IMPROVING ADOLESCENT HEALTH:

FACILITATING CHANGE FOR EXCELLENCE IN SBIRT

NATIONAL COUNCIL *for* Mental Wellbeing

CONRAD N. Hilton FOUNDATION

ACKNOWLEDGEMENTS

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This change package is sponsored by the **Conrad N. Hilton Foundation.**

Original Published Date: 2018 | **Latest Revision:** July 2021

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CONTENT

INTRODUCTION

FACILITATING CHANGE FOR EXCELLENCE IN SBIRT

Adolescence represents both a critical at-risk period for substance use initiation and is 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

- Teen alcohol use is associated with a greater likelihood of alcohol use disorder or substance use disorder in adulthood.
- Marijuana use in adolescence may be associated with loss of IQ points.
- Teens who use tobacco report poorer health outcomes than their nonsmoking peers.
- More than 90% of adult smokers report smoking before they were 18 years old.
- Teens who use marijuana at or before the age of 14 are six times more likely to develop a substance use disorder later in life than those who first try marijuana at age 18 or later.

(Meier et al., 2012; CDC, 2012; HHS, 2016)

(See Appendix A, Tables from the Surgeon General's Report, for more information on adolescent risk and preventive factors and **Appendix B, Adolescent Substance Uses 101,** for more information on substances and their effect on youth.)

WHAT IS A CHANGE PACKAGE?

This document serves as a change package — 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 effective tools to actuate practice transformation in primary care.

HOW WAS THE CHANGE PACKAGE TESTED?

To test the efficacy of the change package, the National Council for Mental Wellbeing, in partnership with Friends Research Institute and Aurora Research Institute, conducted an 18-month pilot program with 12 Federally Qualified Health Centers (FQHCs) from across the country. Sites received targeted, multi-modal and responsive training to implement SBIRT using the change package. Lessons from these sites are shared throughout the document as success stories and tips from pilot participants. (See **Appendix C, Change Package Pilot Program**, for more on the pilot program.)

WHAT IS SBIRT?

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment for individuals at risk for adverse consequences of alcohol and other drug use and for those with problem substance use challenges (Del Boca et al., 2017).

The American Academy of Pediatrics (AAP) recommends pediatricians become familiar with adolescent SBIRT and the potential to incorporate into universal screening and comprehensive care (Committee on Substance Use and Prevention, 2016).

The SBIRT process includes:

1. **SCREENING** to identify a person's risk for a substance use challenge.
2. **BRIEF INTERVENTION (BI)** to raise a person's 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 people at highest risk.

WHY AN ADOLESCENT SBIRT CHANGE PACKAGE?

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

- The younger a person is when they start using, the more likely they are to develop a substance use disorder and continue using later in life.
- Substances can slow and impede brain development, increase health risks and have long-term financial and legal implications.
- Early substance use interventions can prevent development of more severe substance use challenges.
- Widespread SBIRT adoption is often hindered by a lack of uniform and clear implementation guidance.
- Successful models are built on agreed upon, codified and replicable screening tools, processes and interventions.

HOW TO USE THIS CHANGE PACKAGE

This change package outlines a framework for implementing adolescent SBIRT within your primary care practice. The framework includes operational guidance for adopting foundational change management strategies to create optimal conditions for change, as well as clinical areas for action for SBIRT implementation.

TABLE 1. SPECIAL FEATURES OF THE CHANGE PACKAGE

Key Tips	Generalized strategies for SBIRT practice.
Implementation Tools	Tools to successfully implement areas of action and change package recommendations.
Lessons from the Pilot	Implementation advice, key considerations and adaptations from pilot participants to guide SBIRT efforts.
Tips from the Pilot	Insight into different approaches and ideas for implementation utilized by the pilot participants.
Sample Scripts	Examples of dialog you may want to use in your practice.

SCREENING

CHANGE CONCEPTS:

- 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 to screening results.

OUTCOME MEASURES	
Objective	Universal screening with every health maintenance visit (and potentially other visits).
Documentation	**See Appendix F, SBIRT Data Collection Guide, for associated electronic health record (EHR) fields:** ▪ Was screening conducted? ▪ Screening results.
Measure	Proportion of adolescents presenting for well care screened with S2BI within a year (still strongly recommend opportunistic screening at all visits).
Benchmark	90%
Outcome	All adolescents receive screening via the S2BI at least once a year and are appropriately categorized for intervention.

WHO SHOULD BE SCREENED?

Universal screening for alcohol and substance use should be performed with all adolescents aged 12 and older.

Substance use screening that is performed while checking for vital signs and other preventive and lifestyle screenings helps normalize conversations about substance use and diminishes patients feeling singled out. This approach to screening can also identify other health concerns, such as depression and anxiety, and can 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. grow up with a chronic health condition, providers should be sure to screen this population as the risk of substance use is often underestimated and may have important, often critical, implications on their medication regimens, clinical protocols and self-management plans. (See also "Co-occurring Medical and Mental Conditions.")

Providers should also be aware that attitudes of parents and guardians toward substance use and the presence of substance misuse or a person with a substance use challenge in the adolescent's home are important clinical considerations in identifying and treating substance use challenges.

KEY TIP

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

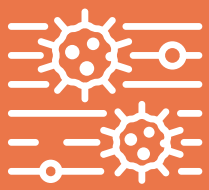
The National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommends that screening for alcohol use begin as early as age 9 (NIAAA, 2015). The goals of screening younger children are twofold: 1) to intervene prior to first or early use of substances and offer prevention and education and 2) to identify a very high-risk group of children who initiate substance use early. Early substance use initiation is associated with particularly poor short- and long-term outcomes (Zeigler et al., 2005).

Conducting SBIRT for college students aged 17-24 is also important as this marks a period of developing independence, peer pressure, availability of substances and increased risk-taking. For college-aged adolescents, the presence of substance use challenges and associated psychiatric conditions may first come to light within a primary care setting in the form of sleep problems, academic or relationship difficulties, injuries sustained while consuming alcohol or other substances, sexually transmitted infections, chronic respiratory infections or conditions that compromise the immune system.

The New Vital Signs:

Necessary Information for Total Picture of Basic Adolescent Health

Blood Pressure



Sexual Activity/ Sexually Transmitted Infections (STIs)

Substance Use

Allergies

Weight

Mood

Sleep

TIPS FROM THE PILOT

Vista Community Clinic incorporated the S2BI into their vital sign measurement workflow at the beginning of each visit. The S2BI is self-administered by the patient as a medical assistant takes their vitals. Parents are asked to wait in the lobby while this occurs, which gives the patient privacy to complete the screening.

THE SCREENING PROCESS

SETTING THE STAGE FOR A COLLABORATIVE CONVERSATION

It is important that all members of the team — from front desk staff and administration to those delivering screening and providers who will deliver the intervention — create a welcoming and non-judgmental environment. The goal is for youth to feel safe providing accurate information and a willingness to discuss next steps..

THE SCREENING TOOL: S2BI

Clinicians need a tool that can accurately assess the likelihood of a substance use disorder. The S2BI **(Massachusetts Child Psychiatry Access Program, 2015)** is one of several valid and reliable screening tools for substance use among youth **(e.g., Brief Screener for Tobacco, Alcohol and Other Drugs [BSTAD], [NIH], CRAFFT [SAMHSA])**. The S2BI offers several advantages that make it ideal for use **(see Appendix D, S2BI Screening Tool: Printable Version)**. It was introduced in 2014 as a no-cost, validated instrument and recognized by both the **AAP** and the **Addiction Medicine Foundation (The Addiction Medicine Foundation, 2016)**.

Boston Children's Hospital has modified the S2BI by adding vaping as a mechanism for consuming nicotine and marijuana to increase sensitivity. We recommend using this newer version because some adolescents who vape nicotine may not consider themselves smokers and some who vape THC may not consider themselves marijuana users.

The S2BI:

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

S2BI: SCREENING TO BRIEF INTERVENTION

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

■ **Tobacco?** (Cigarettes, e-cigarettes, vapes etc.) ■ **Alcohol?** ■ **Marijuana?** (Smoked, vaped, edibles, etc.)	☐ **Never**
STOP if all "Never." Otherwise **CONTINUE**	☐ **Once or twice**
■ **Prescription drugs that were not prescribed for you** (pain medication, Adderall, etc.) ■ **Illegal drugs?** (Cocaine, Ecstacy, etc.) ■ **Inhalants?** (Nitrous oxide, etc.) ■ **Herbs/synthetic drugs** (Salvia, K2, bath salts, etc.)	☐ **Monthly** ☐ **Weekly or more**

ADMINISTERING THE S2BI

Screening can be administered in an interview format or self-administered and can be tailored to different medical settings (Levy et al., 2014; Levy et al., 2016). The results of testing methods of administration in the FaCES learning collaborative suggest that teens are more likely to be candid when answering questions in a private setting, without parents or guardians present. Regardless of administration format, affording the adolescent as much privacy as possible is critical. Staff should review responses and record any staff time and interactions that occur. **(See "Screening Results Inform BI," and Appendix E, Confidentiality and Parental Involvement.)** Combining the screen with other screening protocols helps normalize the process. **(See "Who Should be Screened" and "Co-occurring Medical and Mental Health Conditions"** for special screening considerations for adolescents with chronic health conditions.)

TIPS FROM THE PILOT

- **Be creative about the self-administration medium.**
  - Distribute the S2BI on brightly colored paper to show adolescents that other patients in the clinic are filling out the document to reduce feelings of being singled out. This visual cue also helps providers identify patients who are part of the SBIRT workflow. Medical assistants mark the paper with a checkmark for the provider to complete a brief intervention and an "X" for providers to provide anticipatory guidance.
  - Use technology, if available and appropriate.
- **Build substance use screening into existing workflows.**
  - When developing your S2BI workflow, build upon lessons learned from other screening processes (e.g., depression screening using the PHQ-9). This makes it easier for staff to adapt to new screening tools and streamlines the patient experience.

KEY TIP

Regardless of administration format, afford the adolescent as much privacy as possible.

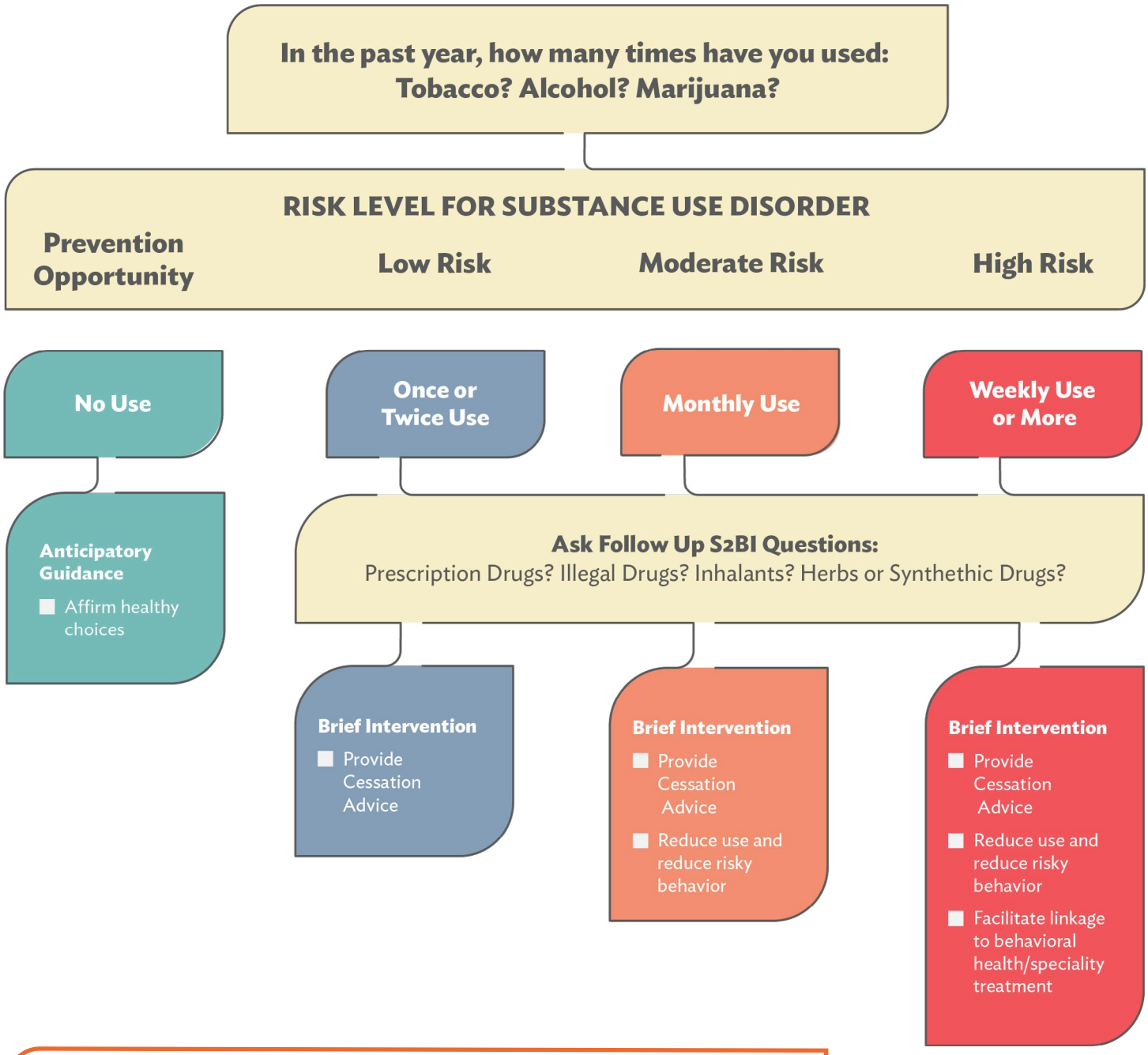
KEY TIP

Patients may disclose their substance use at a later time, so have a process for rescreening during each clinical encounter.

SCREENING RESULTS INFORM BRIEF INTERVENTION

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

TABLE 2. S2BI ALGORITHM



TIPS FROM THE PILOT

Print the S2BI algorithm and make it available to staff as a quick reference during the S2BI workflow.

BRIEF INTERVENTION

CHANGE CONCEPTS:

- Clearly communicate age-appropriate risks of alcohol, tobacco and substance use to health and wellbeing, with patients reporting any use in the past year (based on screening results).
- Leverage primary care team/patient relationship to negotiate behavior change and document a reasonable change plan.
- Ensure BI is responsive to screening results by training applicable staff on how to interpret results and provide age-appropriate assessment and discussion of risks.

OUTCOME MEASURES

Objective	Assess severity and determinants of substance use and negotiate behavior change plan.
Documentation	**See Appendix F, SBIRT Data Collection Guide, for associated EHR fields:** ■ Intervention delivered. ■ BI change plan. ■ If patient is unwilling to follow a BI change plan, document a BI contingency plan. ■ Narrative example. Use Indicated: Tobacco (weekly), alcohol (monthly) THC (monthly), prescription/ illicit/ inhalant (none). Delivered cessation advice. Change plan: Patient will decrease use of tobacco to weekends only. Patient will make an attempt to quit.
Measure	■ Proportion of patients who receive an intervention commensurate with the level of risk.
Benchmark	■ 90%
Measure	■ Proportion of patients who were eligible for BI for whom change plan is documented in patient record.
Benchmark	■ 80%
Outcome	Patients are receiving the appropriate level of BI based on screening result and have a plan to reduce risk/follow-up.

BI IS SHORT IN DURATION BUT NOT SHORT ON IMPACT

THE ART OF BRIEF INTERVENTIONS

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

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

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

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

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

Even if a primary care provider (PCP) has less than five minutes, a BI can be both short in duration and substantial in impact. The PCP can be a positive influence by building rapport over time with adolescents and drawing upon experience with data-informed treatment of chronic conditions — vital skills for addressing substance use. Integrated practices often build on the initial conversation between the PCP and patient by using behavioral health providers for additional patient support and services. Some funding sources will only reimburse certain provider types and specific time intervals. (See Appendix L, Financing SBIRT.)

Age and Developmental Level Considerations

- **Younger adolescents:** Use more structural approaches like having the youth identify specific action steps or having parents monitor higher risk activities. The goal is to limit opportunities for exposure to substances.
- **Older adolescents:** In later teen years, adolescents become better at abstract thinking and can more fully engage in anticipatory planning.

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

KEY TIPS

- Convey your support for the patient's autonomy in having choice and ability to make decisions.
- All patients should be advised of potential health risks and consequences and encouraged not to use. There is no safe level of alcohol consumption for underage youth.
- With evolving changes to cannabis legalization and regulation, explore perceptions of risk, ask about method of intake (e.g., vaping, edibles) and awareness of potency.
- Address trends of increased vaping by reinforcing that, like traditional smoking, vaping can have adverse health effects due to added chemicals and high levels of nicotine.
- Share information about the impacts of substances and their harm to a developing adolescent brain and body. Clearly communicate the spectrum of risk and advise not to use.
- Conflict or resistance is often a signal that our actions are not aligned with the patient's level of readiness. Re-engage by focusing on rapport building and establishing trust.
- Change is not linear and may need to occur over time. Show your support for any steps they are willing to take and utilize the care team for monitoring and follow-up.

OVERCOMING BARRIERS TO EFFECTIVE BRIEF INTERVENTION DELIVERY

TIPS FROM THE PILOT

Sites with experience implementing SBIRT applied the following strategies to increase BI delivery rates:

- **Survey staff to determine their perceived efficacy for delivering a BI.** Use results to develop a training plan tailored to meet your specific educational needs. Seeking staff feedback and providing the right BI training has the potential to increase BI delivery rates.

- **Document BI and analyze data to identify issues**. If you analyze data and find, for example, that a high percentage of staff selected the option "provider chose not to deliver intervention," there is an opportunity to have further discussions around the factors leading to that decision. In one case, a site determined that staff chose not to deliver an intervention to adolescents who responded "No Use" to the screener, missing an opportunity to provide anticipatory guidance.

- **Use visual cues.** Display a psychoeducational poster in exam rooms that furthers your message that screening is a routine part of care. This serves the dual purpose of raising patient awareness and reminding staff to highlight the connection between substance and health. (Family First Health)

KEY TIPS FOR BI

- Asking permission helps level the playing field and step away from authoritative dynamic.
- Highlight confidentiality.
- Goal setting is most effective when it is patient-driven rather than top down.
- Emphasize the value of gathering accurate information and thank the patient for providing it.

PILOT SUCCESS STORY

A patient who screened positive for marijuana and alcohol use and referred to substance use treatment was surprised to learn that these substances could be addictive. During the BI, it became apparent that he had a lot of misinformation and felt social pressure to use. Since receiving services, he has reported a decrease in use. (Delhi Community Health)

REFERRAL AND ONGOING MANAGEMENT

CHANGE CONCEPTS:

- Establish criteria for referral to treatment that considers patient substance use, physical and mental health and developmental level.
- Develop protocol and procedures to refer patients to internal and/or external care, follow up on referred patients and leverage provider and organizational partnerships.
- Ensure capacity, protocols and documentation standards for ongoing care management (including interim management, supporting client readiness and facilitating treatment entry and follow-up).

OUTCOME MEASURES	
Objective	Discuss treatment options and negotiate referral plan. Ask patient for permission to include parents or caregivers.
Documentation:	See Appendix F, SBIRT Data Collection Guide, for associated EHR fields: ■ Type of referral made ■ Referral appointment status ■ If patient attended the appointment. If not, the reason for not attending. ■ Referral plan ■ If patient refuses referral plan, document referral contingency plan
Measure	■ Proportion of charts eligible for referral for whom referral plan is documented.
Benchmark	■ 80%
Measure	■ Proportion of referred patients who attend initial referral visit within 60 days.
Benchmark	■ 50%
Outcome	Based on established criteria, patients receive the necessary level of care to address substance use — both internal ongoing management and external services, if applicable.

REFERRAL TO TREATMENT

Specialty substance use treatment for adolescents can be very effective, but less than less than 0.3% of youth aged 12-17 in need of treatment receive it. Part of the reason is that few adolescents are referred to treatment by their health care providers (SAMHSA NSDUH, 2019; SAMHSA MH Estimates, 2014). It's important to know when to refer to treatment and what type of treatment may be best. It is also important to have protocols in place for managing substance use internally when the patient's needs do not rise to the level of requiring specialty care or if they refuse the referral.

Consider specialty treatment especially if:

- Young (age 14 or younger)
- Co-occurring mental health disorder (e.g., attention deficit hyperactivity disorder [ADHD])
- Co-occurring medical disorder
- History of trauma

WHEN IS REFERRAL TO SPECIALTY SUBSTANCE USE TREATMENT INDICATED?

Referral to specialty treatment (See Appendix K, Specialty Treatment Options) is appropriate when a patient's screening result(s) suggest high risk for a 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 use or more of any substance).

Meeting with an integrated Behavioral Health counselor may be appropriate when the patient's results indicate moderate risk for a substance use disorder (e.g., S2BI results indicate monthly use of any substance).

TABLE 4. DETERMINING WHEN A REFERRAL IS INDICATED

S2BI SCREENING RESULT	BI FOCUS	REFERRAL INDICATED
No Use (Prevention Opportunity)	**Provide anticipatory guidance.**	**No**
Once or Twice Use (Low Risk of Substance Use Disorder)	**Provide cessation advice.**	**No**
Monthly Use (Moderate Risk of Substance Use Disorder)	**Reduce use and reduce risky behaviors.**	**Use clinical judgment.**
Weekly Use or More (High Risk of Substance Use Disorder)	**Facilitate linkage to mental health or substance use treatment**	**Yes**

ASSESSMENT

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

- Age and development levels: Adolescents should be referred to developmentally appropriate programs.
- Co-occuring mental health and/or medical conditions.
- Patient and family motivation, willingness and ability to engage in treatment.
- The presence of high-risk behavior.

CLINICAL SKILLS FOR INITIATING REFERRAL

Approaches to referral should be patient- and/or family-centered, non-confrontational and non- judgmental. **(See Appendix J, Referral to Treatment Sample Script.)** Once you have determined who should make referrals and designed a workflow, train staff on how to have these conversations with patients and parents.

Health providers have a responsibility to manage adolescent substance use just as they would address other health concerns. Ongoing management is accomplished through shared decision-making, documenting referral plans (and contingency plans if the patient refuses the referral), getting creative about what community services they can connect to and following up to ensure care needs are being met.

LESSONS FROM THE PILOT

A learning collaborative site reported good engagement in referral services despite lack of warm handoffs because care coordinators paired treatment appointments with other needs such as food services, medical appointments, insurance enrollment, etc.

Recommend. Make a recommendation and explain the justification.

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

Address. Talk with patient and/or guardian about any concerns they may have about accepting the referral. This may necessitate multiple conversations, but it is critical that buy-in for accepting the referral is developed by the patient or guardian.

Engage. Ensure your patient links to the next level of care. Conduct a warm handoff with a contact/provider/referral source. If available, utilize a resource specialist such as a care coordinator who can help identify an appropriate program and navigate the steps necessary for enrollment. Care coordinators can help reinforce the necessity for a referral, assist with navigation to the referral and follow-up with engagement to help sustain treatment. Care coordinators enhance health outcomes and their role cannot be understated.

ONGOING SUBSTANCE USE SERVICES IN PRIMARY CARE

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

WHY MANAGEMENT MATTERS

- Specialty substance use treatment may not be available.
- The majority of adolescents aged 12-17 classified as needing but not receiving treatment do not perceive the need for treatment (NSDUH, 2019).
- Even if a patient accepts a referral, they may not attend treatment or treatment may be short-term, creating a need for chronic management in primary care.

WORKFLOW AND FORMALIZING REFERRAL ARRANGEMENTS

WHO SHOULD MAKE THE REFERRAL?

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

REFERRAL WORKFLOW

Once you've determined who should make referrals, ensure there is a written, consistent and standardized workflow that assigns staff accountability for everything from referral initiation to follow-up. When developing the workflow, consider the following:

1. If the referral is internal or external. Know who treatment partners are and how they:
   - Accept referrals. Are they in-person or via warm handoff, phone call, email, secure fax, EHR, scheduler, etc.? Residential services often require a phone call.
   - Document. Is paperwork from the referring clinician required or requested?
   - Complete admission (in residential setting). How long does it take and what is required? Some states require patients to obtain insurance clearance to receive services within 24 hours of admission. What challenges could this pose?
2. 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).
3. The expected timeliness of appointments (e.g., emergency, urgent, routine).
4. Coordination with other services. Can appointments be scheduled concurrently with other community services?
5. Staff responsibilities for patient engagement and follow-up. If a patient does not keep the appointment, who conducts follow-up? If patient shows up once but does not return, who is notified? How are details on patient progress shared among partners?
6. Expected frequency of workflow/policies and procedures review. Are they quarterly with new workflows and annually or biannually with established workflows?

WHERE?

INTERNAL

Internal referrals such as one from a pediatric PCP to an embedded behavioral health provider within the same clinic enable patients to remain in a familiar, trusted, non-stigmatizing setting. Additionally, internal referral 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 be identified.

ONGOING SUBSTANCE USE SERVICES IN PRIMARY CARE

In some communities, specialty substance use services may be limited or may not fit the needs of all patients who require additional support to reduce risk. In those case, primary care may need to provide continuing care and specialty services. The following treatment approaches are examples of ways primary care can take ownership of ongoing care and serve as a central point for coordinating both internal and external community services. (See Appendix K, Specialty Treatment Options)

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

Individual mental health and substance use treatment provided by a qualified clinician (e.g., cognitive behavioral therapy, motivational enhancement) that can be integrated into primary care (Watkins et al., 2003).

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

Peer/family support groups such as those organized by the Association of Alternative Peer Groups as part of a comprehensive service plan. Alateen is another national program that is aimed at support for teens who have a family member or friend with a substance use challenge. Having these services available can be an effective way of ensuring that teens and family members are supported on their journey to reduce substance use.

SPECIAL CONFIDENTIALITY PROTECTIONS

It is important to understand both state laws and specific federal confidentiality rules that govern facilities deemed to be federal substance use disorder treatment programs. (See Appendix E, Confidentiality and Parental Involvement for more information.)

According to NSDUH, 2019, receipt of SUD treatment among adolescents was 0.7% and specialty mental health services was 16.7%.

QUALITY IMPROVEMENT FOR REFERRAL TO TREATMENT

- It is strongly advised that a quality improvement process be incorporated for referral to treatment.
- Please refer to the referral to treatment outcomes measures for a minimum acceptable indicator.
- This indicator may be used for both internal and external referrals.

CREATING PARTNERSHIPS TO SUPPORT REFERRAL TO TREATMENT

Strong community partnerships contribute greatly to SBIRT implementation success. They make it possible to coordinate area resources and build local advocacy capacities in service of a common goal: creating a healthy adolescent community. Strong community partnerships also support the goal of creating a healthy adolescent community through promoting inclusion and diversity and reducing health disparities. The most effective partnerships are marked by strong organizational relationships and trust, built and strengthened through clear roles and responsibilities, shared decision-making and mutually beneficial results. Include partners with different interests and perspectives; it extends your reach to a broad range of stakeholders that have different assets, missions, perspectives, constituencies, cultural considerations, relationships and strategies. Through collaboration, new relationships can form and be nurtured for ongoing partnership in other domains. (See **Communicating for Engagement Companion Guide** for tips on how to communicate with stakeholders.)

ESSENTIAL CRITERIA FOR CHOOSING AND ESTABLISHING PARTNERSHIPS

Partnership Do's and Don'ts

DO	DON'T
■ Ask about their needs first. ■ Use data transparently and reveal helpful information. ■ Pursue mutual interests and explore how to help each other. ■ Evaluate the partnership regularly to ensure goals are being met. ■ Communicate more about successes than shortcomings.	■ Put blame on partner when things don't go well. ■ Expect to get something. ■ Limit assistance to a project. ■ Withhold helpful information. ■ Make it about the current arrangement or push a specific position.

LESSONS FROM THE PILOT

Project Vida, in El Paso, Texas, established a relationship with a local school district by starting a pregnancy prevention program. This provided the opportunity to build out the services provided within the schools as they gained the trust of the students and staff. They established a memorandum of understanding (MOU) to place counselors within the schools to provide services related to general wellness, suicide prevention and SBIRT. Over time they expanded the scope of the MOU to include Certified Peer Recovery Specialists. Additionally, Project Vida partnered with a local DWI court to discuss substance use and prevention opportunities.

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)	Finance	Data Collection
Objective	Identify organizational capacity for SBIRT implementation.	Develop sustainable financing strategy based on internal capacity and relevant reimbursement processes.	Design an SBIRT data collection process (selection, collection, analysis, reporting, data-driven decision-making) that fosters continuous quality improvement and informs service delivery.
Documentation	OSA responses.	Develop policy/protocol for billing codes to be used for SBIRT services. ■ Potential billing codes: ▪ Codes for screening. ▪ Codes that allow you to add on to primary care visit (BI). ▪ Codes that allow you to bring client back for follow-up.	Data collection protocol, patient EHR data.
Measure	OSA score.	The number of times identified codes are utilized.	■ Data consistently collected/submitted in accordance with protocols. ■ Data consistently analyzed and shared in a variety of ways.
Benchmark	Ability to address all identified gaps (will be a qualitative explanation/ analysis rather than a numerical score).	50% Increase in use of billable SBIRT visits from baseline.	■ 90% of SBIRT EHR data fields complete. ■ Trends in SBIRT patient data are shared with staff monthly.
Outcome	Organization is prepared to implement SBIRT and engage in a continuous QI process.	Financing strategy ensures SBIRT activities are reimbursed.	Organization implements a data collection protocol that informs service delivery and motivates staff to sustain data collection.

CREATE THE CONDITIONS FOR CHANGE

Implementing change in any organization can be challenging. This is especially true in primary care, a fast-paced setting where effectiveness and efficiency often depend on precise time management. For that reason, it is critical to devote time, resources and effort to creating optimal conditions for change. Change management is an umbrella term that covers all types of processes implemented to prepare and support organizational change. Devising a plan that acknowledges the practical realities of your agency can be complex but is key to ensuring your organization's SBIRT initiative progresses effectively. The **SBIRT Implementation Checklist**, is grounded in the research on implementation science, but incorporates SBIRT-specific considerations to help users develop a comprehensive implementation plan inclusive of both clinical and operational components.

A first step in creating optimal conditions for change is to and inform development of a work plan outlining goals and action steps. Following an OSA, leadership can develop work plans with goals around change processes, measure implementation and outcomes and communicate this information both internally and externally.

The **FaCES Organizational Self-assessment** is also available for your use. If using this tool, it is important to note that there is no cumulative score. Your results denote where you stand as an agency at the point of completion and should be used to monitor and track progress from that point throughout the duration of the SBIRT initiative. The purpose of this tool is to give your implementation team an accurate depiction of where your agency stands based on the six domains that characterize effective SBIRT implementation.

TIPS FROM THE PILOT

The change package pilot sites executed the following strategies to generate support for their SBIRT initiatives:

- **Increase interest in and create staff champions by convening small group meetings.** Include staff like intake nurses and medical assistants to facilitate engagement and provide education to fellow staff. SBIRT champions can then provide additional support in advance of rolling out to pediatricians.
- **Tie the SBIRT initiative to the organization's mission statement.** A mission statement like "provide quality comprehensive care for adolescents" or "strive for national excellence" will highlight SBIRT's connection to overall agency priorities and is a good strategy to engender support from multiple internal stakeholder audiences.
- **Send an all-staff email of support from the chief medical officer or other influential organizational leader** In it, explain that SBIRT will be a part of standard care to help to establish an agency-wide expectation of participation and normalize SBIRT as a consistent part of "business as usual."
- **Launch implementation efforts by sending weekly e-mails to share current trends in the prevalence of adolescent substance use and impact on the local community.** These messages help to create a sense of urgency around the need for a standardized solution to identify and intervene in teen substance use.

COMMUNICATE FOR ENGAGEMENT

Successful SBIRT implementation requires clear communication about the transformation process and support from staff at all levels of an organization; without widespread acceptance the initiative is likely to fail. Communicating for engagement and for garnering support of SBIRT implementation is a continuous process. Raise awareness and provide information about the components and benefits. Focus on simplicity and repetition to ensure understanding and spread of information. Understanding the needs and priorities of the leadership team and other collaborators such as patients, staff and community partners will help develop a tailored approach for this communication.

Key considerations for engagement include aligning SBIRT implementation with the overall mission and values of the organization, clearly identifying the resources necessary for the initiative to be successful and explaining what the expected outcomes of the initiative will be for patients, staff and partners. Build in opportunities to engage in two-way communication. Listen, get feedback and use that input to further refine the approach. Find new ways to communicate and deliver the simple messages you craft in a variety of ways; this will result in better engagement.

The **Communicating for Engagement Companion Guide** comprises tools and resources designed to facilitate the creation of a comprehensive SBIRT communication strategy.

IDENTIFY CHAMPIONS AT ALL LEVELS

Champions are key for SBIRT sustainability (Singh, 2017). They help build organizational engagement, promote SBIRT as a standard practice and facilitate relationships with internal staff and external stakeholders. Champions may lead SBIRT trainings and help secure funding and optimize efficiencies. They provide continuity beyond the start-up phase. Champions should be well-versed in data that supports SBIRT and messaging and story-telling that appeal to target audiences such as funders, providers, policymakers and consumers. Continue to grow your network of champions across the organization to ensure success as attrition occurs.

Executive-level engagement is crucial to creating an effective and 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 an overall legislative environment that is more favorable for SBIRT.

TABLE 5. MESSAGING SBIRT TO ALIGN WITH KEY TARGET AUDIENCE PRIORITIES

Target Audience Examples	Messaging Considerations
	▪ Why are we implementing SBIRT? What will the benefits be? 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, clear and measurable message explaining the change.
Patient	This is part of our screening for whole person health/comprehensive care.
Clinician	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.
Administration	SBIRT allows us to provide comprehensive care that our community needs.
Financial	SBIRT allows us to provide comprehensive care that our community needs. Because it is an early intervention and opportunity for prevention, it has the potential to decrease costs due to risks of injury and illness.
C-Suite	In order to stay viable in the evolving health care landscape, it's important for us to include substance use prevention and early intervention as part of our value proposition as an organization.

PREPARE YOUR WORKFORCE

SBIRT is an opportunity to deliver an integrated approach to care in which various staff can participate. Understanding roles and responsibilities within the care team and providing applicable training 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.

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.

RECRUITING AND ONBOARDING NEW STAFF

Protocols for onboarding staff and medical providers must be established and reside within the human resources department. Ideally, SBIRT training should be identified in orientation protocols, checklists or electronic databases to document that SBIRT training occurred as part of new staff/provider orientation.

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

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:

- Provide an array of training options.
- Standardize frequency of trainings and plan for multiple offerings (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 peer coaching and support after initial training.
- Offer continuing medical education (CME) and continuing nursing education (CNE).

COMPETENCY-BASED EVALUATION

To support 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 (e.g., 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).
- Appoint a staff member responsible for conducting evaluation.
- Minimum level of proficiency required and policy for staff who do not meet standard level of proficiency.
- Documentation method — preferably incorporated into broader competency-based evaluation instruments.

KEY TIP

Some SBIRT billing codes require services that must 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 five-year SAMHSA-funded SBIRT program found that contracted specialist staff was not sustainable and changed their staffing models to in-house staff who were either master's level clinicians or high school graduates or bachelor's level counselors. Other clinics, especially in rural settings, trained certified medical assistants, community health workers or nursing staff (Singh, 2016). Unlicensed staff doing SBIRT may not be sustainable if a clinic can only bill fee-for-service. SBIRT can be sustainable under PPS funding at FQHC's if cost reports are updated or in CCBHC's that are PPS funded.

DEVELOP AN SBIRT CARE PATHWAY

A care pathway is defined as a service bundle provided to patients based on level of need/care, readiness and evidence. It includes guidelines and protocols for how the organization provides care for a particular health issue or condition.

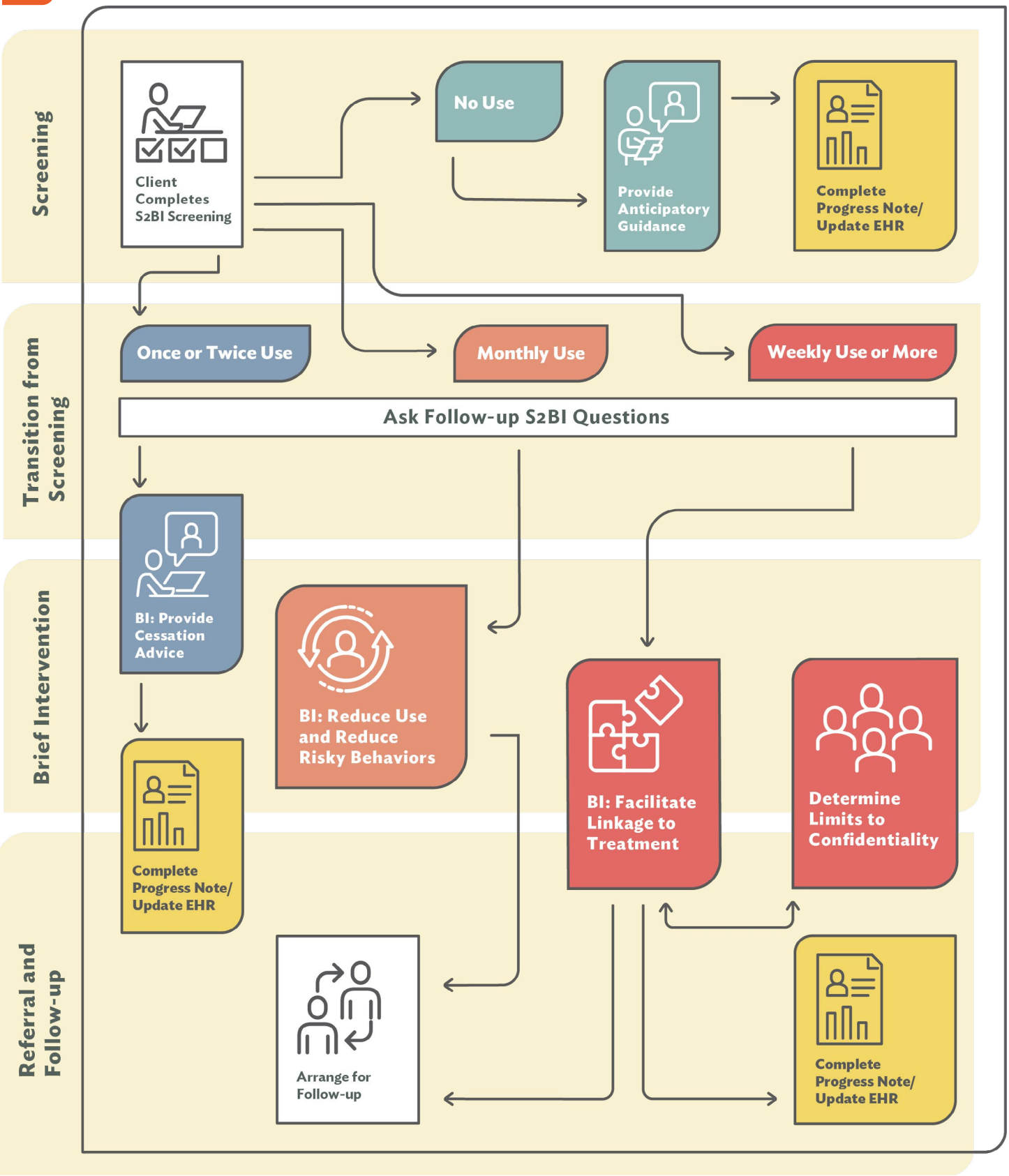
The SBIRT care pathway provides organizational infrastructure and capacity to sustain their SBIRT practice and helps clarify expectations for staff.

A care pathway workflow is a sequence of connected clinical and administrative steps that explain the movement of materials, information and/or people through a process that has clearly defined start and stop points.

A high quality pathway is standardized so staff can concentrate on patient engagement and on crises as they arise without having to recreate the wheel. It is grounded in continuous quality improvement because evidence changes, processes need refining, financing structures are subject to change and staff can evolve. To sustain widespread adoption, consistent training opportunities, ongoing data-driven monitoring, clinical decision support and reminders through EHR are critical facilitators.

DESIGN YOUR WORKFLOW

SAMPLE SBIRT WORKFLOW*



*When tailoring the workflow for your setting, include as much detail as possible. Specify staff roles within tasks (PCP, BH provider, nurse, front desk, etc), how the information will be tracked (paper, electronic, etc) and where each task will occur (waiting area, exam room, etc).

DATA-DRIVEN DECISION-MAKING

For organizations to be truly data-driven and maximize the benefits of a protocol such as SBIRT, they must have the infrastructure in place to both collect and use data in a meaningful way. Implementing a standardized evidence-based screening process can yield important clinical data that is indicative of a patient's health and the overall quality of care and service delivery. In order to provide the best possible care, it is vital that organizations capture data in a streamlined and robust way such as using EHR or data registries. EHR data is also critical for continuous quality improvement and ensuring accurate billing and coding for service reimbursement. (See **Appendix L, Financing SBIRT**.)

HOW TO DEVELOP AN EFFECTIVE AND SUSTAINABLE SBIRT DATA COLLECTION SYSTEM

If a clinic can leverage its EHR capacity, data on SBIRT process adherence can be collected at the time of clinical documentation by using programmable EHR data fields **(See Appendix F, SBIRT Data Collection Guide)**. EHR capabilities and needs for modification should be considered at the beginning of the SBIRT implementation process and factored into the timeline and budget, as considerable resources are often needed to work with vendors to execute changes. If a clinic does not have the ability to modify its EHR, clinical documentation indicating steps in the SBIRT process must be clearly stated and recognizable to a service quality manager.

An effective data analysis process should be in place before data collection begins. This means:

- Having a structured EHR (or alternate documentation) that can capture the SBIRT process.
- Identifying clinical and quality improvement measurements and targets.
- Identifying staff who will be responsible for recording, retrieving and analyzing data for consumption.
- Training staff on data collection procedures.
- Having a plan for how data and reports are shared.

Reviewing data regularly can lead to identifying areas of improvement in the implementation of SBIRT, as well as assessing the overall quality of care and service delivery. **It should not be a burdensome process**. Consider how you may integrate SBIRT data collection and analysis into existing workflows for maximum efficiency.

TIPS FROM THE PILOT

- Employ a patient service quality manager who evaluates progress via EHR data and verifies that each part of SBIRT documentation is done correctly according to the clinic's billing requirements for their funding sources. During staff meetings, the quality manager reports on measures that need to improve and discusses solutions with the clinical team, including the medical director and quality board members.
- Implement a challenge with the nursing staff to increase their S2BI screening percentages. In the pilot, participating staff were so engaged, they started to request updates on how many S2BIs they accomplished.
- Conduct team huddles each morning to flag which patients are eligible for screening that day and review who is responsible for each part of the workflow.
- Work with internal EHR and IT experts to build templates for both the S2BI and CRAFFT for easy entry of screening results.
- Add the S2BI to your EHR via the screening summary so providers can easily see screening results in the patient's file and determine the next steps for brief intervention.
- Program your EHR to send automatic reminders to staff when a patient who needs to be screened comes in. This streamlines the workflow and standardizes SBIRT care.

USING DATA TO MOTIVATE STAFF

Normalizing the S2BI as another vital sign helps staff recognize that substance use is an issue that health provider have a responsibility to address like any other health condition. Including SBIRT measures in routine data reporting is another way to embed the process into familiar daily routines. Staff are more likely to record data in an EHR if they receive feedback on what the data are showing. Here are some ways data can be used to motivate staff and further support SBIRT implementation:

- Individual performance reporting — many primary care settings already conduct individual performance reporting. Consider adding SBIRT measures for use in supervision. (See Appendix G, Sample Data Dashboard.)
- Performance metrics — add benchmarks for individual providers in meeting SBIRT measures for patients on their caseload.
- Staff meetings — share achievements and identify new goals.
- Report sharing — display data charts in common areas like a break room to show periodic snapshots of progress.
- Identify champions — designate staff members who can serve as champions for data and lead the quality improvement process (e.g., primary care doctor partners with a substance use clinician to serve as points of contact for their colleagues and share performance feedback).

USING DATA TO IMPROVE PATIENT OUTCOMES

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

- Identify quality metrics (e.g., Commission on Accreditation of Rehabilitation Facilities [CARF], HRSA, National Commission for Quality Assurance [NCQA]) that are associated with screening for alcohol, tobacco and marijuana.
- Periodically review basic data related to SBIRT clinical information (e.g., how many people screened for high risk) and service data (percentage of patients screened).
- Use screening data to inform clinical decisions and service delivery (e.g., best practice alerts for effective screening).
- Set screening goals and assess the percent of target patient population screened.
- Assess if screening results are more consistently matched with the appropriate intervention over time.
- Monitor whether adolescents with multiple screening results show decreased risk over time.
- Evaluate the processes used to implement referral treatment. It is an important step in maintaining and improving the quality of SBIRT.
- Create data dashboards to track quality improvement and communicate successes and areas for improvement.

(See Appendix F, SBIRT Data Collection Guide)

SPECIAL CONSIDERATIONS

CO-OCCURRING MEDICAL AND MENTAL HEALTH CONDITIONS

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

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 (Jang et al., 2012). Medication interactions can result in dangerous toxicity. Many medications that are used to treat chronic diseases are hepatotoxic (or destructive to liver cells), which can be exacerbated by alcohol use. This makes alcohol and substance use vital topics to discuss and potential anchor points for screening and brief intervention (Weitzman et al., 2018).

Access to SBIRT may bolster health by encouraging behavior choices that can reduce the prevalence of physical and mental health comorbidities (Sterling et al., 2019; Parthasarathy et al., 2021). Physicians may have substantial opportunities to discuss these issues given the high frequency 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 (Weitzman et al., 2019).

TABLE 6. SUBSTANCE USE IMPACT ON COMMON HEALTH CONDITIONS

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-up.
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).

Youth with chronic medical conditions have higher rates of depression, anxiety and other mental health disorders, all of which can be exacerbated by substance use. Substance use and mental health problems can cause and reinforce each other (Knight et al., 2019). Teens who have mental health problems may turn to psychoactive substances to self-medicate because they may believe the short-term effects of alcohol and drugs help them manage their symptoms of depression, anxiety, hyperactivity or other mental health, even though they may make the problems worse in the long term (Chadi et al., 2019).

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.

For example, diagnostic criteria for cannabis withdrawal has some of the same symptoms as major depressive disorder. A person may return to using marijuana, thinking it is relieving the depression, which perpetuates an ongoing withdrawal syndrome.

For more information on the importance of integrated services,
visit **UCLA Integrated Substance Abuse Programs.**

TABLE 7. RECOMMENDATIONS: SCREENING FOR COMMON MENTAL HEALTH COMORBIDITIES

Common Mental Health Comorbidities	Recommendations	Screening Tools
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-Modified with permission from the PHQ (Spitzer et al., 1999) by J. Johnson (Johnson, 2002).
Anxiety	▪ 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). ▪ CES-DC (Weissman et al., 1980; Faulstich et al., 1986). ▪ Screen for Child Anxiety Related Disorders (SCARED) (Birmaher et al., ▪ Screen for Child Anxiety Related Disorders (SCARED) (Birmaher et al., 1999).
Trauma	▪ 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 et al., 2001).

POLYSUBSTANCE USE

The term polysubstance use broadly describes the consumption of more than one drug over a defined period, simultaneously or at different times for either therapeutic or recreational purposes. In substance use prevention and treatment, it usually refers to multiple illicit drug use, but it can also include illicit and prescription medication used for nonmedical purposes. In most settings, polysubstance use will most often present as a positive screening result for alcohol and/or marijuana and/or tobacco use, also known as the "Big 3." Polysubstance use is more common among adolescents than adults. Among e-cigarette users in grades 9-12, almost all (93%) reported other substance use (Gilbert et al., 2021). 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?

- Co-occurring use compounds learning and memory problems and impacts coordination. Health providers 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 providers need guidance on how to address polysubstance use during the BI and when making a referral to treatment (if indicated).
- Using multiple psychoactive substances that have a potential for addiction could accelerate the trajectory to developing a severe substance use disorder.

PRESCRIPTION AND ILLICIT DRUGS

IN 2019,

567,000

adolescents age 12-17 were current nonmedical users of pain medication.

IN 2019,

1,754,000

youth age 18-25 were current nonmedical users of pain medication (SAMHSA, Centers for Behavioral Health Statistics and Quality, 2020)

- 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.
- In 2018, 5% of 12th graders reported use during the past year of sedatives and tranquilizers, 4.6% reported Adderall use, 3.4% opioids, 3.4% cough/cold medicine and .9% Ritalin (SAMSHA, n.d.).

Adolescents who are using more than one substance will generally need **more than a five-minute BI**. The primary intervention goal is to work with them to reduce or stop use. Be aware that they may be willing to focus on reducing use for one substance but not another.

TRAUMA

The National Institute on Drug Abuse (NIDA, 2014) asserts that **two-thirds of those with substance use disorders have previously experienced trauma in childhood.** In 2016, it was estimated that 46% of youth ages 17 and younger experienced at least one traumatic event. (Sacks & Murphey, 2018).

One of the most compelling reasons to implement a trauma informed approach was documented by the **Adverse Childhood Experiences (ACE) Study.** Recent research confirms that trauma leads to brain dysregulation and chronic stress that negatively affects development, health outcomes and life expectancy. (McEwan & Gregerson, 2019).

Many adolescents with substance use disorders have a history of physical, emotional and/or sexual abuse or other trauma. Post-traumatic stress disorder (PTSD) is common among people with substance use disorders, and patients suffering from both these conditions have a more difficult time meeting their treatment goals.

Considering the connection between trauma and substance use, it is critical that service providers infuse trauma-informed practices into their SBIRT process. A trauma-informed approach prioritizes understanding life experiences and their impact on psychological wellness, physical symptoms and outcomes, treatment adherence and other behaviors to deliver more effective care to patients. It is important to understand the following, especially when dealing with youth:

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

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

For more information on advancing trauma-informed primary care, see the **Fostering Resilience and Recovery change package.**

SOCIAL AND CULTURAL CONSIDERATIONS FOR SBIRT

For many adolescents and young adults, substance use is common in their environments and experimentation is normalized in their social circles. It is worth noting that there are a number of additional cultural considerations and social determinants that can provide context for understanding trends in substance use and treatment engagement. A number of hypotheses have been examined to explain ethnic/racial differences in substance use, including individual beliefs, family or cultural factors (Li & Rosenblood, 1994; Oei & Jardim, 2007; Unger et al., 1994) and peer use at school (Ellickson et al., 2003; Gillmore et al., 1990; Roundtree & Clayton, 1999). Because these are all modifiable factors, they have been leveraged in intervention efforts with positive outcomes in behavior modification (Dunn et al., 2000; Eisen et al, 2003; Faggiano et al., 2008; Liu & Flay, 2009; Orlando et al., 2005).

Not only are there differences in substance use rates across ethnic groups (Office of Disease Prevention and Health Promotion, 2020), there are differences in treatment completion rates (Saloner et al., 2013). Growing evidence suggests that systems-level and area-level variables, like where adolescents live (metropolitan versus rural) and Medicaid provider acceptance rates, are not only among the most important contributors to racial/ethnic differences in treatment access and outcomes, but also have a disproportionately negative impact on certain ethnic minorities (Cook et al., 2012). Research also suggests that culturally sensitive treatments offer promise for effectively addressing substance use among racial/ethnic minority youth (Steinka-Fry et al., 2016), underscoring the importance of developing the skill set for delivering services in a culturally sensitive manner.

In addition to individual, familial, school, systems and area factors, some groups also face social stigma and discrimination that put them at risk for higher rates of substance use. For example, discrimination against and denial of civil and human rights of lesbian, gay, bisexual and transgender (LGBT) persons has been associated with higher rates of substance use when compared to the general population (Herek & Garnets, 2007; Ibanez et al., 2005). Providers need to be educated on and sensitive to the unique challenges facing certain vulnerable populations so they can be more effective in delivering contextually appropriate care. When discussing substance use with minority populations, it is critical to do so in a way that is respectful of different cultural perspectives and ensures that messages about substance use and health are communicated in a manner that is responsive

to patients' cultural backgrounds and perspectives. Addressing the unique social, cultural and linguistic needs of identified minority subpopulations around SBIRT is critical to engaging patients in services that promote patient-centeredness and improve outcomes.

Disparities in patterns of use and treatment effectiveness among vulnerable populations and ethnic/racial minorities underscore the need for cultural awareness and sensitivity in SBIRT delivery. While it is important to be aware that different groups of individuals may have different combinations of risk and protective factors, a health provider should not make assumptions about the influence of culture, gender, upbringing or other personal factors in a patient's life. Cultural humility rather than cultural competence may be a more reasonable goal as it honors the patient's lived experience and uniqueness and centers that experience as an integral component of care.

STRATEGIES TO ADDRESS CULTURE IN SBIRT IMPLEMENTATION

Build in flexibility to allow for cultural adaptations of SBIRT processes and tools in policy and procedure.

- Identify vulnerable subgroups within the adolescent patient population.
- Engage patients from diverse cultural backgrounds in the development and delivery of culturally responsive messages and processes to ensure that different worldviews of underlying causes, treatment and care are not barriers to achieving optimal health.
- Be mindful of culturally specific attitudes and values when working with adolescents and families.
- Attention to validated screeners, appropriate use of language/literacy, trust building and incorporation of patient and community health care preferences may enhance SBIRT acceptability and effectiveness (Manuel et al., 2015).

Address implicit bias and its unintentional impacts on service delivery.

- Recruit and retain staff who reflect the ethnicities of the communities served.
- Provide continuous opportunities for learning and dialog through a variety of staff trainings.
- Prioritize diversity, equity and inclusion during the program design and initiative start-up processes to standardize opportunities to ensure cultural sensitivity and assess unintentional negative impacts of interactions with patients. Here is **a list of questions** to consider.
- Utilize open-ended questions with a high degree of empathy to center patients as the expert in their life and driver of decision-making.

Maintain an organizational commitment to a culture of continual learning about issues of cultural humility and sensitivity.

- Provide staff training to increase cultural awareness, knowledge and skills.
- Support opportunities for staff to develop self-awareness, self-worth and cultural identity. Create space for cultural and social exchange among staff and patients so acknowledgement and appreciation of differences is normalized.
- Engage with faith-based communities and/or traditional healers.
- Use community health workers and cultural translators rather than traditional language translators.
- Include family and community members in health care decision-making.
- Establish bidirectional relationships with community partners that integrate them as resources to improve care.

APPENDIX A
TABLES FROM SURGEON GENERAL'S REPORT

TABLE 8: RISK FACTORS FOR ADOLESCENT AND YOUNG ADULT SUBSTANCE USE

Risk Factors	Definition	Adolescent Substance Use	Young Adult Substance Use
Individual/Peer			
Early initiation of substance use	Engaging in alcohol or drug use at a young age.	✓	✓
Early and persistent problem behavior	Emotional distress, aggressiveness and "difficult" temperaments in adolescents.	✓	✓
Rebelliousness	High tolerance for deviance and rebellious activities.	✓	✓
Favorable attitudes toward substance use	Positive feelings towards alcohol or drug use, low perception of risk.	✓	✓
Peer substance use	Friends and peers who engage in alcohol or drug use.	✓	✓
Genetic predictors	Genetic susceptibility to alcohol or drug use.	✓	✓
Family			
Family management problems (monitoring, rewards, etc.)	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.	✓	✓
Family conflict	Conflict between parents or between parents and children, including abuse or neglect.	✓	✓
Favorable parental attitudes	Parental attitudes that are favorable to drug use and parental approval of drinking and drug use.	✓	✓
Family history of substance misuse	Persistent, progressive and generalized substance use and use challenges by family members.	✓	✓

Risk Factors	Definition	Adolescent Substance Use	Young Adult Substance Use
Individual/Peer			
Academic failure beginning in late elementary school	Poor grades in school.	✓	✓
Lack of commitment to school	When a young person no longer considers the role of the student as meaningful and rewarding or lacks investment or commitment to school.	✓	✓
Community			
Low cost of alcohol	Low alcohol sales tax, happy hour specials and other price discounting.	✓	✓
High availability of substances	High number of alcohol outlets in a defined geographical area or per a sector of the population.	✓	✓
Community laws and norms favorable to substance use	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.	✓	✓
Media portrayal of alcohol use	Exposure to actors using alcohol in movies or television.	✓	
Low neighborhood attachment	Low level of bonding to the neighborhood.	✓	
Community disorganization	Living in neighborhoods with high population density, lack of natural surveillance of public places, physical deterioration and high rates of adult crime.	✓	
Low socioeconomic status	A parent's low socioeconomic status, as measured through a combination of education, income and occupation.	✓	
Transitions and mobility	Communities with high rates of mobility within or between communities.	✓	

TABLE 9: PROTECTIVE FACTORS FOR ADOLESCENT AND YOUNG ADULT SUBSTANCE USE

Protective Factors	Definition	Adolescent Substance Use	Young Adult Substance Use
Individual			
Social, emotional, behavioral, cognitive and moral competence	Interpersonal skills that help youth integrate feelings, thinking, and actions to achieve specific social and interpersonal goals.	✓	✓
Self-efficacy	An individual's belief that they can modify, control or abstain from substance use.	✓	✓
Spirituality	Belief in a higher being or involvement in spiritual practices or religious activities.	✓	✓
Resiliency	Positive feelings toward alcohol or drug use, low perception of risk.	✓	✓
Family, School and Community			
Opportunities for positive social involvement	Developmentally appropriate opportunities to be meaningfully involved with the family, school or community.	✓	✓
Recognition for positive behavior	Parents, teachers, peers and community members providing recognition for effort and accomplishments to motivate individuals to engage in positive behaviors in the future.	✓	✓
Bonding	Attachment and commitment to, and positive communication with, family, schools and communities.	✓	✓
Marriage or committed relationship	Married or living with a partner in a committed relationship who does not misuse alcohol or drugs.		✓
Healthy beliefs and standards for behavior	Family, school and community norms that communicate clear and consistent expectations about not misusing alcohol and drugs.	✓	✓

Reproduced from: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016. Available at: https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf

APPENDIX B
ADOLESCENT SUBSTANCE USE 101

PREVALENCE AND RISK

People take drugs to feel good and/or feel better; drugs have the power to produce new experiences and feelings for adolescents while simultaneously lessening anxiety, fear and other negative emotions (University of California Los Angeles Integrated Substance Abuse Programs, 2018). The development of a substance use challenge or other use of substances is dependent on the interplay between multiple risk factors.

DRUG-SPECIFIC RISK FACTORS

- Route of substance administration
- Effect of the drug itself
- Early use
- Availability
- Cost

BIOLOGICAL RISK FACTORS

- Genetics
- Gender
- Mental illness

ENVIRONMENTAL RISK FACTORS

- Childhood loss, abuse and/or neglect
- Household dysfunction
- Adverse life events/ACEs
- Parental substance use and attitudes toward substance use
- Peer influences
- Community attitudes
- Poor school performance
- Poverty

Research indicates adolescents are unlikely to use other drugs if they do not already use alcohol, marijuana and/or tobacco/nicotine (Woodcock et. al., 2015). These three categories of substances have the most prevalent use among adolescents and are, therefore, likely to be seen among patients in a primary care setting. The following is an overview of these drugs and their prevalence to help inform your SBIRT work.

THE DEVELOPING BRAIN

Prolonged substance use in adolescents can cause both structural and functional changes in the brain that can have long-lasting impacts (University of California Los Angeles Integrated Substance Abuse Programs, 2018). As the brain continues to develop during adolescence, neural circuits are being refined (White et. al., 2018). This process can be interrupted by substance use and age of first drug use is highly correlated with development of a substance use disorder (White et. al., 2018). Given that the frontal lobe is in prime development during this time period, much of the alteration caused by substance use happens in this part of the brain, which controls executive functioning (Silveri et al., 2016).

The Drug Enforcement Agency (DEA) maintains a regularly updated **list of drug slang code words.**

SPECIFIC SUBSTANCES AND MIND/BODY EFFECTS

	Alcohol	Marijuana	Tobacco/Nicotine
Effects on Body and Mind (NIDA, 2018)	▪ Stimulates release of naturally occurring opioids in the body, which results in pleasure through dopamine release. ▪ Slows down the body and responses — leads to difficulty with coordination, drowsiness, slurred speech and inhibition reduction. (University of California Los Angeles Integrated Substance Abuse Programs, 2018).	▪ Decreases executive function control, leading to poorer attention, cognitive inhibition, decision-making, risk aversion and abstract reasoning. ▪ Alters mood and perception, resulting in reduced anxiety and stress, increased euphoria and relaxation, and sensory intensification and, potentially, hallucinations. ▪ Causes impaired coordination. ▪ Increases heart rate, hunger and drowsiness.	▪ Increases heart rate, blood pressure and alertness. ▪ Reduces appetite.

Beyond the three most prevalent drugs, adolescents are using a variety of other less prevalent drugs to be aware of when conducting SBIRT. They are listed below in alphabetical order, not order of prevalence.

Drug	Effects on the Body and Mind (NIDA, 2018)
Bath salts (stimulant)	▪ Increase heart rate, energy, sociability and sex drive. ▪ Cause paranoia, hallucinations, panic attacks and delirium.
Cocaine/Crack (stimulant)	▪ Increases alertness, sensitivity to stimuli, irritability, energy level/restlessness. ▪ Increases heart rate, blood pressure and body temperature, among other physical reactions like abdominal pain and headache. ▪ Causes euphoria, paranoia, erratic and violent behavior, psychosis, increased anxiety.
Hallucinogens (LSD,peyote, mushrooms, PCP, DMT, ketamine, salvia)	▪ Causes hallucinations that distort perception (e.g., see/hear/feel things that aren't there), including sensory crossover (e.g., hear colors, see sounds). ▪ Causes mood swings and intensified feelings and sensory experiences. ▪ Increases energy and heart rate.
Heroin	▪ Causes euphoria and nausea/vomiting. ▪ Slows breathing and heart rate. ▪ Produces physical discomforts like dry mouth and itching while lessening pain.
Inhalants	▪ Slows brain activity, causing confusion, slurred speech, lack of inhibition and coordination. ▪ Increases euphoria, dizziness, lightheadedness, drowsiness. ▪ Causes expanded and relaxed blood vessels, hallucinations/delusions, stupor, numbness, loss of consciousness, nausea, headaches.
MDMA — ecstasy, Molly	▪ Alters mood, sensory perception, appetite and sexual arousal. ▪ Increases energy, euphoria, heart rate, blood pressure and lowers inhibition. ▪ Causes muscle tension, nausea, faintness, chills/sweating/change in body temperature.
Methamphetamine	▪ Increases euphoria, wakefulness, physical activity, breathing rate, heart rate, blood pressure, body temperature. ▪ Decreases appetite. ▪ Causes immediate rush and irregular heartbeat.
Opioids	▪ Increases euphoria, pleasure, drowsiness/sedation. ▪ Decreases pain. ▪ Slows thinking, breathing. ▪ Causes nausea and constipation.
Sedative Hypnotics (barbiturates, benzodiazepines, non-benzo hypnotics)	▪ Impairs memory, attention/concentration. ▪ Causes drowsiness/sedation, slurred speech, dizziness, problems with movement. ▪ Lowers blood pressure and slows breathing.

APPENDIX C
CHANGE PACKAGE PILOT PROGRAM

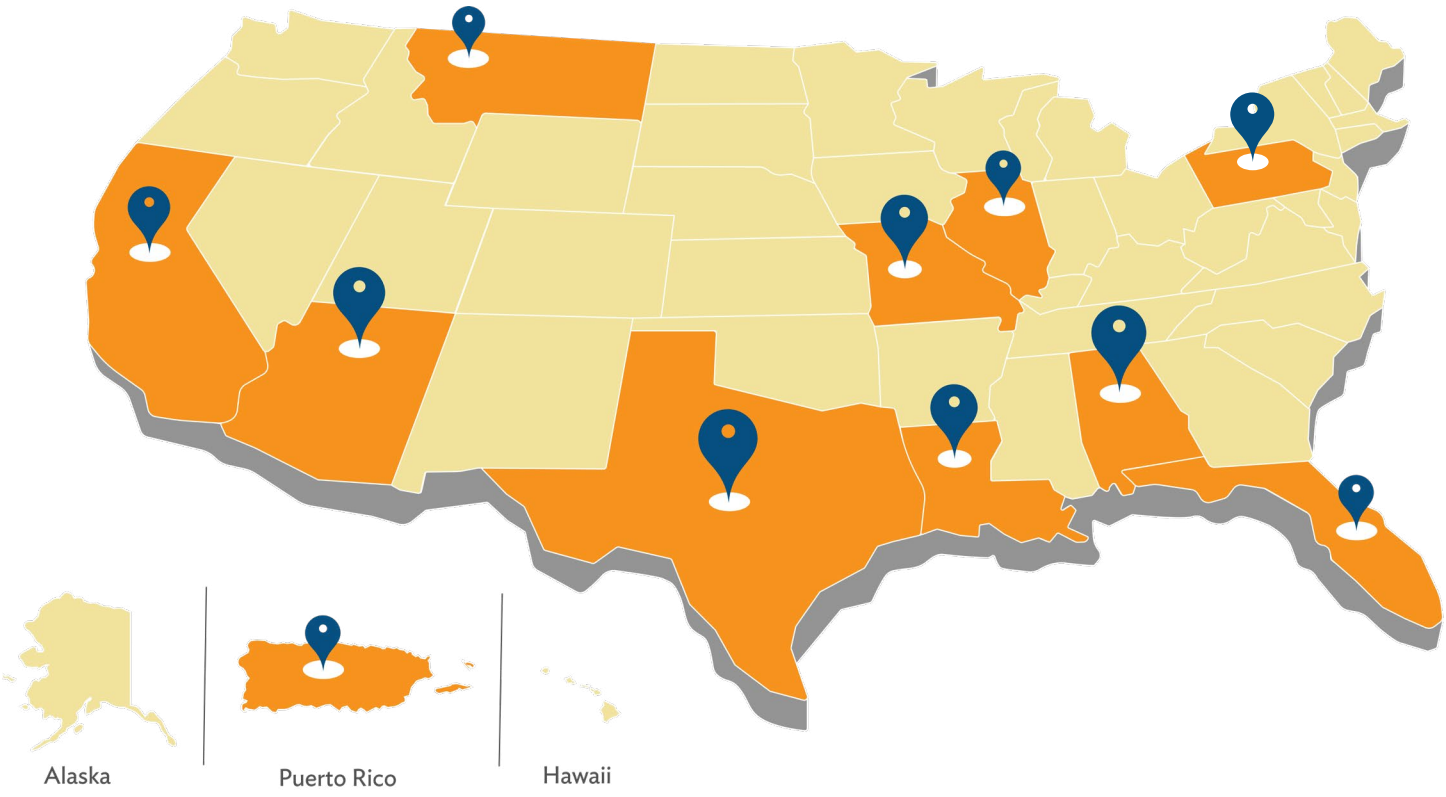
PARTICIPANTS

To test the efficacy of the change package, the National Council for Mental Wellbeing, in partnership with Friends Research Institute and Aurora Research Institute, conducted an 18-month pilot program with 12 FQHCs from across the country. Selected sites had diversity of readiness for implementation, geographic location and setting, center size and patient population demographics to ensure the change package was nationally applicable. Sites received training on a range of topics from a dedicated practice coach, regular group webinars and a series of in-person meetings/site visits.

PILOT RESULTS

Results of a comprehensive evaluation found that pilot sites screened 91% of all adolescents who visited their clinics for well visits, exceeding the 90% benchmark. This represents a significant improvement, as many sites were not screening at all prior to change package implementation. In addition, examination of EHR data indicated fidelity to the change package protocol and that providers were delivering the appropriate intervention based on screening results. In addition to improvements around screening and intervention delivery, sites saw an overall increase in the level of mental health and substance treatment integrated with primary care. Sites scoring higher on measures of integrated care were also viewed by a sample of surveyed personnel to have better communication and cohesion. This supports the idea that greater integration supports FQHCs in being more responsive to the needs of both patients and staff members. Clinicians who perceived more supportive organizational structures also reported greater confidence in properly conducting SBIRT. Finally, when compared to other roles, nurses saw the greatest increase in completion of SBIRT training and greatest gains in positive attitudes toward screening and brief intervention, indicating they are critical stakeholders and champions for adolescent SBIRT.

Pilot Program: Federally Qualified Health Centers (FQHCs)



LESSONS LEARNED

Sites experienced challenges documenting SBIRT practices in their EHRs (especially with brief interventions), navigating confidentiality and patient-parent dynamics and establishing effective workflows and billing practices. Overall, sites learned that implementation required a high level of leadership and provider buy-in at project initiation and, in order to sustain practice, it was imperative to motivate, educate and communicate with staff about the importance of SBIRT. Other general learnings include:

- **Screening**: It is critical to be aware of emerging trends in substance use so providers ask the right questions.
- **Interventions:**
  - Anticipatory guidance was not consistently delivered by pilot sites for all adolescents whose screen indicated "no use." It is important to clarify this requirement so providers take advantage of the prevention opportunity.
  - Brief interventions need to be brief enough to account for the time constraints experienced in the primary care setting. It is ideal to give providers a range of potential scenarios in delivering a brief intervention so that the conversation is flexible, efficient and responsive to each adolescent's needs.
- **Referral to Treatment:** This step requires strong relationships with both internal and external partners and a dedication to documenting follow-up steps. It is also important to stress the responsibility primary care providers have in managing and addressing substance use so adolescents receive comprehensive and integrated care.
- **Communicating for Engagement:** Communication about adolescent SBIRT benefits, implementation goals and progress reporting needs to happen on a continual basis to maintain leadership and staff engagement. SBIRT champions should be prepared with concise messages to engage these audiences and share tools to assist providers in executing SBIRT.
- **Data and Documentation:** For clinics to collect data for population health and continuous quality improvement, staff must be trained on how to collect and enter data (including having an understanding of what each EHR field requires) and reports must be shared routinely to encourage continued data entry. There is no quick fix for EHR modifications; however, sites can improve their chances of success by addressing issues early in the implementation planning process, setting aside resources to prioritize this issue and finding ways to integrate documentation into already-existing workflows.

APPENDIX D

S2BI SCREENING TOOL: PRINTABLE VERSION

This version of the S2BI has been validated and can be viewed **online** (Massachusetts Child Psychiatry Access Program, 2015).

Screening to Brief Intervention (S2BI) Tool

The following questions will ask about your use, if any, of alcohol, tobacco, and other drugs. Please answer every question by checking the box next to your choice.

IN THE PAST YEAR, HOW MANY TIMES HAVE YOU USED:

Tobacco?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

S2BI Tool developed at Boston Children's Hospital with support from the National Institute on Drug Abuse.

It is best used in conjunction with "The Adolescent SBIRT Toolkit for Providers" mass.gov/maclearinghouse (no charge).

Alcohol?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

Marijuana?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

***STOP** if answers to all previous questions are "never." Otherwise, continue with questions on the back.*

Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

Inhalants (such as nitrous oxide)?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

Illegal drugs (such as cocaine or Ecstasy)?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

Herbs or synthetic drugs (such as salvia, "K2", or bath salts)?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

SA3542
MAY 2015

This version of the S2BI includes language reflecting the emerging trends in adolescent substance use and has not been validated with this specific language.

S2BI: SCREENING TO BRIEF INTERVENTION	
In the past year, how many times have you used:	
Tobacco/Nicotine? (such as cigarettes, e-cigarettes, "vapes")	☐ **Never** ☐ **Once or Twice** ☐ **Monthly** ☐ **Weekly or more**
Alcohol?	☐ **Never** ☐ **Once or Twice** ☐ **Monthly** ☐ **Weekly or more**
Marijuana? (smoked, vaped, edibles, etc.)	☐ **Never** ☐ **Once or Twice** ☐ **Monthly** ☐ **Weekly or more**
STOP if all above answers are **"Never"** Otherwise, please **CONTINUE**	
In the past year, how many times have you used:	
Prescription drugs that were not prescribed for you? (such as pain medication or Adderall)	☐ **Never** ☐ **Once or Twice** ☐ **Monthly** ☐ **Weekly or more**
Illegal Drugs?	☐ **Never** ☐ **Once or Twice** ☐ **Monthly** ☐ **Weekly or more**
Inhalants? (such as nitrous oxide)	☐ **Never** ☐ **Once or Twice** ☐ **Monthly** ☐ **Weekly or more**
Herbs or synthetic drugs? (such as salvia, "K2", or bath salts)	☐ **Never** ☐ **Once or Twice** ☐ **Monthly** ☐ **Weekly or more**

APPENDIX E
CONFIDENTIALITY AND PARENTAL INVOLVEMENT

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

> "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: WHICH LAWS APPLY TO YOU?

Numerous federal and state laws protect the privacy of health care information. According to the American Academy of Pediatrics, there are at least four types of laws that affect a health provider's ability to share information about a patient in their care:

- Federal medical privacy rules issued under the federal Health Insurance Portability and Accountability Act (HIPAA)
- State privacy laws
- State minor consent laws
- Family Educational Rights and Privacy Act (FERPA)

There is also federal confidentiality legislation (42 USC § 290dd-2) that governs facilities deemed to be federal alcohol and drug abuse treatment programs under 42 Code of Federal Regulations (CFR) Part 2.

Each type of privacy or confidentiality regulation can change over time, so we recommend regular examination of applicable federal and state laws in coordination with legal counsel to ensure service delivery compliance.

> More information on HIPAA, state privacy laws and state minor consent laws can be found in the **American Academy of Pediatrics, Confidentiality Laws Tip Sheet** and the **Legal Action Center's training resources.**

HIPAA

While 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 or guardian to have access to the medical records for their 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 encourage them to speak directly with their child instead to avoid hindering the effectiveness of treatment. For more information on HIPAA, visit the **HSS.gov. website.**

STATE PRIVACY LAWS

A parent's ability to access their minor child's health information is dependent upon state privacy laws. Examine state laws or seek advice from legal counsel to determine whether they specifically address the confidentiality of a minor's health information. If this issue is not addressed in state law, providers can typically determine whether or not to grant access.

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 two 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 a law that allows minors to consent for care related to drug and alcohol use **(AAP Tip Sheet).**

FERPA

FERPA (20 U.S.C. § 1232g; 34 CFR Part 99) protects the privacy of student education records at all schools that receive funds under an applicable program of the U.S. Department of Education. This law applies to non-high school students, mainly students attending a program in higher education. This law gives parents or guardians certain rights with respect to their children's education records — rights transferred to the student when he or she reaches the age of 18 or attends a school beyond the high school level. **The U.S. Department of Education website** (U.S. Department of Education, 2018) provides additional details on the law.

42 CFR PART 2

In general, federally subsidized substance use 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.

The Legal Action Center has created a **decision tree** (Legal Action Center, 2018) and **fact sheet** (Legal Action Center, 2017) to help determine if Part 2 applies to you or your agency. SAMHSA also provides fact sheets and frequently asked questions on the **SAMHSA website** (SAMHSA, 2019) to further explain Part 2's confidentiality regulations.

Even SBIRT providers who are not subject to Part 2 should have a basic understanding of Part 2's requirements to facilitate communication and engagement with Part 2 programs. Funding streams are moving in the direction of aligning with Part 2's requirements, so it is prudent for all providers to understand what the requirements.

42 CFR Part 2 and HIPAA: Follow both laws, if possible. If 42 CFR Part 2 is more restrictive then its provisions apply.

DISCUSSING CONFIDENTIALITY WITH PATIENTS AND PARENTS OR GUARDIANS

Introduce confidentiality practices.

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

Example messaging to introduce parents to confidential information gathering:

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

LESSONS FROM THE PILOT

Create a safe space for confidential discussions.

Parents or guardians may not be aware of their child's substance use and the adolescent may not disclose their use history to a provider in front of their parent or guardian. During the FaCES learning collaborative, many of the FQHCs piloting adolescent SBIRT implementation experienced this tension and developed solutions that allow the parent or guardian to be comfortable while giving the patient room to discuss their substance use with a provider. Some best practices that emerged from their innovative solutions are:

- **Present the screening tool away from parents or guardians** — Venice Family Clinic in Venice, Calif., created a laminated, self-administered S2BI score card for patients in need of being screened. This has helped with confidentiality, as the patient can take the time privately to write down their answers to the screening questions, rather than be prompted to discuss it verbally.
- **Treat S2BI screening as a vital sign** — Vista Community Clinic in Vista, Calif., established a workflow where a medical assistant takes the patient's vitals (e.g., body temperature, blood pressure) and delivers the self-administered screening tool, while parents or guardians are asked to wait in the lobby.
- **Make private visits the standard once children reach a designated age** — Several clinics made this an expectation and standard part of entering adolescence at their clinic. Some have a pre-distributed policy that parents or guardians stay in the waiting room during well visits for patients over a certain age, therefore eliminating the need to ask parents or guardians if it is okay to meet with the patient alone. At Health Services, Inc., in Montgomery, AL., providers ask that patients come in alone to the visit so they can practice answering questions about their own health instead of looking to their parents or guardians, giving them more ownership over their own health.

DISCUSSING CONFIDENTIALITY WITH PATIENTS AND PARENTS

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

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

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

LESSON FROM THE PILOT

During the first week of screening at one of the sites of Family First Health in South Central Pennsylvania, a 16-year-old patient came in with her parent for an acute visit. She completed the S2BI on paper while her parent sat next to her. The S2BI was then reviewed by the clinician. When her parent left the room, she disclosed regular substance use and risky sexual behavior, which she did not initially indicate during screening. Through a brief intervention conversation, the patient expressed appreciation for the chance to discuss these issues, which would not have happened with her parent in the room. This patient's experience is not unique. Since then, multiple patients have disclosed substance use when a parent left the room, allowing providers to briefly intervene and educate the patient.

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

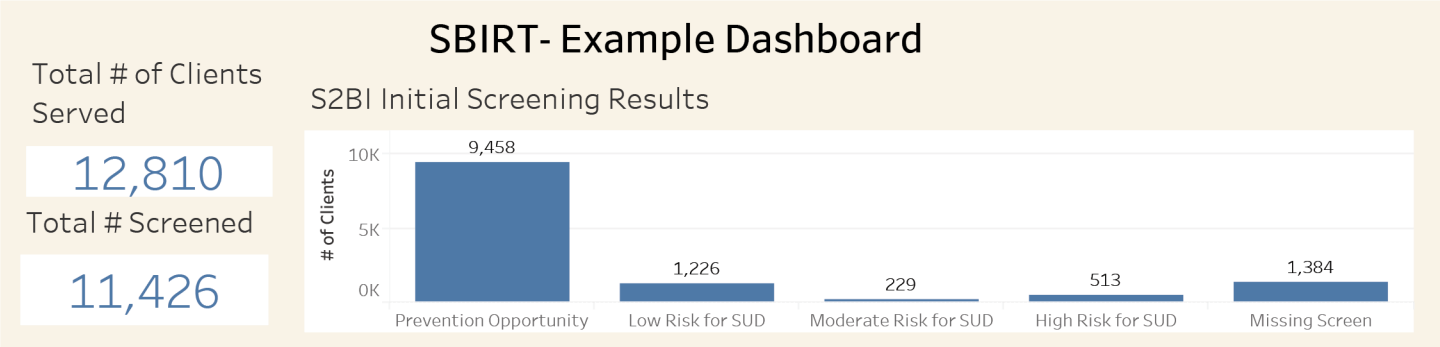
Even when sensitive information such as suicidal or homicidal thoughts needs to be discussed with parents/guardians, the clinician should first discuss with the adolescent what and how information will be presented to parents. By strategizing with the adolescent ahead of time, a clinician can transmit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

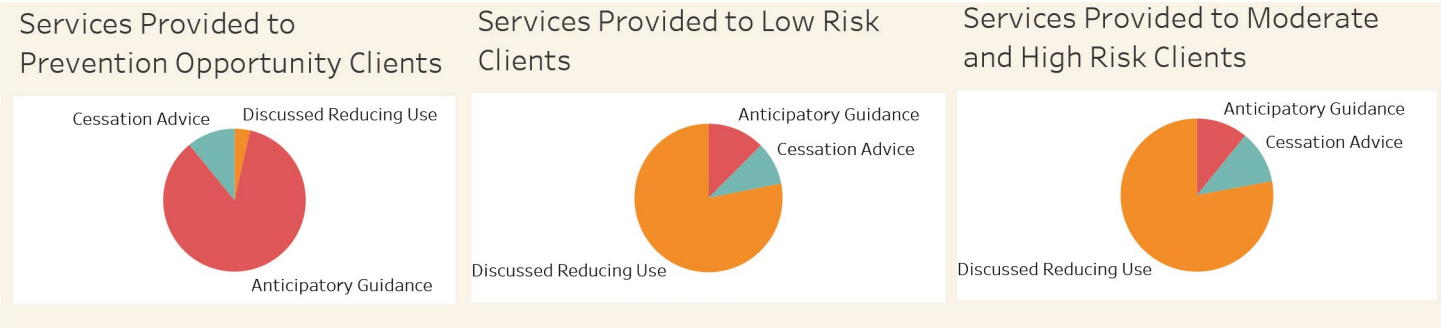
In many cases, by the time an adolescent has developed a substance use disorder, parents are already aware of their use, though they may underestimate the seriousness of the problem. We recommend that clinicians ask adolescents whether their parents are aware of their substance use and encourage them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

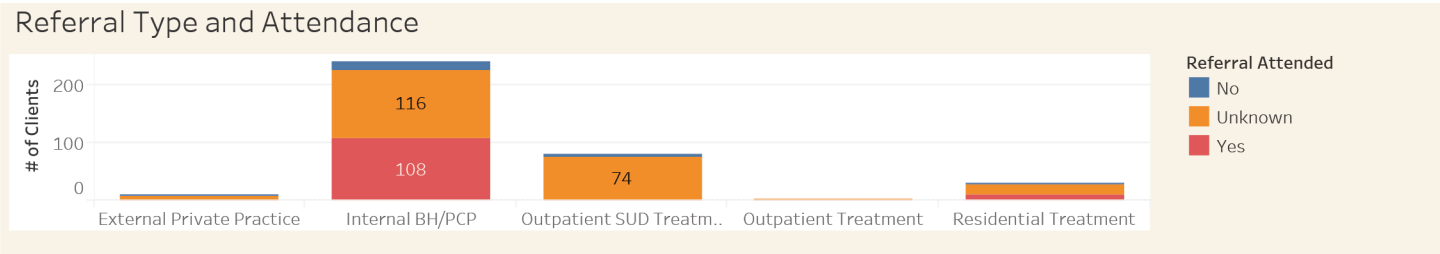
APPENDIX F
SBIRT DATA COLLECTION GUIDE

Client Characteristics	
Demographics	Clinics should explore screening results by client demographics, such as age, gender, race/ethnicity, primary language and sexual orientation.
Co-occurring Conditions	Clinics should investigate how screening results vary across client diagnostic groups. This should include physical health diagnoses, such as diabetes, asthma, and obesity, as well as mental health diagnoses, such as anxiety, depression, and bipolar disorder.
Screening Results	
Individual S2BI Responses	Data should be separately tracked for each substance on the S2BI (tobacco, alcohol, marijuana and prescription drugs). Data should also be tracked using the response options on the S2BI (Never, Once or Twice, Monthly, Weekly).
S2BI Risk Level	Clinics should interpret and record the overall risk level indicated by the S2BI.
Brief Intervention	
Type of Intervention	Record what intervention was delivered to the patient (anticipatory guidance, abbreviated BI, full BI).
Date of BI	The date of the intervention should be recorded. Emphasis should be placed on ensuring brief interventions are delivered the same day as the screening.
Referral to Treatment	
Type of Referral	Was a substance use referral provided to this patient (yes or no)?
Referral Provider Name	Was the patient provided a referral to internal service? If the patient was provided a referral to external services, indicate name of service provider.
Follow-up	
Follow-up Scheduled	Is there a follow-up scheduled for this patient (yes or no)?
Follow-up Date	If so, when is the follow-up scheduled for?

APPENDIX G
SAMPLE DATA DASHBOARD







APPENDIX H
GUIDANCE FOR DELIVERING BRIEF INTERVENTION

This is a practical tool for staff delivering BIs by providing the appropriate level of intervention based on screening results.

No Use (Prevention Opportunity)

What is anticipatory guidance?

Anticipatory guidance is the appropriate response for a screening result of "No Use." It is an opportunity to intervene before substance use begins. It is a process in which the health provider anticipates emerging issues that an adolescent and family may face and provides guidance by delivering information about the benefits of healthy lifestyle choices and practices that promote prevention and encourages parents to discuss healthy, substance-free lifestyles.

Provide positive reinforcement.

Affirm healthy choices. Reinforce patient's reasons for non-use. Deliver preventative advice.

Sample Scripting:

- "It's great that you are choosing not to use substances. Have you ever been offered?"
  - If yes, follow with: "What happened and how did you decide to say no?"
  - If no, follow with: "That's great. It could happen in the future so it's good to be prepared and think through what you would do."
- "Avoiding tobacco, alcohol and drugs is an excellent choice — it's one of the best ways to protect your health. Can I provide some information on how these substances can affect you over time?"
- "There may be times when drugs and alcohol seem tempting, especially at your age. As your doctor, I'm proud of you for making a tough choice that can also positively affect your health."

Staff Considerations: All staff can be trained to provide positive reinforcement. Ensure staff are equipped with psychoeducational tools that are tailored to adolescents.

Once or Twice Use (Low Risk of Substance Use Disorder)

Provide cessation advice.

Recommend that no use is best for health and give accurate information on the harms of substance use. Tailor your responses based on what you know about the patient, their health and life goals.

Sample Scripting:

- "I would like to talk about your responses to the screener to find out more about your experiences with alcohol or other drugs. Would that be okay?"
- "As your health provider I recommend not using alcohol or drugs."
- "Did you know use of (x) can impact your (grades, sports, diabetes, asthma, depression, etc.)?"

Staff Considerations:

- PCPs should ideally perform this task due to level of influence and follow the same process as providing health advice for other disease states.
- Mental health or substance use treatment providers, nursing staff and other staff can reiterate the health advice if in contact with the patient.

Monthly Use (Moderate Risk of Substance Use Disorder)

1. **Provide cessation advice.**
2. **Reduce use and reduce risky behaviors.**

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

Sample Scripting:

"What are the good things about using (x)? What are the not so good things?"

"Have you ever quit or cut back before? What were your reasons?"

"How would you go about making a change in your use, if you decided to?"

"How can I best support you?"

Staff Considerations:

- PCPs ideally performs this task due to level of influence and relationship with the patient.
- Mental health and substance use treatment providers can perform this task if PCP is unable.

Weekly Use (High Risk of Substance Use Disorder)

1. **Provide cessation advice.**
2. **Reduce use and reduce risky behaviors.**
3. **Facilitate linkage to mental health/substance use treatment.**

   Reinforce options and your ongoing support. Connect the patient with others who may be able to meet any needs that are outside your scope of practice. Make warm handoffs/referrals when possible.

Sample Scripting:

- "I'm concerned because (connect back to identified hook for health problems and other negative consequences [e.g., social anxiety, sleeping troubles])."
- "I'd like to introduce you to another member of our care team who works with many of my patients. They may be helpful in discussing other services that could be of interest to you. What are your thoughts?"

Staff Considerations:

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

Assess for imminent risk of suicide:

For suicidality, provide a safety planning intervention and discuss means restriction. If possible, include caregivers in the conversation (break confidentiality if necessary). Encourage mental health services and for imminent risk, refer for urgent services.

Resource: Training in Motivational Interviewing (MI) can be helpful for enhancing brief intervention skills. For more information: https://motivationalinterviewing.org/motivational-interviewing-resources

APPENDIX I
SAMPLE CONVERSATION CASE EXAMPLE

SARAH, A 17-YEAR-OLD HIGH SCHOOL SENIOR, presents on Monday morning with a severely sprained, swollen and painful left ankle. On her S2BI she reports consuming about four or five drinks about once a month, on average.

Provider: (Following a friendly check-in, engaging rapport) Can you tell me more about what happened to bring you in today?

Patient: I was walking in new boots Saturday night and wasn't used to them. I slipped on the sidewalk and twisted my ankle.

Provider: Did it hurt a lot when it happened?

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. It's definitely swollen and I'll put in an order for an x-ray. While they set up, can we look over the questions you answered on this form?

Patient: Sure, I guess.

Provider: Thank you for filling it out and letting me know about how much and how often you drink. What do you enjoy about it?

Patient: Well it's fun because I'm hanging out with friends.

Provider: I can understand wanting to be with friends. Relationships are important! In what way, if at all could alcohol have affected your fall the other night?

Patient: I don't know. My friends gave me crap for it but I only had a couple shots.

Provider: It is common for alcohol to increase accidental injuries since it can affect our coordination and perception. My goal is not to tell you what you should do, rather to ask; if you were to cut back, or even stop drinking for some period of time, what would that look like for you?

Patient: It would be a little weird because my friends might give me a hard time. But I'm embarrassed about this. And you know what? Only one of my friends texted the next day to see if I was ok. I need a break from the others anyway.

Provider: It seems one person in the group is really thoughtful.

Patient: Right. She doesn't really drink anyway... and doesn't care what the others think!

Provider: Sounds like you've identified for yourself some reasons and some options going forward. How can I best support you?

Patient: I'm just glad you didn't lecture me. I feel stupid enough already because of my ankle.

Provider: Let's get the x-ray, then make a plan to get you feeling better. I'm glad to be a resource for you anytime.

APPENDIX J

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 to the questions about substance use indicate that you might benefit from some help cutting back on drinking, and I can see from our conversation that you have already started thinking seriously about these issues. Working on this through outpatient counseling with a counselor or other health provider 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 your 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 K
SPECIALTY 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 or able to be away from home.)
- What quality programs are available in the community and who has space?
- What will insurance cover?

MEDICATION-ASSISTED TREATMENT/MEDICATION FOR ADDICTION TREATMENT

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

INTENSIVE OUTPATIENT TREATMENT

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

INTENSIVE OUTPATIENT TREATMENT AND PARTIAL HOSPITALIZATION

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

RESIDENTIAL/INPATIENT TREATMENT

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

MEDICALLY MANAGED INTENSIVE INPATIENT TREATMENT

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

APPENDIX L
FINANCING SBIRT

It is important to identify all the components that require funding for successful and sustainable SBIRT implementation. To carry out SBIRT with positive outcomes for adolescents, the following elements require financial support: supportive/administrative costs, training and coaching of providers, monitoring fidelity, tracking outcomes of SBIRT on youth and young adults and sustainability planning.

Securing reimbursement for services is key to sustaining SBIRT and there are also additional funding elements to consider. SBIRT is an Affordable Care Act-recommended service and base, contract or grant dollars may be available to support its implementation. Coding and billing policies and regulations, however, remain a patchwork in evolution. There are three primary billing methods that can be considered for purposes of reimbursement for SBIRT services — Medicaid, Medicare and commercial health plans — and coding and coverage policy vary based on payer.

The complexity of Medicaid and/or Medicare payment can be a barrier to PCPs' implementing SBIRT, so it is important to understand what is necessary to bill for SBIRT. Because Medicaid and commercial fees will vary by locale and payer, building a relationship with your state's Medicaid office and learning from local health centers that are billing for SBIRT can help determine best practices for SBIRT billing in your area. Additionally, payment for FQHCs is bundled in some states, which means traditional screening and BI codes cannot be used. It is important to know your state's requirements and restrictions for SBIRT billing because of the complexity in billing structure and variability between states.

SBIRT FINANCING STRATEGY PLANNING GUIDE

Below is a list of items to think through and questions to answer as you budget and secure funding for SBIRT services. This list contains many key steps and elements for consideration but is not a comprehensive implementation checklist and should be modified as necessary to fit the needs of your clinic.

1. Outline All Components of Cost

Begin this exercise by developing a general outline of all resources necessary to implement and sustain SBIRT. Details of staff time required will become clearer as you answer these questions about SBIRT implementation.

Operating Expenses How much does each SBIRT resource cost?	
Staffing, technology, office space, benefits	▪ For the most part, SBIRT processes should be rolled into existing workflows, protocols and existing infrastructure. Only consider added resources needed, for example, if you plan to work with your EHR vendor to modify your existing system.
Training	▪ Cost of regular and responsive training for all staff involved in SBIRT.
Opportunity Costs	▪ If your organization was not doing SBIRT, it would be devoting time, attention, resources, staff and space to other work with a different financial makeup. Outline operating expenses for this work just as you outlined them above for SBIRT resources.

2. Confirm Implementation Components and Assess Costs

Staff time and resources are dependent upon your clinic's unique SBIRT workflow. Consider the following questions to accurately project staffing costs.

General SBIRT Procedures	▪ Which staff members will be involved and in which components of SBIRT? ▪ How often will you meet as a team? ▪ How often will you conduct trainings? ▪ Are there any similar interventions at your clinic, such as adult SBIRT or adolescent mental health screening that could serve as a cost model for adolescent SBIRT?
Screening	▪ How will you administer the S2BI? ▪ Who will administer the S2BI? ▪ What is your process and workflow for interpreting the score of the S2BI? ▪ What equipment or technology will you need to administer and interpret the screening results? ▪ How will you record/document the raw data and interpretation of the S2BI?
Brief Intervention	▪ How will you conduct the brief intervention? ▪ How much time will they spend with the adolescent? How much time will they spend with the parent/guardian or family? ▪ How will the amount of time spent vary based on screening results? ▪ How will the brief intervention be documented? Who will be documenting?
Referral to Treatment	▪ Will your referrals be internal, external or both? ▪ Who will be involved in warm handoffs or other transitional referral workflows? ▪ Which support services will be part of your referrals? Are there costs associated with referrals? ▪ Will you implement memorandums of understanding (MOUs) or other legal arrangements with external community partners? Will you require external legal consult for these arrangements? ▪ How will you document referrals? What will care management look like in your organization?
Enabling Services	▪ Will you directly offer and connect patients to enabling services, such as transportation, babysitting or translation? ▪ How can you connect to the **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit** — a Medicaid-mandated benefit service that covers screening and enabling services?
Follow-up	▪ How will you determine how many appointments are needed or if a follow-up is needed at all? ▪ What is the expected time between appointments? ▪ What mechanisms will be in place for ensuring engagement between the patients and services? ▪ What is the protocol for information sharing between entities?
Additional Considerations	▪ What is the expected frequency of policy and procedure review? ▪ What mechanisms are in place for continuous quality improvement within these policies and procedures? How are you using data to inform this process? ▪ How are you monitoring the fidelity of SBIRT practice implementation? How are you monitoring documentation of SBIRT in each step of the process? ▪ How are you planning for SBIRT sustainability? ▪ How are you implementing a population health framework to SBIRT implementation?

3. Identify Potential Funding Sources for SBIRT

Review the potential funding sources to determine what is available in your state and clinic.

Medicaid	▪ **Medicaid pays for preventive screenings and brief interventions.**
	▪ **Who can bill?**
	  ▪ For preventative 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.
	▪ **Additional considerations for billing Medicaid:**
	  ▪ Many FQHCs are paid through a prospective payment system (PPS), which includes SBIRT costs in its framework when SBIRT is completed within the provider requirements.
	  ▪ Medicaid reimbursement policies and fee schedules are determined on a state-by-state basis. For information on your specific state codes, please reference your state's Medicaid website for updated information. Other related factors may include your state's Medicaid expansion status and the existence or absence of **1115 Medicaid Waivers for Expansion of SUD Services (Medicaid), Medicaid Health Homes (Medicaid)** and/or **Managed Care (Medicaid)** in your state's Medicaid program.
	  ▪ Collaborate with your state Medicaid agencies on billing codes and capitated payment arrangements.

Commercial Insurance	▪ Commercial insurance coverage of SBIRT services varies between different payers and each plan will have individual regulations about what type of providers can bill and further limitations around qualifications those providers must possess. Typically, commercial insurance will accept CPT codes if they reimburse for SBIRT, but it is important to understand the individual billing rules for each commercial insurance carrier. (Wisconsin Initiative to Promote Healthy Lifestyles, 2010)
Additional Potential Funding Opportunities	▪ SAMHSA — SAMHSA's Substance Abuse Prevention and Treatment Block Grant (Substance Abuse and Mental Health Services Administration, 2017) program funds state and territory efforts to prevent and treat substance use issues, which includes SBIRT. ▪ SAMHSA — Also funds **several SBIRT-specific programs (SAMHSA, 2019),** including 17 Medical Residency Cooperative Agreements, 32 State Cooperative Agreements, 12 Targeted Capacity Expansion Campus Screening and Brief Intervention (SBI) Grants and 14 SBIRT Medical Professionals Training grants. ▪ HRSA — **HRSA's Maternal and Child Health Block Grant** (HRSA, 2019) supports the health of women and children and has funds specifically devoted to preventative services, including SBIRT. Health screening is often covered under this grant program and FQHCs have utilized this resource for adolescent SBIRT funding. For additional information about populations of focus and the Title V block grant, please see **Community Catalyst's resource on funding SBIRT for young people** (Community Catalyst, 2018). ▪ Children's Health Insurance Plan (CHIP) — Similar to Medicaid, CHIP regulations are state-based and have different restrictions for billing across the country. Some states have a separate, free-standing CHIP program, some have included CHIP in their Medicaid expansion and some have combined approaches. See **Medicaid's CHIP Map** (Medicaid, 2015) to determine which approach your state has taken to determine next steps. ▪ Value-based Payment Arrangements — As the American health care system moves toward paying for quality of services provided, SBIRT is a key component to population health management and primary and mental health and substance use treatment organization and can be included in your value-based payment contracts with managed care organizations. ▪ Private Funding — Private grants, typically from foundations or other philanthropic organizations, are periodically available as another option to fund SBIRT services.

Billing differs from state to state, so it is important to understand your state's specific billing nuances.

	Alcohol and Drugs		Tobacco	
Medicaid H-Codes	**H0049** Full Screen	**H0050** Per 15-minute intervention	**99406** > 3- to 10-minute intervention	**99407** > 10-minute intervention
Medicare G-Codes	**G0396** 15-30 minutes Brief screen and intervention	**G0397** > 30-minute Screen and intervention	**G0436** > 3- to 10-minute counseling (intermediate)	**G0437** > 10-minute counseling (intensive)
Commercial (CPT)	**99408** 15-30 minutes Full screen and intervention	**99409** > 30-minute Full screen and intervention	**99406** > 3- to 10-minute intervention	**99407** > 10-minute intervention

4. Form a Team to Implement Financing Policies and Procedures

Once you have developed an SBIRT budget and identified funding streams, form a team to develop and implement financing policies and procedures.

Specify Requirements and Limitations of Each Funding Source	▪ What are the specific billing rules and requirements for each source?
	  ▪ Co-pays, sliding fee
	  ▪ Number of approved services/number of reimbursable screenings per year
	  ▪ Duration of the services - individual session, sessions over time
	  ▪ Staff qualifications or licensures
	  ▪ Telehealth services
	  ▪ Training hours and/or training curriculum
	▪ What are the documentation and reporting requirements?

Identify Types of Codes for Claims Processing	▪ What kind of codes are you using - Medicaid H codes, CPT codes, E&M codes, HBAI codes, etc.? ▪ What specifically does each code support (e.g., one code supports screening, one supports BI and one supports referral to treatment)? ▪ What will documentation look like in your EHR?

Assess Potential Challenges to Reimbursement	▪ How will you work through challenges that arise with the following areas of SBIRT?
	  ▪ Difficulty implementing billing procedures
	  ▪ Lack of reimbursement options in your state
	  ▪ No shows
	  ▪ Same-day services
	  ▪ Time management
	  ▪ Overspending
	  ▪ Location/space/equipment issues

Outline Process for Financial Review	▪ How will you ensure compliance across funding sources? ▪ Who will ensure billing happens accurately and in a timely manner? This includes, but is not limited to, billing frequency, appropriate staff engagement and accurate and timely provider documentation. ▪ How will you code services based on funding source? Do you need different billing workflows based on funding source?

ADDITIONAL BILLING RESOURCES AND TIPS

- **Look to primary care-specific billing resources.** This Substance Use/Abuse Coding Fact Sheet for Primary Care Pediatrics (AAP, 2017) outlines billing codes to use across different billing code systems, such as Current Procedural Terminology (CPT), International Classification of Diseases (ICD-10) and Healthcare Common Procedure Coding System (HCPSCS). It breaks down each billing code system by specific codes to use, restrictions and requirements for using that coding system and definitions of services.

- **Code even if you don't get paid.** If you are not able to get reimbursed for delivering SBIRT services right now, it is helpful to independently track and monitor your SBIRT service delivery through coding. This can be done by creating a coding system as though you were to bill a funder for your services or by using an existing coding system without submitting claims to a funder. This will be powerful over time and will lead to a smooth transition once you are able to bill for SBIRT. Some of the organizations involved in the FaCES Learning Collaborative did not bill for SBIRT based on the PPS they have in place at the FQHC, but Venice Family Clinic in Venice, CA., among others, still coded for SBIRT to better track their services and found this to be valuable.

- **Remember that role matters when it comes to SBIRT billing. Identifying which providers and professionals can bill for each element of SBIRT is crucial for each funding source**. Many of the FQHCs that participated in the FaCES Learning Collaborative found this to be critical in their journey toward current Procedural Terminology For example, Pillars Community Health in La Grange, IL., hired a licensed therapist to provide brief interventions, which allowed them to bill for services they had previously been providing without reimbursement.

LESSONS FROM THE PILOT

Adopting a strategy from their adult SBIRT process, Vista Community Clinic, in Vista, CA. programmed their EHR — NextGen — to automatically code H0049 when the provider documents a completed screen and H0050 when the provider documents a brief intervention or a referral to treatment.

REFERENCES

American Academy of Pediatrics (AAP). (n.d.). Confidentiality laws tip sheet. **https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Confidentiality_Laws.pdf**

AAP. (n.d.). Substance use screening and brief intervention for youth. **https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Substance-Use-Screening.aspx**

AAP. (2010). Information for teens: What you need to know about privacy. **https://www.healthychildren.org/English/ages-stages/teen/Pages/Information-for-Teens-What-You-Need-to-Know-About-Privacy.aspx**

AAP. (2011). Substance use screening, brief intervention, and referral to treatment for pediatricians. Pediatrics, 128, e1330-40. **https://pediatrics.aappublications.org/content/128/5/e1330**

AAP. (2017). Substance use/abuse coding fact sheet for primary care pediatricians. **https://www.aap.org/en-us/Documents/coding_factsheet_substance_use.pdf**

Barnett, E., Sussman, S., Smith, C., Rohrbach, L., Spruijt-Metz, D. (2012). Motivational interviewing for adolescent substance use: A review of literature. Addictive Behaviors, 37(12), 1325-1334. **https://pubmed.ncbi.nlm.nih.gov/22958865/**

Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): A replication study. *Journal of the American Academy of Child and Adolescent Psychiatry,* 38(10), 1230–6. **https://pubmed.ncbi.nlm.nih.gov/10517055/**

Caetano, R., Clark, C.L., Tam, T. (1998). Alcohol consumption among racial/ethnic minorities: Theory and research. *Alcohol Research and Health*, 22(4), 233-241. **https://pubmed.ncbi.nlm.nih.gov/15706749/**

Center for Behavioral Health Statistics and Quality. (2016). 2016 National survey on drug use and health: Detailed tables. Substance Abuse and Mental Health Services Administration. **https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf**

Center for Behavioral Health Statistics: Monitoring the future 2018 survey results. (2018). **https://www.drugabuse.gov/drug-topics/trends-statistics/infographics/monitoring-future-2018-survey-results**

Centers for Disease Control and Prevention. (2012). National Center for Health Statistics Mortality Data on CDC WONDER. **https://wonder.cdc.gov/mortSQL.html**

Chadi, N., Li G., Cerda, N., Weitzman, E.R. (2019). Depressive symptoms and suicidality in adolescents using e-cigarettes and marijuana. *J Addict Med, 1*. **https://journals.lww.com/journaladdictionmedicine/Abstract/2019/10000/Depressive_Symptoms_and_Suicidality_in_Adolescents.5.aspx**

Clayton, H.B., Andrzejewski, J., Johns, M., Lowry, R., Ashley C. (2019). Does the association between substance use and sexual risk behaviors among high school students vary by sexual identity?. Addictive Behaviors, 103(4). **https://pubmed.ncbi.nlm.nih.gov/30708337**

Cohen, E., Feinn, R., Arias, A., Kranzler, H. R. (2007). Alcohol treatment utilization: findings from the National Epidemiologic Survey on Alcohol and Related Conditions. *Drug Alcohol Depend, 86*(2-3), 214-221. doi:S0376-8716(06)00229-8 [pii] 10.1016/j.drugalcdep.2006.06.008. **https://pubmed.ncbi.nlm.nih.gov/16919401/**

Committee on Substance Use and Prevention. (2016). Substance Use Screening, Brief Intervention, and Referral to Treatment. Official Journal of the American Academy of Pediatrics. Volume 138, Issue 1. Retrieved from **https://pediatrics.aappublications.org/content/138/1/e20161210**

Community Catalyst. (2018). Advocate toolkit: Funding screening, brief intervention and referral to treatment (SBIRT) with young people. **https://www.communitycatalyst.org/resources/publications/document/2018/Funding-Youth-SBIRT-Toolkit.pdf**

Cook, B.L., McGuire, T.G., Zaslavsky, A.M. (2012). Measuring racial/ethnic disparities in health care: Methods and practical issues. *Health Serv Res,* 1232e54. **https://pubmed.ncbi.nlm.nih.gov/22353147/**

D'Amico, E. J., Ellickson, P.L., Collins, R.L., Martino, S., Klein, D.J. (2005). Processes linking adolescent problems to substance-use problems in late young adulthood. *Journal of Studies on Alcohol and Drugs,* 66(6), 766-75. **https://www.jsad.com/doi/10.15288/jsa.2005.66.766**

Del Boca, F.K., McRee, B., Vendetti, J., Damon, D. (2017). The SBIRT program matrix: A conceptual framework for program implementation and evaluation: SBIRT program matrix. *Addiction*, 112(S2):12-22. **https://www.researchgate.net/publication/312354743_The_SBIRT_program_matrix_a_conceptual_framework_for_program_implementation_and_evaluation_SBIRT_program_matrix**

Derogatis, L.R. (2001). Brief Symptom Inventory 18 (BSI® 18). Clinical Psychology. New York City: Pearson Publishing. **https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-%26-Biopsychosocial/Brief-Symptom-Inventory-18/p/100000638.html**

Dunn, M.E., Lau, H.C., Cruz, I.Y. (2000). Changes in activation of alcohol expectancies in memory in relation to changes in alcohol use after participation in an expectancy challenge program. *Experimental and Clinical Psychopharmacology,* 8:566–575. **https://psycnet.apa.org/record/2000-02949-012**

Eisen, M., Zellman, G.L., Murray, D.M. (2003). Evaluating the Lions-Quest "Skills for Adolescence" drug education program: Second-year behavior outcomes. *Addictive Behaviors*. 2003;28:883–897. **https://pubmed.ncbi.nlm.nih.gov/12788263/**

Ellickson, P.L., Tucker, J.S., Klein, D.J. (2003). Ten-year prospective study of public health problems associated with early drinking. *Pediatrics*, 111(5 Pt 1):949–955. **https://pubmed.ncbi.nlm.nih.gov/12728070/**

Faggiano, F., Vigna-Taglianti, F.D., Versino, E., Zambon, A., Borraccino, A., Lemma, P. (2008). School-based prevention for illicit drugs use: A systematic review. *Preventive Medicine,* 46:385–396. **https://pubmed.ncbi.nlm.nih.gov/18258289/**

Faulstich, M.E., Carey, M.P., Ruggiero, L., Enyart P., Gresham, F. (1986). Assessment of depression in childhood and adolescence: An evaluation of the Center for Epidemiological Studies Depression Scale for Children (CES-DC). *American Journal of Psychiatry,* 143(8):1024–1027. **https://pubmed.ncbi.nlm.nih.gov/3728717/**

Foa, E.B., Johnson, K.M., Feeny, N.C., Treadwell, K.R. (2001). The child PTSD Symptom Scale: a preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology,* 30(3), 376-84. **https://pubmed.ncbi.nlm.nih.gov/11501254/**

Gilbert, P.A., Kava, C.M., Afifi, R. (2021). High-school students rarely use e-cigarettes alone: A sociodemographic analysis of polysubstance use among adolescents in the United States. *Nicotine & Tobacco Research*, 23(3), 505-510. **https://academic.oup.com/ntr/article-abstract/23/3/505/5735099?redirectedFrom=fulltext**

Gillmore, M.R., Catalano, R.F., Morrison, D.M., Wells, E.A., Iritani, B., Hawkins, J.D. (1990). Racial differences in acceptability and availability of drugs and early initiation of substance use. *American Journal of Drug and Alcohol Abuse,* 16:185–206. **https://pubmed.ncbi.nlm.nih.gov/2288320/**

Glass, J. E., Hamilton, A. M., Powell, B. J., Perron, B.E., Brown, R.T., Ilgen, M.A. (2015). Specialty substance use disorder services following brief alcohol intervention: a meta-analysis of randomized controlled trials. *Addiction*, 110(9), 1404-1415. doi:10.1111/ add.12950. **https://pubmed.ncbi.nlm.nih.gov/25913697/**

Griffin K.W., Botvin, G.J., Scheier, L.M., Epstein, J.A., Doyle, M.M. (2002). Personal competence skills, distress, and well-being as determinants of substance use in a predominantly minority urban adolescent sample. *Prevention Science*, 3(1), 23–33. **https://link.springer.com/article/10.1023/A:1014667209130**

Grossberg, P., Halperin, A., Mackenzie, S. Gisslow, M., Brown, D., Fleming, M. (2010). Inside the physician's black bag: Critical ingredients of brief alcohol interventions. *Substance Abuse*, 31(4), 24-250. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3050497/pdf/nihms182591.pdf**

Health Resource & Services Administration (HRSA) Maternal Child Health. (2019). Title V Maternal and Child Health Services Block Grant Program. **https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program**

Herek, G.M., Garnets, L.D. (2007). Sexual orientation and mental health. *Annu Rev Clin Psychol*, 3:353-75. **https://pubmed.ncbi.nlm.nih.gov/17716060/**

Horsfall, J., Cleary, M., Hunt, G.E., Walter, G. (2009). Psychosocial treatments for people with co-occurring severe mental illnesses and substance use disorders (dual diagnosis): A review of empirical evidence. *Harv Review Psychiatry*, 17(1), 24-34. **https://journals.lww.com/hrpjournal/Abstract/2009/01000/Psychosocial_Treatments_for_People_with.2.aspx**

Ibañez G.E., Purcell D.W., Stall R., Parsons J.T., Gómez, C.A. (2005). Sexual risk, substance use, and psychological distress in HIV-positive gay and bisexual men who also inject drugs. *AIDS*,*19*(suppl 1):49-55. **https://pubmed.ncbi.nlm.nih.gov/15838194/**

Jang, E.S., Jeong, S-H., Hwang, S.H. Kim, H. Y., Ahn, S. Y., Lee, J., Lee, S.H., Park, Y.S., Hwang, J.H., Kim, J-W., Kim, N., Lee, D.H. (2012). Effects of coffee, smoking, and alcohol on liver function tests: A comprehensive cross-sectional study. *BMC Gastroenterol*, 12,145. **https://bmcgastroenterol.biomedcentral.com/articles/10.1186/1471-230X-12-145**

Jasik, C.B., Berna, M., Martin, M., Ozer, E.M. (2016). Teen preferences for clinic-based behavior screens: Who, where, when, and how? *Journal of Adolescent Health, 59*(6), 722-724. **https://pubmed.ncbi.nlm.nih.gov/27884300/**

Joffe, A. (2016). Teenagers like electronic media for screenings and follow-up. *New England Journal of Medicine Journal Watch*. **https://www.jwatch.org/na42984/2016/12/09/teenagers-electronic-media-screenings-and-follow**

Johnson J, Harris E, Spitzer R, Williams JBW. (2002). The patient health questionnaire for adolescents Validation of an instrument for the assessment of mental disorders among adolescent primary care patients. Journal of Adolescent Health. Volume 30, Issue 3, P196-204. Retrieved from **https://www.jahonline.org/article/S1054-139X(01)00333-0/fulltext**

Johnson, M., Jackson, R., Guillaume, L., Meier, P., Goyder, E. (2011). Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: A systematic review of qualitative evidence. *Journal of Public Health*, 33(3), 412–421. **https://academic.oup.com/jpubhealth/article/33/3/412/1557958**

Knight, A., Vickery, M., Faust, L., Muscal, E., Davis, A., Harris, J., Hersh, A.O., Rodriguez, M., Onel, K., Rubinstein, T., Washington, N., Weitzman, E.R., Conlon, H., Woo, J.M.P., Gertstbacher, D., von Scheven, E. (2019). Gaps in mental health care for youth with Rheumatologic conditions: A mixed methods study of perspectives from behavioral health providers. *Arthritis Care Res (Hoboken),* 71(5), 591-601. **https://pubmed.ncbi.nlm.nih.gov/29953741/**

Kroenke, K., Spitzer, R.L., Williams, J.B. (2001). The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med,* 16(9), 606-13. **https://pubmed.ncbi.nlm.nih.gov/11556941/**

Legal Action Center. (2016). Trainer materials – Patient privacy & confidentiality for SBIRT providers. **https://www.lac.org/resource/federal-alcohol-and-drug-confidentiality-rules-sbirt-services-for-youth**

Legal Action Center. (2017). Fact Sheet: Do federal alcohol & drug confidentiality rules apply to your SBIRT services? **https://www.lac.org/assets/files/SBIRT_Tool1_FactSheet.pdf**

Legal Action Center. (2018). Decision tree: Do federal alcohol & drug confidentiality rules apply to your SBIRT services? **https://www.lac.org/assets/files/SBIRT_Tool1_DecisionTree.pdf**

Levy, S., Dedeoglu, F., Gaffin, J.M., Garvey, K.C., Harstad, E., MacGinnitie, A., Rufo, P.A., Huang, Q., Ziemnik, R.E., Wisk, L.E., Weitzman, E.R. (2016). A screening tool for assessing alcohol use risk among medically vulnerable youth. Vrana, K.E., et. *PLoS One,* 11(5), e0156240. **https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0156240**

Levy, S., Weiss, R., Sherritt, L., Ziemnik, R., Spalding, A., Van Hook, S., Shrier, L.A. (2014). An electronic screen for triaging adolescent substance use by risk levels. *JAMA Pediatrics,* 168(9), 822–828. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4270364/**

Levy, S.J., Williams, J.F. (2016). Substance use screening, brief intervention and referral to treatment. *American Academy of Pediatrics,* 138(1). **https://pediatrics.aappublications.org/content/pediatrics/138/1/e20161211.full.pdf**

Li, H.Z., Rosenblood, L. (1994). Exploring factors influencing alcohol consumption patterns among Chinese and Caucasians. *Journal of Studies on Alcohol*, 55:427–433. **https://www.jsad.com/doi/10.15288/jsa.1994.55.427**

Liu, L.C., Flay, B.R. (2009). Evaluating mediation in longitudinal multivariate data: Mediation effects for the Aban Aya Youth Project drug prevention program. *Prevention Science,* 10:197–207. **https://pubmed.ncbi.nlm.nih.gov/19288196/**

Livingston, J.D., Milne, T., Fang, M.L., Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction*, 107(1), 39-50. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3272222/**

Manuel, J.K, Satre, D.D., Tsoh, J., Moreno-John, G., Ramos, J.S., McCance-Katz, E.F., Satterfield, J.M. (2015). Adapting screening, brief intervention and referral to treatment (SBIRT) for alcohol and drugs to culturally diverse clinical populations. *J Addict Med,* 9(5), 343-351. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4626638/**

Massachusetts Child Psychiatry Access Program. (2015). Screening to brief intervention (S2BI) tool. **https://www.mcpap.com/pdf/S2BI_postcard.pdf**

McEwan, C.A., Gregerson, S.F. (2019). A critical assessment of the adverse childhood experiences study at 20 years. *American Journal of Preventive Medicine*, 56(6), 790-794. **https://pubmed.ncbi.nlm.nih.gov/30803781/**

Medicaid.gov. (n.d.). 1115 substance use disorder demonstrations. **https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-substance-use-disorder-demonstrations/section-1115-demonstrations-substance-use-disorders-serious-mental-illness-and-serious-emotional-disturbance/index.html**

Medicaid.gov. (n.d.). Early and periodic screening, diagnostic, and treatment. **https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html**

Medicaid.gov. (n.d.). Health homes. **https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html**

Medicaid.gov. (n.d.). Managed care. **https://www.medicaid.gov/medicaid/managed-care/index.html**

Medicaid.gov. (2015). Children's health insurance program. **https://www.medicaid.gov/chip/index.html**

Medley, G., Lipari, R.N., Bose, J., Cribb, D.S., Kroutil, L.A., McHenry, G. (2016). Sexual orientation and estimates of adult substance use and mental health: Results from the 2015 national survey on drug use and health. Substance Abuse and Mental Health Services Administration NSDUH Data Review. **https://www.samhsa.gov/data/sites/default/files/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015.pdf**

Meier, M.H., Caspi, A., Ambler, A., Harrington, H., Houts, R., Keefe, R.S.E., McDonald, K., Ward, A., Poulton, R., Moffit, T.E. (2012). Persistent cannabis users show neuropsychological decline from childhood to midlife. *Proc Natl Acad Sci USA,* 109(40), E2657-2664. **https://www.pnas.org/content/109/40/E2657**

Monge, P., Fulk, J., Parnassa, C., Flanagan, A., Rumsey, S., Kalman, M. (2000). Cooperative Interagency approaches to the illegal drug problem. *International Journal of Police Science and Management,* 2: 229–241. **https://journals.sagepub.**

com/doi/10.1177/146135570000200304

National Council for Mental Wellbeing (n.d.). Conversation guide to delivering a trauma-informed brief intervention. https://www.ysbirt.org/wp-content/uploads/2021/06/052621_NCMW_TraumaConversationGuide.pdf

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2011). Alcohol screening and brief intervention for youth: A practitioner's guide. https://www.niaaa.nih.gov/alcohols-effects-health/professional-education-materials/alcohol-screening-and-brief-intervention-youth-practitioners-guide
National Institute of Health (NIH) (n.d.). Brief screener for tobacco, alcohol, and other drugs. https://www.drugabuse.gov/ast/bstad/#/

National Institute of Health (NIH), National Institute on Drug Abuse (NIAAA). (2012). What are 'co-occurring disorders?' https://archives.drugabuse.gov/blog/post/what-are-co-occurring-disorders

NIH, NIAAA. (2015). Alcohol screening and brief intervention for youth: A practitioner's guide. https://www.niaaa.nih.gov/alcohols-effects-health/professional-education-materials/alcohol-screening-and-brief-intervention-youth-practitioners-guide

National Institute on Drug Abuse (2014). Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide. https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide

NIDA. (n.d.). Opioids: Brief description. https://www.drugabuse.gov/drugs-abuse/opioids

NIDA. (2018). Media Guide. https://www.drugabuse.gov/publications/media-guide

NIDA. (2018). Teen Drug Use: Monitoring the Future 2018. https://www.drugabuse.gov/drug-topics/trends-statistics/infographics/monitoring-future-2018-survey-results

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. https://www.chcs.org/media/Copy-of-Adolescent-SBIRT-Learners-Guide-V1.1-all-modules-1.pdf

Oei, T.P., Jardim, C.L. (2007). Alcohol expectancies, drinking refusal self-efficacy and drinking behaviour in Asian and Australian students. *Drug and Alcohol Dependence*, 87:281–287. https://pubmed.ncbi.nlm.nih.gov/16996231/

Office of Disease Prevention and Health Promotion. Substance Abuse: Latest Data. (n.d.). https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Substance-Abuse/data

Orlando, M., Ellickson, P.L., McCaffrey, D.F., Longshore, D.L. (2005). Mediation analysis of a school-based drug prevention program: Effects of Project ALERT. *Prevention Science*, 6:35–46. https://pubmed.ncbi.nlm.nih.gov/15766004/

Parthasarathy, S., Kline-Simon, A.H., Jones, A., Hartman, L., Saba, K., Weisner, C., Sterling, S. (2021). Three-Year Outcomes After Brief Treatment of Substance Use and Mood Symptoms. *Pediatrics*,147(1): e2020009191). https://pediatrics.aappublications.org/content/pediatrics/147/1/e2020009191.full.pdf

Powers, E., Shiffman, R., Melnick, E., Hickner, A., Sharifi, M. (2018). Efficacy and unintended consequences of hard-stop alerts in electronic health record systems: A systematic review, *Journal of the American Medical Informatics Association,* 25(11), 1556–1566. https://academic.oup.com/jamia/article/25/11/1556/5101436

Rountree, P.W., Clayton, R.R. (1999). A contextual model of adolescent alcohol use across the rural-urban continuum. *Substance Use and Misuse*, 34:495–519. https://pubmed.ncbi.nlm.nih.gov/10210090/

Sacks, V., Murphey, D. (2018). The prevalence of adverse childhood experiences nationally, by state, and by race/ethnicity. Child Trends, Publication #2018-03. **https://www.childtrends.org/wp-content/uploads/2018/02/ACESBrief_ChildTrends_February2018.pdf**

Saloner, B., Carson, N., Lê Cook, B. (2014). Explaining Racial/Ethnic Differences in Adolescent Substance Abuse Treatment Completion in the United States: A Decomposition Analysis. *Journal of Adolescent Health,* 54, 646e653. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035388/**

Schizer, M., Weitzman, E.R., Levy, S. M. (2015). Medical issues in adolescent substance use: background and role of the primary care physician. In: Zucker R, Brown S, eds. The Oxford Handbook of Adolescent Substance Abuse. Oxford, England: Oxford University Press. **https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199735662.001.0001/oxfordhb-9780199735662-e-39**

Silveri, M.M., Dager, A.D., Cohen-Gilbert, J.E., Sneider, J.T. (2016). Neurobiological signatures associated with alcohol and drug use in the human adolescent brain. *Neuroscience & Biobehavioral Reviews,* 70, 244-259. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5494836/**

Singh, M., Gmyrek, A., Hernandez, A., Damon, D., Hayashi, S. (2017). Sustaining screening, brief intervention and referral to treatment (SBIRT) services in health-care settings addiction. *Addiction*, 112(S2), 92-100. **https://onlinelibrary.wiley.com/doi/10.1111/add.13654**

Spitzer RL, Kroenke K, Williams JBW, and the Patient Health Questionnaire Primary Care Study Group. (1999). Validation and Utility of a Self-report Version of PRIME-MD: The PHQ Primary Care Study. JAMA. 1999;282(18):1737–1744. Retrieved from **https://jamanetwork.com/journals/jama/fullarticle/192080**

Spitzer, R.L., Kroenke, K., Williams, J.B., Loewe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Arch Intern Med,* 166(10), 1092-7. **https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410326**

Squeglia, L.M., Jacobus, J., Tapert, S.F. (2009). The influence of substance use on adolescent brain development. *Clinical EEG and Neuroscience*, 40(1), 31-38. **https://journals.sagepub.com/doi/10.1177/155005940904000110**

Steinka-Fry, K.T., Tanner-Smith, E.E., Dakof, G.A., Henderson, C. (2017). Culturally sensitive substance use treatment for racial/ethnic minority youth: A meta-analytic review. *Journal of Substance Abuse Treatment,* 75, 22–37. **https://pubmed.ncbi.nlm.nih.gov/28237051/**

Sterling, S., Kline-Simon, A.H., Jones, A., Hartman, L., Saba, K., Weisner, C., Parthasarathy, S. (2019). Health care use over 3 years after adolescent SBIRT. *Pediatrics, 143(5).* **https://pediatrics.aappublications.org/content/143/5/e20182803**

Subramaniam, G., Levy, S. (2013). Treatment of opioid-dependent adolescents and young adult using sublingual buprenorphine. Providers Clinical Support System. **https://pcssnow.org/wp-content/uploads/2014/03/PCSS-MATGuidanceTreatmentofOpioidDependantAdolescent-buprenorphine.SubramaniamLevy1.pdf**

Substance Abuse and Mental Health Services Administration (SAMHSA) Center of Excellence for Integrated Health Solutions. (2012). Billing and Financial Worksheets. **https://www.thenationalcouncil.org/integrated-health-coe/resources/**

SAMHSA. (2014). Results from the 2013 national survey on drug use and health: Summary of national findings, NSDUH Series H-48, Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration. **https://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf**

SAMHSA. (2020). Results from the 2019 National Survey on Drug Use and Health: Detailed tables. **https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect1pe2019.htm**

SAMHSA. (2019). Screening, Brief Intervention, and Referral to Treatment (SBIRT) Grantees. **https://www.samhsa.gov/sbirt/grantees**

SAMHSA. (2019). Substance Abuse Confidentiality Regulations. **https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs**

SAMHSA. (2017). Substance abuse prevention and treatment block grant. **https://www.samhsa.gov/grants/block-grants/sabg**

SAMHSA. (n.d.). The CRAFFT screening interview. **https://www.thenationalcouncil.org/wp-content/uploads/2021/04/CRAFFT_Screening_interview.pdf?daf=375ateTbd56**

SAMHSA and Addiction Technology Transfer Center (ATTC) Network. (n.d.). SBIRT: A resource toolkit for behavioral health providers to begin the conversation with federally qualified healthcare centers. **https://c4bhi.com/wp-content/uploads/2018/04/SBIRT-Guide-for-FQHCs.pdf**

SAMHSA, National Institute of Alcohol Abuse and Alcoholism (NIAAA). (2011). A Pocket Guide for Alcohol Screening and Brief Intervention for Youth. **https://www. niaaa.nih.gov/sites/default/files/publications/YouthGuidePocket.pdf**

The Addiction Medicine Foundation. (2016). Identifying and responding to substance use among adolescents and young adults: A compendium of resources for medical practice. **https://www.adolescentsubstanceuse.org/wp-content/uploads/2017/09/ABAM-Compendium-of-Resources.pdf**

Unger, J.B., Ritt-Olson, A., Soto, D.W., Baezconde-Garbanati, L. (1994). Parent-child acculturation discrepancies as a risk factor for substance use among Hispanic adolescents in Southern California. *Journal of Immigrant and Minority Health,* 11:149–157. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3745998/**

U.S. Department of Education. (2018). Family education rights and privacy act (FERPA). **https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html**

U.S. Department of Health and Human Services (HHS). (2012). Preventing tobacco use among youth and young adults: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. **https://www.ncbi.nlm.nih.gov/books/NBK99237/**

U.S. Department of Health and Human Services (HHS), Office of Adolescent Health. (2016). Adolescents and Tobacco: Trends. https://opa.hhs.gov/adolescent-health?adolescent-development/substance-use/drugs/tobacco/trends/index.html

U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016). Facing addiction in America: The surgeon general's report on alcohol, drugs, and health. HHS. **https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf**

United States Drug Enforcement Administration (DEA). (2017). Drug slang code words. **https://www.dea.gov/sites/default/files/2018-07/DIR-020-17%20Drug%20Slang%20Code%20Words.pdf**

University of California Los Angeles Integrated Substance Abuse Programs. (2021). Adolescent Substance Use 101 [PowerPoint slides]. https://www.ysbirt.org/wp-content/uploads/2021/06/Slides_Adolscent-Substance-Use-101.pdf

Van Cleave, J., Gortmaker, S.L., Perrin, J.M. (2010). Dynamics of obesity and chronic health conditions among children and youth. *JAMA, 202(7), 623-30.* **https://jamanetwork.com/journals/jama/fullarticle/185391**

Watkins, K., Pincus, H.A., Tanielian, T.L., Lloyd, J. (2003). Using the chronic care model to improve treatment of alcohol use disorders in primary care settings. J Stud Alcohol, 64(2):209–218. **https://pubmed.ncbi.nlm.nih.gov/12713194/**

Weitzman, E.R., Magane, K.M., Wisk, L.E. Allario, J., Harstad, E., Levy, S. (2018). Alcohol use and alcohol-interactive medications among medically vulnerable youth. *Pediatrics*, 142(4), e20174026. **https://pubmed.ncbi.nlm.nih.gov/30228168/**

Weitzman, E.R., Salimian, P.K., Rabinow, L., Levy, S. (2019). Perspectives on substance use among youth with chronic

medical conditions and implications for clinical guidance and prevention: A qualitative study. Gullo MJ, ed. PLoS One, 14(1), e0209963. **https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0209963**

Weissman, M.M., Orvaschel, H., Padian N. (1980). Children's symptom and social functioning self report scales: Comparison of mothers' and children's reports. *Journal of Nervous Mental Disorders* ,168(12):736–740. **https://pubmed.ncbi.nlm.nih.gov/7452212/**

Whyte, A.J., Barker, J.M., Torregrossa, M.M., Gourley, S.L. (2018). Long-Term Consequences of Adolescent Drug Use: Evidence From Pre-clinical and Clinical Models. *Frontiers in Behavioral Neuroscience,* 12, 83. **https://www.frontiersin.org/articles/10.3389/fnbeh.2018.00083/full**

Wills, T.A., Walker, C., Resko, J.A. (2005). Longitudinal studies of drug use and abuse. *Epidemiology of Drug Abuse,* 177–192. **https://link.springer.com/chapter/10.1007%2F0-387-24416-6_12**
Wilson, C.R., Sherrit, L., Gates, E., Knight, J.R. (2004). Are clinical impressions of adolescent substance use accurate? *Pediatrics*, 114(5), e536-540. **https://pediatrics.aappublications.org/content/114/5/e536**

Winters, K.C., Tanner-Smith, E.E., Bresani, E., Meyers, K. (2014). Current advances in the treatment of adolescent drug use. *Adolescent Health, Medicine and Therapeutics*, 5, 199-210 **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4241949/**

Wisconsin Initiative to Promote Healthy Lifestyles. (2010). Coding, billing and reimbursement manual. **https://www.dhs.wisconsin.gov/publications/p0/p00852.pdf**