



SUBSTANCE USE SCREENING AND INTERVENTION IMPLEMENTATION GUIDE

NO AMOUNT OF SUBSTANCE USE IS SAFE FOR ADOLESCENTS

What's inside...

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INTRODUCING THE GUIDE

Substance use by adolescents has an enormous impact on their health and well-being. It impairs healthy growth and development, is associated with risky behaviors such as unprotected sex and dangerous driving, and contributes to the development of many other health problems.

Pediatric care providers play a critical, ongoing role in the lives of their adolescent patients and therefore have a unique opportunity to educate them about the dangers of substance use and to influence their behaviors. Compared to people in other age groups, adolescents are at the highest risk for experiencing health problems related to substance use (Committee on Substance Abuse, 2015), and the potential benefits of identifying substance use and intervening to reduce or prevent it are substantial.

The American Academy of Pediatrics (AAP) has developed this guide to help pediatricians incorporate screening, brief intervention, and referral to treatment (SBIRT) for use of alcohol, tobacco, marijuana, and other drugs among adolescent patients.



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WHY IS IT IMPORTANT TO IDENTIFY AND TREAT ADOLESCENT SUBSTANCE USE?

Adolescence is a time of rapid change and maturation. It is also a time of experimentation—with new hairstyles, clothes, attitudes, and behaviors. Some of these experiments are harmless. Others, such as using alcohol or other drugs, can have long-lasting harmful consequences. Here are 7 reasons why it is important to identify and treat adolescent substance use.

1. Substance use is common among adolescents

Alcohol, marijuana, and tobacco are the substances most commonly used by youth (Johnston et al., 2014), and alcohol often is the first substance to be used (Johnston et al., 2010). The percentage of young people who have used alcohol increases with age.

SEE APPENDIX 1: What Is a Standard Drink? to learn about the alcohol content of various types of alcoholic beverages.

By eighth grade, 28% of students have tried alcohol, and 12% have been drunk at least once; by twelfth grade, 68% of students have tried alcohol, and more than half have been drunk at least once (Johnston et al., 2014).

In 2012, 45% of students in grades 9 through 12 reported ever having used marijuana, and 24% reported having used marijuana in the preceding 30 days. Between 2008 and 2012, the proportion of teens who used marijuana daily increased from 5% to 8% (PDFA, 2013).

According to a survey published in 2014, 41% of students in grades 9 through 12 reported having tried cigarettes. Nearly one-quarter said they had used tobacco in some form in the past 30 days (Kann et al., 2014).

A substantial percentage of adolescents, including 15% of 12th graders, report misuse (i.e., use

without a prescription) of prescription medication, especially stimulants and pain medications (Johnston et al., 2014).

2. Substance use has its own risks and also is associated with other risky behaviors

Adolescent substance use poses both short-term and long-term risks. In the short term, drinking, for example, can result in unintentional injuries and death, suicidal behavior, motor vehicle crashes, intimate partner violence, and academic and social problems (Brown et al., 2008; Cole et al., 2011; Weitzman and Nelson, 2004). These outcomes occur because excess alcohol consumption leads to decreased cognitive abilities, inaccurate perception of risk, and impaired bodily control. These effects, in combination with the fact that compared to adults, adolescents tend to be more physically active when under the influence of alcohol, put adolescents at greater risk of harm. For example, at blood alcohol concentrations

SEE APPENDIX 2: Negative Health Effects of Adolescent Substance Use

AND APPENDIX 3: Drinking Too Much: Acute and Chronic Health Effects to learn more about why substance use is risky for adolescents.

greater than zero, adolescents are at increased risk of being fatally injured or involved in fatal

crashes in single, two, and more vehicles compared with sober male driver ages 21-34 (Voas et al., 2012). Marijuana use is associated with diminished lifetime achievement (Meier et al., 2012). Tobacco use results in poor health in the short and long term, and it can be a gateway to the use of other drugs (Sims, 2009).

Alcohol Consumption and Pregnancy

Any alcohol consumption by a woman who is pregnant or who may be pregnant increases the risk of fetal alcohol spectrum disorders (HHS, 2005). There is no known safe amount of alcohol that a woman can consume during pregnancy. Avoiding alcohol completely is the only certain way to prevent fetal alcohol spectrum disorders.

Sexually active adolescents should consistently use effective methods of contraception and abstain from alcohol.

The risk of substance use is compounded because it is associated with other risky behaviors, such as unplanned, unprotected sex, which can result in pregnancy (Brown, 2008; Levy et al., 2009; Tapert et al., 2001). Adolescents who misuse prescription

Why Is It Important to Identify and Treat Adolescent Substance Use?

opioids are at high risk of transitioning to injection drugs and overdosing (McCabe et al., 2012).

Any level of substance use can be harmful for adolescents—no amount is safe.

3. Adolescence is a particularly vulnerable period for brain development and maturation

Adolescence—which extends from the ninth year of life into the third decade—is a long period of intense neurodevelopmental growth and maturation. As a result, the adolescent brain is particularly vulnerable to the toxic effects of alcohol and other drugs and to the potential for addiction. Persistent marijuana use in adolescence, for example, is associated with neuropsychological impairments across a range of functional domains (Meier et al., 2012). Moreover, stopping use does not fully restore neuropsychological functioning, suggesting particular harm for the adolescent brain.

4. Use tends to increase over time

National estimates of the prevalence of drinking indicate that older youth drink more and drink more heavily than do younger youth (SAMHSA, 2010). This fact makes it all the more important for pediatricians to start early with screening and brief intervention so as to prevent or delay alcohol use for as long as possible.

5. Substance use in adolescence is associated with harm in adulthood

The earlier an adolescent begins using substances, the greater are his or her chances of continuing to use and of developing substance use problems later in life. For example, compared to people who do not start drinking until they are young adults, people who begin to drink before age 15 are 5 times as likely to develop alcohol dependence or abuse (Chambers et al., 2003; Grant and Dawson, 1997; Hingson and Zha, 2009). Compared with adolescents who first try marijuana at age 18, those who begin using at 14 or younger are 6 times as likely to meet criteria for illicit drug dependence or abuse later in life (SAMHSA, 2010). More than 80% of adults who smoke tobacco began before they were 18 (Sims, 2009).

6. Pediatric care providers tend to underestimate the prevalence of adolescent substance use

Substance use is widespread among adolescents. Even the “good kids” may be using, and their substance use may be causing health and other problems. Discussing substance use with all patients ensures that no one falls through the cracks. Results from a 2014 needs assessment conducted by the AAP indicated that while 88% of pediatricians are screening, only 23% are using a validated tool. Using a validated screening instrument is essential because research shows that the use of personal or clinical judgment alone underestimates the number of adolescents who are using. Even experienced physicians can fail to detect substance use disorders when they rely on clinical impressions, which tend to focus on readily apparent, late-stage signs like school problems. Therefore, while pediatricians are using SBIRT in some sense, there is room for practice improvement.

7. Pediatric care providers can help adolescents avoid and reduce substance use

Most adolescents visit a physician every year (Hagan et al., 2008). Adolescents consider physicians to be an authoritative source of information about alcohol and other drugs and are willing to discuss the issue of substance use with them, if the adolescents feel that the conversation will remain confidential (Ford et al., 1997). For adoles-

cents who are not using, these discussions provide an opportunity to encourage healthy and smart choices. Studies show that this reinforcement works (Brown and Wissow, 2009). For adolescents who are using, conversations about substance use show that pediatric care providers are sincerely concerned about the health of their patients, and research suggests that youth have positive impressions of providers who are willing to discuss sensitive issues like substance use (Brown and Wissow, 2009). Physicians therefore have a unique opportunity to address substance use and can have a marked impact on patient behaviors by providing SBIRT.

For a more detailed discussion of issues surrounding confidentiality, see the section titled **Key Issues to Consider**.

WHAT DO WE MEAN BY SBIRT?

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) recommends that health care providers use substance use SBIRT as a part of routine health care (SAMHSA, n.d.). SBIRT has 3 components: screening, brief intervention, and referral to treatment.

SCREENING

Screening identifies substance use along a continuum, from no use to a severe substance-use disorder, using questions from a validated screening tool. The American Academy of Pediatrics recommends screening for substance use at every annual physical examination. Screening can also be conducted at other opportunities:

- In the emergency department or urgent care center
- When seeing patients who:
 - *have not been seen in a while*
 - *are likely to drink, such as youth who smoke cigarettes*
 - *have conditions associated with increased risk for substance abuse (e.g., depression, anxiety, ADD/ADHD, or conduct problems)*
 - *have health problems that might be alcohol related (e.g., problems related to accidents or injuries; sexually transmitted infections or pregnancy; changes in eating or sleeping patterns; gastrointestinal disturbances; chronic pain)*
 - *show substantial behavioral changes (e.g., oppositional behavior, significant mood changes, loss of interest in activities, trouble with the law, change of friends, drop in grade point average, or many unexcused school absences)*

BRIEF INTERVENTION

A brief intervention is a short dialogue (lasting anywhere from a few seconds to several minutes) between the pediatric care provider and the patient that focuses on preventing, reducing, or stopping substance use. Because a primary care visit is often an adolescent's only opportunity to discuss substance use with a professional, these brief conversations can be especially influential.

A brief intervention should be tailored to the level of use identified by the screener. For adolescents who do not use substances, the screener can support and reinforce this decision and other related healthy behaviors. For adolescents who report infrequent substance use, the brief intervention should focus on encouraging them to change their behavior to support their health. The intervention should include clear advice to stop using, brief information on the negative effects of using, discussion of a plan to stop using, and recognition and encouragement of other strengths and positive behaviors of the patient that can support abstinence.

REFERRAL TO TREATMENT

For most adolescents who are identified as substance users, brief intervention can be carried out in the office setting and can increase quit rates among new or low-frequency users (Harris et al., 2012). However, a different approach is required when screening identifies high-risk behaviors or when an adolescent presents with a health problem related to substance use, such as suicidal ideation. In these cases, a referral to treatment is warranted.

Many kinds of substance use treatment are available, ranging from motivational interviewing and individual, group, or family counseling to intensive outpatient, hospital, or residential treatment. This multiplicity of treatment options allows pediatricians to match patient needs to the appropriate type and intensity of treatment.

CONDUCTING SBIRT IN YOUR PRACTICE

PREPARE

Before you institute comprehensive substance use SBIRT, prepare your practice. Educate your clinical and office staff so that they understand the importance of universal screening and brief intervention and are comfortable discussing substance use with adolescent patients. Obtaining the agreement and commitment of your staff will be essential to successfully establishing and maintaining substance use SBIRT in your practice.

PLAN

Once you have the staff's commitment, you will need to set up your practice to carry out SBIRT efficiently and effectively. This involves several critical planning steps.

Determine How to Incorporate Substance Use SBIRT into Your Clinical Practice

- Discuss how your practice currently manages the flow of activities during office visits and how the flow will need to be altered to incorporate substance use screening and brief intervention at each visit with each adolescent.
- Review available validated screening instruments and determine which one you will use. Some screening tools are designed to screen for alcohol alone; others can be used for multiple substances.

See the **Execute** section for more details on these steps.

- Determine how you will conduct the screening. Will you ask patients to fill out the screening instrument, or will a staff member ask the questions? Will you use hard-copy or computerized forms?

- Determine how you will provide referrals to treatment. What process will you use to determine that a referral is necessary, and how will you go about making the referral?
- Decide where and how screening, brief intervention and follow-up, and referral to treatment will be charted, giving consideration to ways to ensure confidentiality. Adjust your electronic medical record system as needed to ensure that the information is recorded. Incorporate cues and reminders into your charting system to encourage consistent, universal screening, interventions, and follow-up.
- Establish procedures for ensuring the confidentiality of screening test results and information discussed during visits and follow-up care. Have the staff become familiar with your state's laws on disclosure of medical records, a minor's consent to substance abuse treatment, parental notification, and the use of professional judgment in determining the limits of confidentiality.
- Create a list of local adolescent substance-use treatment resources and keep the list in exam rooms. Develop relationships with staff at these resources so that you can appropriately match the referral to your patient's needs.
- Place patient educational materials about alcohol and other drugs, as well as other supporting information resources, in exam rooms.

Determine Staff Roles and Responsibilities

- Identify a "champion" from your staff who will lead the practice in establishing SBIRT procedures. The champion also will be responsible for monitoring implementation, evaluating results, and recommending adjustments over time.
- Determine who will conduct the screening. Will clinical assistants or physicians do the screening? If the clinical assistants will do it, then establish procedures so that the results are available to the physician for brief intervention.

Train Staff

- Provide training to those who need it. Training reinforces the knowledge and skills of staff members who are familiar with SBIRT and gives those who are new to SBIRT an opportunity to gain those skills.

SEE APPENDIX 4: **Training for Screening Staff**

AND APPENDIX 5: **Training to Deliver Brief Interventions for guidance on training your staff to conduct substance use screening and brief interventions.**

Conducting SBIRT in Your Practice

PILOT TEST

- To identify problems, pilot the process you have established. A pilot test is critical because it gives you a chance to evaluate the feasibility and acceptability of your plan under actual clinical conditions in your practice. A pilot test is also useful because it:
 - *shines a spotlight on SBIRT and its importance to the practice*
 - *gives staff members a chance to practice their knowledge and skills*
 - *identifies what works and what does not work*
 - *makes it clear that you expect problems to arise during SBIRT implementation and that you are committed to solving them*
 - *provides an opportunity for staff members to suggest improvements, thereby enhancing their commitment to the effort's success*
- Gather feedback from staff members on all aspects of their experience during the pilot test.
- Use the information you gathered, and other lessons learned, to refine and improve your procedures.

EXECUTE

Use the screening tool that is most appropriate for your patients and practice. Ask the questions in the screening tool exactly as they are written,

SEE APPENDIX 6: **Screening Tools** for a list of screening tools that have been validated for use with adolescents.

but also incorporate your knowledge of the patient and family when assessing risk.

If you administer the screening in person, you can encourage honest and accurate answers by doing the following:

- Building time alone with your patient into the visit for this purpose.
- Explaining your confidentiality policy. Make sure your patient (and his or her parents) understand that unless the adolescent is in danger, the details of your conversations will remain private.
- Being your patient's advocate. Explain that you are not singling out certain patients, that you screen all your patients for substance use. Emphasize that your goal is to offer good medical advice and to keep your patients healthy, not to cause problems for them.

Provide Brief Intervention

Match your patient's level of substance use to one of the following brief interventions. Use additional assessment tools if you need more information in order to provide an intervention.

For Patients Who Do Not Drink or Use Other Drugs

Provide positive encouragement and clear messages. Praise these patients and frame the decision not to use alcohol or other drugs as an active choice: "You've made a smart decision not to use alcohol/tobacco/marijuana." Probe to find out why they have made this decision; their answers will give you an additional opportunity to support them and affirm their choice.

Follow up with a clear, strong message about not using: "As your doctor, I care about your health. One of the best things you can do to stay healthy is to continue not to use alcohol, tobacco, or other drugs." Encourage your patients to participate in activities they enjoy, to choose friends who also do not drink or use other drugs, and to never ride in a car with someone who has been using.

Prevent misinterpretations that your screening for substance use means that you expect your patients to be using or that substance use is normal: "I'm glad to hear that you, like many teens your age, don't drink or use other drugs" or "Most teens your age don't drink or use other drugs. For your own health and well-being, I encourage you to continue not to use either." This message may be especially important for younger adolescents.

For Patients Who Do Drink or Use Other Drugs

Patients who report infrequent use are unlikely to have a substance use disorder. A key goal of brief intervention with these patients is to prevent escalation of use to a higher-risk level. Research indicates that physician-delivered brief intervention can encourage adolescents to stop using (Harris et al., 2012).

When you provide a brief intervention, include the following elements:

- Clear advice to quit: "I recommend that you stop drinking, and now is the best time."

Conducting SBIRT in Your Practice

- Information about the harmful effects of substance use: “You’ve probably heard that tobacco causes heart disease and cancer and a lot of other health problems. Quitting now will help you stay healthy. Also, tobacco is one of the most addictive substances.

SEE APPENDIX 7: **Brief Intervention Guidance**
AND APPENDIX 8: **Practice Cases for Role Play**
for guidance on how to conduct brief interventions.

Quitting now will be much easier than quitting later, when you are addicted.”

- Reinforcement for the adolescent’s strengths and healthy decisions: “I see you’re on the soccer team at school. That’s great. Not using marijuana will help you perform your best on the field.”
- Assistance with making a plan to quit or reduce use. Many adolescents are concrete thinkers, and helping them think through the specifics of how to quit and how to deal with related challenges can be valuable. This process also can help adolescents feel in charge of their own behavior and can enhance their commitment to behavior change. This kind of “change plan” can be similar to an asthma or diabetes change plan. Include the change plan in your patient’s medical record so that you can evaluate your patient’s progress over time and amend the plan as needed. If you think the information in the plan may be harmful to your patient if viewed by the parent or guardian, or relates to legal issues of confidentiality involved in counseling of teens for the use of alcohol or other substances, steps must be taken to ensure confidentiality in the medical record.

After you have provided a brief intervention, follow up with your patients, either in a specifically scheduled visit or at the next health supervision visit. Follow-up gives you the opportunity to ask your patients whether they met their goals, what challenges they experienced, and how they dealt with the challenges. Not meeting the goals laid out in the plan may indicate a more serious substance-use disorder, which will help you determine the next steps for care.

Refer to Treatment

Adolescents who report weekly or more frequent substance use are likely to have a severe substance use disorder. In many cases, by the time an adolescent has reached this point, parents are already aware of the drug use, although they may underestimate the seriousness of the problem.

Adolescents with serious substance-use disorders require more-intensive care as soon as possible, including a comprehensive evaluation by a substance use specialist, assessment for co-occurring mental health disorders, and referral to treatment. Your patient or the family may be unwilling to pursue

these options. Brief intervention may be a useful first step in helping the patient and family accept the need for more-intensive treatment.

Physicians have 2 major roles to play during the referral process. The first is to work with the patient and family to ensure that they accept the need for treatment and to demonstrate support during discussions and decision-making about treatment options. The second is to facilitate the referral process to ensure that the patient and

family are linked with the most appropriate professionals and programs. Determining the most appropriate treatment option depends on the availability of treatment, insurance coverage, and the preferences

of the patient and family. Adolescents should be treated in the least restrictive setting possible.

SEE APPENDIX 9: **Motivational Interviewing** for a link to an AAP video on this intervention approach.

SEE APPENDIX 10: **Referral Resources**

AND APPENDIX 11: **Substance Use Treatment Programs** for guidance on developing a list of referral options and for information on types of treatment programs.

SEE APPENDIX 12: **Steps to Referral** for guidance on the referral process.

EVALUATE AND REFINE

To ensure that your SBIRT protocols and procedures are working smoothly, monitor these activities so that you can refine and improve them over time. Consider doing the following:

- Obtain regular feedback from your staff on what is working well and what needs improvement.
- Set specific time intervals at which to evaluate your program, just as you do other aspects of your practice.
- Stay current with research on substance abuse screening, interventions, and treatment for adolescents.
- Learn from others. Talk with other practices to see what they are doing and what is working for them.

KEY ISSUES TO CONSIDER

CONFIDENTIALITY

Protecting the confidentiality of information is an important consideration for determining whether adolescents will answer questions honestly and accurately, seek help, and stay engaged with their pediatricians and other health care professionals. Health care organizations, including the American Academy of Pediatrics, the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the Society for Adolescent Health and Medicine, have established positions and recommendations about confidentiality and informed consent for adolescents.

Practical Considerations

- **Explain your practice's confidentiality policies to your patient and his or her parents.** Describe these policies before the first visit at which you will spend time with the patient alone (the 7- or 8-year visit), or at the first visit with an adolescent new patient.
- **Set aside private time with your adolescent patient as a routine matter.** This will set the stage for regular private conversations and contribute to building a strong partnership with your patient.
- **Decide when and how to break confidentiality.** As you work with your patient on substance use, you may need to decide whether to break confidentiality and inform the parents. Your clinical judgment and your state's minor consent laws will help you make this decision.

Consider your patient's age, level of use, and risk of injury associated with the use and whether your patient has any other medical conditions. Occasional use of alcohol or marijuana by an

SEE: **State Minor Consent Laws: A Summary (English et al., 2010)** for a brief descriptions of laws across a range of issues, including drug and alcohol treatment. **Appendix A (p. 289–90)** of the publication is a handy summary chart for all the states.

older adolescent may not warrant breaking confidentiality. In contrast, it may be necessary if your patient does not honor commitments to reduce

or stop substance use, if the substance use escalates, or if the patient is very young, reports driving while impaired, or has a chronic medical or mental health condition (e.g., diabetes or a major depressive disorder) that may be exacerbated by substance use.

- **Work with your patient to make a plan for disclosing information.** First tell your patient that the information must be disclosed to his or her parents and then work out a strategy together for how to disclose the information. Adolescents may be less resistant to disclosure if you discuss in advance why it is necessary, who will disclose the information, how the disclosure will help, and what the next steps might be. The goal is to have your patient agree to involve his or her parents. Your patient may be more agreeable to disclosing information to parents if details that would not materially affect the disclosure can be withheld.

Here is one way to begin the discussion: "I want you to understand that when we talk about your alcohol/tobacco/other drug use, what you tell me is confidential. This means that what we talk about is just between you and me and that other people, including your parents, will not find out about it unless you want them to know. One exception to this is if I am concerned that you are at serious risk of harm. In that situation, your parents will have to be informed, but I will talk to you first so we can figure out the best way to handle it."

- **Keep follow-up visits confidential.** Follow-up is critical to the success of brief intervention. You may need to come up with a reason, other than substance use, to schedule a follow-up appointment so you can ensure that you have the opportunity to talk with your patients about how they are doing with their change plan.

Key Issues to Consider

- **Take steps to ensure that standard procedures do not inadvertently break confidentiality.** Develop strategies so that standard procedures, such as appointment reminders and billing and payment procedures, do not inadvertently disclose confidential information.
- **Know your state's laws pertaining to releasing medical records.** This knowledge can protect you if a parent should ask for access to a child's medical record.

BILLING AND PAYMENT

Billing and payment for screening and office-based brief intervention vary by payer. The AAP has several resources with useful information:

- The AAP site Practice Management Online has a comprehensive fact sheet about coding, including CPT coding of behavior change intervention for substance abuse. <https://www.aap.org/en-us/professional-resources/practice-Transformation/Pages/practice-transformation.aspx>
- Further clarification is available through the AAP coding hotline, at AAPCodinghotline@aap.org, and through the annually updated AAP publication titled Coding for Pediatrics (AAP, 2015).

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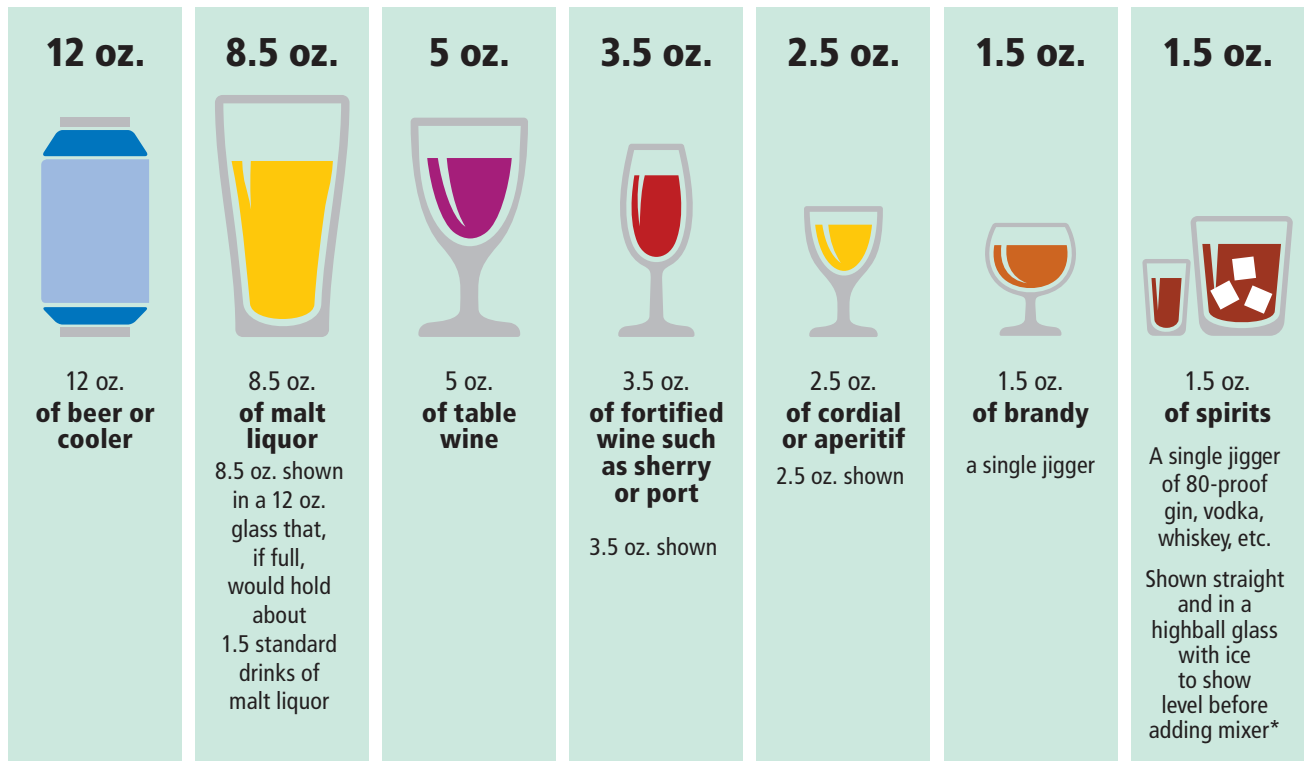
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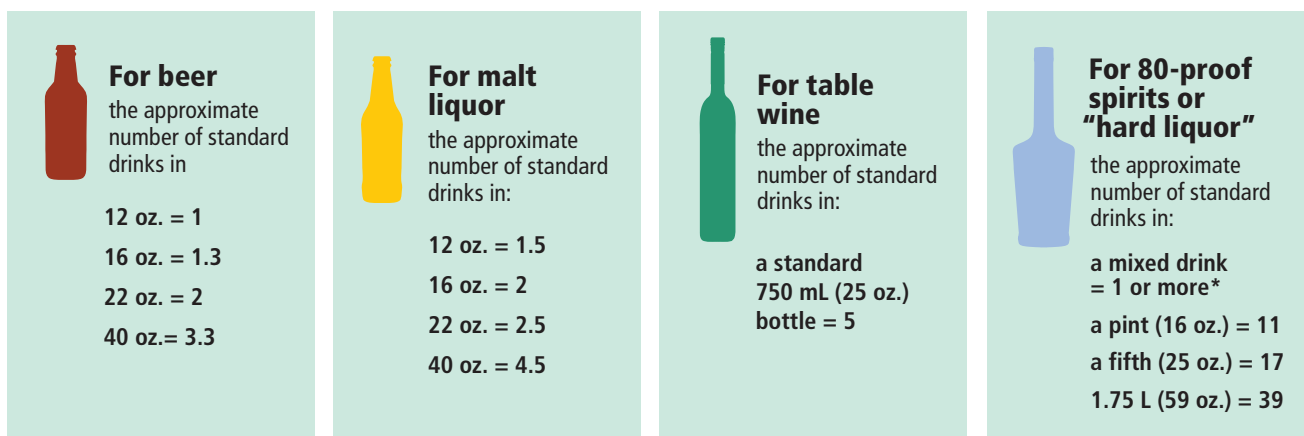
Appendix 1

What Is a Standard Drink?^a

A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents. These are approximate, since different brands and types of beverages vary in their actual alcohol content.



Many people don't know what counts as a standard drink and so they don't realize how many standard drinks are in the containers in which these drinks are often sold. Some examples:



*Note: It can be difficult to estimate the number of standard drinks in a single mixed drink made with hard liquor. Depending on factors such as the type of spirits and the recipe, a mixed drink can contain from one to three or more standard drinks.

^a National Institute on Alcohol Abuse and Alcoholism. *Helping Patients Who Drink Too Much: A Clinician's Guide* 2007. http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide13_p_mats.htm

What is a Standard Drink? [CONTINUED]

How much alcohol is in a standard drink?



Smirnoff Ice Bottle
(12oz)/5% alcohol



Shot
(1.5oz)/40% alcohol



Glass of Wine
(5oz)/10-12% alcohol



Mike's Hard Lemonade
(12oz)/5.2% alcohol



Budweiser Beer Can
(12oz)/4-5% alcohol



Bud Light Beer Can
(12oz)/4-5% alcohol

All of these drinks contain the SAME amount of alcohol

How many drinks does it REALLY equal?



Negative Health Effects of Adolescent Substance Use^{a,b}

ALCOHOL

Alcohol is the psychoactive substance most commonly used by teens. Adolescent drinking patterns tend to be episodic and heavy. More than 90 percent of alcohol consumed by teens is in the context of a binge (Office of Juvenile Justice and Delinquency Prevention, 2005). Studies using rat models verified the common experience with humans: adolescents are less sensitive to the motor impairing effects of alcohol and are more likely to be awake and active at significant levels of impairment (Little et al, 1996). Adverse effects of early onset and heavy alcohol use have been well described.

- Heavy alcohol use in early to middle adolescence impairs memory function (Brown, Tapert, Granholm, & Delis, 2000).
- Alcohol is particularly damaging to the hippocampus, part of the brain that is important for memory and learning (De Bellis, 2000). Teens who drink heavily have poorer school performance than their peers (Brown & Tapert, 2004). A “black out” occurs when the concentration of alcohol in the blood is high enough to temporarily affect brain cells that lay down new memories (White, n.d.).
- Teens who start drinking at an earlier age are at high risk for motor-vehicle accidents, fights, and unintentional injuries when they were using alcohol (R. Hingson, Heeren, & Zakocs, 2001; Ralph Hingson, Heeren, Levenson, Jamanka, & Voas, 2002; Ralph W. Hingson, 2000; Slap, Chaudhuri, & Vorters, 1991).
- They are also more likely to engage in risky sexual behaviors that could result in early pregnancies, STDs, etc. (Tapert, Aarons, Sedlar, & Brown, 2001).

Alcohol use in pregnancy can result in fetal alcohol syndrome and other behavior effects. There is no safe level of alcohol use during pregnancy (US Surgeon General, 2005). Sexually active teens should either use birth control and condoms, or refrain from any use of alcohol and other drugs.

TOBACCO, ELECTRONIC CIGARETTES AND HOOKAH

Most adolescents know that tobacco use has devastating consequences on health, but they may not know that the nicotine in tobacco products is especially toxic to the developing brain. Animal research shows that nicotine produces structural and chemical changes in the brain that increase the risk of future alcohol and other drug addiction, panic attacks and depression. It is likely that because of the way nicotine changes the brain, people who start smoking (even occasionally) as adolescents may show signs of dependence (Abreu-Villaça et al., 2003).

Electronic cigarettes or “E-cigs” do not contain tobacco. They deliver liquefied nicotine via vapor instead of smoke. While rates of tobacco use have fallen dramatically since the 1990’s, electronic cigarettes have become increasingly popular among adolescents. Because electronic cigarettes do not produce smoke, their danger is not always recognized. However, the liquid nicotine may contain toxins and contaminants. As concerning, the nicotine itself is highly addictive. E-cigs are sometimes marketed as a tobacco cessation device. They are not a safe alternative to tobacco, and threaten to attract

^a Adapted from Centers for Disease Control and Prevention. *Planning and implementing screening and brief intervention for risky alcohol use: a step-by-step guide for primary care practices*. Atlanta, GA: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, 2014.

^b Adapted from Massachusetts Department of Public Health, Bureau of Substance Abuse Services. *Adolescent SBIRT toolkit for providers*. Boston, MA: Massachusetts Department of Public Health, 2015. https://www.mcpap.com/pdf/SBIRTWorkbook_A.pdf

increasing numbers of youth to using nicotine with flavors such as cotton candy and bubble gum. Currently, the FDA only regulates the marketing of electronic cigarettes for therapeutic purposes (Products, n.d.).

Hookah refers to a pipe that passes smoke through a water basin and delivers vapor for inhalation. Hookah is most often used for flavored tobacco, but can also be used for other substances, including tobacco-free products. In some cities hookah bars have opened and allow teens ages 18 and older to smoke. Hookah is not a safe alternative to smoking. Users often spend 30-60 minutes at a time during which large volumes of toxins are inhaled. Rates of hookah use are rising among US teens (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2014), with rates highest among teens with a parent(s) with higher education, and from small or large Metropolitan Statistical Areas (Palamar, Zhou, Sherman, & Weitzman, 2014).

MARIJUANA

In this information age adolescents can easily obtain a large body of information about marijuana from the Internet. This information may influence their behavior; the inverse relationship between perceived risk of harm and use of a substance has been very well established (Johnston, O'Malley, Bachman, et al., 2014). The problem is many teens have information that is only partially correct, slanted, or misinterpreted. The good news is that research has demonstrated that adolescents support the idea of physician-initiated advice regarding substance use (Yoast, Fleming, & Balch, 2007), which suggests that

brief physician advice may be particularly salient. Below is a list of adverse effects of marijuana use for which there is a *high* level of confidence in the evidence for association (Volkow, Baler, Compton, & Weiss, 2014).

Marijuana use is associated with:

- Symptoms of chronic bronchitis
- Addiction to marijuana and other substances
- Diminished lifetime achievement
- Motor vehicle accidents, in a number of studies

PRESCRIPTION OPIOIDS

While not as common as alcohol and marijuana use, the risk of prescription opioid misuse is high because of the addiction liability of opioids. One study found that many adolescents who “misuse” opioids (i.e., use them without a prescription) do so in order to address pain, albeit inappropriately (McCabe et al, 2012). These adolescents can benefit from medical assessment, pain management, and brief advice regarding the risks of opioid misuse.

Adolescents who develop opioid use disorders are at high risk of associated complications including transition to injection drug use and fatal overdose. For these teens, access to medication assisted treatment and psychosocial support should be provided as treatment is effective (Woody et al., 2008). There are medication assisted treatments available for adolescents. To learn more, go to the website of the Providers' Clinical Support System for Medication Assisted Treatment (<http://pcssmat.org/>).

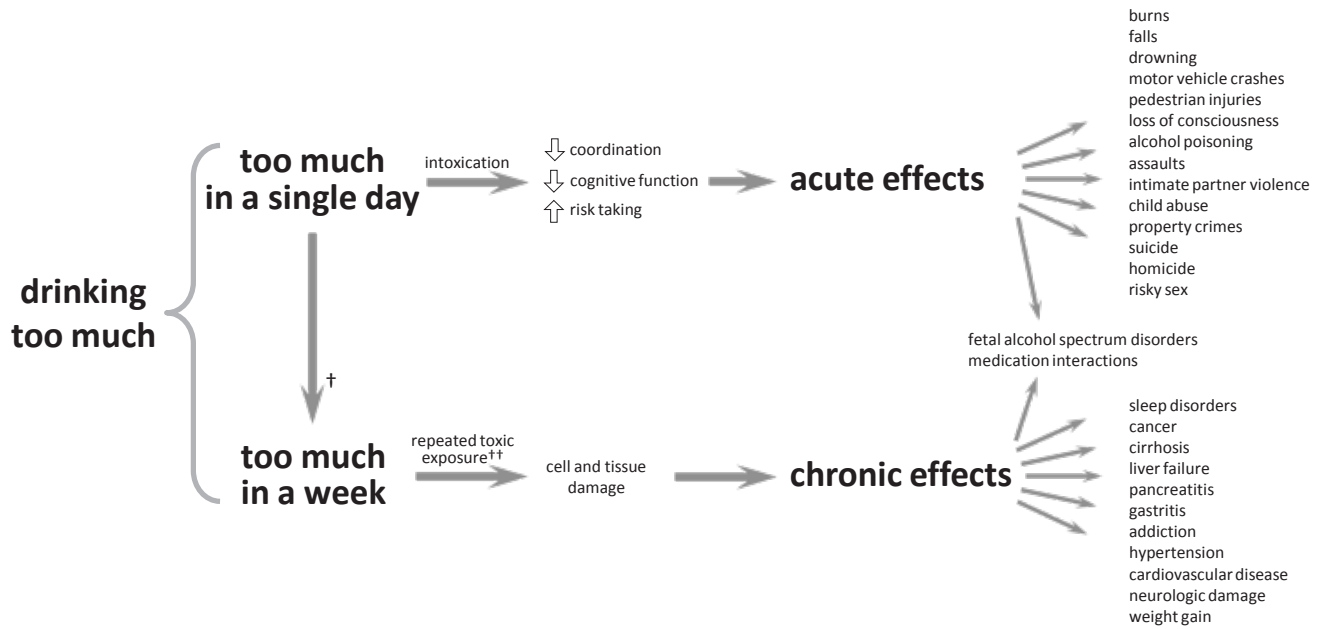
Appendix 2

Negative Health Effects of Adolescent Substance Use [CONTINUED]

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Drinking Too Much: Acute and Chronic Health Effects^a



† People regularly drinking over the daily limit may experience both acute and chronic effects.
 †† Alcohol is toxic to human cells at relatively low levels.

^a Adapted by D Hungerford from: Cole S, Bogenschutz M, Hungerford D (2011). Motivational interviewing and psychiatry: use in addiction treatment, risky drinking and routine practice. FOCUS, 9:42-54.

Training for Screening Staff^a

It is probably best to create your own training for staff who will be screening patients. This avoids any confusion from videos and materials from other programs that use instruments and procedures different from those you have chosen.

Consider the following learning objectives and training elements as you create training for your screening staff.

LEARNING OBJECTIVES

1. Understand the nature and scope of alcohol-related risks.
2. Understand the purpose of screening for alcohol use, rather than solely for alcohol problems and dependence.
3. Understand the screening instruments and be able to follow screening procedures.
4. Understanding how screening fits within the overall alcohol SBI plan.

TRAINING ELEMENTS FOR SCREENING STAFF

- Describe the purpose of your screening plan so that screeners will understand how their work fits into the overall alcohol SBI plan.
- Explain why routine use of validated screening instruments produces better results than subjective judgments of staff.
- Describe the specific steps in your screening procedures. Name the instrument or instruments to be used, and describe how they help identify patients at risk.
- Review each instrument, its function within your overall system, the questions involved, how to introduce it to patients, how to score it, and how to report that score to all who need to know.
- Confirm that screeners understand what each score means and what will happen to patients with each score.
- Brainstorm what questions patients might ask with trainees, and help them develop appropriate responses.
- Discuss the limits of the screener's role and who will be performing the other alcohol SBI functions.
- Ask trainees for their questions about screening and the alcohol SBI plan in general, and discuss answers to those questions so they are both informed and comfortably supportive of their roles.
- Have all screening staff practice the functions they will be required to perform.

^a Centers for Disease Control and Prevention. *Planning and implementing screening and brief intervention for risky alcohol use: a step-by-step guide for primary care practices*. Atlanta, GA: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, 2014.

Training to Deliver Brief Intervention^a

In general, brief intervention training consists of four broad areas:

1. Confidence or Self-Efficacy
2. Style
3. Content
4. Practice

1. CONFIDENCE OR SELF-EFFICACY

People are more likely to become good at any job if they not only know that the job can be done, but also that they can do it. The first step in brief intervention training is to review the rationale that has led you to establish your alcohol SBI service.

- The main target population for brief interventions is nondependent, risky drinkers. These drinkers are not addicted, so the goal of the intervention is to motivate them to cut back or stop drinking.
- Patients who have alcohol dependence are also risky drinkers, but there will be far fewer of them. For them the goal is different. Not only do we want to motivate them to change their drinking patterns, but we also want to motivate them to seek further help. We know the brief intervention, by itself, is unlikely to be sufficient help.
- Research on brief interventions for risky drinking has been widely successful in primary care settings. Many studies were implemented by regular primary care staff who received training similar to what you will provide to your staff.
- Staff should understand that not all patients will reduce their drinking with only one intervention. However, studies show that reductions in drinking by those patients who do respond make the overall service highly beneficial and cost-effective.
- Staff should also understand that such interventions are effective even though they are quite simple to provide, take only a few minutes, and are regularly done by their peers.

2. STYLE

You have selected certain members of your staff to perform brief interventions in large part because of the sort of people they are—friendly, interested in patients, good listeners, and empathetic. Those are also the primary skills that seem to make brief interventions successful.

- Staff should understand that the main job of a brief intervention is to motivate patients to be aware of alcohol consumption patterns, understand the associated risks, and make their own decisions. The slide presentation on “How to Increase Motivation” by a physician who is one of America’s leading SBI scholars provides useful information and tips on how best to motivate patients. The presentation is available at <http://bumc.bu.edu/care/files/2008/09/1how-to-increase-motivation-saitz-2008.pdf>
- An advanced degree or certification is NOT required to deliver an effective brief intervention. However, staff can enhance their skills by using tools taught by various programs of motivational interviewing. Some of those items are available at: http://motivationalinterview.org/clinicians/Side_bar/skills_maintenance.html.
- Although the following videos demonstrate brief interventions conducted in an emergency department, they will help trainees recognize the features of a “good” brief intervention by dramatically comparing them with “bad” interventions. See 1) Anti-SBIRT (Doctor A) and 2) using SBIRT Effectively (Doctor B) at <http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educationalmaterials/sbirt-videos/>

^a Centers for Disease Control and Prevention. *Planning and implementing screening and brief intervention for risky alcohol use: a step-by-step guide for primary care practices*. Atlanta, GA: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, 2014.

Training to Deliver Brief Intervention [CONTINUED]

3. CONTENT

Staff need training in all the particulars of what they should do to deliver a brief intervention. It is important that they understand these matters before they watch videos and consult other training materials so that they will know how your plan differs from what they may encounter elsewhere. Only you can provide a full list of that content, based upon your planning. Address the following issues during your training:

- When and where brief interventions will be delivered, and what happens if they cannot be done on the same day as screening.
- How the subject will be introduced to patients.
- What elements are to be included in the intervention.
- What materials, if any, staff will use as reminders or share with patients as well as where those materials will be and who is responsible for producing and distributing them.
- How long (and how short) interventions should be.
- How staff will know which patients should receive interventions.
- What special elements are to be used with screened patients identified as likely to have alcohol dependence.
- What referral procedures have been established and how they are to be used.
- How follow-up should be scheduled and conducted with patients.
- How to document each intervention with respect to patient records, other clinicians, billing, etc.
- What data on interventions will be collected and analyzed for quality improvement.
- How to report issues relating to alcohol interventions that others should know about.

4. PRACTICE

Understanding alcohol brief interventions is one thing; doing them is another. The best training about this subject is no substitute for actually doing it. So every training of staff who will perform brief interventions should include opportunities for practice, with feedback on performance.

Seeing others conduct interventions is one way for people to learn—as long as those demonstrations come close to being what your planning team has decided upon for your practice. The following websites provide video demonstrations that might prove useful.

1. NIAAA provides 10-minute videos of four cases of how practitioners can conduct alcohol SBI for at-risk drinkers but also manage severe cases, including addiction, if they choose. The videos are available at: <http://niaa.nih.gov/publications/clinical-guides-and-manuals/niqua-clinicians-guide-online-training>
2. View a 4:36-minute intervention with a male who is drinking at hazardous levels. You can play or download the example “Brief Intervention: Steve” at <http://www.sbirtoregon.org/movies.php>. To compare the same script with different actors, view the video labeled “Michael” at <http://www.sbirtnc.org/vid-eodemonstrations/>
3. View a 5:15-minute intervention with a woman who has hypertension and is drinking at harmful levels. You can play or download the example “Brief Intervention: Jill” at <http://www.sbirtoregon.org/movies.php>. To compare the same script with different actors, view the video labeled “Marie” at <http://www.sbirtnc.org/video-demonstrations/>

After you view video demonstrations, you can easily create a fictional patient whose role can be played by you or another staff member. After practice, the person playing the patient can provide feedback on what seemed good and what could be improved. More practice and practice with different “patients,” will build both skills and confidence. Practice will also help you and your trainees become comfortable delivering brief interventions. In time, delivering an alcohol intervention will be no more difficult than taking blood pressure.

Screening Tools

Screening tools validated for use with adolescents^a

S2BI

- Frequency screen
- Screens for tobacco, alcohol, marijuana, and other illicit drug use
- Discriminates between no use, no substance use disorder (SUD), moderate SUD, and severe SUD, based on DSM-5 diagnoses

NIAAA YOUTH ALCOHOL SCREEN

- Two question screen
- Screens for friends' use and own use

CRAFFT

- Car, Relax, Alone, Friends/Family, Forget, Trouble
- The CRAFFT is a good tool for quickly identifying problems associated with substance use.

BSTAD

- Brief Screener for tobacco, alcohol, and other drugs
- Identifies problematic tobacco, alcohol, and marijuana use in pediatric settings

GAINNS

- Global Appraisal of Individual Needs
- Assesses for both substance use disorders and mental health disorders

AUDIT

- Alcohol Use Disorders Identification Test
- Assesses risky drinking

^a Williams JF, Smith VC, the Committee on Substance Abuse. Fetal Alcohol Spectrum Disorders. *Pediatrics*. Nov 2015, 136(5) e1395-e1406.

Brief Intervention Guidance^a

The Brief Intervention Training Notes on the next page is a reference sheet developed from ten, day-long training sessions on alcohol SBI supported by three federal agencies and presented for staff from emergency departments and trauma centers around the United States. Although designed for acute-care clinical settings, it is also applicable in primary care settings.

FEEDBACK ON SCREENING RESULTS

The FLO (Feedback, Listen, Options) mnemonic was developed to encompass the three major elements of a brief motivational intervention. The feedback element is more important than it might seem at first. Although you may choose not to use the RANGE mnemonic as presented (under the 'Feedback' section), each of those five elements is important in helping patients understand their screening results. Moreover, the fifth element, 'Elicit patient's reaction' is particularly important because it turns responsibility for the discussion over to the patient.

LISTEN FOR CHANGE TALK

The Listen step is the heart of the brief intervention. It may be the most difficult for many in the medical professions because they are trained to dispense expert advice, not to listen, so their first question might be, "Listen for what?" First, listen to how patients feel about getting a screening result that means they are drinking too much. Then summarize those feelings. The goal is to help patients think about the pros and cons of their current drinking pattern. By asking for both, you are not setting up an argument you will lose, that is, an argument where you are on the side of drinking less or stopping, and the patient is on the side of continuing the current behavior. That's an argument the patient has already practiced.

Instead, you set up a balanced approach by setting the patient up to argue with him or

herself, both pro and con. Then, you are in a position to listen for "change talk," the patient's own words that support change. The important thing is to listen for patients' specific language, so that you can repeat it back. By using their words, you make it clear that you are not arguing, but are just neutrally pointing out that they have thoughts and feelings on both sides of the issue.

OPTIONS

In the Options step, you start to conclude the interaction. If the patient is ready to do that, all you have to ask is "Where does this leave you?" They will take it from there. With other patients, you can just present the five choices provided by the MENUS mnemonic.

As a healthcare expert you may be pulled to provide advice. If you do that, make sure to use the Ask-Advise-Ask method. It not only reduces resistance but also indicates respect, strengthens rapport, and lets you know whether the patient actually heard your advice.

Sometimes, people wonder why 'Continue Usual drinking pattern' is included as an option. No matter what you might believe, the power to decide, in reality, belongs to the patient. In acknowledging that reality, you communicate to them clearly that the responsibility for changing behavior is theirs. No matter which option they choose, you understand the difficulty of their situation and respect their right to control their own lives. That will help end the interaction on good terms.

^a Centers for Disease Control and Prevention. *Planning and implementing screening and brief intervention for risky alcohol use: a step-by-step guide for primary care practices*. Atlanta, GA: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, 2014.

Orient the Patient

- Identify yourself** and explain your role on the trauma team.
- Get permission**, explicit or implicit, from the patient to talk together for a few minutes.
- Explain the purpose** of this discussion is to
 - 1) give them information about health risks that may be related to their drinking,
 - 2) get their opinions about their drinking, and
 - 3) discuss what, if anything, they want to change about their drinking.

Feedback

Using Binge Question

- R**ange: The number of drinks people have on a single occasion varies a great deal, from nothing to more than 10 drinks.
- A**nd we know that having too many drinks at one time can alter judgment and reaction times.
- N**ormal: Most drinkers in the United States have fewer than 2 () or 3 () drinks on a single occasion.
- G**ive Binge Questions results. "You drank more than that ___ times last month, increasing your risk for health problems."
- E**licit the patient's reaction. "What do you make of that?"

Using AUDIT

- R**ange: AUDIT scores can range from 0 (non-drinkers) to 40 (probably physically dependent on alcohol).
- A**UDIT has been given to thousands of patients in medical settings, so you can compare your score with theirs.
- N**ormal AUDIT scores are 0–7, which represent low-risk drinking. About half of the U.S. population doesn't drink.
- G**ive patients their AUDIT score. "Your score of ___ means you are (at risk or high risk), putting you in danger of health problems."
- E**licit the patient's reaction. "What do you make of that?"

Listen for Change Talk

- Goals**
- a) Listen for pro-change talk—the patient's concerns, problem recognition, and downsides of drinking.
 - b) Summarize the patient's feelings both for and against current drinking behavior.
"On the one hand . . . On the other hand . . ."

- Methods**
- "What role do you think alcohol played in your injury?"
 - Explore **pros and cons** of drinking. "What do you like about drinking? What do you like less about drinking?"

Is this patient interested in change?

- "On a scale of 0 to 10 [with 0 indicating not important, not confident or not ready], rate. . ."
- ". . . how **important** it is for you to change your drinking behavior?"
- ". . . your level of **readiness** to change your drinking behavior?"
- "Why did you choose ___ [the # stated] and **not a lower** number?"

If the patient is interested in changing, use these questions.

- "What would it take to raise that number?"
- "How **confident** are you that you can change your drinking behavior?"

Reflect and summarize throughout.

Options

"Where does this leave you? Do you want to quit, cut down, or make no change?"

- You could:
- M**anage your drinking,
 - E**liminate drinking from your life,
 - N**ever drink and drive,
 - Continue **U**sual drinking pattern, or
 - S**eek help.

If appropriate, ask about a **plan**. "How will you do that? Who will help you? What might get in the way?"

Close on Good Terms

- S**ummarize the patient's statements in favor of change.
- E**mphasize the patient's strengths.
- W**hat agreement was reached?

✓ **Always thank the patient for speaking with you.**

If You Give Advice

When you have significant concerns or important information to impart, use this approach. It reduces the possibility of patient resistance.

- Ask:** Ask permission to discuss your concerns.
- Advise:** If permission is granted, give information or share your concerns.
- Ask:** Ask for the patient's reaction to your comments.

April 2009: C Dunn, C Field, D Hungerford, S Shellenberger, J Macleod

Practice Cases for Role Play^a

Instructions for Case Practices:

You can think through these vignettes on your own, or you can use them to role play with your colleagues. If possible, try to pull together at least 4 people for each exercise. If you have more, they can watch and give comments if someone gets “stuck” (and their turn in the hot seat will be next)!

Steps for practice cases:

Select 4 “volunteers”

- Two people will be the adolescent (one actor, one coach)
- Two people will be the PCP (one actor, one coach)

Everyone else forms the audience and should read both roles

- Read your role
- Act out scenario
- If you are playing the PCP, you can refer to “Help for PCP”
- If you are a “coach” or audience member, feel free to jump in if an actor gets “stuck”
- Have fun!

CASE A: JOSH

Adolescent Role: You are Josh, a 16-year-old boy coming in for a check-up. Your mother is in the waiting room.

If your PCP screens you for substance use in the past year:

- You have been drinking at parties about once a month.
- You have used marijuana once or twice.
- You do not use tobacco products or any other substances.

If your PCP asks follow-up substance use questions:

- You drink at unsupervised house parties.
- You usually have 6-8 drinks at a party.
- You don’t drive yet.
- You often forget how you get home from parties.
- You admit that you don’t like to think about it because the thought can be frightening.

If your PCP makes a plan with you about your substance use:

- You are not going to quit drinking.
- You agree to limit yourself to two drinks per occasion.
- You refuse to let your PCP discuss the plan with your mother.

What is your S2BI result?

- No use
- Once or twice
- Monthly or more
- Weekly or more

What is your risk category?

- No use
- No SUD
- Mild/Moderate SUD
- Severe SUD

What intervention did your PCP try with you?

- Positive reinforcement
- Brief advice to quit
- Assess, discuss, and make a plan
- Assess, discuss, make a plan, and refer

^a Massachusetts Department of Public Health. Adolescent SBIRT toolkit for providers. Boston, MA: Massachusetts Department of Public Health Bureau of Substance Abuse Services, 2015.

Appendix 8

Practice Cases for Role Play [CONTINUED]

CASE A: JOSH CONTINUED

PCP Role: Josh is a 16-year-old boy presenting for an annual check-up. His mother is in the waiting room. You use the S2BI screen.

What is Josh's S2BI result?

- No use
- Once or twice
- Monthly or more
- Weekly or more

What is Josh's risk category?

- No use
- No SUD
- Mild/Moderate SUD
- Severe SUD

What intervention should you try with Josh?

- Positive reinforcement
- Brief advice to quit
- Assess, discuss, and make a plan
- Assess, discuss, make a plan, and refer

Would you tell Josh's mother about his substance use?

- Yes
- No

If yes, what would you say to her?

Help for PCP

If you get stuck, here is some help.
Sample counseling language:

- **Ask Josh for his own reasons to stop drinking.**
What are your concerns about drinking? Why might you want to stop drinking? Tell me more...When was the last time that happened?

- **Reflect back what Josh tells you about his reasons to stop drinking.**

It sounds like you like to drink at parties, and, at the same time, you end up in some pretty frightening situations when you drink. Is that what you mean? Did I get it right?

- **Elicit his knowledge about the problems that can arise from drinking, and provide corrections and additions as you summarize and affirm.**

What does a blackout mean about the drinking? It sounds like you know a lot about the negative effects of drinking on the brain. As you said, a blackout means that you drank enough to poison your brain cells, at least temporarily.

- **Affirm his change language and summarize his reasons for not drinking.**

As you pointed out, kids often get themselves into trouble when they "black out." It sounds as if you have had some frightening experiences. Given your experiences, it makes sense that you might be considering not drinking.

- **Give clear advice, while acknowledging agency.**

As your PCP, I recommend that you stop drinking alcohol for at least until you are older. How can you work toward not drinking?

- **Ask questions to empower Josh to develop a plan.**

How do you think you can take care of yourself in the future? It sounds like you have made a very important decision to limit your drinking. What sorts of things will help you to follow your plan?

What else should I do?

- **Ask Josh for permission to discuss the plan with his mother.**
- **According to the requirements of your site and any applicable laws, record the plan in the medical record to prompt yourself to follow up on Josh's drinking at his next visit.**

Appendix 8

Practice Cases for Role Play [CONTINUED]

CASE B: TRACY

Adolescent Role: You are Tracy, a 17-year-old girl coming in for a check-up. Your mother is in the waiting room. You plan to go to college next year.

If your PCP screens you for substance use in the past year:

- You have been using marijuana a couple of times a week.
- You drink about once a month.
- You have tried “lots of things,” including Ecstasy (“a few times”) and cocaine (“twice”).

If your PCP asks follow-up substance use questions:

- You smoke marijuana to try to relieve stress from school and friendships.
- You don’t think it’s a big deal. After all, marijuana is legal for medical use, isn’t it?
- Your marijuana use has caused stress in your relationship with your mother—she knows about your marijuana use and is upset about it because she thinks it is unhealthy.
- You sometimes smoke marijuana before school.
- You were recently suspended from school for coming to school high.
- Your grades have declined over this school year—you used to get As and Bs, but now you are getting Cs and you are failing your first subject of the day, English.
- You sometimes drive high.

If your PCP makes a plan with you about your substance use:

- You are willing to speak with a counselor, although you are not sure about it.
- You are willing to let your PCP discuss the plan with your mother.
- You are not sure you can stop using marijuana; you are just so stressed.

What is your S2BI result?

- No use
- Once or twice
- Monthly or more
- Weekly or more

What is your risk category?

- No use
- No SUD
- Mild/Moderate SUD
- Severe SUD

What intervention did your PCP try with you?

- Positive reinforcement
- Brief advice to quit
- Assess, discuss, and make a plan
- Assess, discuss, make a plan, and refer

Appendix 8

Practice Cases for Role Play [CONTINUED]

CASE B: TRACY CONTINUED

PCP Role: Tracy is a 17-year-old girl presenting for an annual check-up. She plans to go to college next year. Her mother is in the waiting room. You use the S2BI screen.

What is Tracy's S2BI result?

- No use
- Once or twice
- Monthly or more
- Weekly or more

What is Tracy's risk category?

- No use
- No SUD
- Mild/Moderate SUD
- Severe SUD

What intervention should you try with Tracy?

- Positive reinforcement
- Brief advice to quit
- Assess, discuss, and make a plan
- Assess, discuss, make a plan, and refer

Would you tell Tracy's mother about her substance use?

- Yes
- No

If yes, what would you say to her?

Help for PCP

If you get stuck, here is some help.
Sample counseling language:

- **Provide a balanced summary, using empathy.**
It seems that you are trying to use marijuana to help you manage stress and, at the same time, marijuana use is causing tension between you and your mother and has gotten you into trouble at school.

- **Develop discrepancy between marijuana use and values/goals/desired behaviors; elicit ambivalence about marijuana use.**

Can you tell me more about how marijuana has affected your relationship with your mother? How would you like your relationship with your mother to be? How does using marijuana fit in with how you'd like to be in that relationship? Tell me more about school...What are you thinking you would like to do after high school? How does your marijuana use fit in with those plans?

- **Affirm consideration of discontinuing use.**

It is clear that you are really thinking carefully about your marijuana use, its role in your life, and the effects that it is having.

- **Give clear advice, while acknowledging agency.**

As your PCP, I recommend that you stop using marijuana for the sake of your health, your plans for your life, and the relationship between you and your mother. How can you work toward not using marijuana?

- **Make a referral.**

Talking through these issues with a counselor can be very helpful as you develop your plan to address them. What do you think about that?

What else should I do?

- **Propose involving the parents.**

Let's invite your mother in to discuss your plan. That way you can give her the chance to see that you are taking the concerns about your marijuana use seriously.

- **Make a follow-up appointment.**

I would like to see you and your mother again in a month to see how your plan is going.

- **According to the requirements of your site and any applicable laws, record the plan in the medical record.**

Appendix 8

Practice Cases for Role Play [CONTINUED]

CASE C: ANTHONY

Adolescent Role: You are Anthony, a 16-year-old boy coming in for a check-up. Your mother is in the waiting room.

If your PCP screens you for substance use in the past year:

- You are using alcohol, marijuana, tobacco, and prescription medications at least weekly.

If your PCP asks follow-up substance use questions:

- You actually use opioids every day.
- You get Vicodin® and Oxycontin® from friends' medicine cabinets and from dealers at high school.
- You think your opioid use is a problem.
- You tried stopping on your own, but you felt so sick (nausea, stomach aches, diarrhea, muscle aches) that you had to start up again.
- You want help, but you are afraid to tell your parents—they'll be so disappointed in you.
- You are so relieved to have told your PCP.

If your PCP makes a plan with you about your substance use:

- You absolutely do not want to enter a hospital for detox.
- You are willing to consider an outpatient detox program and counseling.
- You do not want your PCP to discuss the plan with your mother, but you might reconsider.

What is your S2BI result?

- No use
- Once or twice
- Monthly or more
- Weekly or more

What is your risk category?

- No use
- No SUD
- Mild/Moderate SUD
- Severe SUD

What intervention did your PCP try with you?

- Positive reinforcement
- Brief advice to quit
- Assess, discuss, and make a plan
- Assess, discuss, make a plan, and refer

^a Massachusetts Department of Public Health. Adolescent SBIRT toolkit for providers. Boston, MA: Massachusetts Department of Public Health Bureau of Substance Abuse Services, 2015.

Appendix 8

Practice Cases for Role Play [CONTINUED]

CASE C: ANTHONY CONTINUED

PCP Role: Anthony is a 16-year-old boy presenting for an annual check-up. His mother is in the waiting room. You use the S2BI screen.

What is Anthony's S2BI result?

- No use
- Once or twice
- Monthly or more
- Weekly or more

What is Anthony's risk category?

- No use
- No SUD
- Mild/Moderate SUD
- Severe SUD

What intervention should you try with Anthony?

- Positive reinforcement
- Brief advice to quit
- Assess, discuss, and make a plan
- Assess, discuss, make a plan, and refer

Would you tell Anthony's mother about his substance use?

- Yes
- No

If yes, what would you say to her?

Help for PCP

If you get stuck, here is some help.
Sample counseling language:

- **Ask for more information about Anthony's substance use.**

You indicated that you use prescription drugs at least weekly. Can you tell me more about that? What kinds of prescription drugs?

- **Affirm Anthony's recognition of his problem with opioids and his desire to stop using them.**

It's so important that you are being honest with yourself about your problem with prescription pain medications and that you have decided to quit.

- **Elicit Anthony's understanding about his symptoms of withdrawal and how that indicates dependence and the need for detox.**

Tell me more about how you felt the last time you tried to stop using prescription pain medications...What do you think that means?...What do you know about how people quit prescription pain medications when they are dependent on them?

- **Ask questions to empower Anthony to make a plan.**

There are two main options for detox; hospitalization and outpatient medication and counseling. Which do you think you would like to try?

- **Help Anthony to consider barriers and supports in implementing his plan.**

What will you tell your parents? How will you make it to the appointments? What about using your insurance to cover the visits? Do you think that your parents might find out on their own that you are in treatment? It can be hard to tell your parents and yes, they may be disappointed. But they also may be relieved you're getting help. At the same time, they may be glad that you are trying to quit and taking control of the situation, and they can support you in taking this important step. I've successfully helped other patients with this conversation. What do you say we give it a try?

What else should I do?

- **Conduct a safety assessment.**
- **Make a referral, if possible, when the patient is in the office.**
- **Make an emergency plan, especially if the patient refuses a referral.**

At any time, you can decide to start detox by going to the emergency department of your local hospital. Just call my office and the doctor on-call can let the emergency department know that you are coming in and why.

- **Make a follow-up appointment.**

I would like to see you again next week to see how your plan is going.

- **According to the requirements of your site and any applicable laws, record the plan in the medical record.**

Appendix 9

Motivational Interviewing

AAP video on motivational interviewing:

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/motivational-interviewing.aspx>



Referral Resources^a

When making referrals, involve your patient and a parent or guardian in the decision and schedule a referral appointment while your patient is in the office. If available in your community, arrange for an interagency facilitator to help make sure your patient connects with the treatment provider.

FINDING EVALUATION AND TREATMENT OPTIONS

For patients with insurance:

Contact a behavioral health case manager at the insurance company for referrals.

For patients who are uninsured or underinsured:

Contact your local health department about substance abuse treatment services for adolescents.

For older patients who are employed or in college:

Ask about access to an employee assistance or school counseling program that includes substance abuse treatment.

To locate adolescent treatment options in your area:

- Ask behavioral health practitioners affiliated with your practice for recommendations.
- Seek local directories of behavioral health services.
- Contact local hospitals and mental health service organizations.
- Call the National Drug and Alcohol Treatment Referral Routing Service (1-800-662-HELP) or visit the Substance Abuse Treatment Facility Locator Web site at www.findtreatment.samhsa.gov.

For a helpful list of criteria

For selecting a substance abuse treatment program for adolescents, see the American Academy of Pediatrics Policy Statement on *Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians* (AAP Committee on Substance Abuse, 2016).

FINDING SUPPORT GROUPS

Groups specific to your area:

Through those knowledgeable about your local behavioral health options, seek groups that provide treatment aftercare and support to adolescent patients and their families.

Nationwide groups:

Consider contacting Alcoholics Anonymous (AA) to ask whether any local groups primarily draw young people (for phone numbers, visit www.aa.org). Note, however, that all AA groups are open to those of all ages at any time. To avoid a possible mismatch, it may be best to consider AA referrals only for older youth who have had a formal evaluation. For support groups for family members, contact Al-Anon (www.al-anon.alateen.org).

LOCAL RESOURCES

List your local resources below. Make copies and keep them in exam rooms and other accessible locations. Develop working relationships with these resources to facilitate referrals and access to care.

^a National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism. Alcohol screening and brief intervention for youth: a practitioner's guide. Rockville, MD: National Institutes on Alcohol Abuse and Alcoholism, 2011.

Substance Use Treatment Programs^a

OUTPATIENT

Licensed, adolescent community-based outpatient programs provide assessment and counseling services for young people with a substance use problem and their families. Services offered include assessment, individual counseling, group therapy, family therapy and intervention services, and intensive outpatient.

INDIVIDUAL COUNSELING

Adolescents with substance use disorders should receive specific treatment for their substance use; general, supportive counseling may be a useful adjuvant but should not be a substitute. Several therapeutic modalities (motivational interviewing, cognitive behavioral therapy, contingency management, etc.) have all shown promise in treating adolescents with substance use disorders.

GROUP THERAPY

Group therapy is a mainstay of substance use disorder treatment for adolescents with substance use disorders. It is a particularly attractive option because it is cost effective and takes advantage of the developmental preference for congregating with peers.

FAMILY THERAPY

Family directed therapies are the best validated approach for treating adolescent substance use. A number of modalities have all been demonstrated effective. Family counseling typically targets domains that figure prominently in the etiology of substance use disorders in adolescents—family conflict, communication, parental monitoring, discipline, child abuse/neglect, and parental substance use disorders.

INTENSIVE OUTPATIENT PROGRAM

Intensive outpatient programs (IOP) serve as an intermediate level of care for patients who have needs that are too complex for outpatient treatment but do not require inpatient services. These programs allow individuals to continue with their daily routine and practice newly acquired recovery skills both at home and at school.

Intensive outpatient treatment works with young people in the community who have tried to control their substance use, but require more intensive support. Sometimes referred to as day treatment or structured outpatient, they are generally comprised of a combination of supportive group therapy, educational groups, family therapy, individual therapy, relapse prevention and life skills, 12-step recovery, case management, and aftercare planning. The programs generally range from three days per week after school with, a minimum of 2.5 hours per day and last one to three months. These programs are appealing because they provide a plethora of services in a relatively short period of time.

PARTIAL HOSPITALIZATION PROGRAM

Partial hospitalization is a short term, comprehensive outpatient program in affiliation with a hospital that is designed to provide support and treatment for patients with co-occurring substance use and mental health disorders. The services offered at these programs are more concentrated and intensive than regular outpatient treatment as they are structured throughout the entire day and offer medical monitoring in addition to individual and group therapy. Participants typically attend sessions for seven or eight hours a day, at least five days a week for one to three weeks. As with IOPs, patients return home in the evenings and have a chance to practice newly acquired recovery skills.

^a Massachusetts Department of Public Health. Adolescent SBIRT toolkit for providers. Boston, MA: Massachusetts Department of Public Health Bureau of Substance Abuse Services, 2015.

INPATIENT/RESIDENTIAL**DETOXIFICATION AND BEHAVIORAL STABILIZATION**

Detoxification refers to the medical management of symptoms of withdrawal. Medically supervised detoxification is indicated for any adolescent who is at risk of withdrawing from alcohol or benzodiazepines and may also be helpful for adolescents withdrawing from opioids, cocaine, or other substances. Individualized care is provided by an interdisciplinary treatment team of professionals, including psychiatrists, physicians, registered nurses, registered practical nurses, licensed social workers, and licensed mental health and substance abuse clinicians. Family involvement and family sessions are encouraged as part of the patient's Individualized Treatment Plan.

ACUTE RESIDENTIAL THERAPY

Acute residential treatment (ART) is a short-term (days/weeks) residential placement designed to stabilize patients in crisis, often prior to entering a longer term residential treatment program. ART programs typically target adolescents with co-occurring mental health disorders.

RESIDENTIAL TREATMENT

Residential treatment programs are highly structured live-in environments that provide therapy for those with severe substance use disorders, mental illness, or behavioral problems that require 24-hour care. The goal of residential treatment is to promote the achievement and subsequent maintenance of long-term abstinence as well as equip each patient with both the social and coping skills necessary for a successful transition back into society. Residential programs are classified by length of stay: less than 30 days is considered short-term; long-term is considered longer than 30 days.

Adolescent substance use disorder residential treatment programs provide short-term substance use disorder treatment services for medically stable youth between the ages of 13 and 17 and are appropriate for high-risk youth experiencing health, emotional/behavioral, family, developmental, and/or social dysfunction as a result of alcohol and other drug use, and whose issues have not been resolved in less-intense, community-based levels of care. Length of stay in the programs varies based on the youth's treatment needs (45-90 days). Each youth participates in highly structured, developmentally appropriate individual, group and family clinical services in addition to having his/her medical and psychiatric needs addressed. An in-house educational coordinator coordinates educational objectives with the child's school from his/her community.

Transitional Age/Young Adult residential programs provide a nurturing, structured, and safe environment for young people. These programs promote self-care, self-reliance, and community responsibility through structured activities and the experience of living in an alcohol- and drug-free residential treatment setting. An average length of stay is four to six months depending on treatment and recovery related goals. Services include: assessment; comprehensive substance use disorder treatment; mental health counseling referrals; case management and coordination; psycho-education on a variety of topics relating to health and wellbeing; life skills enhancement; vocational/educational support; recovery support; parent/care giver support; and aftercare planning.

THERAPEUTIC BOARDING SCHOOL

Therapeutic boarding schools are educational institutions that provide constant supervision for their students by a professional staff. These schools offer a highly structured environment with set times for all activities, smaller, more specialized classes, and social and emotional support. In addition to the regular services offered at traditional boarding schools, therapeutic schools also provide individual and group therapy for adolescents with mental health or substance use disorders.

Appendix 12

Steps to Referral^a

DISCUSS WITH TEEN	Use brief motivational intervention strategies when discussing with the teen why you recommend a referral.
INVOLVE PARENTS	Ask the teen for permission to include parents. If the teen’s behavior is judged to be putting him/herself or others at risk, consider breaching confidentiality and discussing with parents even if permission is not obtained.
DETERMINE LEVEL OF CARE AND ACUITY	Adolescents who are suicidal or at risk of withdrawing from benzodiazepines or alcohol should be referred to the emergency department for medical clearance and referred to youth stabilization programs for medically supervised detoxification. Most other patients can be managed in an “urgent” (as opposed to “emergent”) manner and can be referred directly to youth stabilization.
SELECT APPROPRIATE PROGRAMS	<p>Create a list of providers/programs that meet the appropriate level of care.</p> <ul style="list-style-type: none">• Teens should ALWAYS be referred to programs designed for their age/developmental level. Adolescents should not attend programs designed for adults.• Insurance coverage.• Location/transportation, particularly for intensive outpatient and partial hospital programs, which require frequent trips from home.
CALL FOR ADMISSION PROCEDURES	<p>If possible, assign someone from your practice to assist parents with the initial phone call to determine admission procedures and bed availability.</p> <ul style="list-style-type: none">• Patients may need to wait at home several days until a bed becomes available.• Some insurance products require an emergency department evaluation prior to admission for “medical and insurance clearance.” In these cases, a letter from the primary care provider explaining the rationale for level of care may be helpful.
KEEP IN TOUCH WITH PATIENTS AND FAMILIES WHILE THEY ARE WAITING FOR PLACEMENT	Patients and families are vulnerable while they are waiting for placement in a treatment program. Many treatment programs will offer parent or family groups while waiting for admission. Have families come for brief office visits to check in with you during this window, or if this is not possible, have the practice call the family to check in. If behaviors escalate, the level of acuity may need to be reconsidered.
CONTINUE TO FOLLOW TEENS AND PARENTS WHILE THEY ARE IN TREATMENT	Schedule a visit or speak with parents while their teen is in treatment to see how things are going and to advise on discharge planning. Ask for a release of information and speak directly with program staff if at all possible.
FOLLOW UP WITH PATIENTS SOON AFTER DISCHARGE	As with any medical condition, follow up shortly after discharge from a higher level of care is warranted. Review the course of treatment and continuing care plans. Substance use disorders are not “cured,” and patients should continue in a lower level of care after discharge from more intensive treatment. Ongoing recovery supports are also recommended.

^a Massachusetts Department of Public Health. Adolescent SBIRT toolkit for providers. Boston, MA: Massachusetts Department of Public Health Bureau of Substance Abuse Services, 2015.



Youth substance use treatment and support decision tree

The following flowchart applies to adolescents in need of treatment for a substance use disorder including:

- Patients who report “weekly or more” use of any substance on the S2BI
- Patients who report monthly use of any substance and are judged to be in need of more treatment (such as very young patients, patients with known underlying medical, behavioral, or mental health disorders, or patients with a significant adverse outcome despite limited use)
- Patients who are seeking treatment (such as medication-assisted treatment for an opioid use disorder) or patients whose parents or other adults report concerns related to substance use

Follow up with all youth & caregivers and offer resources

Youth Substance Use Treatment & Support Decision Tree

