IMPROVING ADOLESCENT HEALTH:
FACILITATING CHANGE
FOR EXCELLENCE IN SBIRT
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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% 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 addiction.
- Teens who use marijuana at or before the age of 14 are six times more likely to develop illicit drug dependence or abuse later in life than those who first try marijuana at age 18 or later (Meier et al., 2012; CDC, 2012; HHS, 2016).
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This document represents a change package. A change package is a practical toolkit that is specific enough for clinicians and practices to implement, test, and measure progress on an evidence-based set of changes while being generalizable enough to be scaled in multiple settings. Change packages are proven effectual tools to actuate practice transformation in primary care.

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).

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** 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.

*(See Appendix A for more information on adolescent risk and preventative factors.)*

**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 for uptake and implementation. These include:

- Substance use's 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.

WHAT IS A CHANGE PACKAGE?

This document represents a change package. A change package is a practical toolkit that is specific enough for clinicians and practices to implement, test, and measure progress on an evidence-based set of changes while being generalizable enough to be scaled in multiple settings. Change packages are proven effectual tools to actuate practice transformation in primary care.

The National Institute of Alcoholism and Alcohol Abuse (NIAAA) recommends that screening for alcohol use begin as early as age 9, or as soon as children are interviewed alone, without a parent present.
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Use the Screening to Brief Intervention or S2BI (self-administered version) to screen for substance use risk in adolescents

Ensure capacity for evidence-based response based on screen results

Objective: Universal screening with every health maintenance visit (and potentially other visits)

Documentation: Screening Results documented in chart

Measure: Proportion of charts with screening documented

Benchmark: 90% of adolescent presenting for well care screened with s2bi within a year (still strongly recommended opportunistic screening using clinical discretion)

EHR Fields: Field for well visit, and other visits

End Goal: All adolescents receive screening via the S2BI at least once a year, and are appropriately categorized for intervention
Universal screening for alcohol and substance use should be performed with all adolescents aged 12 and older. In fact, The National Institute of Alcoholism and Alcohol Abuse (NIAAA) recommends that screening for alcohol use begin as early as age 9, or as soon as children are interviewed alone, without a parent present (NIAAA, 2015). The goals of screening younger children are twofold: 1) present a prevention message to younger children prior to their first opportunity to try substances, and 2) identify very high-risk group of children that initiate substance use early. Early substance use initiation is associated with particularly poor short and long-term outcomes (Zeigler et al., 2005).

Screening in the pre-teen years is also important since relying on provider impressions is unreliable and may underestimate prevalence and associated problems (Wilson et al., 2004). Substance use screening that is performed while checking for vital signs and other preventive and lifestyle screenings helps normalize conversations about substance use and diminish patients feeling “singled out.” This can also identify other health concerns, such as depression and anxiety, as well as broadly inform clinical care, in the event alcohol and drug use are the source of presenting symptoms or may interfere with prescribed medications and test results.

Given that approximately 25% of youth in the U.S. are growing up with a chronic health condition, providers should be sure to screen this population as their risk is often underestimated and yet substance use has important and often critical implications on their medication regimens, clinical protocols, and self-management plans. (See also “Co-Occurring Medical and Mental Conditions.”)

Conducting SBIRT for college students ages 17-24 is also vital as this marks a period of independence, peer pressure, availability of substances, and increased risk taking and represents a life stage at which individuals are at highest risk for alcohol and substance abuse, as well as comorbid psychiatric conditions, such as depression and anxiety (National Survey on Drug Use and Health, 2015). For the college-aged adolescent, the presence of substance use disorders and associated psychiatric conditions may first come to light within a primary care setting in terms of presenting sleep problems, academic or relationship difficulties, injuries sustained while consuming alcohol or other substances, and the presence of STIs, as well as recurring presenting concerns, such as chronic respiratory infections or other conditions that compromise the immune system.

KEY TIP

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

Providers should also be aware that parental/guardian attitudes toward substance use, and the presence of substance abuse or addiction in the adolescent’s home environment, are important clinical considerations in the identification and treatment of substance misuse.
The New Vital Signs:
Necessary Information for Total Picture of Basic Adolescent Health

- Sexual Activity/
  Sexually Transmitted
  Infections (STIs)
- Substance Use
- Allergies
- Weight/Weight A1c
- Mood
- Sleep
THE SCREENING PROCESS
SETTING THE STAGE FOR AN HONEST CONVERSATION

It is important that all members of the clinic team—from those delivering the screening instruments to providers who will be implementing the intervention—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.

Provider Tips

Build rapport, find common ground, and secure patient buy-in

Make your pitch and reinforce confidentiality

THE SCREENING TOOL: SCREENING TO BRIEF INTERVENTION (S2BI)

The Screening to Brief Intervention (S2BI) was introduced in 2014 as a no-cost, validated instrument endorsed by both the American Academy of Pediatrics and the Addiction Medicine Foundation. There are a number of advantages to S2BI.

Advantages to S2BI

- Quick and practical for short visits
- Effectively screens for The Big Three: alcohol, tobacco, and marijuana
- Correlates with Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) diagnoses
- Although non-diagnostic, S2BI is an accurate way to identify those who may have severe substance use disorders
- Results can guide provider responses
- S2BI is compatible with electronic health records (EHRs)

Administering the S2BI

Screening is best done as self-administered—either online before arrival to the clinic, upon arrival in either pen and paper or electronic tablet formats, or while patients are having their vital signs checked. Combining the screen with other screening protocols helps make it seem like essential data and a normalized process. (See also “Who Should be Screened” and “Co-Occurring Medical and Mental Health Conditions” for special screening considerations for adolescents with chronic health conditions.)

Evidence suggests that teens are more likely to be candid when answering self-administered questions rather than in person. Regardless of administration format, affording the adolescent as much privacy as possible is critical. It is important that staff review responses and record any staff time and interactions that do occur. (See also, “Screening Results Inform BI,” “Assessments,” and Appendix G on Confidentiality.)
BRIEF INTERVENTION

Brief intervention (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 American Academy of Pediatrics has also explored the evidence for BI and effectiveness of BI with adolescents.

CHANGE CONCEPTS:

- Clearly communicate age-appropriate risks of alcohol, tobacco, and substance use to health and well-being, with patients reporting any past year use (*linked to screening response)
- Leverage primary care team-patient relationship to discuss behavior change, negotiating, and documenting a reasonable change plan
- To ensure BI is responsive to screening results the ensure entire primary care team should receive training that includes age appropriate assessment of risks

OUTCOME MEASURES

Objective: Assess severity and determinants of SU and negotiate behavior change plan

Documentation:

- Document change plan in medical record
- Document plan for follow-up in record
- Document contingency plan

Example: "Patient is not interested in changing alcohol or marijuana use at this time, and is also not interested in a referral to treatment. I have asked patient to consider signs or problems that indicate change is necessary and return in 3 months to review/discuss"

Measure:

- Proportion of patients who were eligible for BI for whom change plan is documented in chart
- Proportion of patients who return for a follow up visit within 3 months

Benchmark: 80% documentation of change plan and follow up plan, or contingency plan

EHR Fields: Narrative field to document plan (change/follow-up/contingency)

End Goal: Patients are receiving the appropriate level of BI based on screening result
BI is short in duration but not short on impact.

**ART OF BI**

**FRAMING THE BRIEF INTERVENTION**

BI is a conversation between a health professional and adolescent to promote behavior change in order to reduce substance use. BI is a structured, goal-oriented conversation that borrows stylistic features of Motivational Interviewing (MI), including use of a non-judgmental, non-confrontational style that engages the adolescent in discussion. Components of a brief intervention include eliciting drivers of substance use and reasons for abstaining, providing accurate and personalized medical information, and negotiating realistic and specific harm reduction or abstinence goals that meet the adolescent at his/her level of readiness to change.

BI is short in duration but not short on impact. The BI is most commonly around 10-15 minutes in length. Some funding sources will reimburse at a 15 or 30-minute interval. *(See Section on Financing.)*
### BACKGROUND OF BI

#### TABLE 1. PATH OF SCREENING TO BRIEF INTERVENTION

<table>
<thead>
<tr>
<th>CORE ELEMENTS</th>
<th>CLINICAL ACTIVITIES</th>
<th>DIALOGUE/PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raise the Subject and Engage</td>
<td>▪ Ask permission to level the playing field and step away from parental dynamic</td>
<td>▪ Before downloading a lot of information, asking permission is fundamental to inviting your patient into a different dynamic and giving them some control of the conversation.</td>
</tr>
<tr>
<td></td>
<td>▪ Build or engage rapport through patient-centered conversation</td>
<td>▪ Affirm autonomy: “What you decide to do is up to you.”</td>
</tr>
<tr>
<td></td>
<td>▪ Highlight confidentiality</td>
<td>▪ Summarize pros and cons and fill in information</td>
</tr>
<tr>
<td></td>
<td>▪ Thank for honesty</td>
<td>▪ Recommend that no use is best for health, then ask if willing to take an abstinence challenge.</td>
</tr>
<tr>
<td>Confirm Screening Results and</td>
<td>▪ Listen for ambivalence and explore connections with determinants and effects of</td>
<td>Use open-ended questions to uncover details and drivers of use and reasons to abstain</td>
</tr>
<tr>
<td>Explore/Ask for More Details</td>
<td>substance use</td>
<td>Sample Questions:</td>
</tr>
<tr>
<td>about Use</td>
<td></td>
<td>▪ What do you like about it?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ What don’t you like about it?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Have you had any problems?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Do you have any regrets?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Have you ever tried to quit?</td>
</tr>
<tr>
<td>Personalize Additional</td>
<td>▪ Ask permission again (MI principle)</td>
<td>▪ Give accurate information on the harms of substance use. PERSONALIZE – based on what you know about the patient. Include information on medical risks for kids with medical problems, mental health risks for kids with mental health problems, or for those using to deal with anxiety or depression, etc.</td>
</tr>
<tr>
<td>Information/Correct Misinformation</td>
<td></td>
<td>▪ Express concern beyond curiosity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Get patient’s reaction –What do you think about this? (Open-ended question)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Final step for Low Risk users]</td>
</tr>
<tr>
<td><strong>Assess Readiness and Negotiate Change</strong></td>
<td><strong>Sample Questions:</strong></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------</td>
<td></td>
</tr>
</tbody>
</table>
| ▪ Assess readiness for change—Explore motivation for change/self-efficacy  
  ▪ Ask to make a change (e.g., “Would you be willing to quit for 3 months to see how it goes?”)  
  ▪ Goal setting—has to be patient driven (see Appendix B for an example template) | ▪ Ambivalence is not always obvious and may require providers deconstruct teen’s messaging to understand their attitudes and beliefs  
  ▪ “On a scale from 0-10, where 0 is not at all ready and 10 is very ready, how ready are you to stop drinking alcohol/using marijuana?” If exploring harm reduction, ask “How ready are you to cut back or take steps to stay safer…”  
  ▪ Allow the adolescent to choose a number. Then ask, “What made you choose X instead of a lower number?”  
  ▪ Follow similar questioning. “How confident are you that you could stop or cut back drinking alcohol/using marijuana?” Allow the adolescent to choose a number. “What made you choose X?” “What would a shift in use look like for you?”  
  ▪ “What would be a first step for you?”  
  ▪ “What do you intend to do?”  
  ▪ “What are some of the best reasons you can think of to stop drinking or using marijuana/cut back on drinking or using marijuana?” Allow the adolescent to list as many reasons as they can.  
  ▪ “How might your life be better if you stopped drinking/using marijuana?” Offer prompts if they cannot think of examples. “For example, for some people alcohol or marijuana gets in the way of shorter term and longer term goals such as…”  
  ▪ “How would you know if drinking/using marijuana was becoming a problem for you (or for someone you care about such as a friend or sibling)?” Offer examples if they adolescent cannot think of any indicators of a worsening problem. |

<table>
<thead>
<tr>
<th><strong>Follow-Up</strong></th>
<th><strong>Provider Questions to Consider:</strong></th>
</tr>
</thead>
</table>
| ▪ Engage patient in process  
  ▪ Establish that you will be talking about this again (make follow-up appt. if possible; if patient is unwilling to return, document so that follow-up can be triggered at next intercurrent appointment  
  ▪ Document results and plan appropriately (See also Appendix D.) | ▪ How will we follow up with patients receiving SBIRT services? (Examples: In-person, phone, web)  
  ▪ At what interval will we do systematic follow-up? (Examples: 1 month, 3 months, 6 months)  
  ▪ Who will conduct the follow-up?  
  ▪ What elements will be included in a follow-up? |
SCREENING RESULTS INFORM BI

Screening results guide the intensity of BI delivery. This risk stratification chart illustrates how to respond to different levels of use, with the spectrum of Anticipatory Guidance to Brief Intervention.

FIGURE 2. S2BI ALGORITHM

S2BI Algorithm

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

<table>
<thead>
<tr>
<th>No Use</th>
<th>Once or Twice</th>
<th>Monthly Use</th>
<th>Weekly Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipatory Guidance</td>
<td>Ask Follow up S2BI Questions: prescription drugs, Illegal drugs, inhalants, herbs?</td>
<td>Abbreviated BI (Steps 1-3)</td>
<td>Full Brief Intervention: Assess Fruther(CRAFFT), advise to quit, negotiate a change plan</td>
</tr>
<tr>
<td>Reduce Use &amp; Risky Behavior</td>
<td>Facilitating linkage to treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 2. 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>
</tr>
</thead>
<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>
</tr>
<tr>
<td>Provider Uncertainty of How to Respond</td>
<td>Adolescents may need additional prompting to open up.</td>
<td>General approaches</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &quot;I’m concerned about you&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “Thank you for being honest”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &quot;I appreciate the accuracy of the information you provide because it helps me provide better care”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guidance/prompts for how to connect to presenting issues/personal experiences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &quot;What would make this important to you?’”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &quot;When would you see this as a problem?’”</td>
</tr>
<tr>
<td>&quot;Yeah, but”</td>
<td>Opportunity to discuss both sides of the issue</td>
<td>Look for opportunities to agree on common ground.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide additional health information, if appropriate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emphasize the adolescent's autonomy in decision-making.</td>
</tr>
<tr>
<td>Co-Occurring Conditions</td>
<td>Potentially necessitates breaking confidentiality</td>
<td>Remain straight forward and clear to maintain trust, but do what is necessary for the patient’s treatment</td>
</tr>
<tr>
<td>Polysubstance Use</td>
<td>Safety and other health risks and concurrent vs. simultaneous use</td>
<td>Collaboratively determine with the adolescent where to begin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focus on values to incentivize positive behavior change.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(See also Section on Polysubstance Use.)</td>
</tr>
<tr>
<td>Treatment Refusal</td>
<td>Focus on problems that are bothersome to the patient.</td>
<td>Overarching goal is to empower individual to change and may be a process that occurs over time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Refusal is not the end of the process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Determine where the patient is willing do more?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Ask the patient to self-monitor and return for follow-up to discuss.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If substance use/symptoms of depression/stress, etc. continue, re-consider treatment entry.</td>
</tr>
<tr>
<td>*Suicidality</td>
<td>Assess for active vs. passive</td>
<td>For passive suicidality, insure an appropriate safety plan. Include patients in the conversation (break confidentiality if necessary). Refer for urgent mental health services.</td>
</tr>
<tr>
<td>Follow-Up/Next Steps</td>
<td>It can be difficult to re-engage adolescents, capitalize on full range of follow-up options.</td>
<td>Define what follow-up is and what it looks like. Could be a phone conversation, email, or texts not necessarily just coming into the office</td>
</tr>
</tbody>
</table>

(See also Appendix D. for additional tools, including materials for differing levels of patient risk.)
Specially substance use treatment for adolescents can be very effective, but less than 10% of youth in need of treatment ever receive it. Part of the reason is that few adolescents are referred to treatment by their health care providers (SAMHSA NSDUH 2015; SAMHSA MH Estimates 2014). As such, it’s important to know when to refer to treatment and what type of treatment may be best.

**CHANGE CONCEPTS:**

- Establish criteria for referral to treatment linked to patient substance use, and physical and mental health
- Develop protocol and procedures to link patients to internal and/or external care, leveraging provider/organizational partnerships
- Ensure capacity, protocols, and documentation standards for ongoing care management (including interim management, supporting client readiness, facilitating treatment entry and follow-up)

**OUTCOME MEASURES**

**Objective:** Agree with patient on need for and acceptable level of service. Ask patient for permission to include parents or caregivers

**Documentation:**

- Patient agreement
- Example: “Patient has agreed to outpatient counseling at (RESOURCE; Patient HAS or HAS NOT agreed to share information with parents; Patient HAS or HAS NOT agreed to 3 month follow up; OR "I have recommended IOP, patient is not interested in any further services at this time; ... Parents..., ...follow up ....)

**Measure:**

- Proportion of charts eligible for referral for whom referral plan is documented in medical record
- Proportion of referred patients who attend initial referral visit within 60 days
- Proportion of patients for whom a follow up and contingency plan is

**Benchmark:**

- Proportion of charts eligible for referral for whom referral plan is documented in medical record
- Proportion of referred patients who attend initial referral visit within 60 days – 50%
- Proportion of patients for whom a follow up and contingency plan is documented – 100%

**EHR Fields:**

- Checkbox to denote if eligible for referral
- Narrative field to designate referral plan/follow up/contingency plans
- Date field to document scheduled referral visit

**End Goal:**

- Based on established criteria pts receive the necessary level of care management to link to and monitor care
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 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 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 several subsequent clinic visits (e.g., 3-4 visits) and office-based BI is ineffectual then focus should shift to referral and treatment initiation, as described above.

**TABLE 3.**

<table>
<thead>
<tr>
<th>S2BI Screening Result</th>
<th>BI Focus</th>
<th>Referral Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Use (Potential Risk)</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Once or Twice (Low Risk)</td>
<td>Abbreviated BI (Steps 1-3)</td>
<td>No</td>
</tr>
<tr>
<td>Monthly Use (Moderate Risk)</td>
<td>Negotiations to reduce and/or abstain use and risky behavior</td>
<td>Use clinical judgment</td>
</tr>
<tr>
<td>Weekly Use (Severe Risk)</td>
<td>Reduction of use and/or abstinence and reduction of risky behaviors, with a primary focus on facilitating referral to treatment.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**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

**Abbreviations:**
- S2BI: Screening Tool for Brief Interventions
- BI: Brief Intervention

**Notes:**
- Young (age 14 or younger)
- Co-occurring mental health disorder
- Co-occurring behavioral health disorder (ADHD)
- Co-occurring medical disorder
TREATMENT
HOW TO OPERATIONALIZE REFERRAL TO TREATMENT AND FOLLOW-UP

Referrals from primary care to behavioral health can be challenging. Barriers can arise even when patients agree to engage in more intense levels of care (e.g., insurance coverage, admission procedures). It is particularly difficult for adolescent referrals as there are multiple and complex considerations, including but not limited to 1) adolescent ambivalence, concerns about missed school, and refusal to follow through; 2) weighing parental involvement and consent; and 3) confidentiality provisions specific to substance abuse treatment (e.g., 42 Code of Federal Regulations (CFR) and state regulations).
ASSESSMENT
Considerations for the referral will involve individual needs and circumstances, and systemic capacity, such as:

- Age and developmental level: 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.

Approaches should be patient- (and/or family) centered, non-confrontational and non-judgmental. (See also Appendix E. Types of Treatment Options and Appendix F. Referral to Treatment Sample Script.)

WHO SHOULD MAKE THE REFERRAL?
Pediatricians, behavioral health clinicians, nurses, or other clinicians can make treatment referrals; clinics should assess who may be the most appropriate personnel. Successful referrals typically require more than a brief intervention and are ideally done after meeting with the patient and family to discuss treatment options, explore knowledge or lack thereof, and willingness or resistance to treatment. Referrals include the following four steps:

1. **Recommend.** Make a recommendation and explain the justification.

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

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

4. **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.
Once you've determined who should make referrals, ensure there are written, consistent, and standardized workflows with accountability (whether scheduling and referrals are taking place via warm handoff, phone call, scheduler, secure fax, email, EHR, communication, etc.). Consider the following:

1. The expected **timeliness** of appointments (i.e., emergency, urgent, routine).
2. Expected **engagement** responsibilities and accountability. (If a patient is a no-show, who conducts follow up? If patient shows once but does not return, who is notified?)
3. How **information** is shared (e.g., written 42CFR part 2-compliant consent forms; minimum treatment information to be shared by all parties; frequency of routine communication) (NORC, 2016).
4. Expected **frequency** of workflow/policies and procedures review. (Quarterly with new workflows; annually or biannually with established workflows).
5. If referral is to adolescent acute residential treatment or residential level of care, issues to consider include:
   - How are referrals accepted? (In many cases, patients have to call for a bed.)
   - Is paperwork from clinician making the referral helpful/required?
   - What is required for admission? In some states patients need level of care “insurance clearance” within 24 hours of admission, so patients have to go to emergency department on the day a bed becomes available, and lots can go wrong at this step.
   - Also good to know how long the typical admission is and how discharge planning is done.

---

**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 organization. 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 handoff.”

**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 have been identified.
SPECIAL CONFIDENTIALITY PROTECTIONS

It is important to understand both state laws and specific federal confidentiality rules that govern facilities deemed to be federal alcohol and drug abuse treatment programs. (See Appendix G. Confidentiality and Parental Involvement for more information.)

QUALITY IMPROVEMENT FOR REFERRAL TO TREATMENT

Engagement rates for behavioral health referrals are estimated at less than 20%.

It is strongly advised that a QI process be incorporated for RT. Please refer to the RT outcomes measures for a minimum acceptable indicator. This indicator may be used for both internal and external referrals.
IMPLEMENTATION CONSIDERATIONS
ORGANIZATIONAL CHANGE SUSTAINABILITY

CHANGE CONCEPTS:

- Conduct an organizational self-assessment (needs assessment) to determine:
  - Gaps between current organizational practice and change package recommendations
  - Organizational change readiness
  - Strengths and barriers to implementation
- Identify and develop sustainable financing strategy to support SBIRT, including identification of relevant policy, reimbursement processes, and opportunities within existing service incentive programs
  - Cross reference developed workflows with available reimbursement options to assess funding options for all planned components
  - Highlight expected activities and determine which are billable in your state
- Maximize data collection and utilization strategy, including use of EHRs, to translate data into action and foster continuous quality improvement

OUTCOME MEASURES

Organizational Self Assessment (OSA)

**Objective:** Identify organizational capacity for SBIRT implementation

**Documentation:** OSA responses

**Measures:** OSA Score

**Object Form/EHR Field:** N/A

**Benchmark:** Ability to fill identified gaps (May be more narrative than a score)

**Finance**

**Objective:** Develop sustainable financing strategy based on internal capacity and relevant reimbursement processes

**Documentation:**

- develop policy/protocol for billing codes to be used for SBIRT services
- Potential Billing Codes:
  - Codes that allow you to add on to primary care visit (BI)
  - Codes that allow you to bring client back for F/U

**Measures:** The number of times identified codes are utilized

**Object Form/EHR Field:** N/A

**Benchmark:** 50% Increase use of billable SBIRT visits from baseline

**End Goal:** Financing strategy ensures SBIRT activities are reimbursed
**OUTCOME MEASURES Cont.**

**Data Collection**

**Objective:** Design a data collection process that fosters CQI: Selection, analysis and utilization of SBIRT data to enhance service delivery

**Documentation:** Data Collection protocol

**Measures:**

- Consistent assessment and utilization of SBIRT data in meetings to enhance service delivery
- Data consistently submitted in accordance with identified deadlines

**Benchmark:** 100% completion of OSA

**Object Form/EHR Field:** N/A

**End Goal:** Data collection protocol that informs service delivery and *supports monthly FaCES submissions

*For pilot participants only*
LEADERSHIP BUY-IN

Executive level buy-in is crucial to the success of creating an effective, sustainable SBIRT process. Committed leaders at multiple levels of organizational management are needed to support a new best practice by providing resources and time for the champion to implement the process. The engagement of policymakers and relevant associations can also be helpful in moving forward. A first step in assessing leadership buy-in is to implement an Organizational Self-Assessment (OSA) tool to identify and prioritize opportunities and to develop a work plan outlining goals and action steps.

### TABLE 4.

<table>
<thead>
<tr>
<th>BI Focus</th>
<th>1 STRONGLY DISAGREE</th>
<th>2 DISAGREE</th>
<th>3 NEUTRAL</th>
<th>4 AGREE</th>
<th>1 STRONGLY AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our organization has a clearly defined strategic plan. Progress or setbacks in achieving strategic plan goals are communicated with all stakeholders.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational strategic priorities are linked to QI projects.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our organization does a good job of managing change.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mechanisms are in place to identify and respond to communication lapses.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our organization’s culture includes a focus on measurement/using data to inform care provision and business strategy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership establishes organization-level goals and associated metrics that are tied to individual, clinical team, and administrative deliverables/ performance metrics.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual goals and team goals are clearly linked to the organization’s strategic goals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership consistently and clearly communicates to staff, patients, funders, and the community about clinical and fiscal data indicating progress/lack of progress in achieving clinical and business targets.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Following an OSA, leadership can develop work plans with target goals around change processes, measure implementation and outcomes, and communicate this information both internally and externally.
IDENTIFYING CHAMPIONS AT ALL LEVELS

Champions are a key factor for SBIRT sustainability (Singh, 2017). Champions help build organizational buy-in. Having a champion helps promote SBIRT as a standard practice and facilitates relationships with internal staff as well as external partners and stakeholders. Champions may provide presentations, lead SBIRT trainings, and help secure funding and optimize efficiencies. They provide continuity beyond the start-up phase. Grow the network of champions across the organization to ensure success as attrition occurs. Champions should be well versed in data that supports SBIRT, messaging and story telling that appeals to target audiences such as funders, providers, policy makers, consumers, and other key stakeholders.

FIGURE 3. MESSAGING SBIRT TO ALIGN WITH KEY TARGET AUDIENCE PRIORITIES

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Appropriate Messaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Why are we implementing SBIRT? What will be the benefits? How will things be different? How will we get there? Senior leadership should focus on the “why” and the “what”. Front line staff and their supervisors should be empowered to identify the “how.” Change communications typically take longer than champions expect. Repeat a simple and clear measurable message explaining the change.</td>
</tr>
<tr>
<td>Patient</td>
<td>This is part of our screening for whole person health/comprehensive care.</td>
</tr>
<tr>
<td>Clinician</td>
<td>SBIRT addresses a key modifiable health behavior for adolescents by bringing substance use into the continuum of care and spectrum of overall health and wellness.</td>
</tr>
<tr>
<td>Administration</td>
<td>SBIRT allows us to provide comprehensive care that our community needs.</td>
</tr>
<tr>
<td>Financial</td>
<td>SBIRT allows us to provide comprehensive care that our community needs.</td>
</tr>
<tr>
<td>C-Suite</td>
<td>In order to play in the new healthcare landscape, it's important for us to address BH – it must be a part of our value proposition as an organization.</td>
</tr>
</tbody>
</table>
PREPARING YOUR WORKFORCE

SBIRT is an opportunity to deliver an integrated approach to care in which various staff can participate. Understanding of roles and responsibilities within the care team is critical to success. Considerations include:

- Provider experience, willingness and capacity
- Licensure and credentialing of staff (Can they bill for services?)
- Knowledge of the relationship between substance use and other health conditions

Assess current workforce needs and recruit team members that have skills that will drive the service outcomes you seek and what the market place is demanding/paying for (e.g., multidisciplinary team-based care, National Committee for Quality Assurance (NCQA)/Centers for Medicaid & Medicare Services (CMS) Quality Measures, evidence-based practice (EBP), population health management, and use of data to inform care coordination/customer service).

WHO HAS THE TIME? WHO HAS THE SKILLS? WHO GETS PAID?

TABLE 5.

<table>
<thead>
<tr>
<th>Staff</th>
<th>SBIRT Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians and Clinical Staff</td>
<td>BI, warm-handoffs, EHR, work flow</td>
</tr>
<tr>
<td>Operational Administration</td>
<td>Work flow, similar to clinician, QI/measurement</td>
</tr>
<tr>
<td>Financial Staff</td>
<td>Billing, EHR</td>
</tr>
<tr>
<td>C-Suite</td>
<td>Talking points, relationship development</td>
</tr>
</tbody>
</table>

LESSONS FROM THE FIELD

Wisconsin’s SBIRT program and SBIRT Colorado both use trained health coaches to deliver services. Some SBIRT billing codes require services be delivered by a physician or other licensed provider.

Costs of various staff also need to be considered, along with training needs and supervisory support. Grantees from a 5-year SAMHSA-funded SBIRT program found that contracted specialist staff was not sustainable and, thus, staffing models changed to in-house staff (who were either master’s level clinicians or high school or bachelor’s level counselors). Others clinics, especially in rural settings, trained certified medical assistants, community health workers, or nursing staff (Singh, 2016).
Contact your state Medicaid office for more information on SBI codes and credentialing requirements. *(See also the Substance Abuse and Mental Health Administration (SAMHSA)/Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS) billing worksheets, reimbursement codes, and Institute for Research, Education & Training in Addictions (IRETA) map.)*

**REDESIGNING YOUR WORKFLOW**

**Decision Points**
- **Who:** PCP/Nurse/NP/PA/BH Provider
- **What:** Self-Administration/Paper/Tablet/Interview
- **Where:** Any private space - Intake/Exam Room/Other
- **When:** Every time the patient presents
DEVELOPING SBIRT GUIDELINES AND PROTOCOLS

Practice guidelines are based on scientific evidence about SBIRT, while operating protocols provide standardization for essential operational activities within the clinical practice. Together, these policies provide an organizational infrastructure and capacity to sustain SBIRT practice, and help to clarify expectations to support staff and supervisors. Formalized guidelines demonstrate that leadership is fully bought-in and the culture has been primed for implementation. Intentional workflow development drives practice integration. To sustain widespread adoption, consistent training opportunities, ongoing data-driven monitoring, clinical decision support, and reminders through EHR are critical facilitators.

<table>
<thead>
<tr>
<th>PRACTICE GUIDELINES</th>
<th>OPERATING PROTOCOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematically developed into organizational policy that guides clinical decision-making</td>
<td>Provides clarity on how to execute important practice and regulatory activities, reimbursement, or other accountability factors</td>
</tr>
<tr>
<td>Allows for impact measurement</td>
<td>Defines team member roles and responsibilities</td>
</tr>
<tr>
<td>Reduces practice variance through intervention standardization</td>
<td>Helps assure key activity execution of when daily workloads may otherwise hinder implementation</td>
</tr>
<tr>
<td>Transcends transitions in leadership and staff-written and approved regardless of changes</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 6.

TRAINING AND SUPERVISION, LICENSURE/CERTIFICATION

Sustainability requires that staff receive appropriate training and support to conduct SBIRT, including onboarding new staff, ongoing training for current staff, and competency based evaluations.

ONGOING TRAINING FOR CURRENT STAFF

To ensure full integration of effective SBIRT, it is critical to build in ongoing training opportunities so that staff can maintain and build on the required skill set for implementation. In your design, consider the following:

- Standardize frequency of trainings (quarterly; semi-annually; annually)
- Standardize mode of trainings (whether in-person or web-based)
- Identify a minimum requirement to demonstrate competency and fidelity
- Identify a SBIRT coach to provide ongoing coaching and support after initial training.

ONBOARDING NEW STAFF

Protocols for onboarding staff and medical providers must be established and reside within the Human Resources Department. Ideally, SBIRT training would be identified in orientation protocols, checklists, or database systems (such as Health Stream) to document that SBIRT training occurred as part of new staff/provider orientation.
COMPETENCY-BASED EVALUATION

Supports quality and fidelity of SBIRT implementation, the practice should define, in a written protocol, the mechanism for regular competency-based evaluation of all staff involved in SBIRT. This includes:

- Evaluate appropriate staff member competencies for each component of SBIRT (i.e., screening assessment required for Medical Assistant evaluation)
- Frequency of competency-based evaluation (no less than annually)
- Mechanism for evaluation (e.g., standardized patient, role play for observation, observation in practice, written test)
- Staff member responsible for conducting evaluation
- Minimum level of proficiency required and policy for staff that do not meet standard level of proficiency
- Documentation method—preferably incorporated into broader competency-based evaluation instruments.

REFERRAL AND FOLLOW-UP

Defines process to facilitate hand-off from brief intervention to successful RT, including:

- Addressing roles and responsibilities of various staff
- Defining process for staff tasked with RT, including:
  - Identifying process for each type/category of treatment resource (public, private, crisis, information/call-line)
  - Providing guidance on referral options for different patient preferences (e.g., medication-assisted treatment (MAT) for opioid addiction, inpatient for complex cases)
  - Providing detailed listings and profiles of different treatment resources
  - Identifying protocol for follow-up by referring providers
  - Defining documentation requirements
  - Providing a tool for assessing barriers to access.

DOCUMENTATION THROUGH ELECTRONIC HEALTH RECORD (EHR)

Helps practice understand the following:

- Mechanics for modifications/customization of EHR to accommodate tools for SBIRT
- Mechanics for future modifications/customization of EHR
- Contact information for outside vendors, as appropriate
- Data dictionary of operational terms used for coding and documentation
- Copies of screenshots
- Process for use of the EHR screens for SBIRT documentation (access to different screens required for SBIRT).

SUSTAINABLE QUALITY IMPROVEMENT, SUPERVISION, FIDELITY, AND QUALITY CONTROL

Identifying SBIRT measures as part of the practice’s overall QI plan approved by leadership. Protocol developed and approved should define:

- Specific indicators and targets (i.e., all patients at every visit will receive a screen—target 75% of patient encounters)
- Frequency of data collection
- Report format, including data dictionary of all indicators
- Process for data abstraction from EHR
- Roles and responsibilities of staff for data abstraction, data monitoring, and plan of correction
- Reporting of measures to medical, administrative, and board governance.
DATA-DRIVEN DECISION MAKING

ENTERING S2BI INTO ELECTRONIC HEALTH RECORDS AND FOLLOW-UP

How screening is entered and stored in a practice’s EHR system will depend on the clinic’s EHR vendor; however, it can be customized to fit individual practice work flow. This includes how the information is reported to third party payers in order to avoid stigmatizing patients and in order to protect patient privacy. There are several current procedural terminology (CPT) and evaluation and management (E&M) codes that can be used for reimbursement for SBIRT activities. (Also see “How to Get Credentialed to Get Paid” and Appendix H. Financing SBIRT for more on reimbursement.)
DATA DRIVEN

Here are some types of data and data-related activities that clinics can consider to inform and assess their SBIRT activities:

- Quality Metrics (e.g., Commission on Accreditation of Rehabilitation Facilities (CARF), HRSA, NCQA) that are associated with screening for alcohol, tobacco & marijuana
- Reporting
- Using screening data to inform clinical decisions and service delivery
- Using data to track QI
- Assessing the percent of target patient population screened and screening goals
- Evaluating the processes used to implement RT is an important step in maintaining and improving the quality of SBIRT.

HOW TO TRANSLATE DATA INTO BETTER PATIENT OUTCOMES

If a clinic has the ability to modify its EHR capacity, data on process adherence can be collected at the time of clinical documentation by way of structured data fields. If a clinic does not have the ability to modify its EHR capacity, clinical documentation indicating steps in the screening and referral process must be clearly stated and recognizable to a quality reviewer in order to collect data on adherence to the process.

Reviewing process data can lead to identifying areas of improvement in implementation of SBIRT in clinics and answer the following questions:

- Are clinics routinely screening for substance use?
- Are clinics utilizing a validated, evidenced-based screening tool to identify substance use in adolescents?
- Are clinics initiating RT when screening indicates moderate to severe risk?
- Are there sufficient internal and external treatment resources to successfully deliver adolescents and families to treatment?
- Are clinics utilizing an effective method to successfully deliver adolescents and families to treatment?
- Are clinics effective in successfully delivering adolescents and families to treatment?
- Are clinics referring and delivering adolescents and families to treatment in a timely manner?
- Are referrals to treatment resulting in a reduction in or abstinence from substance use and risky behaviors?

Clinics should develop a change plan based on the results of the review and any identified problem areas.
One in four youth in the U.S. grows up with a chronic medical condition, such as diabetes, asthma, or arthritis that requires long-term follow-up by a clinical care team (Van Cleave et al., 2010). Screening these adolescents for substance use and attending to special risks given their condition are recommended.
Youth with chronic medical conditions may differ in the type of specific diagnoses they carry and, with that, follow varying disease management and treatment regimens. Common to this group is the need for adhering to medication regimens, clinical monitoring protocols, self-management plans, and control of health behaviors essential to disease control.

Population data about youth at-large doesn't account for special health populations and, as such, may underestimate substance use risks among adolescents with chronic medical conditions, who may be particularly vulnerable. Therefore, screening tools should be tailored to these youth.

**Tailor screening tools and guidance to youth with chronic medical conditions.**

For example, even “lower risk” alcohol or other drug use may expose youth to co-occurring 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). While these factors are generally well tolerated by healthy youth, they can lead to disease exacerbation and serious complications among the chronically ill. Alcohol and other drugs may pose unique risks to the validity of diagnostic test interpretation, impacting treatment protocols derived from them, and undermine the safety of prescription medications. This makes alcohol and substance use vital topics to discuss, as well as potential anchor points for screening and brief intervention. Physicians may have substantial opportunity to discuss these issues with these youth given the high frequency with which youth with chronic conditions interact with the health care system. Long-term rapport with specialty providers may increase the salience of health guidance and messages.
TABLE 7.

Health Conditions that Interfere with Substance Use

### Diabetes

- Symptoms of impairment from psychoactive substances may be difficult to distinguish from hypoglycemia.
- Alcohol results in unpredictable blood sugars.
- Glucagon may not work as effectively as a rescue medication while the liver is metabolizing alcohol.

### Asthma

- Smoking any substance results in pulmonary exposure to toxic products of combustion, which can be damaging to the lungs.
- Marijuana use may have an immediate bronchodilatory effect, though long-term marijuana smoking is associated with an increase in symptoms suggestive of obstructive lung disease.

### Inflammatory Bowel Disease

- Alcohol worsens inflammatory bowel disease symptoms (e.g., diarrhea, abdominal pain, bloating).
- Alcohol can alter the composition of intestinal microbiomes in a way that promotes increased intestinal permeability, which may increase the risk of a flare.

### Obesity

- Depression and obesity have several shared symptoms, including sleep problems, sedentary behavior, and dysregulated food intake.
- Substance use disorders and obesity are both linked to dysfunction in the brain’s reward system (Johnson & Kenny 2010).

Psychological comorbidities—they are the rule, not the exception, and it is important to recognize them (Horsfall et al., 2009). Substance use and mental health problems can cause and reinforce one another. Individuals who have mental health problems may turn to psychoactive substances to self-medicate, since the short-term effects of alcohol and drugs may help them manage their depression, anxiety, hyperactivity, or other mental health symptoms even while making the problems worse in the long term.

Conversely, psychoactive substances can lead to psychological distress and changes in behavior that are consistent with several mental health disorders (National Institute on Drug Abuse 2012; Horsfall et al., 2009) or in some cases, precipitate mental health disorders, including depression and thought disorders.

In addition, it is recommended that when substance use is identified, providers also screen patients for eating disorders and trauma.
### TABLE 8. RECOMMENDATIONS: SCREENING FOR COMMON COMORBIDITIES

<table>
<thead>
<tr>
<th>COMMON COMORBIDITIES</th>
<th>RECOMMENDATIONS</th>
<th>SCREENING TOOLS</th>
</tr>
</thead>
</table>
| DEPRESSION           | U.S. Preventive Services Task Force (USPSTF) recommends screening all adults and adolescents (ages 12-18) for depression with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Behavioral activation (assisting individuals to identify and engage in daily activities and situations they find positively reinforcing and consistent with their long-term goals) is a promising strategy for BI and has been demonstrated as an evidence-based practice for depression. | • **PHQ-9** (Kroenke, 2001)  
• The Brief Symptom Checklist-18 (Derogatis, 2001)  
• PHQ- A Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002) |
<table>
<thead>
<tr>
<th>ANXIETY</th>
<th>TRAUMA</th>
</tr>
</thead>
</table>
| ▪ Validated, brief screening tools are available.  
▪ Interventions for anxiety (passive psychoeducation, bibliotherapy) may be offered as a BI to patients screening positive for mild-to-moderate levels of anxiety | ▪ **GAD-7** (Spitzer, 2006)  
| ▪ There is a strong correlation between trauma and addiction, therefore universal screening for trauma is recommended.  
▪ Validated, brief screening tools are available. | ▪ **Center for Youth Wellness ACEs Tool** (CYW ACE-Q)  
▪ **Life Events Checklist for DSM-5 (LEC-5)**  
▪ **Primary Care PTSD Screen** (PC-PTSD)  
▪ **PTSD Checklist for DSM-5 (PCL-5)**  
▪ **Matrix** of screening tools of children and adolescents  
▪ **The Child PTSD Symptom Scale** (CPSS) (Foa, Johnson, Feeny & Treadwell, 2001) |
POLYSUBSTANCE USE

WHAT IS 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.” It is important to establish a clear picture of frequency, quantity, and pattern for each substance used during the screening period.

WHY IS THIS IMPORTANT? (RISK)
- Increased risk of harm associated with mixing substances simultaneously.
- Health 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 brief intervention 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.

### TABLE 9.

<table>
<thead>
<tr>
<th>Alcohol and Prescription Drug Use</th>
<th>Alcohol and Cigarettes</th>
<th>Alcohol and Marijuana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixing puts youth at risk for dangerous reactions, including: drowsiness, increased risk for overdose, slowed or difficulty breathing, impaired motor control, unusual behavior, memory problems</td>
<td>Increased risk of cancer, particularly of the mouth</td>
<td>Marijuana has an antiemetic effect, which can prevent the body from vomiting when too much alcohol is consumed, leaving the body to process high levels of dangerous toxins.</td>
</tr>
<tr>
<td></td>
<td>Higher risk of all-cause mortality</td>
<td>Alcohol and marijuana are both depressants, which slow the central nervous system.</td>
</tr>
<tr>
<td></td>
<td>Negative effects on auditory-verbal learning and memory/prospective memory/working memory, executive functions, visual search speeds, psychomotor speed, cognitive flexibility, general intellectual abilities, and balance</td>
<td>Tetrahydrocannabinol (THC) is absorbed faster when alcohol is in the system.</td>
</tr>
<tr>
<td></td>
<td>Tobacco can enhance the effects of alcohol and can increase risk in heavy/problematic drinking</td>
<td></td>
</tr>
</tbody>
</table>
PRESCRIPTION AND ILLICIT DRUGS

Opioids: Misuse + Adolescents

In 2015, 276,000 adolescents age 12-17 were current nonmedical users of pain medication.

829,000 youth age 18-25 were current nonmedical users of pain medication (SAMHSA, Centers for Behavioral Health Statistics and Quality, 2016)

- People often share their unused pain relievers, unaware of the dangers of nonmedical opioid use.
- Mental health disorders and early initiation of alcohol, marijuana, and tobacco increase the risk of opioid addiction.

WHAT WILL THIS LOOK LIKE IN MY OFFICE?

TRAUMA

The National Institute on Drug Addiction asserts that two-thirds of all those with substance use disorders have previously experienced trauma in childhood.

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 of these conditions have a more difficult time meeting their treatment goals.

Considering this 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:

- Remember that in children, trauma often refers to recurrent trauma rather than a single big event.
- Can present in many different ways and can mimic many different disorders.
- Substance use is common, and may be instrumental (i.e., use of marijuana to dissociate and manage difficult feelings)
- In these cases, trauma work is CRITICAL and should co-occur with substance use disorder work.
CULTURAL CONSIDERATIONS
When discussing substance use with youth, it is important to remember that for many adolescents and young adults, substance use is very common in their environments and social circles. It’s possible that for some racial/ethnic minority youth, substance use may be more common in the home because of different cultural traditions and norms around substance use (Caetano, R., Clark, C. L., & Tam, T., 1998); substance use may also be more prevalent among lesbian, gay, bisexual, transgender (LGBT) individuals than the general public (Medley G., Lipari, R.N, Bose, J., Cribb, D.S., Kroutil, L.A., McHenry, G., 2016). When discussing substance use with minority populations, it is critical to do so in a way that is respectful of different cultural perspectives that patients may have regarding substance use, and to ensure that messages about substance use and health are communicated in a manner that is respectful and responsive to patients’ cultural backgrounds and perspectives.

STIGMA
Substance use is highly stigmatized in our society, particularly because many individuals view it as a moral issue rather than a health issue. In both popular culture and within the medical field, it is not uncommon to view substance use and substance use disorders as overindulgence, poor self-control, or criminal (Livingston et al., 2012). However, research and experience in the past few decades have shown that these stereotypes are misguided, and that substance use and substance use disorders should be viewed as unhealthy behaviors rather than ethical shortcomings.

Individuals who use alcohol and drugs regularly can be particularly sensitive to being judged for their substance use, and statements from medical providers that are perceived as judgmental can make patients reluctant to openly discuss their alcohol and drug use. Consequently, it is essential that when communicating with patients about substance use that medical providers use a non-judgmental tone and emphasize that they are concerned about substance use because of its potential impact on patient health, not because they think it is morally “wrong.”
### Risk Factors Definition

#### Individual/Peer

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Definition</th>
<th>Adolescent Substance Use</th>
<th>Young Adult Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early initiation of substance use&lt;sup&gt;46,47&lt;/sup&gt;</td>
<td>Engaging in alcohol or drug use at a young age.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Early and persistent problem behavior&lt;sup&gt;48,49&lt;/sup&gt;</td>
<td>Emotional distress, aggressiveness, and “difficult” temperaments in adolescents.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Rebelliousness&lt;sup&gt;48,50&lt;/sup&gt;</td>
<td>High tolerance for deviance and rebellious activities.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Favorable attitudes toward substance use&lt;sup&gt;51,52&lt;/sup&gt;</td>
<td>Positive feelings towards alcohol or drug use, low perception of risk.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Peer substance use&lt;sup&gt;53-55&lt;/sup&gt;</td>
<td>Friends and peers who engage in alcohol or drug use.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Genetic predictors&lt;sup&gt;56&lt;/sup&gt;</td>
<td>Genetic susceptibility to alcohol or drug use.</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

#### Family

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Definition</th>
<th>Adolescent Substance Use</th>
<th>Young Adult Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family management problems (monitoring, rewards, etc.)&lt;sup&gt;57-60&lt;/sup&gt;</td>
<td>Poor management practices, including parents' failure to set clear expectations for children's behavior, failure to supervise and monitor children, and excessively severe, harsh, or inconsistent punishment.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Family conflict&lt;sup&gt;61-63&lt;/sup&gt;</td>
<td>Conflict between parents or between parents and children, including abuse or neglect.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Favorable parental attitudes&lt;sup&gt;64,65&lt;/sup&gt;</td>
<td>Parental attitudes that are favorable to drug use and parental approval of drinking and drug use.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Family history of substance misuse&lt;sup&gt;66,67&lt;/sup&gt;</td>
<td>Persistent, progressive, and generalized substance use, misuse, and use disorders by family members.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Risk Factors</td>
<td>Definition</td>
<td>Individual/Peer</td>
<td>Adolescent Substance Use</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>Academic failure beginning in late elementary school&lt;sup&gt;68,69&lt;/sup&gt;</td>
<td>Poor grades in school.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Lack of commitment to school&lt;sup&gt;70,71&lt;/sup&gt;</td>
<td>When a young person no longer considers the role of the student as meaningful and rewarding, or lacks investment or commitment to school.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Low cost of alcohol&lt;sup&gt;90,92&lt;/sup&gt;</td>
<td>Low alcohol sales tax, happy hour specials, and other price discounting.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>High availability of substances&lt;sup&gt;73,74&lt;/sup&gt;</td>
<td>High number of alcohol outlets in a defined geographical area or per a sector of the population.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Community laws and norms favorable to substance use&lt;sup&gt;75,76&lt;/sup&gt;</td>
<td>Community reinforcement of norms suggesting alcohol and drug use is acceptable for youth, including low tax rates on alcohol or tobacco or community beer tasting events.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Media portrayal of alcohol use&lt;sup&gt;77-79&lt;/sup&gt;</td>
<td>Exposure to actors using alcohol in movies or television.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Low neighborhood attachment&lt;sup&gt;80,81&lt;/sup&gt;</td>
<td>Low level of bonding to the neighborhood.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Community disorganization&lt;sup&gt;82,83&lt;/sup&gt;</td>
<td>Living in neighborhoods with high population density, lack of natural surveillance of public places, physical deterioration, and high rates of adult crime.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low socioeconomic status&lt;sup&gt;84,85&lt;/sup&gt;</td>
<td>A parent’s low socioeconomic status, as measured through a combination of education, income, and occupation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitions and mobility&lt;sup&gt;80,86&lt;/sup&gt;</td>
<td>Communities with high rates of mobility within or between communities.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Protective Factors Definition

### Individual/Peer

<table>
<thead>
<tr>
<th>Protective Factor</th>
<th>Definition</th>
<th>Adolescent Substance Use</th>
<th>Young Adult Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social, emotional, behavioral, cognitive, and moral competence&lt;sup&gt;87,88&lt;/sup&gt;</td>
<td>Interpersonal skills that help youth integrate feelings, thinking, and actions to achieve specific social and interpersonal goals.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Self-efficacy&lt;sup&gt;89,90&lt;/sup&gt;</td>
<td>An individual’s belief that they can modify, control, or abstain from substance use.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Spirituality&lt;sup&gt;91,92&lt;/sup&gt;</td>
<td>Belief in a higher being, or involvement in spiritual practices or religious activities.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Resiliency&lt;sup&gt;88&lt;/sup&gt;</td>
<td>Positive feelings towards alcohol or drug use, low perception of risk.</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

### Flexible ways.

<table>
<thead>
<tr>
<th>Protective Factor</th>
<th>Definition</th>
<th>Adolescent Substance Use</th>
<th>Young Adult Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities for positive social involvement&lt;sup&gt;93,94&lt;/sup&gt;</td>
<td>Developmentally appropriate opportunities to be meaningfully involved with the family, school, or community.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Recognition for positive behavior&lt;sup&gt;51&lt;/sup&gt;</td>
<td>Parents, teachers, peers and community members providing recognition for effort and accomplishments to motivate individuals to engage in positive behaviors in the future.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Bonding&lt;sup&gt;95-97&lt;/sup&gt;</td>
<td>Attachment and commitment to, and positive communication with, family, schools, and communities.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Marriage or committed relationship&lt;sup&gt;98&lt;/sup&gt;</td>
<td>Married or living with a partner in a committed relationship who does not misuse alcohol or drugs.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Healthy beliefs and standards for behavior&lt;sup&gt;91,99&lt;/sup&gt;</td>
<td>Family, school, and community norms that communicate clear and consistent expectations about not misusing alcohol and drugs.</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

## Goal Setting Discussion Summary

This goal-setting template is meant to document the agreed upon plan with the patient. Some possible examples include: limiting to one drink per drinking night; limit drinking to one night per week; establishing a safe transportation plan; avoiding sexual intercourse on drinking nights; and discussing and practicing safe sex whenever intercourse takes place. The provider and patient should agree to a follow-up date (e.g., 3 months) of when to revisit this plan and assess progress and make modifications as necessary.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
<th>Location: Phone</th>
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<tbody>
<tr>
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**Attendees and Affiliation:**

<table>
<thead>
<tr>
<th>Goal 1:</th>
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</thead>
<tbody>
<tr>
<td>Follow-up Action</td>
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<table>
<thead>
<tr>
<th>Goal 2:</th>
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<tbody>
<tr>
<td>Follow-up Action</td>
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</table>

<table>
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<tr>
<th>Goal 3:</th>
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<tbody>
<tr>
<td>Follow-up Action</td>
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</table>

**Detailed Notes:**
Sarah, a 17-year-old high school senior, presents on Monday morning with a severely sprained, swollen and painful left ankle.

**Provider:** Following a friendly check-in, engaging rapport, Provider asks, “Can you tell me more about what happened to bring you in today?”

**Patient:** “…I was walking in these new high heels Saturday night and really wasn’t used to them, and I slipped on the sidewalk and twisted my foot…”

**Provider:** “Did it hurt a lot at the time?”

**Patient:** “Just a little, but it was a lot worse Sunday morning and I couldn’t walk.”

**Provider:** “Sorry to hear that you are in pain. Tell me more about your evening. What were you doing? Had you been drinking Saturday night?”

**Patient:** “I was at a party at one of my friend’s houses.”

**Provider:** “Was there alcohol or other drugs at the party?”

**Patient:** “Yeah, some kids were drinking.”

**Provider:** “How about you? Were you drinking?”

**Patient:** “Oh, just a little...actually I had less than I usually do.”

**Provider:** “How much do you think you had?”

**Patient:** “About 2 or 3 drinks.”

**Provider:** “How much do you usually have?”

**Patient:** “It really varies, but I guess on average I have about 4-5 drinks.”

**Provider:** “Do you usually feel drunk?”

**Patient:** “Yeah, I definitely get buzzed. I had a couple of blackouts last month, and I know that is too much, so I have been cutting back.”

**Provider:** “How often do you drink?”

**Patient:** “Not really that often – I usually go to about one party a month.”

**Provider:** “Have you ever had problems because of drinking?”

In response, patient reports the following:
- Consumes 4-5 drinks about once a month on average
- Reports having had 2 blackouts

You have effectively engaged this patient in an initial conversation regarding her alcohol use and are ready to continue your brief intervention while attending to her sprained ankle.

**Next steps:**
- Elicit problems associated with drinking, or other reasons the patient may choose not to drink
- Provide accurate medical information about alcohol. Ask about making a behavioral change. Would this patient consider an abstinence trial for a specific length of time? If not, would she reduce the frequency of drinking, and/or the amount (1 drink per occasion)?
- Help identify and encourage use of protective behavioral strategies
- Schedule follow-up visit
APPENDIX D: ADDITIONAL BI AND FOLLOW-UP RESOURCES AND TOOLS

GENERAL RESOURCES/TOOLS

- Memorandum of Understanding (MOU), pages 17-18 “SBIRT: A Resource Toolkit for Behavioral Health Providers to Begin the Conversation with Federally Qualified Healthcare Centers,” a guide created by the Advanced Leadership Institute in partnership between the Addiction Technology Transfer Center (ATTC) Network and SAMHSA Partners for Recovery. This toolkit provides a sample template to establish an MOU between an FQHC and behavioral health providers.
- Follow-up Step 4, page 12 of Alcohol Screening & Brief Intervention for Youth: A Practitioners Guide created by the National Institutes of Health (NIH), National Institute on Alcohol Abuse and Alcoholism (NIAAA).
- Learner’s Guide to Adolescent SBIRT. “Follow-up & Support, Types of Follow-up, Making Phone Contact, Screening at Follow-up”, slides 211-220 by NORC at University of Chicago.

RESOURCES AND TOOLS FOR DIFFERENT LEVELS OF RISK

- Readiness Ruler
- Contract for Life – Negotiating a Plan
- Pledge for Life
- NIH, NIAAA Pocket Guide for Alcohol Screening and Brief Intervention for Youth
- Inside the Physician’s Black Bag: Critical Ingredients of Brief Alcohol Interventions
- Paper on teen preferences for clinic-based behavior screens and follow-up article on teens and electronic media
- Motivational Interviewing for Adolescent Substance Use: A Review of the Literature
  - Review of 39 studies with 67% reporting statistically significant improvement in substance use outcomes.
  - Abstinence Challenge (see below)

Abstinence Challenge

I, ___________________, agree to not drink alcohol, use drugs, or take anyone else’s medication for the next ____________ days. I also will not provide drugs, alcohol, or prescription medications for anyone else during this time. In addition, I agree to not drive a motor vehicle while under the influence of drugs or alcohol, nor will I ride with a driver who has been drinking or using drugs.

I will come to my follow-up appointment with ____________ on ____________.

Signed ___________________

Date ____________________
APPENDIX E: 
TYPES OF TREATMENT OPTIONS

Important considerations include:

- What level of care will meet the patient's needs? What level of care is the patient willing to go to? (Some patients would benefit from acute residential treatment but are not willing to sleep away from home.)
- What quality programs are available in the community and who has space? What will insurance cover?

Types of Treatment Options

EARLY, BRIEF INTERVENTION SERVICES

These services are for individuals who do not meet the criteria for severe substance use disorder. Early intervention often consists of educational or brief intervention services that aims to help the adolescent recognize the negative consequences of substance use and to understand and address the adolescent’s problems that are likely related to their substance use (Winters et al, 2014).

MEDICATION-ASSISTED ADDICTION TREATMENT

Medication-assisted 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 addiction, as well as nicotine and alcohol.

INTENSIVE OUTPATIENT TREATMENT

During outpatient treatment, adolescents typically meet with a therapist for 6 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 a less severe level of care is warranted, as a step down from a more intensive treatment or to increase the adolescent’s motivation to engage in a higher level of care. Individual, group, and family therapy are some of the options for outpatient treatment.

INTENSIVE OUTPATIENT TREATMENT AND PARTIAL HOSPITALIZATION

Adolescents in intensive outpatient treatment are in need of a treatment program that can offer comprehensive services for up to 20 hours per week. The adolescents often attend in the evening or weekends but live at home (ranging in length from 2 months to 1 year). 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 4-6 hours a day for 5 days a week.

RESIDENTIAL/INPATIENT TREATMENT

This is a high level of care for adolescents who have not only severe addiction but also have complex mental health, family, or medical problems that would interfere with treatment and the ability to get and stay clean and sober. Residential/inpatient treatment includes programs that provide treatment services in a residential setting (lasting from 1 month to 1 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 that they require 24-hour primary medical care. The length of care is dependent on the adolescent’s needs and progress.
APPENDIX F: REFERRAL TO TREATMENT SAMPLE SCRIPT

“We have talked a bit about your struggles at home, at school and with your health, and I think some changes around alcohol could help with the issues you identified. Your answers on the questions about substance use indicate that you might benefit from some help with cutting back on drinking, and I can see from our conversation that you have already started thinking about these issues seriously. Working on this through outpatient counseling with a counselor or other health professional like myself could be really helpful. What do you think of this idea?”

“I'm glad that you want to make significant changes in your health by decreasing the amount you drink. You know, adolescents in your situation are often more successful if they also see a counselor who specializes in this topic. We have some excellent programs in our area that have helped many people in exactly your situation. Would you be willing to see one of these counselors to assist you with your plan of recovery?”

“We've talked about the impact that the use of marijuana has had at school and playing sports, and I think some changes around marijuana could help with the issues you've identified. Your answers indicate that you might benefit from some help reducing your marijuana use. I understand that you also use marijuana to help you manage stress, and it will be really important that we help you find other ways to manage stress. Working on this with a counselor or a nurse like myself could be really helpful. What do you think of this idea?”

(NORC, 2016)
APPENDIX G:  
CONFIDENTIALITY AND PARENTAL INVOLVEMENT

Although the age cut off may vary by state, providers will need to make a clinical judgment as to whether the circumstances for referral warrant consideration for parental involvement. In most states, unless clinical judgment suggests the patient is in imminent danger because of risky behavior, confidentiality cannot be breached. In this case, the clinician should focus discussions with the patient on allowing the parent to be included in their substance use and treatment discussions.

KEY CONSIDERATIONS

Explain the confidentiality policy—including the limits of confidentiality—to the patient and parent(s) simultaneously. In this way, 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.

Confidentiality provisions should be introduced and defined prior to the first time that the adolescent is interviewed without a parent present or during the initial visit for adolescents new to a practice.

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, which are at higher risk for both the acute and chronic consequences of substance use.

Breaching confidentiality for safety is a matter of clinical judgment. The “limit” of confidentiality, is generally the need to prevent imminent harm and protect someone's safety.

Even when sensitive information such as suicidal or homicidal ideation needs to be revealed, the clinician should first discuss with the adolescent what and how information will be presented to parents. By strategizing with the adolescent ahead of time, a clinician can transmit necessary information to parents while simultaneously protecting the physician-patient bond.

PARENTAL INVOLVEMENT

Even in situations where there is not an acute safety risk, adolescents may benefit from support from their parents 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. “Teen participation in confidential health services should not overshadow the desirability of parental involvement. Participation of parents 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 serious substance use disorder, parents are already aware of their drug use, although 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 whenever possible. This can be a rewarding experience for the adolescent if the clinician focuses on points of mutual agreement.
CONFIDENTIALITY

- Which laws do and don't apply to you?

Protecting an appropriate level of confidentiality of adolescents' health care information is an essential determinant of whether adolescents will access care, answer questions honestly, and whether a therapeutic alliance between doctor and patient can be maintained. Fear that clinicians will reveal private information can cause concern and lead to a failure to answer screening questions accurately. However, when it comes to alcohol use by patients who are minors it is essential that concerns about confidentiality are not a deterrent from screening and intervening as needed. “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).

REGULATORY CONSIDERATIONS

Numerous federal and state laws protect the privacy of health care information. In particular, at least 4 types of laws affect the ability of physicians to share information about a patient in their care.

This includes:
- Federal medical privacy rules issued under the federal Health Insurance Portability and Accountability Act (HIPAA).

While the HIPAA rules permit sharing information between providers, there are unique considerations for minors who have legally consented to care. In general, HIPAA allows a parent to have access to the medical records for his or her minor child, when the access is consistent with state or other law. Providers should inform parents that they have the right to access their child's medical records, but it may hinder the effectiveness of the treatment. Parents should be encouraged to speak directly with their child, instead.

Exceptions to the HIPAA Privacy Rule are as follows:
- When a minor has consented for the care and the consent of the parent is not required by state or other applicable law;
- When a minor obtains care at the direction of a court;
- When a parent agrees that a health care provider and minor may have a confidential relationship;
- State privacy laws.

In the case of consenting minors, parents do not automatically have the right to access the minor’s health information. Whether they can do so is dependent on state laws. Examine state laws, or seek advice from legal consult, to determine whether they specifically address the confidentiality of a minor's health information and, if not, professionals can typically determine whether or not to grant access.

A State-by-state resource list on privacy laws, minor consent laws, and contacts in state mental health agencies, state protection and advocacy agencies, and state mental health associations are available [here](https://www.samhsa.gov) on the (SAMHSA) website.
STATE MINOR CONSENT LAWS

State minor consent laws govern whether minors can give their own consent for health care (e.g., care obtained without the consent of a parent or guardian). Every state has enacted these laws, which fall into 2 overall categories:

1. Laws that are based on the status of the minor (minors who are emancipated, living apart from parents, married, pregnant, and/or parenting)
2. Laws that are based on the type of care that is sought (emergency, family planning, drug/alcohol, and mental health).

Nearly all states have enacted some type of law that allows minors to consent for care related to drug and alcohol use (AAP Tip Sheet).

42 CFR PART 2

There are specific federal confidentiality rules that govern facilities deemed to be federal alcohol and drug abuse treatment programs. In general, federally subsidized substance abuse treatment programs must abide by Part 2 and cannot disclose health information for treatment, payment, and health care operations without prior written consent and authorization.

To determine if 42 CFR applies to you or your agency, the Legal Action Center has created this decision tree and fact sheet.

Even those SBIRT providers who are not subject to Part 2, however, need a basic understanding of Part 2's requirements to facilitate communication and engagement with Part 2 programs. Furthermore, funding streams are moving in the direction of aligning with 42 CFR requirements, so it is prudent for all providers to start understanding what it is and how it affects them.

42 CFR Part 2 and HIPPA: Follow both laws, if possible. If 42 CFR Part 2 is more restrictive, then its provisions apply.
APPENDIX H: FINANCING SBIRT

STATE MINOR CONSENT LAWS

It is important to clarify all the components that necessitate funding for successful and sustainable SBIRT implementation.

Securing reimbursement for services is key to sustaining SBIRT. However, there are also other funding needs to consider. In order to carry out SBIRT statewide with positive outcomes for adolescents the following elements also require financial support:

- Supportive/administrative costs
- Training and coaching of providers
- Monitoring fidelity
- Tracking outcomes of SBIRT on youth and young adults
- Sustaining SBIRT.

SBIRT is an Affordable Care Act-recommended service; base, contract, or grant dollars may be available to support its implementation. However, coding and billing policies and regulations are still a patchwork in evolution. There are three primary billing methods that can be considered for purposes of reimbursement for SBIRT services. Coding and coverage policy varies based on payer: Medicaid, Medicare, and commercial health plans.

SBIRT can often be reimbursed through commercial/private insurance. SBIRT can also be reimbursed through Medicaid or Medicare SBI codes in many states, though restrictions do exist as far as staff and setting types. It’s important to understand what credentials are necessary to bill for SBIRT when thinking about staffing at the outset. Medicaid and commercial fees will vary by locale and payer.

<table>
<thead>
<tr>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Medicaid</td>
<td>H0049</td>
<td>Alcohol and/or drug screening</td>
</tr>
<tr>
<td></td>
<td>H0050</td>
<td>Alcohol and/or drug service, brief intervention, per 15 minutes</td>
</tr>
<tr>
<td>Medicare</td>
<td>GO396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
</tr>
<tr>
<td></td>
<td>GO397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>CPT 99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
</tr>
<tr>
<td></td>
<td>CPT 99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
</tr>
</tbody>
</table>
MEDICAID BILLING

- For preventive screenings, a physician or other licensed practitioners must recommend the service, within the scope of their practice under State law.

- For other services, such as BI, States establish the qualifications of the practitioner when they cover a service in their Medicaid State Plan. In many instances, qualifications for practitioners offering substance use treatment include, but are not limited to:
  - Licensed or certified to perform substance use services by the State in which they perform the services;
  - Qualified to perform the specific substance use services rendered;
  - Supervised by a licensed practitioner of the healing arts (in some instances, when a qualified non-licensed professional renders the service); and

- Working within their State Scope of Practice Act.

MEDICARE BILLING

- Medicare pays for medically reasonable and necessary SBIRT services in physicians' offices and outpatient hospitals

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, or clinical social workers can bill for SBIRT.

- To bill Medicare, providers of mental health services must be:
  - Licensed or certified to perform mental health services by the state;
  - Qualified to perform the specific mental health services rendered; and
  - Working within their State Scope of Practice Act.
REFERENCES

INTRODUCTION


SCREENING

National Institutes of Health (NIH), National Institute on Alcohol Abuse and Alcoholism (NIAAA). Alcohol Screening and Brief Intervention for Youth: A Practitioners Guide. Available at: https://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf


BRIEF INTERVENTION


REFERRAL TO TREATMENT


IMPLEMENTATION CONSIDERATIONS


SPECIAL CONSIDERATIONS


NIH, National Institute on Drug Abuse. What are “Co-Occurring Disorders?” March 8, 2012. Available at: https://teens.drugabuse.gov/blog/post/what-are-co-occurring-disorders


NORC at the University of Chicago. (2016). Learner’s Guide to Adolescent Screening, Brief Intervention and Referral to Treatment (SBIRT). Bethesda, MD: NORC at the University of Chicago.
