CONTINUING EDUCATION (CE) COURSE MATERIAL
Course No. CE1201P5 – Prevention and Education: Secondary Youth Prevention

COURSE OBJECTIVE

An examination of effective youth prevention programs, with the focus on the secondary or tertiary prevention and treatment of alcohol and other drug use among youth.

COURSE MATERIAL

Substance use and abuse varies at different stages and at different degrees among the youth population. The goal of primary prevention is to target youth who have never experimented with alcohol and drugs and prevent or delay the use of alcohol and other drugs. It is important that primary prevention is started at an early age. I feel it must be started begin prior to age of 8. [1] According to the Ohio State University youth's Intellectual development does not begin until age 10 or 11. It is believed that youth grades K-3 are seeking approval from adults. This is the time to begin to begin teaching alcohol and drug prevention methods.

Secondary prevention focuses on youth who have begun experimentation, use and abuse of drugs. The following definitions are used to describe the target of secondary prevention.[2]

- *Experimentation.* The individual has one or perhaps a few experiences with a particular drug out of curiosity or because of peer pressure.
- *Occasional use.* This is usually unplanned and generally occurs in social situations where the drug is readily available.
- *Regular use.* Drug taking becomes routine.
- *Drug dependency.* The individual's psychological and physical well-being is so closely linked to the chosen chemical that it becomes a necessity. At this stage of addiction, physical withdrawal signs occur if the drug is abruptly discontinued.

Experimentation does not constitute that a youth will continue to use. Some youth at this stage may realize they do not like the effects be it physical or psychological decided they will not continue to use alcohol or drugs. However, this may be a time when secondary prevention is beneficial. During the experimentation phase may be a good time to assist in the prevention of occasional or regular use. Youth who are experimenting are curious and probably do not require an inpatient or outpatient treatment program. But they do require further education and prevention information to prevent or delay further use of alcohol and other drugs.

When working with youth it is important to realize that not all youth who become involved with alcohol and other drugs will continue on with regular or occasional use, or become dependent. And it is equally important to realize that all youth who are referred to treatment are not all regular users, or are dependent on alcohol and other drugs. It is crucial to remember that when youth are referred for treatment they are referred from a variety of organizations for a variety of reasons.

Many youth are referred because they have been caught using, admitted to using or are in possession of drugs. Youth are referred to counseling at different stages of substance use and abuse and it is important that their issues and concerns are addresses on an individualized basis.

[1] http://ohioline.osu.edu/4h-fact/0015.html
[2] http://cpmcnet.columbia.edu/texts/guide/hmg04_0006.html

Prevention is part of an interrelated continuum of services that also includes intervention and treatment, often referred to as secondary and tertiary prevention.[3] Primary prevention often relies on the development of policies, regulations and behavioral norms to change drinking and other drug practices. In contrast, secondary and tertiary prevention includes activities related to activities used to change behavior of individuals who are involved with or suffer from problems related to alcohol and other drug use. Services and activities include but are not limited to; crisis intervention, targeted education, peer group intervention, detoxification services, inpatient and outpatient treatment.

Experimentation is at the end spectrum of primary prevention, it is to prevent or delay use. Since Experimentation is closely associated with primary prevention, we will focus on use and abuse not experimentation. In conjunction with the DSM-IV the term substance abuse is used in the general sense to cover both substance abuse disorders and substance dependence. Many youth recovery programs appear to have a high rate of youth who relapse, when in essence the youth has never been in recover and had no intention on discontinuing use.

Terence T. Gorski states, “Because adolescents lack power in their lives, they are experts at compliance.[4] When the power of their parents, the legal system, and the school system is brought to bear, most adolescents are capable of playing the games. The result is a perfect patient during treatment and a rapid return to chemical use when the adolescent is returned to a less restrictive environment. High Relapse rates results”.

But is it considered relapse. The definition of relapse is “regression to a former state, such as recurrence of an illness during recuperation or after recovery to lapse back, as into illness or addiction,[5] to regain, to return to a former state.[6]

Many youth programs are asked, “What is your success rate?” I always answer that question: “Success according to whom?” Each party involved with the youth who was referred to treatment has there own agenda and standards for success.

- Probation; they need for the youth to complete court and probation requirements. Example; Complete 3 months of a treatment program
- School: They need for the youth to return to school therefore they need to attend 1 month of counseling
- The Treatment programs goal is to educate the youth and get them clean and sober
- The parents wants their child fixed so they will quit causing problems
- The youth just wants to get off probation, return to school, get their parents off their back and tell the treatment program what they want to hear.

Most youth in the use and abuse stage have no intention of getting clean and sober. The youth does not realize any negative consequences associated with alcohol and drug use. They are on probation because the cops were messing with them, so what they caught with marijuana on school campus they are attending school and are a C average. However their parents drink, use drugs, are not around, are abusive, so the parents are the problem not the youths drug use.

[3] Center for Substance Abuse, Prevention Primer
[4] Bell, Tammy, Preventing Adolescent Relapse 1990
[5] Webster Pocket Dictionary, 2002
[6] Webster Pocket Dictionary, 2002

The youth has not realized that his choice to use alcohol and other drugs may have been the cause of them being on probation, expelled from school, or referred to the treatment program has anything to do with their drug use. And why should they quit using they haven't associated any negative effects?

All of the above parties have a vested interested in the youth becoming clean and sober except for the youth. For an effective secondary prevention program it is important to understands the youth desire and motivation for change.

During the past 20 years, considerable research has focused on different ways to motivate substance abusers to initiate and continue treatment. A series of motivational techniques have been identified to enhance a clients motivation to chance which include[7]

- Motivation is key to change
- Motivation is multidimensional
- Motivation is a dynamic and fluctuating state
- Motivation is interactive
- Motivation can be modified
- The clinicians style influence client motivation

One research that is being widely used today is the *Transtheoretical Model of Change*. The "Transtheoretical Model" (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Velicer, 1997) is an integrative model of behavior change. This model helps a person modify or change behaviors, it focus on the decision making of the individual where the individual currently is at in the process of change. There are hundreds of different theories of human behavior. Prochaska and his colleagues researched many different theories to determine whether there were instead a limited number of processes for change that applied across different theories.

They found that while researchers and individuals may have many different theories about behavior change, the actual process of change is remarkably similar across different studies using a variety of theoretical approaches.[8]

The Transtheoretical Model is developed is from an examination of 18 psychological and behavioral theories about how change occurs. They developed this model that shows the stages and process of behavior change and called it the Transtheoretical Model because it applies different theories.

They identified five stages of behavior change. Each stage has its own characteristics and can occur at anytime and in almost any order. The five stages of change are, ***Precontemplation, Contemplation, Preparation, Action and Maintenance***. A person can begin at precontemplation advance to action; move back to contemplation, maintenance and back to precontemplation. The stages of change can be seen as a spiral because people tend to circle through the stages rather then linear.

The definitions of the five stages of The Transtheoretical Model of change as a process are as following:[9]

[7] U.S. Department of Health and Human Services TIP Series 35
[8] State of California, Building Quality HIV Prevention Counseling Skills
[9] Changing for Good, J. Prochaska, J. Norcross and C. DiClements, 1992

Precontemplation(Not thinking about it) is the stage in which people are not intending to take action in the foreseeable future, usually measured as the next six months. People may be in this stage because they are uninformed or under-informed about the consequences of their behavior. Or they may have tried to change a number of times and become demoralized about their ability to change. Both groups tend to avoid reading, talking or thinking about their high-risk behaviors. They are often characterized in other theories as resistant or unmotivated or as not ready for health promotion programs. The fact is traditional health promotion programs are often not designed for such individuals and are not matched to their needs.

The Precontemplators has no intention of changing the behavior in the near future, they are unaware that a problem exist. When the Precontemplators seek counseling they are generally seeking counseling because they are pressured from family, required by the courts, employers or schools. During this stage the client is resistant and has no intention of modifying their behavior.

Contemplation(Thinking about It) is the stage in which people are intending to change in the next six months. They are more aware of the pros of changing but are also acutely aware of the cons. This balance between the costs and benefits of changing can produce profound ambivalence that can keep people stuck in this stage for long periods of time. We often characterize this phenomenon as chronic contemplation or behavioral procrastination. These people are also not ready for traditional action oriented programs.

At this stage, the person recognizes a problem exist and is seriously thinking about changing behaviors, but has not yet made a commitment. Contemplators spend considerable effort and amount of time weighing the pros and the cons of the problems and solutions. They are seriously considering change but they may not have the motivation to endure the effort that change requires

Preparation(Ready for Action) is the stage in which people are intending to take action in the immediate future, usually measured as the next month. They have typically taken some significant action in the past year. These individuals have a plan of action, such as joining a health education class, consulting a counselor, talking to their physician, buying a self-help book or relying on a self-change approach. These are the people that should be recruited for action-oriented smoking cessation, weight loss, or exercise programs.

This person has every intention of making a change and has plans to do so within the next month or has taken may have taken action previously but failed. This type of person could be someone who has wanted to quit smoking and has cut down on the number of cigarettes that they smoke, or they may have decided that they would only drink on weekends.

Action is the stage in which people have made specific overt modifications in their life-styles within the past six months. Since action is observable, behavior change often has been equated with action. But in the Transtheoretical Model, Action is only one of five stages. Not all modifications of behavior count as action in this model. People must attain a criterion that scientists and professionals agree is sufficient to reduce risks for disease. In smoking, for example, the field used to count reduction in the number of cigarettes as action, or switching to low tar and nicotine cigarettes. Now the consensus is clear--only total abstinence counts. In the diet area, there is some consensus that less than 30% of calories should be consumed from fat. The Action stage is also the stage where vigilance against relapse is critical.

At this stage the client has made changes and modifications to their behavior, attitude or environment. While action is a dramatic and rewarding stage it is not the same thing as successfully achieving and maintaining a behavior change.

Maintenance is the stage in which people are working to prevent relapse but they do not apply change processes as frequently as do people in action. They are less tempted to relapse and increasingly more confident that they can continue their change.

This stage is attained when the client has successfully maintained their behavior change for six months or longer. This stage is a maintenance stage and therefore is viewed as on going and continued maintenance. The person must continue to focus on preventing relapse while on the road to recovery.

Anthony (1993) identifies recovery as " a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles."[10] It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life

The youth who are at the precontemplation stage has no desire to discontinue use. They have been forced into treatment and their only goal is to get out of the program. As mentioned earlier one way of motivation the client is the style of the clinician. It is important that the clinician has a motivational interviewing style.

Motivational interviewing is a style of interviewing a client that elicits their motivation for change. According to the CSAT Consensus Panel successful Motivational Interviewing will contain the following:[11]

- Express empathy
- Communicate respect for and acceptance of clients and their feelings
- Establish a nonjudgmental, collaborative relationship
- Be a supportive and knowledgeable consultant
- Compliment rather than denigrate
- Listen rather then tell
- Gently persuade, with the understanding the change is up to the client
- Provide support throughout the process of recovery
- Develop discrepancy between clients' goals or values and current behavior, helping clients recognize the discrepancies between where they are and where they hope to be
- Avoid argument and direct confrontation, which can degenerate into a power struggle
- Adjust to, rather than oppose, client resistance
- Support self-efficacy and optimism; that is, focus on clients' strengths to support the hope and optimism needed to make change.

OARS is a strategy that is useful in Motivational interviewing. OARS is a term coined by Miller & Rollnick,. Some of the terms are directive and non-directive:

- Open-ended Questions
- Affirmation
- Reflective Listening

[10] William Anthony, Director of the Boston Center for Psychiatric Rehabilitation
[11] DHHS Publication No.(ADP) 99-8554

- Summary

It is important that during the initial stages of interviewing and assessing the clients needs and stage of motivation that clinicians ask open ended questions, therefore giving the client an opportunity to expound on information and not just answer with a yes or no. This technique keeps conversations going and is helpful in keeping the focus on the client.

Affirmation allows the counselor to communicate true understanding and express genuine empathy. The affirmations build on the clients' strengths, past success and goals. One affirmation that assist in building clients confidence is thanking the client for coming in for counseling.

Counselors show that they are listening to clients through reflecting or paraphrasing what the client has said. This method is a way to eliminate any misunderstandings. It test whether what the speaker means is what the listener understands. There are three levels of reflection; ***Repeating***, then is when you use the clients' words and repeat the essence of what was said. ***Rephrasing,*** whereas you say the same thing in a slightly different way, and ***Paraphrase***, where you restate to capture the meaning and emotion of what was said and adding something that was not said or implied.

Summarizing what was said during session or over a course of several sessions allows you to highlight concerns, ambivalence, discrepancies or success. Always support the client through affirmation of the client's strengths and motivation to change and be sure to summarize the counseling session to ensure the client of you interest in their progress or lack of.

This Stage of Change model is pertinent to youth as well as the adult population and the techniques work for both populations. However as in an effort to be effective treatment must be client centered and based on the client's age, level of development and Motivation to change. The majority of youth who are referred to outpatient treatment who have been identified as experimentation, use and abuse are most likely to be at the **Precontemplation Stage**. These youth have not yet considered change, is unwilling or unable to change. These youth tend to be rebellious and need to be in control. They are reluctant for change because they need additional information about the need to change some of their behaviors while feeling capable and confident that they can make the change. The Goal of Precontemplation is; *To Identify Defenses And Raise Awareness*. During this stage and the different stages of change, the following strategies for the clinician are suggested[12]

- Establish rapport, ask permission, and build trust
- Raise doubts or concerns in the client about substance using patters by:
    - Exploring the meaning of events that brought the client to treatment or the results of previous treatments
    - Eliciting the client's perceptions of the problems
    - Offering factual information about the risks of substance use
    - Providing personalized feedback about assessment findings
    - Explore the pros and cons of substance use
    - Helping a significant other intervene
    - Examining discrepancies between the client's and others' perceptions of the problem behavior.

[12] Richardson, Helen and Tomlin, Kathleen LPC,CADC2

Also be sure to express concern and keep the door open for communication.

When you have a client who acknowledges concerns and is considering the possibility of change bus is ambivalent and uncertain this client is contemplating change and is considered to be in the **Contemplation stage.** The Goal of the Contemplation stage is; *Decide for Change* and the following motivational strategies for clinicians are suggested.

- Normalize Ambivalence (Uncertain, especially as related to contradictory emotions, unsure how to proceed, *Webster dictionary*)
- Help the client "tip the decisional balance scales" toward change by
  - Eliciting and weighing pros and cons of substance use and change
  - Changing External to internal motivation
  - Examining the clients personal values in relation to change
  - Emphasizing the clients free choice, responsibility, and self efficacy for change
- Elicit self motivational statements of intent and commitment from the client
- Elicit ideas regarding the clients perceived self-efficacy and expectations regarding treatment.
- Summarize self-motivational statements

For the client who is committed to and planning to make a change is at the **Preparation Stage** but this client is only preparing and is still considering what to do. The Goal for Preparation Stage is: *Get Ready To Make Change*. The clinician can assist the client in the following manner.

- Clarify the clients own goals and strategies for change
- Offer a menu of options for change or treatment
- With permission, offer expertise and advice
- Negotiate a change-or treatment-plan a behavior contract
- Consider and lower barriers to change
- Help the client enlist social support
- Explore treatment expectancies and the clients role
- Elicit from the client what has worked in the past either for him or others whom he knows
- Assist the client to negotiate potential barriers
- Have the client publicly announce plans to change

Once the client begins to actively take steps to change they are in the **Action Stage.** The Goal for Action Stage is *Monitor and Assist Action Plans* and as a clinician you can do the following;

- Engage the client in treatment and reinforce the importance of remaining in recovery
- Support realistic views of change through small steps
- Acknowledge difficulties for the client in early stages of change
- Help the client identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these.
- Assist the client in finding new reinforces of positive change
- Help the client assess whether she ahs a strong family and social support.

For the client that has achieved the initial goal of sobriety and is maintaining the client is in the **Maintenance Stage**. The Goal for Maintenance is; *Reassure, Assist, Improve Resolve for Change* and will benefit from the clinicians help in the following areas;

- Help the client identify and sample drug-free sources of pleasure
- Support lifestyle changes

- Affirm the clients resolve and self-efficacy
- Help the client practice and use new coping strategies to avoid return to use
- Maintain supportive contacts
- Develop a fire escape plan if the client resumes substance use
- Review long-term goals with the client

Many times we realize that the best-proven techniques are not always successful. It may take a person weeks, months and even years to progress to contemplation stage. A client can be at the precontemplation stage and jump directly to the Action Stage; Example
This is an example of an actual client biopsychosocial and how the stages of change was used to help prevent further use and abuse of alcohol and other drugs and reduce the risk that alcohol and other drugs caused in the youths life.

Mary is a 15-year-old African American Female who currently resides in a group home environment, and appears to be fairly healthy. The client is sexually active and states that she does not always use protection during sexual intercourse. The client is in the tenth grade and states her grades are average. She has not had any problems with school and states her classes are not difficult and she is bored with school. Mary is currently working in a clothing store and has been working there for the past 2 months.

Mary reports that she does not spend the majority of her free time with friends that use alcohol and other drugs. She states she has friends who are clean and sober and she does hang out with them. She states her biological mother and grandparents uncles and 2 aunts have experienced alcohol and drug problems. She reports that some family members are chemically dependent, but she denies being chemically dependent. She reports that she has received treatment in the past for emotional or psychological problems, she reported using alcohol and marijuana for the past 3 years. She drank more approximately seven or more drinks per day on the days that she drank in the past month. She was intoxicated for the first time at age 11. Mary is not at all bothered by alcohol and drug problems even though she has been arrested three times for selling drugs and is on probation.

Mary admits to selling drugs in order to buy drugs, clothes and food. She does not feel like she needs to stop using drugs because all she uses is alcohol and marijuana and these are not considered bad. At this time she is at the precontemplation stage. She has no desire to or intention of stopping the use of alcohol and marijuana.

By Mary's third session, which was the beginning of treatment planning, she progressed from the Precontemplation Stage to Actions Stage According to the Transtheoretical Model. Mary did not agree to quit using alcohol or marijuana but she did agree to change some of her high-risk behaviors. Mary agreed to reduce the Harm that Alcohol and Marijuana could cause in her life. She agreed to the following plan;

- To not use drugs before, during or after school
- Not to sell drugs at school
- She will not drink, use and drive and will not drive with others who are under the influence
- She will use condoms each time she has sexual intercourse
- She will attend individual counseling sessions weekly
- She will attend AOD groups

This client at this time does not feel she needs to complete stop using, but understands that she can reduce her risk of further involvement with the juvenile justice system, continue to attend school and reduce her risk of HIV, STD's and pregnancy by changing some of her behaviors. In secondary prevention is valuable to incorporate a Harm Reduction model for Precontemplators. When incorporating a Harm Reduction Method as part of secondary prevention remember to incorporate the following methods:

HARM REDUCTION PRINCIPLES/CONCEPTS: [13]

Be nonjudgmental
Avoid being parental/authoritarian
Meet the client where they are
Avoid having preconceived goals
Provide guidance and consultation
Provide support
Value the client's information
Be aware of power differences (skills, education, race, money)
Build rapport/trust
See small changes as success
Recognize denial as normal
Emphasize client's strengths
Emphasize personal responsibility for outcomes
Avoid unnecessary labeling
Normalize drug use

Principals of Harm Reduction

Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence.[14] Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.

Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use

Most therapeutic services for drug users, including drug treatment, are designed to serve the priorities of providers instead of the needs of consumers. Drug education and prevention campaigns are largely ineffective, attempting to scare people away from using drugs instead of equipping them with accurate information about drugs and drug use, including their adverse and harmful effects.

Therefore if your client is determined to stay in the precontemplation stage because they do not perceive any long-term dangers or adverse effects of alcohol and drug use, as the motivational clinician you can assist them to get advance to the Action stage. Once they are in the action stage and begin to increase knowledge of how alcohol and drugs affects their life and how gateway drugs. "Gateway drugs" are drugs that serve as the "gate" or path that almost always precedes the use of illicit drugs such as marijuana, cocaine, heroin, and LSD.[15] These gateway

[13] http://www.metrokc.gov/health/apu/harmred/princ.htm
[14] http://www.harmreduction.org/prince.html
[15] http://www.drugs.indiana.edu/publications/iprc/factline/gateway.html

drugs serve as almost essential precursors to the use of other drugs, and often lead to adoption of the drug-using lifestyle. Gateway drugs, or drugs-of-entry, serve to initiate a novice user to the drug-using world.

Conclusion

There is no timeframe on how long a client may be in the precontemplation. It is important to work with the client where they are at in their use and willingness to abstain from use and abuse. It is imperative if you have a youth that refuses to abstain after exploring the pros and cons of substance use, and you have elicited the clients perception of the problem that you work with the youth on reduces harm that the drugs and alcohol can cause in their life. It is important to distinguish between

Primary prevention is a safety net that provides individuals with information and resources raise their awareness of both risky and healthy behaviors, and helps shape environments to promote health and protect people from harm.[16]

Intervention or secondary prevention is the next level safety net for those who are involved with alcohol and other drugs with the goal of preventing further use. Intervention may target those who have begun to experience problems with substances can benefit from secondary prevention. All individuals are not at the point where they wish to abstain from the use of alcohol and drugs. It is the Clinician responsibility to work with the client to access their level and Motivation for Change. To further assist the resistant client who's goal is not to stop using alcohol and other drugs, they can move in to the Action Stage by reducing alcohol consumption to low risk levels, thus prevention the development of further alcohol or drug related problems.

BIBLIOGRAPHY AND SUGGESTED ADDITIONAL RESOURCES

- Ohio State University
- Columbia University College of P& S Complete Home Medical Guide
- Center for Substance Abuse, Prevention Primer, encyclopedia of alcohol, tobacco and other drug prevention terms
- Bell, Tammy, Preventing Adolescent Relapse, 1990
- Webster Dictionary
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Rockville, MD
- U.S. Department of Health and Human Services TIP Series 35
- State of California, Building Quality HIV Prevention Counseling Skills
- Changing for Good, J. Prochaska, J. Norcross and C. DiClements, 1992
- William Anthony, Director of the Boston Center for Psychiatric Rehabilitation ….
- DHHS Publication No.(ADP) 99-8554
- Richardson, Helen and Tomlin, Kathleen LPC,CADC2
- Public Health, Seattle and Kings County, HIV program, Harm Reduction Principals and concepts
- Public Health, Seattle and Kings County, HIV program, Harm Reduction Principals and concepts
- Indiana Resource Center, Factline on Gateway Drugs
- Center for Substance Abuse, Prevention Primer

[16] Center for Substance Abuse, Prevention Primer

ACKNOWLEDGEMENTS

This course material was prepared by V. Vannessa Lindsey, MA. Ms. Lindsey, earned her Master of Arts in Addictive Disorders degree, and is currently a candidate for the Doctor of Addictive Disorders (Dr.AD) Degree, from Breining Institute. Ms. Lindsey serves as the Chief Executive Officer of Another Choice, Another Chance (ACAC), a non-profit agency that provides substance abuse and dual diagnosis treatment, specializing in comprehensive individual, group and family services, with a target population of youth between the ages of 12 and 23. Breining Institute has edited the original material for the purpose of presentation in this course.

CONTINUING EDUCATION (CE) EXAMINATION QUESTIONS
Course No. CE1201P5 – Prevention and Education: Secondary Youth Prevention

You are encouraged to refer to the Course Material when answering these questions. Choose the best answer based upon the information contained within the Course Material. Answers which are not consistent with the information provided within the Course Material will be marked incorrect. A score of 70% correct answers is required to receive Continuing Education credit. GOOD LUCK!

QUESTIONS

12. Secondary prevention focuses on youth who:
    a. Have never experimented with alcohol and drugs
    b. Have begun experimentation, use and abuse of drugs.
    c. Both of the above.
    d. Neither of the above.

13. The material identifies important components of working with youth, including all of the following except:
    a. It is important to realize that not all youth who become involved with alcohol and other drugs will continue on with regular or occasional use, or become dependent.
    b. It is important to remember that youth alcohol and drug users are generally financially self-sufficient, and that they should be required to pay for their own treatment.
    c. It is important to realize that all youth who are referred to treatment are not all regular users, or are dependent on alcohol and other drugs.
    d. It is important to remember that when youth are referred for treatment they are referred from a variety of organizations for a variety of reasons.

14. Services and activities related to secondary or tertiary treatment include, but are not limited to, which of the following:
    a. Crisis intervention.
    b. Peer group intervention
    c. Inpatient and outpatient treatment.
    d. All of the above.

15. The “Transtheoretical Model” is an integrative model of behavior change, which includes which of the following:
    a. Helps a person modify or change behaviors.
    b. Focuses on the decision making of the individual where the individual currently is at in the process of change.
    c. Both of the above.
    d. Neither of the above.

16. The Transtheoretical Model identified five stages of behavior change, including each of the following, except:
    a. Contemplation.
    b. Preparation.
    c. Digestion.
    d. Maintenance.

17. "OARS" is a strategy useful in motivational interviewing. The OARS acronym comes from the following terms, except:
    a. O = Open-ended questions.
    b. A = Attitude.
    c. R = Reflective listening.
    d. S = Summary.

18. Once a client begins to actively take steps to change, he/she is considered to be in which stage of the Transtheoretical Model?
    a. Contemplation.
    b. Preparation.
    c. Action.
    d. Maintenance.

19. "Harm Reduction Principles / Concepts" include which of the following:
    a. Provide support.
    b. Build rapport/trust.
    c. Emphasize client's strengths.
    d. All of the above.

20. Drug education and prevention campaigns are largely ineffective, according to the course material, because they:
    a. Attempt to scare people away from using drugs instead of equipping them with accurate information about drugs and drug use, including their adverse and harmful effects.
    b. Attempt to educate, rather than punish, thus giving the youthful users no realistic incentive to stop reliance on the alcohol or drugs.
    c. Both A and B above.
    d. Neither A nor B above.

21. "Gateway drugs:"
    a. Are drugs that serve as the "gate" or path that almost always precedes the use of illicit drugs such as marijuana, cocaine, heroin, and LSD.
    b. Serve as almost essential precursors to the use of other drugs, and often lead to adoption of the drug-using lifestyle.
    c. Serve to initiate a novice user to the drug-using world.
    d. All of the above.

This is a ten-question examination. Answer Questions 12 through 21 for full CE credit in this course. Questions 1 through 11 have been omitted.

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CONTINUING EDUCATION (CE) ANSWER SHEET

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1.	A	B	C	D	8.	A	B	C	D	15.	A	B	C	D
2.	A	B	C	D	9.	A	B	C	D	16.	A	B	C	D
3.	A	B	C	D	10.	A	B	C	D	17.	A	B	C	D
4.	A	B	C	D	11.	A	B	C	D	18.	A	B	C	D
5.	A	B	C	D	12.	A	B	C	D	19.	A	B	C	D
6.	A	B	C	D	13.	A	B	C	D	20.	A	B	C	D
7.	A	B	C	D	14.	A	B	C	D	21.	A	B	C	D

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