 4	Strongly Disagree 5
1. I felt comfortable talking with my counsellor	1	2	3	4	5
2. What I did in the session gave me a new way of looking at my cannabis use.	1	2	3	4	5
3. I felt my counsellor understood me and my feelings about my cannabis use.	1	2	3	4	5
4. I believe that the counsellor genuinely cared about me as a person.	1	2	3	4	5
5. I feel that the counsellor appreciated mycoming in for the session.	1	2	3	4	5
6. I feel that the counsellor listened to what I had to say.	1	2	3	4	5
7. The counsellor tried to convince me to quit using cannabis.	1	2	3	4	5
8. I felt the counsellor was judgmental of me and my attitudes towards my cannabis use	1	2	3	4	5
9. I felt my meeting with the counsellor was a waste of time.	1	2	3	4	5

We are also interested in your opinions about the feedback that you received. Please answer each question by circling the number that best indicates how you feel about each of the statements.

10. How satisfied were you with the length of your feedback meeting?

1	2	3	4	5
Very Satisfied	Moderately Satisfied	Neither Satisfied nor Dissatisfied	Moderately Dissatisfied	Very Dissatisfied

11. How satisfied were you with the counsellor you saw?

1	2	3	4	5
Very Satisfied	Moderately Satisfied	Neither Satisfied nor Dissatisfied	Moderately Dissatisfied	Very Dissatisfied

We are interested in finding out what parts of your feedback you found most helpful. Please circle the number that best describes how helpful each of the following was to you.

12. Getting feedback about my cannabis use and its consequences was . . .

1	2	3	4	5	6
Extremely Helpful	Moderately Helpful	Neither Helpful nor Unhelpful	Moderately Unhelpful	Extremely Unhelpful	This did not apply to me

13. My counsellor was . . .

1	2	3	4	5
Extremely Helpful	Moderately Helpful	Neither Helpful nor Unhelpful	Moderately Unhelpful	Extremely Unhelpful

14. Filling out the forms and questionnaires was . . .

1	2	3	4	5
Extremely Helpful	Moderately Helpful	Neither Helpful nor Unhelpful	Moderately Unhelpful	Extremely Unhelpful

15. Was there anything else about the feedback meeting that you particularly liked?

16. Was there anything else about the feedback meeting that you particularly did not like?

17. If more meetings with the counsellor were possible, would you be interested in meeting again with the counselor to continue to discuss the effects of cannabis, the good and not-so-good things about cannabis , ways to reduce use, or anything else you may want to discuss?*(Please check your response)*

____ (1) Yes **____ (0) No**

If Yes, How many more meetings would you want? ____ **Number of meetings**

Finally, please answer the following questions about where you are at right now regarding your cannabis use.

1. **In general, how important is it for you to continue your current level** of cannabis smoking, on a scale from 0 to 10, where 0 = not at all important, 5 = somewhat important, and 10 = very important? (CIRCLE RESPONSE)

0	1	2	3	4	5	6	7	8	9	10
Not at all important				**Somewhat important**						**Very important**

2. **How interested are you in reducing or stopping** your cannabis smoking <u>right now</u> , on a scale from 0 to 10, where 0 = not at all , 5 = somewhat, and 10 = very much? (CIRCLE RESPONSE)

0	1	2	3	4	5	6	7	8	9	10
Not at all important				**Somewhat important**						**Very important**

3. **In general, how important is it for you to reduce or stop** smoking cannabis , on a scale from 0 to 10, where 0 = not at all important, 5 = somewhat important, and 10 = very important? (CIRCLE RESPONSE)

0	1	2	3	4	5	6	7	8	9	10
Not at all					**Somewhat**					**Very much**

4. **How confident are you that you'd be able to reduce or stop** your cannabis smoking today if you tried, on a scale from 0 to 10, where 0 = not at all confident, 5 = somewhat confident, and 10 = very confident? (CIRCLE RESPONSE)

0	1	2	3	4	5	6	7	8	9	10
Not at all confident				**Somewhat confident**						**Very confident**

Thank you for answering these questions. Please place this in the envelope, seal it, and give it back to the counsellor on your way out.