IMPROVING ADOLESCENT HEALTH: FACILITATING CHANGE FOR EXCELLENCE IN SBIRT

PROVIDER GUIDE
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<td><strong>Pillars Community Health</strong>&lt;br&gt;LaGrange, Illinois</td>
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<td><strong>Vista Community Clinic</strong>&lt;br&gt;Vista, California</td>
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Adolescence represents both a critical at-risk period for substance use initiation as well as an opportune time to intervene and prevent behaviors from developing into more acute health problems. Not all adolescents who experiment with drugs and alcohol will develop a substance use disorder; however, all psychoactive substances have negative effects on the still-developing adolescent brain. Systematic screening can lead to beneficial health outcomes and reduce future misuse (Surgeon General’s Report, 2016).

**Sobering Facts about Teen Substance Use**

* Marijuana use in adolescence may be associated with loss of IQ.
* Teens who use tobacco report poorer health outcomes than their nonsmoking peers.
* More than 90 percent of adult smokers reported smoking before they were 18 years old.
* Teen alcohol use is associated with a greater likelihood of adult alcohol dependence or substance use disorder.
* Teens who use marijuana at or before the age of 14 are six times more likely to develop a substance use disorder older in life than those who first try marijuana at age 18 or later (Meier et al., 2012; CDC, 2012; HHS, 2016).
WHAT IS SBIRT?

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an integrated and comprehensive, evidence-based, early intervention implemented in primary care settings to identify, reduce, and prevent alcohol and drug use, abuse, and dependence (Del Boca, 2017). It is **NOT** another task that will take a significant amount of time to carry out; rather it is an intervention that can and should be incorporated into existing processes and procedures in the primary care setting to facilitate effective and necessary care for adolescents.

The SBIRT process includes:

1. **SCREENING** to identify an adolescent’s place on a spectrum from non-use to substance use in order to deliver an appropriate response.

2. **BRIEF INTERVENTION** (BI) to raise patient awareness of risks, elicit internal motivation for change, and help set behavior-change goals.

3. **REFERRAL TO TREATMENT** to facilitate access to and engagement in specialized services and coordinated care for patients at highest risk.

WHY SBIRT?

Despite evidence suggesting its effectiveness, SBIRT is not yet widely implemented. Although the intervention can be challenging, there are several key reasons for why SBIRT should be considered. These include:

- Substance use’s negative impact on overall health.
- SBIRT’s support of a full clinical picture of a patient, rather than compartmentalized care.
- Early substance use interventions can prevent development of more severe substance use disorders.
- Protocol standardization supports substance use identification.
- You don’t have to be a specialist. SBIRT can be integrated into routine care and fits into workflows.
- Cost savings and increased accountability from a range of payers.

HOW TO USE THIS PROVIDER GUIDE

The Provider Guide is an abbreviated version of the full change package, *Improving Adolescent Health: Facilitating Change for Excellence in SBIRT*. It serves as a quick reference for providers who work directly with adolescents to deliver SBIRT in a primary care setting and are seeking clinical guidance and easy access to provider tools. Thus, it presents a condensed version of the clinical areas of action for SBIRT implementation, and omits operational considerations such as policies, procedures, and change management strategies. For comprehensive clinical guidance and resources, please refer to the full change package.
SCREENING

WHO SHOULD BE SCREENED?

Universal screening for alcohol and substance use should be performed with all adolescents aged 12 and older. In fact, the National Institute on Alcohol Abuse and Alcoholism recommends that screening for alcohol use begin as early as age 9 or as soon as children can be interviewed alone, without a parent present (NIAAA, 2015). The goals of screening younger children are twofold: 1) to present a prevention message to younger children prior to their first opportunity to try substances and 2) to identify a very high-risk group of children who initiate substance use early. Early substance use initiation is associated with particularly poor short- and long-term outcomes (Zeigler et al., 2005).

KEY TIP

Given the rapidly changing nature of adolescent substance use risk, it’s recommended that every adolescent is screened at every clinical encounter.

THE SCREENING TOOL: SCREENING TO BRIEF INTERVENTION (S2BI)

The S2BI (Massachusetts Child Psychiatry Access Program, 2015) is a no-cost, validated instrument recognized by both the American Academy of Pediatrics (AAP) and the Addiction Medicine Foundation (The Addiction Medicine Foundation, 2016). The S2BI offers several advantages that make it ideal for use in many public health settings:

- Is quick and practical for short visits.
- Effectively screens for alcohol, vapes, tobacco and marijuana (research indicates that if adolescents are not using one of the three, it is highly unlikely that they are using other substances [Woodcock et al., 2015]).
- Correlates with Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) diagnoses.
- Although non-diagnostic, provides an accurate way to identify those who may have severe substance use disorders.
- Provides results that can guide provider responses.

S2BI: Screening to Brief Intervention

In the past year, how many times have you used:

- Tobacco? (Cigarettes, e-cigarettes, vapes, etc.)
- Alcohol?
- Marijuana? (Smoked, vaped, edibles, etc.)

STOP if all “Never.” Otherwise CONTINUE.

- Prescription drugs that were not prescribed for you (Pain medication, Adderall, etc.)
- Illegal drugs? (Cocaine, Ecstasy, etc.)
- Inhalants? (Nitrous oxide, etc.)
- Herbs/synthetic drugs? (Salvia, K2, bath salts, etc.)

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ADMINISTERING THE S2BI

• Create a welcoming and non-judgmental environment so youth feel safe to honestly answer assessment questions and discuss intervention next steps based on their responses. Build rapport, find common ground, and secure patient buy-in.

• Screening that is performed while checking for vital signs and other preventive and lifestyle screenings helps normalize conversations about substance use and diminishes patients feeling singled out.

• Screening is best done as self-administered. Teens are more likely to be candid when answering self-administered questions rather than in person.

• Regardless of administration format, it is critical to afford the adolescent as much privacy as possible.
SCREENING RESULTS INFORM BRIEF INTERVENTION

Screening results guide the intensity of BI delivery. This risk stratification chart illustrates how to respond to different levels of use, along the spectrum of anticipatory guidance to BI. (See “Clinical Guidance for Delivering BI.”)

### TABLE 2. S2BI ALGORITHM

**S2BI Algorithm**

In the past year, how many times have you used:
- Tobacco? Alcohol? Marijuana?

<table>
<thead>
<tr>
<th>Prevention Opportunity</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Use</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Once or Twice</td>
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<td></td>
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<tr>
<td>Monthly Use</td>
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<tr>
<td>Weekly Use</td>
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</table>

#### Risk for Substance Use Disorder

- **Anticipatory Guidance**
  - Affirm Healthy Choices

- **Brief Intervention**
  - Provide cessation advice
  - Reduce use and reduce risky behavior

- **Ask Follow Up S2BI Questions:**
  - Prescription drugs? Illegal drugs? Inhaling? Herbs?

- **Brief Intervention**
  - Provide cessation advice
  - Reduce use and reduce risky behavior
  - Facilitate linkage to behavioral health/specialty treatment
BI has been shown to be effective with adolescents even after accounting for various settings (including diverse and non-traditional settings), approach and delivery formats. The AAP has also explored the evidence for BI and effectiveness of BI with adolescents and found that adolescence is the time of greatest risk of experiencing substance use–related acute and chronic health consequences and are most likely to derive the greatest benefit from universal SBIRT (Levy & Williams, 2016).

**BI is short in duration but not short on impact.**

**THE ART OF BRIEF INTERVENTIONS**

BI is a collaborative conversation between a health professional and adolescent to promote behavior change in order to reduce substance use.

It is a structured, goal-oriented exchange that draws from motivational interviewing (MI), including use of a non-judgmental, non-confrontational style that engages the adolescent in discussion.

Components of a BI include sharing health information, delivering cessation advice, discussing reducing use and risky behaviors and, when indicated, facilitating linkages to treatment.

Whenever delivering BI, be sure to advocate for non-use as the healthiest choice. Meet patients where they are, treating them as the expert on themselves and creating opportunities together that support all pathways to better health. For teens who are not ready or willing to attempt to quit, reducing use or risky behaviors may be a first step.

The BI components will vary in duration and intensity based on level of risk. Ultimately, the focus of the process is to highlight the link between substance use and health and encourage cessation to ensure lowest levels of risk. If the adolescent is not willing to stop using, acknowledge the positive effects of reducing use.

Even if a primary care physician (PCP) has less than five minutes, a BI can be both short in duration and substantial in impact. The PCP can be a positive influence by building rapport over time with adolescents and drawing upon experience with data-informed treatment of chronic conditions — vital skills for addressing substance use.

**KEY TIPS**

- All patients should be advised of potential health risks and consequences and encouraged not to use. There is no safe level of alcohol consumption for underage youth.
- With evolving changes to cannabis legalization and regulation, explore perceptions of risk, ask about method of intake (e.g., vaping, edibles) and awareness of potency.
- Address trends of increased vaping by reinforcing that, like traditional smoking, vaping can have adverse health effects due to added chemicals and high levels of nicotine.
- Share information about the impacts of prescription drug misuse and that it is particularly harmful to a developing adolescent brain and body. Clearly communicate the spectrum of risk and advise not to use.
CLINICAL GUIDANCE FOR DELIVERING BRIEF INTERVENTION

This chart is a practical reference for staff delivering BIs to provide the appropriate level of intervention based on screening results.

### TABLE 3. PATH OF SCREENING TO BRIEF INTERVENTION

<table>
<thead>
<tr>
<th>Anticipatory Guidance</th>
<th>No Use (Prevention Opportunity)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is anticipatory guidance?</strong></td>
<td>Anticipatory guidance is the appropriate response for a screening result of &quot;No Use.&quot; It is an opportunity to intervene before substance use begins. It is a process in which the health care professional anticipates emerging issues that an adolescent and family may face and provides guidance by delivering information about the benefits of healthy lifestyle choices and practices that promote injury and disease prevention and encourages parents to discuss healthy, substance-free lifestyles.</td>
</tr>
<tr>
<td><strong>Provide positive reinforcement.</strong></td>
<td>Affirm healthy choices. Reinforce patient’s reasons for non-use. Deliver preventative advice.</td>
</tr>
<tr>
<td><strong>Sample Scripting:</strong></td>
<td><strong>Sample Scripting:</strong></td>
</tr>
<tr>
<td>o “It’s great that you are choosing not to use substances. Have you ever been offered?” If yes, follow with: “What happened and how did you decide to say no?” If no, follow with: “That’s great. It could happen in the future so it’s good to be prepared and think through what you would do.”</td>
<td>o “Avoiding tobacco, alcohol and drugs is an excellent choice — it’s one of the best ways to protect your health. Can I provide some information on how these substances can affect you over time?” o “There may be times when drugs and alcohol seem tempting, especially at your age. As your doctor, I’m proud of your for making a tough choice that can also positively affect your health.”</td>
</tr>
<tr>
<td><strong>Staff Considerations:</strong> All staff can be trained to provide positive reinforcement. Ensure staff are equipped with psychoeducational tools that are tailored to adolescents.</td>
<td><strong>Staff Considerations:</strong></td>
</tr>
<tr>
<td><strong>Time:</strong> Approximately one minute.</td>
<td><strong>Time:</strong> Approximately one minute.</td>
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<table>
<thead>
<tr>
<th>Brief Intervention</th>
<th>Once or Twice Use (Low Risk of Substance Use Disorder)</th>
<th>Monthly Use (Moderate Risk of Substance Use Disorder)</th>
<th>Weekly Use (High Risk of Substance Use Disorder)</th>
</tr>
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<tr>
<td><strong>1. Provide cessation advice.</strong></td>
<td>Recommend that no use is best for health and give accurate information on the harms of substance use. Tailor your responses based on what you know about the patient, their health and life goals.</td>
<td><strong>Sample Scripting:</strong></td>
<td><strong>Sample Scripting:</strong></td>
</tr>
<tr>
<td>o “I would like to talk about your responses to the screener to find out more about your experiences with alcohol or other drugs. Would that be okay?”</td>
<td>o “As your health provider I recommend not using alcohol or drugs.” o “Did you know use of (x) can impact your (grades, sports, diabetes, asthma, depression, etc.)?”</td>
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<tr>
<td><strong>Staff Considerations:</strong></td>
<td>- PCPs should ideally perform this task due to level of influence and follow the same process as providing health advice for other disease states. - Behavioral health providers and nursing staff can reiterate the health advice if in contact with the patient.</td>
<td><strong>Time:</strong></td>
<td><strong>Time:</strong> Approximately two minutes.</td>
</tr>
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<td><strong>Time:</strong></td>
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### CLINICAL GUIDANCE FOR DELIVERING BRIEF INTERVENTION

| Brief Intervention | KEY TIPS FOR BI
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<tr>
<td></td>
<td>- Asking permission helps level the playing field and step away from authoritative dynamic.</td>
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<td></td>
<td>- Highlight confidentiality.</td>
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<td></td>
<td>- Goal setting is most effective when it is patient driven rather than top down.</td>
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<tr>
<td></td>
<td>- Emphasize the value of gathering accurate information and thank the patient for providing it.</td>
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#### Sample Scripting:

**1. Provide cessation advice.**

**2. Reduce use and reduce risky behaviors.**

Explore the ways substance use is impacting the patient's life; the perceived benefits versus downsides. Ask how the patient might go about making a change.

**Sample Scripting:**

- "What do you like about using(x)?"
- "Are there things that you don't like?"
- "Have you gotten in trouble at school or work?"
- "Have you ever quit or cut back?"
- "Do you think it would be difficult to quit?"
- "What would be the first step to quitting?"
- "Based on what I've heard, (X) helps you with (y), but at the same time, x causes tension with your parents/is bad for health/can interfere with brain development/can interfere with sports performance."
- "I would recommend that you don't use at all. Is that something you have ever thought about? Could you try for one month?"
- "How can I best support you?"

**Staff Considerations:**

- PCPs ideally performs this task due to level of influence and relationship with the patient.
- Behavioral health providers can perform this task if PCP is unable.
- Nursing staff can perform this task if PCP is unable.

**Time:** Approximately one minute.

### Age and Developmental Level Considerations

- **Younger adolescents:** Use more structural approaches like having parents monitor or restrict activities. The goal is to eliminate opportunities for exposure to substances.

- **Older adolescents:** As children get older, they become better at abstract thinking, can do more advance planning and can generally engage better in treatment modalities.

**Note:** If a very young adolescent is using substances, it is extremely likely that they also have trauma, family problems or other challenges and should have a thorough evaluation.

#### Staff Considerations:

- PCPs should ideally initiate the warm hand-off to build trust in the team process.
- Behavioral health providers explore patient readiness and interest in additional services.
- Care coordination staff maintain linkages with up-to-date community resources.

**Time:** Can be done within five minutes.
This chart offers strategies to address potential barriers that may arise when delivering a BI.

**TABLE 4. NAVIGATING POTENTIAL BARRIERS AND SITUATIONS OF IMPORTANT HEALTH CONSEQUENCE**

<table>
<thead>
<tr>
<th>Barriers and Challenges</th>
<th>Opportunities to Explore</th>
<th>Navigation Strategies and Dialogue</th>
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<tbody>
<tr>
<td>Importance vs. Confidence</td>
<td>Many adolescents have high confidence, but do not see the importance of behavior change.</td>
<td>Provide accurate medical information regarding the risks and harms of substance use; correct misconceptions. Reinforce autonomy and highlight that changing risky behavior is a choice.</td>
</tr>
<tr>
<td>Lack of Time</td>
<td>Don't allow BI to detract from the original presenting issue.</td>
<td>BI can be done very briefly and across several sessions.</td>
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| Provider Uncertainty of How to Respond  | Adolescents may need additional prompting to open up.                                     | General approaches:  
  • “I’m concerned about you.”  
  • “Thank you for being honest.”  
  • “I appreciate the accuracy of the information you provide because it helps me provide better care.”  
  Guidance/prompts for how to connect to presenting issues/personal experiences:  
  • “What would make this important to you?”  
  • “When would you see this as a problem?” |
| “Yeah, but...”                           | Opportunity to discuss both sides of the issue.                                            | Look for opportunities to agree on common ground. Provide additional health information, if appropriate. Emphasize the adolescent's autonomy in decision-making. |
| Co-occurring Conditions                  | Potentially necessitates breaking confidentiality.                                         | Remain straightforward and clear to maintain trust, but do what is necessary for the patient's treatment. |
| Polysubstance Use                        | Safety and other health risks and concurrent vs. simultaneous use.                       | Collaboratively determine with the adolescent where to begin. Focus on values to incentivize positive behavior change. *(See section on Polysubstance Use.)* |
| Treatment Refusal                       | Focus on problems that are bothersome to the patient. For example, discuss treatment entry as the best way to facilitate improving symptoms of depression. | Overarching goal is to empower individual to change and may be a process that occurs over time.  
  • Refusal is not the end of the process.  
  • Determine where the patient is willing to do more.  
  • Ask the patient to self-monitor and return for follow-up to discuss. If substance use/symptoms of depression/stress, etc. continue, re-consider treatment entry. |
| Suicidality                              | Assess for active vs. passive.                                                            | For passive suicidality, ensure an appropriate safety plan. Include patients in the conversation (break confidentiality if necessary). Refer active suicidality for urgent mental health services. |
| Follow-Up/Next Steps                     | It can be difficult to re-engage adolescents, capitalize on full range of follow-up options. | Define what follow-up is and what it looks like. Options could be a phone conversation, email or text, not just coming into the office. |
ADDITIONAL BI AND FOLLOW-UP RESOURCES & TOOLS

- *Readiness Ruler*. Center for Evidence-Based Practices at Case Western Reserve University.
WHEN IS REFERRAL TO SPECIALTY SUBSTANCE USE TREATMENT INDICATED?

Referral to treatment is appropriate when a patient’s screening result(s) suggest the likelihood of a moderate-to-severe substance use disorder. Severity should be determined by the patient’s score on a validated, evidence-based screening tool (e.g., S2BI results indicate weekly or more use of any substance).

Specialty treatment (especially to low-barrier treatment such as meeting with an integrated behavioral health counselor) may be appropriate when the patient's results indicate mild-to-moderate substance use disorder (e.g., S2BI results indicate monthly use of one or more substances). Treatment initiation is often less likely under these circumstances due to a lower perceived need for treatment, competing family priorities or stigma associated with treatment. However, if patients continue to screen at mild-to-moderate disorder over three-to-four subsequent clinic visits and office-based BI is not effective, focus should shift to referral and treatment initiation, as previously described.

Consider specialty treatment especially if:
- Young (age 14 or younger)
- Co-occurring mental health disorder
- Co-occurring behavioral health disorder (ADHD)
- Co-occurring medical disorder

### TABLE 5. S2BI SCREENING RESULT

<table>
<thead>
<tr>
<th>Determining When a Referral is Indicated</th>
<th>BI Focus</th>
<th>Referral Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Use (Prevention Opportunity)</td>
<td>Provide anticipatory guidance.</td>
<td>No</td>
</tr>
<tr>
<td>Once or Twice (Low Risk of Substance Use Disorder)</td>
<td>Provide cessation advice.</td>
<td>No</td>
</tr>
<tr>
<td>Monthly Use (Moderate Risk of Substance Use Disorder)</td>
<td>Reduce use and reduce risky behaviors.</td>
<td>Use clinical judgment.</td>
</tr>
<tr>
<td>Weekly Use (High Risk of Substance Use Disorder)</td>
<td>Facilitate linkage to behavioral health/treatment.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

ASSESSMENT

Considerations for the referral will involve individual needs and circumstances, and systemic capacity, such as:

- Age and development levels: Adolescents should be referred to developmentally appropriate programs.
- Co-occurring mental health and/or medical conditions.
- Patient and family motivation, willingness and ability to engage in treatment.
- The presence of high-risk behavior.
Primary care providers have a responsibility to manage adolescent substance use just as they would address other health concerns. Ongoing management is accomplished through shared decision-making, documenting referral plans (and contingency plans if the patient refuses the referral), getting creative about what community services they can connect to and following up to ensure care needs are being met.

LESSONS FROM THE PILOT

A learning collaborative site reported good engagement in referral services despite lack of warm hand-offs because case managers paired treatment appointments with other needs such as food services, medical appointments, insurance enrollment, etc.

CLINICAL SKILLS FOR INITIATING REFERRAL

Approaches to referral should be patient- and/or family-centered, non-confrontational and non-judgmental. Once you have determined who should make referrals and designed a workflow, train staff on how to have these conversations with patients and parents.

Recommend. Make a recommendation and explain the justification.

Discuss. Talk about types of treatment with the patient (and parent, if appropriate) and what level of intensity best addresses the patient’s needs.

Identify. Ensure your patient links to the next level of care. Conduct a warm hand-off with a contact/provider. If available, utilize a resource specialist who can help identify an appropriate program and navigate the steps necessary for enrollment.

Engage. Engage a care coordinator (whether full-time or incorporated into an existing role). Care coordinators can help reinforce the necessity for a referral, assist with navigation to the referral and follow-up with engagement to help sustain treatment. Care coordinators enhance health outcomes and their role cannot be understated.

ONGOING SUBSTANCE USE SERVICES IN PRIMARY CARE

In cases where a specialty treatment referral is not warranted, the patient does not follow-through on the recommended treatment or when a patient has a severe substance use disorder or co-occurring mental health disorder and requires additional services, there are several effective strategies for managing substance use in primary care. In fact, substance use disorders are common conditions appropriate for long-term primary care (Watkins et al., 2003).

WHY MANAGEMENT MATTERS

- Specialty substance use treatment may not be available.
- Many patients do not accept referrals because they do not believe they need it (Cohen et. al., 2007; Glass et al., 2015).
- Even if a patient accepts a referral, they may not attend treatment or treatment may be short-term, creating a need for chronic management in primary care.
WORKFLOW AND FORMALIZING REFERRAL ARRANGEMENTS

REFERRAL TYPES

Pediatricians, behavioral health clinicians, nurses or other clinicians can make treatment referrals; clinics should assess who may be the most appropriate personnel. Ideally, pediatricians should initiate the warm hand-off to build trust in the team process. Behavioral health providers are great options for exploring patient readiness and interest in additional services, while care coordinators create links to community resources.

Successful referrals typically require more than a BI and are ideally done after meeting with the patient and family to discuss treatment options, explore knowledge or lack of knowledge and willingness or resistance to treatment.

WHERE?

INTERNAL

Although some regulations may apply regardless of the setting (e.g., 42CFR), internal referrals can be quite successful — such as one from a pediatric primary care provider to an embedded behavioral health provider within the same clinic. Internal referrals enable patients to remain in a familiar, trusted, non-stigmatized setting and allow providers easier record sharing, less logistical barriers and a simpler warm hand-off.

EXTERNAL

Clinic personnel making external referrals should, at minimum, have access to information about respective treatment program service offerings, criteria for attendance (e.g., age, gender, severity, insurance) and processes for referrals and intakes. Ideally, a designated contact/intake person for treatment programs will be identified.
ONGOING SUBSTANCE USE SERVICES IN PRIMARY CARE

Specialty substance use services may be limited in the community or may not fit the needs of all patients who require additional support to reduce risk – specialty services are often driven by co-occurring mental health concerns. The following treatment approaches are examples of ways primary care can take ownership of ongoing care and serve as a central point for coordinating both internal and external community services.

**Ongoing brief intervention services** should be provided to adolescents who do not meet the criteria for severe substance use disorder and can be provided during subsequent primary care visits. Early intervention often consists of educational or BI services that aim to help the adolescent recognize the negative consequences of substance use and understand and address the adolescent’s problems that are likely related to their substance use (Winters et al., 2014).

**Individual behavioral health treatments** provided by a behavioral health clinician (e.g., cognitive behavioral therapy, motivational enhancement) that can be integrated into primary care (Watkins et al., 2003).

**Peer support groups** such as those organized by the Association of Alternative Peer Groups as part of a comprehensive service plan. Alateen is another national program that is aimed at support for teens who have a family member or friend with a substance use disorder.

**School-based health care** often offers a wide range of services for students, including those that may help support adolescents in managing substance use. Because privacy and confidentiality laws differ in schools, there are particular considerations for health care sites when sharing information. However, even if there is not a formal referral system in place, primary care may benefit from exploring relationships with schools in the community and learning what types of services they offer so that they can educate patients and parents about the types of supports available to them.
MEDICATION-ASSISTED TREATMENT/MEDICATION FOR ADDICTION TREATMENT

Medication-assisted treatment or medication for addiction treatment (MAT) is defined as the use of medication in combination with counseling and behavioral therapies to provide a whole-patient approach to substance use dependence. MAT can be used in the treatment of opioid, nicotine, and alcohol dependence (Subramaniam, G., & Levy, S., 2013). MAT is typically used in a subset of older teens.

INTENSIVE OUTPATIENT TREATMENT

During intensive outpatient treatment, adolescents typically meet with a therapist for six hours a week or less for a period dependent on progress and the treatment plan. This level of treatment is appropriate for adolescents whose assessment indicates they would benefit from a high level of support that is beyond the scope of the primary care setting, yet does not rise to the level of residential treatment. Individual, group and family therapy are some of the options for outpatient treatment.

INTENSIVE OUTPATIENT TREATMENT AND PARTIAL HOSPITALIZATION

Adolescents in intensive outpatient treatment need a treatment program that can offer comprehensive services for up to 20 hours per week. For a period ranging from two months to one year, adolescents often attend in the evening or weekends but live at home. Partial hospitalization is for adolescents who have a more severe substance use disorder, but their living environment does not negatively impact their treatment. These programs are often four to six hours a day for five days a week.

RESIDENTIAL/INPATIENT TREATMENT

This high level of care is for adolescents who have not only a severe substance use disorder but also have co-occurring mental health or medical conditions (such as depression) or a family dynamic that would interfere with treatment and the ability to get and stay in recovery. Residential/inpatient treatment includes programs that provide treatment services in a residential setting and lasts from one month to one year.

MEDICALLY MANAGED INTENSIVE INPATIENT TREATMENT

This is the highest level of treatment and is most appropriate for adolescents whose substance use, biomedical and emotional problems are so severe they require 24-hour primary medical care. The length of care is dependent on the adolescent’s needs and program.
CONFIDENTIALITY AND PARENTAL INVOLVEMENT

Protecting an appropriate level of confidentiality for adolescents' health care information is an essential determinant of whether this population will access care, answer questions honestly, and develop and maintain a therapeutic alliance with their doctor. Fear that clinicians will reveal private information can cause concern and lead adolescents to answer screening questions inaccurately. It is essential that providers understand confidentiality laws and how to navigate discussions with patients and parents so that they are able to screen and intervene as needed. Although privacy and minor consent laws vary by state, providers will need to make a clinical judgment as to whether the circumstances for referral warrant parental involvement. In most states, confidentiality cannot be breached unless clinical judgment suggests the patient or another individual is in imminent danger because of risky behavior.

For more information on confidentiality laws, see Improving Adolescent Health: Facilitating Change for Excellence in SBIRT.

“All of the major medical organizations and numerous current laws support the ability of clinicians to provide confidential health care, within established guidelines, for adolescents who use alcohol” (NIAAA, 2011).
DISCUSSING CONFIDENTIALITY WITH PATIENTS AND PARENTS

Introduce confidentiality practices.
Confidentiality provisions should be introduced and defined during the initial visit for adolescents new to a practice and prior to the first time the adolescent is interviewed without a parent present. Explain the confidentiality policy — including the limits of confidentiality — to the patient and parent(s) simultaneously. By doing so, the clinician can reassure parents that they will receive any information involving the immediate safety of their child, while also reassuring the adolescent that details discussed will remain confidential. The American Academy of Pediatrics’ (AAP) Information for Teens: What You Need to Know About Privacy (American Academy of Pediatrics, 2010) can help adolescents understand their privacy rights, what to expect from interactions with their provider around drugs and alcohol and additional information regarding parental involvement.

Example messaging to introduce parents to confidential information gathering:

- Starting at age (x) all patients are seen for at least a portion of their visit without parents so they can start having opportunities to take ownership of their health.
- Our goal is to have a trusted relationship with you and your child where accurate information is shared so we can provide the best care possible. When confidentiality is not upheld, young people are less likely to talk about potentially sensitive and important information, which means they are less likely to get the care they need.
- As your teen’s health care provider, it's important that I build a relationship of trust with him/her. While sometimes teens tell their doctor things that they won't tell their parents, I want you to trust that I will bring you in on any serious health problems or issues of personal safety.

Maintain confidentiality unless there is imminent risk.
We recommend maintaining an adolescent's confidentiality unless their health or safety, or the health or safety of another individual, is acutely in danger. Older adolescents generally may be afforded more confidentiality than younger teens, who are at higher risk for both the acute and chronic consequences of substance use. Decisions about breaching confidentiality should be discussed with supervisors when a provider is unsure of whether to disclose information. In cases that warrant parental involvement, the clinician should focus discussions with the patient on allowing the parent to be included in their substance use and treatment discussions.

Examples of instances when confidentiality may need to be broken include, but are not limited to:

- The patient discloses thoughts and/or attempts of suicide — “I've been thinking a lot about death and I wish I were dead.”
- The patient discusses thoughts or desires to harm another person — “I was so angry that he was making fun of me that I wanted to kill him.”
- The patient is at high risk for an overdose based on the severity of reported use.

Encourage parental involvement whenever possible. Even in situations where there is not an acute safety risk, adolescents may benefit from parental support in accessing recommended services. As many clinicians who provide care for adolescents can attest, teens are unlikely to follow through with referrals without the support of an adult—even more so if they are being referred for treatment of a diagnosis that they may not agree with, such as a substance use disorder. Parental participation in the health care of their adolescents should usually be encouraged but should not be mandated (Schizer et al., 2015).

In many cases, by the time an adolescent has developed a substance use disorder, parents are already aware of their use, though they may underestimate the seriousness of the problem. We recommend that clinicians ask adolescents whether their parents are aware of their substance use and encourage them to invite their parents into the conversation. This can be a rewarding experience for the adolescent if the clinician focuses on points of mutual agreement.
SPECIAL CONSIDERATIONS

CO-OCCURRING CONDITIONS
SUBSTANCE USE IMPACT ON COMMON HEALTH CONDITIONS

Alcohol or other drug use can lead to disease exacerbation and serious complications among adolescents with a chronic illness and may expose them to other risks that generally worsen health such as inadequate sleep, skipped meals, exposure to smoke and unprotected sex (a particular hazard for youth taking teratogenic or immune suppressing medicines) (Levy, Dedeoglu, Gaffin, 2016; Wisk & Weitzman, 2016; Weitzman, Magane, Wisk, Allario, Harstad, & Levy, 2018).

For example, for patients who are diabetic, it is important to know that alcohol use results in unpredictable blood sugar levels. Know the co-occurring health condition histories of your patients and consider how substance use may uniquely impact them.
POLYSUBSTANCE USE

The term polysubstance use broadly describes the consumption of more than one drug over a defined period, simultaneously or at different times for either therapeutic or recreational purposes. In substance use prevention and treatment, it usually refers to multiple illicit drug use, but it can also include illicit and prescription medication used for nonmedical purposes. In most settings, polysubstance use will most often present as a positive screening result for alcohol and/or marijuana and/or tobacco use, also known as the “Big 3.” Polysubstance use has a number of risks:

- Co-occurring use compounds learning and memory problems and impacts coordination. Health care professionals have a duty to identify very high-risk substance use and intervene.
- Initiation of polysubstance use, even on a limited basis during adolescence, confers an increased risk of expanded polysubstance use in early adulthood.
- Health professionals need guidance on how to address polysubstance use during the BI and when making a referral to treatment (if indicated).
- Using multiple psychoactive substances that have a potential for addiction could accelerate the trajectory to developing a severe substance use disorder.
Many adolescents with substance use disorders have a history of physical, emotional and/or sexual abuse or other trauma. Post-traumatic stress disorder (PTSD) is common among people with substance use disorders, and patients suffering from both these conditions have a more difficult time meeting their treatment goals.

Considering the connection between trauma and addiction, it is critical that service providers infuse trauma-informed practices into their SBIRT process. It is important to understand the following, especially when dealing with youth:

- Trauma often refers to recurrent trauma rather than a single big event.
- Trauma can present in many different ways and can mimic many different disorders.
- Substance use is common and may be instrumental (e.g., use of marijuana to dissociate and manage difficult feelings).
- Trauma work is CRITICAL in these cases and should co-occur with substance use disorder work.

(See Conversation Guide for Delivering a Trauma-informed Brief Intervention.)
REFERENCES


REFERENCES


