Implementing Screening, Brief Intervention, and Referral to Treatment for Youth:

SURVEY RESULTS ACROSS SETTINGS

January 2017

The Conrad N. Hilton Foundation's
Youth Substance Use Prevention and
Early Intervention Strategic Initiative

CONRAD N. Hilton FOUNDATION

Abt ASSOCIATES

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Introduction

Youth substance use is a leading public health concern across the nation. The United States spends over $700 billion a year on alcohol, tobacco, and drug-related problems related to health, crime, and lost productivity in the workplace.[1] Because most substance use concerns manifest in adolescence and the young adult years, evidence-based prevention and early intervention strategies for youth are particularly vital to reducing the burden of substance use on individuals, families, and communities. In recent years, policies and services implemented as a result of healthcare reform have significantly impacted primary care and behavioral health delivery systems by emphasizing the value of preventive services, promoting models for primary care and behavioral health integration, engaging communities in population health strategies, and increasing access to substance use and mental health services. The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified the prevention of substance use and mental illness as one of its strategic initiatives. Through this initiative, SAMHSA promotes and implements prevention and early intervention strategies to reduce the impact of mental and substance use disorders in America's communities.[2]

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a public health approach to identifying and addressing substance use and related risks – including health, social, and legal consequences. The SBIRT framework is unique because it screens for all levels of substance use risk, not just high-risk use or substance use disorders. Each step of the SBIRT process provides information and assistance tailored to the individual patient and his or her needs. **Screening** refers to the routine, universal administration of validated questions to identify potential risks related to alcohol and drug use, followed by positive reinforcement for youth who screen as 'no' or 'low' risk. **Brief intervention** includes one or more short, motivational conversations, typically incorporating feedback, advice, and goal setting around decreasing 'moderate' risk related to substance use. This step is intended to prevent progression to more serious levels of use. **Referral to treatment** describes the process of connecting individuals with more severe substance use ('high' risk) to appropriate assessment, treatment, and/or additional services based on their level of need. SBIRT has emerged as a critical strategy for targeting the large but often overlooked population that exceeds 'low'-risk use. While SBIRT was originally intended as a process to reduce adult alcohol misuse, research demonstrates that intervening early with individuals at moderate risk is effective in reducing substance use, in preventing health and other related consequences, and in saving healthcare costs.[3]

This report describes the results of a survey of programs implementing SBIRT across various settings: community-based programs, primary care or pediatric clinics, school-based health centers (SBHC), and schools.

Project Overview

The Conrad N. Hilton Foundation (the Foundation) is laying the groundwork for long-term change through its *Youth Substance Use Prevention and Early Intervention Strategic Initiative*. This multi-faceted approach is designed to promote learning and disseminate best practices in training, implementation, and research around the delivery of SBIRT services for youth age 15 to 22. In order to reach young people, their families, and their communities through innovative substance use prevention messages and early intervention approaches, the Foundation identified three overarching goals for the strategic initiative:

1. Ensure health professionals and other youth-serving providers have the knowledge and skills to provide screening and early intervention services;
2. Improve funding for, access to, and implementation of screening and early intervention services; and
3. Conduct research and advance learning to improve screening and early intervention practices.

In 2014, the Foundation selected Abt Associates to serve as the Monitoring, Evaluation, and Learning (MEL) partner for the initiative. As part of the MEL Project, Abt conducted a survey in January 2016 to gain a better understanding of the various approaches to implementation of youth SBIRT being utilized across the Foundation's diverse grantees. The survey was designed to collect information about how SBIRT services are defined and administered within the Foundation's 10 funded implementation projects, and to identify similarities and differences between implementation models across sites. The results of the survey will inform the entire grantee community and help the Foundation and its partners better support cross-grantee learning and engagement. In addition, the survey data will contribute to the larger SBIRT and youth substance use research and evidence base, and advance learning to improve screening and early intervention practices.

In partnership with the Foundation, Abt developed a sixty question, twenty to thirty minute survey for sites that were in the implementation phase of their grant for at least six months (ten grantees). Abt disseminated the survey to individuals who were designated as the point of contact by each grantee based on their in-depth insight into how the site defines and implements SBIRT services for their project. The survey was sent out via email with an option to complete it electronically through a web link, or by downloading the survey, completing it on paper, and mailing in the response to Abt. Abt followed

up with the grantee points of contact through phone calls and emails during the month of February 2016. The survey was open until early March 2016. There was an 80 percent response rate with 82 site staff members completing the survey. Additionally, there were nine incomplete surveys and eleven individuals who did not respond.

The following sections describe the results of the 2016 survey, compare the results to evidenced-based practices in SBIRT implementation, and highlight examples from grantees across various settings.

The Role of SBIRT in Preventing Youth Substance Use

SBIRT is a continuum of services identifying and addressing substance use and related risks – including health, social, and legal consequences attributed to substance use. SBIRT interventions include the following components:

- **Screening**: routine, universal administration of validated questions to identify potential risk related to alcohol and/or drug use. Research has shown that simply asking young people about drug and alcohol use can lead to positive behavior changes.[4,5]
- **Brief intervention**: one or more short, motivational conversations, typically incorporating feedback, advice, and goal setting around decreasing risk related to substance use. In one study of teens ages 14- 18, brief counseling led to a 30 percent reduction in the consequences of alcohol use, such as skipping school or fighting with friends or family because of alcohol.[6]
- **Referral to treatment:** the process of connecting individuals with more severe substance use to appropriate assessment, treatment, and/or additional services based on their level of need.

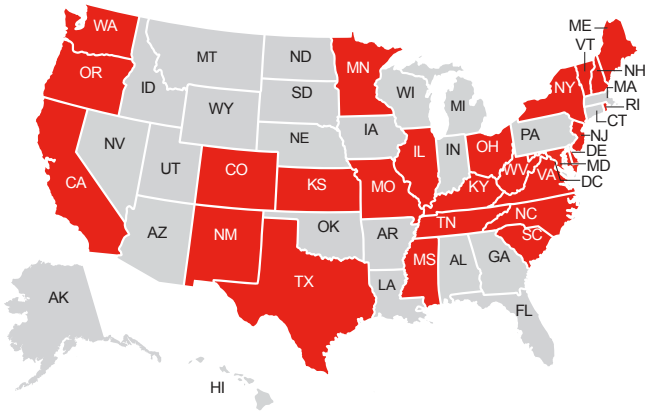
The SBIRT process can be adapted for various settings to reach youth. SBIRT can be implemented effectively in hospital emergency rooms, primary care offices and clinic practices, schools, and as part of other community-based programs providing the opportunity for early intervention before more serious consequences occur. Research shows that brief interventions delivered to youth in schools and medical settings decrease drug and alcohol use, and their related consequences.[7,8] Additionally, brief interventions delivered in a primary care office,[9] emergency department,[10] or a school setting[11] have reduced marijuana use in adolescents. In one study, short counseling sessions led young people ages 14 to 21 to use marijuana four fewer days per month.[12] Studies have also found that implementing SBIRT is cost effective. On average, cost savings are $4 to $6 for every $1 spent on SBIRT.[13]

The SBIRT process presents an opportunity to begin a conversation about substance use and engage individuals who may be in need of treatment, and also has the potential to reach youth who are 'low' to 'moderate' risk of substance use who could still benefit from a brief intervention. The Institute of Medicine and SAMHSA classify substance use prevention into three domains: universal, selected, and indicated interventions. Universal prevention programming attempts to reach a large population to stop any use before it even begins; selected prevention tries to target subgroups that may be at risk to reduce the impact or "dial back" a behavior once it has started; and indicated prevention focuses on individuals who have early signs or symptoms of a problem, or may need treatment once the behavior or condition has escalated to a serious level. Research increasingly shows that not addressing the gap between abstinence and serious use requiring treatment is a missed opportunity to impact the continuum and improve the health and wellbeing of teens and young adults by reaching them before use has more serious consequences. The SBIRT approach fills this gap and is inclusive of youth who may fall somewhere between abstinence and serious substance use. The Foundation's strategic initiative aims to explore promising practices for implementing youth SBIRT across various settings, with the ultimate goal of increasing the health and wellness of youth through early identification, prevention, intervention, and treatment of substance use. The following sections describe characteristics of grantee implementation efforts in more detail.

Snapshot of Survey Respondents

The survey highlighted activity among grantees with projects implementing SBIRT across settings that interact with youth. Research shows that community prevention programs with consistent messages that reach youth in their environment- at home, school, extracurricular clubs, faith-based organizations, and through various modes of social media- may be most effective.[14] Survey respondents reflect the diversity of sites in which the Foundation is investing. Additionally, these programs are located across the country, with survey respondents in seventeen states with varying political contexts and health care policies.

Survey Responses by State



Respondents include staff working in medical settings such as primary care or pediatric clinics, within schools, in school-based health centers, and in other community-based programs. Exhibit 1 below provides a breakdown of grantee survey respondents by setting (Exhibit 1).

Exhibit 1: Responding Grantee Sites by Setting

Site	Primary care or pediatric clinic	School	School- based health center	Community-based program	Total
Behavioral Health System Baltimore	10	0	1	2	13
Children's Hospital Corporation	1	0	0	0	1
Kaiser Foundation Research Institute	1	0	0	0	1
National Council for Behavioral Health	0	2	0	17	19
New Hampshire Charitable Foundation	7	0	0	0	7
Reclaiming Futures/Portland State University	0	1	0	4	5
School-based Health Alliance	0	0	6	0	6
University of Minnesota	0	1	0	0	1
University of New Mexico	0	0	5	0	5
YouthBuild, USA	0	6	0	18	24
Total	19	10	12	41	82

Schools

Youth spend a large majority of their time in school, making schools ideal locations to intervene with youth at risk. Schools are also uniquely invested in the health, education, and overall well-being of youth. The Foundation's school grantee sites are:

- Implementing screening processes and protocols;
- Developing policies supporting SBIRT; and
- Conducting research on intervention models for adolescents that have been referred from schools.

These programs, while operating in a school setting, are not school-based health centers and are not directly part of the delivery of healthcare services.

Respondents to this survey come from ten school sites and are associated with four Foundation grantees across the country.

School-Based Health Centers

School-based health centers (SBHCs) are primary care medical clinics located within schools and are an integral part of the health care safety net in the United States. Students depend on SBHCs for a full range of health care services, including health education, oral health care, and treatment for acute or chronic illnesses in a location that is safe, convenient, and accessible.[15] With an emphasis on prevention, early intervention, and risk reduction,[16] school-based health centers are a natural venue for delivering youth SBIRT services.

Foundation grantees are developing and providing adolescent-specific SBIRT trainings and technical assistance to integrate SBIRT into school-based health centers. SBHC sites are:

- Supporting training and technical assistance to support multidisciplinary health care teams to screen, identify, refer, and treat students for substance use; and
- Piloting peer-support approaches.

Twelve SBHCs, associated with three different Foundation grantees, responded to the survey.

Primary Care or Pediatric Clinics

There is strong evidence supporting the use of SBIRT in primary care settings.[17] Universal screening of adolescents in general medical settings can be instrumental in identifying substance use early, before further problems develop and when brief interventions are more likely to be effective.[18] Additionally, substance use assessment and treatment for adolescents and their families in primary care settings, offers better access and a less stigmatized environment for receiving treatment than specialty programs.[19] Grantees focusing their efforts in primary care or pediatric clinics are:

- Developing effective strategies for engaging parents in SBIRT;
- Training clinical staff on adolescent SBIRT protocols;
- Adapting electronic medical records to incorporate SBIRT; and
- Establishing workflows to integrate SBIRT into routine pediatric primary care.

Nineteen primary care or pediatric clinic sites, from four Foundation grantees, responded to the survey.

Community-Based Settings

Community-based organizations that serve youth at critical juncture points in their lives have unique opportunities for delivering prevention interventions or linkage to other needed services, including for substance use disorders. However, they have not traditionally implemented SBIRT. Foundation grantees implementing SBIRT in community-based settings include a diverse array of programs demonstrating the versatility of SBIRT as an intervention. For example, grantees with community-based programs are:

- Implementing SBIRT in community mental health centers servicing adolescents receiving care for mental health concerns;
- Implementing screening and intervention into programs serving low-income adults attaining their GED and

acquiring job skills and training; and

- Integrating SBIRT services into juvenile justice settings to expand early intervention and diversion opportunities for court involved youth.

Survey respondents from 41 community-based sites representing four Foundation grantees are implementing SBIRT.

Breaking Down the SBIRT Components: Analysis across Sites and Settings

Screening

Screening is occurring at high rates across all settings. Sites are using various validated instruments and techniques to screen youth and identify those who need a brief intervention. Research has demonstrated that substance use screening instruments are a viable means of early detection and should be used frequently.[20] This section highlights screening practices among survey respondents in school-based health centers, primary care or pediatric clinics, schools, and community-based programs.

Targeted versus Universal Screening

Across settings, the majority of programs surveyed are conducting universal screening among clients as opposed to targeted screening. Targeted screening focuses on a defined sub-set of youth, using criteria such as age, other demographics, or risk factors. Universal screening of adolescents can be instrumental in identifying substance use early, before further problems develop,[21] and creates awareness about one of the most preventable health issues—substance abuse.[22] With the current opioid epidemic and the changing face of addiction, universal screening helps ensure no adolescent is excluded from receiving a potentially lifesaving intervention. Overall, 60 of the 82 (73%) responding sites report that they are conducting universal screening, while 22 (26%) programs report they are providing targeted screening. The following proportions of sites in each setting are conducting universal screening:

- 90 percent of school programs,
- 84 percent of primary care or pediatric clinics,
- 67 percent of school-based health centers, and
- 66 percent of community-based programs.

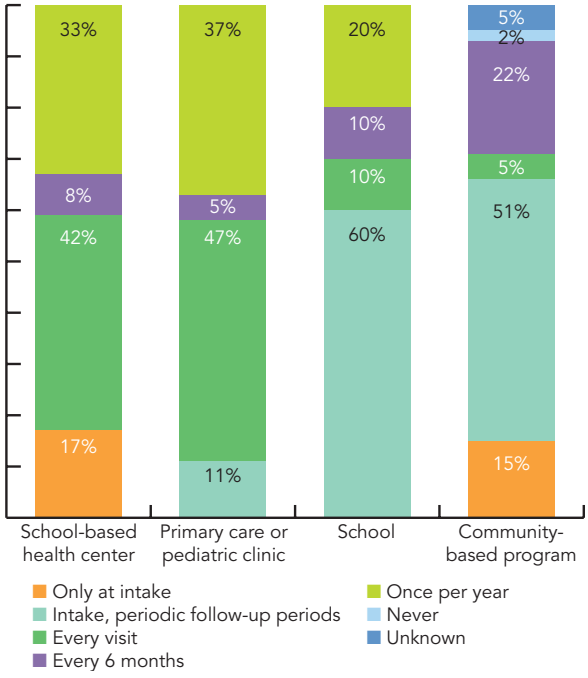
Sites providing targeted screening utilize a variety of criteria to determine which youth are screened, including the following:

- Specific age range;
- Referral or recommendation from another program or staff member;
- Youth who have interacted with the juvenile justice system or another state agency, such as child and family services; and
- Youth who are seeking mental health services.

Frequency of screening

Frequency of screening across settings varies. In medical settings, research recommends screening for tobacco use every visit, and alcohol and drugs at least yearly, if not every visit—especially for adolescents.[23] The American Academy of Pediatrics (AAP), one of the Foundation's health care grantees, recommends all adolescents be screened for substance use, mental health, risk reduction, and injury prevention as part of routine medical care. The goal is to normalize and standardize screenings and early interventions in routine medical visits as well as in other places youth appear, such as schools or community programs. School-based health centers and primary care clinics had fairly similar statistics and screened 42 percent and 47 percent of youth at each visit (respectively). Schools and community-based programs screened much less frequently. Only 10 percent of schools and five percent of community-based programs screened youth each visit. Most youth in schools (60%) and community-based programs (51%) are screened at intake with periodic follow-up. School-based health centers and community-based programs were the only settings that reported screening only at intake. Looking across all settings, only two percent of community-based programs reported not conducting any SBIRT screening. See Exhibit 2 for additional details.

Exhibit 2: Frequency of Screenings by Setting



Use of validated tools

To meet their screening needs, programs are using a variety of validated screening tools including the CRAFFT, AUDIT, AUDIT-C, DAST-10, and others. Best practices suggest that a validated screening tool increases accuracy in identifying levels of need and to provide standardization across respondents. The CRAFFT is the tool most often suggested for work with youth,[24]

Exhibit 3: Proportion of Programs Using Validated Screening Tools

	AUDIT	AUDIT-C	CRAFFT	CAGE	DAST-10	GAIN	S2BI	UNCOPE	OTHER
All Settings	35%	17%	60%	4%	29%	6%	5%	4%	27%
Community-based program	46%	7%	41%	5%	39%	7%	0%	7%	29%
Primary care or pediatric clinic	11%	37%	95%	0%	5%	0%	21%	0%	16%
School	60%	0%	30%	10%	60%	20%	0%	0%	20%
School based health center	17%	33%	92%	0%	8%	0%	0%	0%	42%

Note: Other screeners sites are using include GAIN SS, eSHQ, GAPS, PHQ2, PHQ9, health risk assessments, checklists and surveys.

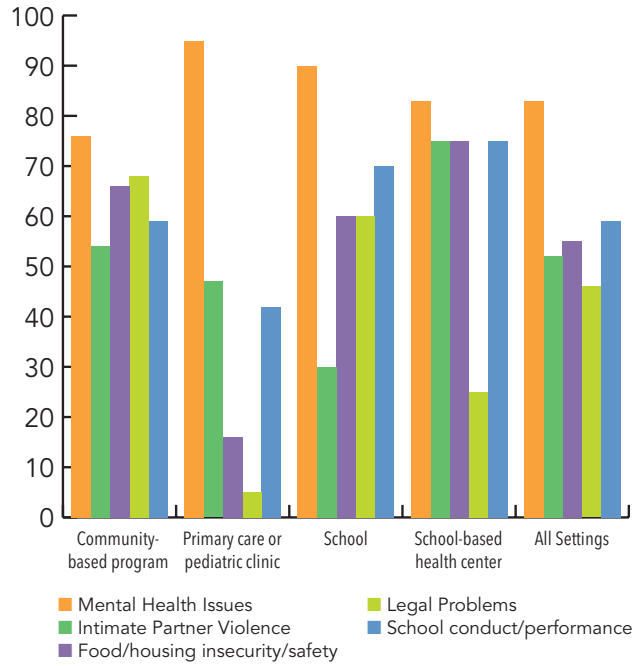
as well as the one question screener (*How often have you used [drug] over the past year?)* identified as being as effective as the CRAFFT by Levy and colleagues.[25] As shown in Exhibit 3 below, the CRAFFT is the most widely used screening instrument identified by the literature and is prevalent across settings. Use of a standardized and validated screening tool is essential, as it is the recognized best practice for programs determining whether to provide a brief intervention or refer to a higher level of care since the administer can reliably use a defined and validated cut off score to determine the next step.

The CRAFFT is the most popular screening tool used in primary care or pediatric clinics and school-based health centers, whereas the AUDIT is the most prevalent tool used in schools and community-based programs. The AUDIT is typically used with an adult population, and is the most popular among sites who serve older youth (ages 18 to 25). Twenty-two respondents are using tools besides the validated substance use screening instruments listed in Exhibit 3, either on their own or in combination with a validated tool (Exhibit 3).

Screening For Other Health-Related Social Needs

The implementation survey asked programs what other health-related social issues they address when screening youth for substance use: mental health, intimate partner violence, food/housing insecurity/safety, legal problems, and school conduct/performance. Across settings, the issue most widely screened for was mental health issues. The 2014 National Survey on Drug Use and Health (NSDUH) found that in the past year, 7.9 million people had both a mental disorder and substance use disorder, also known as co-occurring mental health and substance use disorders. For adults with past-year serious mental illness and co-occurring substance use disorders, rates were highest among those ages 18 to 25 (35.3%) in 2014, highlighting the importance of screening for these issues in adolescence. Routinely screening for these issues may also result in cost savings. Primary care or pediatric clinics screened for mental health issues the most, with 95 percent of programs indicating that they screen for mental health issues. School programs and school-based health centers also have high screening rates for mental health issues at 90 percent and 83 percent respectively. However, only 76 percent of community-based programs are conducting mental health screenings (see Exhibit 4).

Exhibit 4: Proportion of Programs Screening For Other Health-Related Social Needs



Delivery of Screening

Different settings tend to have different preferences for the method of screening delivery, likely to account for the differences in workflow across settings. For instance, in primary care and pediatric practices, where clinicians may have time constraints, patients often complete a paper and pencil screening (42% of the time) in conjunction with verbally administered screens (37% of the time). The paper and pencil method may be a more efficient use of appointment time, rather than having clinicians spend the time to administer the screening for each youth. For example, a recent study found that a physician-conducted CRAFFT screen interview required an average of 74 seconds to complete, whereas a computer self-administered version took an average of 49 seconds.[26] While this example uses an electronic screen, it suggests that self-administered screening tools may be more efficient.

In contrast, in schools where demands for school personnel time may not be as high, verbally administered screens are the norm, and occur 60 percent of the time. Verbally administered

screens are also the preferred method in community-based programs, occurring 61 percent of the time. In contrast, school-based health centers used verbal screenings the least of all settings, screening verbally only 17 percent of the time. However, SBHCs had the highest rate of screening via an electronic device, which accounted for half of all screens. In all other settings, self-administered screening through an electronic device was the least utilized method.

Discussing Screening

Depending on the setting and workflow in which SBIRT is being implemented, different types of providers may be responsible for administering and discussing the screen with their patient. We use the term "provider" for professionals conducting screening with youth. For instance, in primary care or pediatric clinics surveyed, 83 percent noted the primary care provider as being responsible for overseeing SBIRT screening, while behavioral health providers held this responsibility for 16 percent of primary care practices. Similarly, within school-based health centers surveyed, primary care providers are responsible for administering screens in 83 percent of programs, while behavioral health providers held this responsibility within 33 percent of SBHCs.

Only a small percentage of community-based programs utilize primary care providers to administer SBIRT screening (2%). Behavioral health providers held this responsibility in the majority of programs surveyed (59%), and case managers or care coordinators were the next most common (27% of programs). Similarly, schools programs surveyed report that behavioral health providers are responsible for screening 50 percent of the time; however, respondents did not indicate who is responsible for administering and discussing screening within 30 percent of school SBIRT programs.

Brief Intervention Practices

Brief intervention is an evidence-based practice seeking to build awareness and resolve ambivalence about substance use or other related issues. Brief interventions are designed to motivate individuals to change their behavior by helping them understand the consequences of their substance use. As reflected by the Foundation grantees, brief interventions can take place in various settings, be of varying duration, and be implemented by individuals of different professional backgrounds. Research has found that motivational interviewing techniques are effective in approaching youth substance use,[27,28] as well as interventions that incorporate individual goal setting, and focus on the weighing of costs and benefits of continued use.[29] Brief interventions are not intended to treat people with serious substance use disorders, but rather aim to treat problematic or risky substance use behavior. Skillfully conducted brief interventions are essential to preventing or reducing youth substance use and other risky behaviors.

Duration and Frequency

Brief interventions can range in duration from five minutes of quick advice to fifteen to thirty minutes of brief counseling.[30] Research from smoking cessation has found efficacy and effectiveness of brief interventions lasting just three to five minutes.[31] The highest percentage of survey respondents in SBHCs (67%), primary care or pediatric clinics (42%), and community-based programs (49%) are conducting brief interventions between five and fifteen minutes. Survey responses suggest that brief interventions in school-based programs may be longer than those in other settings, with 80 percent of respondents conducting brief interventions between fifteen and thirty minutes and twenty percent lasting over thirty minutes. Thirty-seven percent of primary care or pediatric clinics responded that the duration of their brief interventions is less than five minutes, suggesting there are more time constraints in medical settings due to challenges with financing and reimbursement.

Exhibit 5: Duration and Frequency of Brief Interventions

Brief Intervention	School-based health center	Primary care or pediatric clinic	School	Community-based program
DURATION Proportion of programs whose BIs have the following duration:				
< 5 min	0%	37%	0%	5%
5-15 min	67%	42%	0%	49%
15-30 min	33%	11%	80%	37%
>30 min	0%	11%	20%	10%
FREQUENCY Proportion of programs that conduct a BI in:				
A Single Session	17%	53%	10%	22%
Multiple Sessions	8%	0%	30%	24%
Both Single and Multiple Sessions	75%	47%	60%	54%
FOLLOW-UP Proportion of programs use a follow-up or booster after initial BI	92%	47%	100%	76%

Brief intervention sessions may occur as a one-time short conversation or for a series of up to five counseling sessions,[32] depending on the needs of the individual. Most of the programs that responded to the survey are conducting both single and multiple sessions for their brief interventions. However, primary care or pediatric clinics are mostly conducting single sessions (53% of programs), which may be due to time limitations in primary care appointments. One-hundred percent of survey respondents in school-based programs and less than half (47%) of respondents in primary care/pediatric clinic settings indicated that they follow-up or provide a booster after an initial brief intervention with youth. Due to the constraints of the healthcare system, these sites are less likely to implement a curriculum-based, multi-session version of brief intervention.

See Exhibit 5 for more details on duration and frequency of brief interventions among Foundation programs.

Techniques

Brief intervention techniques include an empathetic approach, support for the client's perception of self-efficacy, and optimism that they can modify risky behavior. Brief intervention conversations consist of feedback about personal risk, explicit advice to change, emphasis on patient's responsibility for change, and provide a variety of ways to effect change.[33] The two most common behavioral therapies used in SBIRT programs are brief versions of cognitive behavioral therapy and motivational interviewing, or some combination of the two. Motivational interviewing is a clinical approach that helps individuals with substance use disorders and other chronic conditions make positive behavioral changes to support better health. The approach upholds four principles—expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy.[34] Brief motivational interviewing has been associated with reduced young adult (18- to 24-year-olds) alcohol consumption at six- and 12-month follow-up.[35] This study has also shown a reduction in the incidence of alcohol-related injury, traffic violations, and driving after drinking among 18- and 19-year-olds.

Other common brief intervention techniques include:

- Brief advice, when the brief interventionist offers guidance to youth about how to modify behavior;
- Brief Negotiated Interview (BNI) which includes a listing of questions and responses that a health provider can use during a brief intervention; and
- The FRAMES Model which involves feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy.[36]

Among survey respondents:

- Motivational interviewing techniques are the most common across all settings (83% of SBHCs, 53% of primary care or pediatric clinics, 70% of schools, and 78% of community-based programs).
- While no school-based health centers and only two percent of community-based programs are using brief advice, 32 percent of primary care or pediatric clinic sites are using this brief intervention technique, perhaps due to time constraints with patients.
- A small percentage of SBHCs (8%) and community-based programs (5%) are using brief negotiated interviewing. However, neither primary care or pediatric clinics nor schools reported utilizing these techniques.
- Programs across all settings are using FRAMES or other manualized interventions that include goal setting or "change talk."

Referral to Treatment

After a screening result of 'high' risk, an individual is referred to treatment. This is a proactive process that facilitates access to specialty care for those who may require more extensive assessment.[37]

Survey respondents at school-based health centers are primarily referring youth to behavioral health clinicians within their facility, whereas primary care or pediatric clinics, schools, and community-based programs indicated they are referring mostly to local substance use disorder treatment providers. Exhibit 6 provides additional details about where sites are referring youth.

Exhibit 6: Proportion of Programs Referring Youth to Various Treatment Programs

Type of Treatment Program	SBHC	Primary Care or Pediatric Clinic	Schools	Community-Based Program
Behavioral Health clinicians w/in organization or co-located w/in facility	75%	58%	30%	51%
Local substance use disorder treatment providers	58%	68%	70%	85%
Medication-assisted treatment provider (e.g. suboxone)	25%	21%	20%	15%

Only a small percentage of providers are working in an integrated care system, exclusively with providers and resources internal to the organization. Well over half of all programs are not working in an integrated care system and have developed an external network of providers for referrals. Many sites are working with both internal and external providers to refer adolescents to treatment.

- Fifty-eight percent of school-based health centers, 74 percent of primary care or pediatric clinics, 78 percent of community-based programs, and 80 percent of school sites have a standard network of providers for referrals outside of the organization in which they work.
- Half of SBHC sites indicated these providers are both internal and external to their site.
- Only five percent of community-based programs and primary care or pediatric clinics, eight percent of SBHCs

and 10 percent of schools have an internal network of providers they are working to refer adolescents to treatment.

Communication with Treatment Providers

Communicating regularly with treatment providers can help better coordinate care for youth. A significant majority of schools (60%) and community-based programs (80%) responded to the survey indicating that they have established regular communication with treatment providers. Only a quarter of school-based health center (25%) and primary care or pediatric clinic (26%) sites are communicating with treatment providers to monitor progress of patients/clients. Sites that are communicating regularly with local treatment providers are mostly doing so after they have made a referral. However, some sites have regular meetings with treatment providers to share general information about programs and to review referral protocols. Additionally, a small proportion of sites across all settings have a qualified services organization agreement (QSOA) in place, which allows organizations to communicate with treatment providers about individual patients.

While level of communication with treatment providers varies, a numerous survey respondents indicated they are following-up with patients/clients who have received a referral to monitor progress, a core component of the SBIRT process. Among survey respondents, 67 percent of SBHCs, 53 percent of primary care or pediatric clinics, 80 percent of schools, and 66 percent of community-based programs are following-up with individuals after making referrals to treatment.

Exhibit 7: Communication with Treatment Providers

Communication Method	SBHCs	Primary Care or Pediatric Clinic	School	Community-based Program
Regular Meetings	17%	5%	10%	15%
QSOA allowing patient information sharing	8%	11%	20%	10%
Communication after a referral only	25%	21%	50%	73%

Engagement of Family Members of Caregivers

A significant percentage of community-based programs (88%) inform family members or caregivers when they refer an adolescent to treatment services. More than half of school-based health centers (58%), 63 percent of primary care or pediatric clinics, and 80 percent of school programs indicated they inform family members about referral to treatment. Involving parents and other caregivers in substance use treatment offers the potential for greater impact yet continues to present distinct challenges for Foundation grantees. Involving parents in consent processes and program sessions can be difficult and youth are often resistant to seeking their parents' permission for substance use prevention and early intervention services. Parental engagement in signing consent forms and participating in services, as well as parental concerns about confidentiality in different settings, could potentially impact their child's participation in the SBIRT process. Relationship dynamics between parents and youth, and a parent's level of awareness about their child's substance use, have an effect on youth's willingness to engage their parents in the process, as well as how the parent supports the intervention and referral to treatment.

SBIRT Training

Among survey respondents, there is variation in how they are delivering training for SBIRT providers. Training providers has increased confidence in their ability to perform SBIRT and instilled a greater sense of responsibility to screen.[38] Research suggests that SBIRT training does not have to be elaborate or complicated; it can be as simple and straightforward as providing links to standard SBIRT training materials and specifying a time frame within which they are to be completed.[39] Research indicates that single trainings of medical providers will not be sufficient to adequately establish effective SBIRT interventions.[40] Ongoing support and training to address questions regarding the appropriate identification and treatment of patients with need for substance use disorder treatment interventions is necessary.[41]

Over 60 percent of survey respondents across settings are using training involving boosters to support ongoing learning of interventionists. Additionally, the majority of interventionists are receiving training specific to the setting in which they work (i.e. SBHC (80%), primary care or pediatric clinic (66%), school (82%), or community-based program (55%)). Sites vary on whether they are conducting competency assessments as part of their training. At least half of the sites in schools (50%) and SBHCs (55%) are conducting competency assessments, whereas only 37 percent of primary care or pediatric sites and 22 percent of community-based programs include these assessments. Assessments are important to ensure staff members conducting brief interventions have the knowledge and skill set to do their job effectively.

Brief intervention training methods among survey respondents include manualized curriculum, motivational interviewing, role playing, and observed practice. Motivational interviewing was the most popular training technique among SBHCs (64%), primary care or pediatric clinics (47%), and community-based programs (49%). While 60 percent of school sites indicated they included motivational interviewing, 80 percent used manualized curriculum as part of training. Observed practice was the least popular training component. Among survey respondents, 27 percent of SBHCs, 20 percent of schools, 11 percent of primary care or pediatric clinics, and seven percent of community-based programs included observed practice as part of their training curriculum.

Additionally, sites are using various tools to support staff providing brief interventions to ensure consistency of delivery (Exhibit 8). Some of the tools include a checklist of intervention

Exhibit 8: Methods of Support for Brief Interventionists

Support Tools	School-based health center N=12	Primary care or pediatric clinic N = 19	School N = 10	Community-based program N = 41
Check-list	17%	21%	30%	29%
Observing staff	25%	5%	20%	27%
Booster training	8%	32%	20%	37%
Regular case conference calls	50%	26%	50%	44%

components, observing staff, and offering booster training sessions or regular case conferences for staff. As outlined in Exhibit 8:

- Primary care or pediatric clinics are primarily ensuring consistency through booster trainings for staff (32%). Only five percent of programs are using staff observation to ensure consistency.
- Fifty percent of schools and school-based health centers and 44 percent of community-based programs are holding regular case conferences for staff.
- Only eight percent of SBHCs are holding booster trainings for staff.

Financing for SBIRT Programs

A critical leverage point for SBIRT implementation has been in developing and using payment structures. As the largest source of coverage for behavioral health services, including those related to substance use disorders, Medicaid can play a powerful role in addressing substance use disorder.[42] Effective January 2008, state Medicaid plans may reimburse for SBIRT services. However, the MEL Project has found that health care organizations may not be able to bill for SBIRT protocols for a variety of reasons, one being that Medicaid billing codes have not been activated in many states. Furthermore, even when the screening and brief intervention reimbursement codes are activated, many providers are not using them due to the time-based nature of the code. A SBIRT encounter needs to last a minimum of 15 minutes for payment under certain billing rules.[43] A 2011 study noted physician concern with conducting SBIRT interventions and the feasibility of adding time to already overbooked medical practices.[44]

Screening and brief intervention (SBI) reimbursement codes were consistently one of the lowest utilized forms of payment across settings. Respondents from primary care settings and schools are not using SBI reimbursement codes, while only one school-based health center and one community-based program surveyed reported using this method of financing. One survey respondent noted that it can be difficult to bill for brief interventions due to time requirements. Another site decided not to bill directly for SBIRT services because the state training requirements, especially for non-licensed staff, are too burdensome, which would have significantly delayed implementation. Sites are leveraging private foundation funding, federal grants, state grants, and other sources to finance the interventions in spite of health care payment reform and movement towards paying for outcomes and value across the country. This reimbursement concern speaks to the impact on the sustainability of SBIRT implementation efforts.

Programs are using a combination of other funding mechanisms to support screenings, brief interventions, and referrals to treatment. Programs across settings are relying on services embedded in other billable encounters to finance SBIRT interventions; schools are using mostly federal grants. The survey results reflect the need for continued advocacy and education efforts around the critical issue of SBIRT financing and sustainability.

Conclusion and Key Findings

The Hilton Foundation's Youth Substance Use Prevention and Early Intervention Strategic Initiative is laying the groundwork for long-term, systemic change. Survey respondents indicate that grantees are making significant progress in implementing SBIRT, not only in medical settings, but also in new, non-traditional programs like school-based health centers, schools, and community-based programs to reach more youth across the country. The survey also highlighted areas in which more in depth exploration or site support is needed. Key findings from the implementation survey include:

- **Youth SBIRT interventions can occur in a variety of settings and be delivered by individuals with different professional backgrounds**. Foundation grantee sites are demonstrating youth SBIRT interventions may occur in settings throughout the community. Primary care clinicians, behavioral health providers, social workers, counselors, therapists, and school personnel are among the professionals administering SBIRT across settings.
- **Screening is occurring at high rates across settings, but many sites are not conducting routine screening**. The American Academy of Pediatrics recommends all adolescents be screened for substance use, mental health, risk reduction, and injury prevention as part of routine medical care. Routine screening is critical and helps facilitate important discussions to ensure youth do not fall through the cracks.
- **There is increased need for evidence-based practices.** While survey respondents are following evidence-based SBIRT practices in many instances, overall, there is there is a gap in utilization of validated screening instruments,

evidence-based brief intervention models, and best practices in treatment referrals and follow-up.

- **Financing SBIRT as an ongoing challenge**. A critical leverage point for SBIRT implementation has been in developing and using payment structures. However health care organizations and providers may not be able to bill for SBIRT protocols for a variety of reasons. Medicaid billing codes have not been activated in many states and even when the screening and brief intervention reimbursement codes are activated, many providers are not using them due to the time-based nature of the codes. Sites are turning to other funding mechanisms such as private foundations and state or federal sources to finance SBIRT.

Grantee implementation efforts are contributing to the growing body of research on SBIRT implementation. Continued examination of the delivery of SBIRT services across such diverse settings will inform different approaches to SBIRT for the broader field.

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Appendix: Survey Questionnaire

Implementation Assessment: SBIRT Core Components

As part of the Conrad N. Hilton Foundation's Monitoring, Evaluation, and Learning Project, Abt Associates would like to gain a better understanding of the various approaches to implementation of youth substance use screening, brief intervention, and referral to treatment (SBIRT) across the Foundation's grantees. The following questionnaire is designed to collect information about how SBIRT services are defined and administered within your project and to identify similarities and differences between implementation models across sites.

You were selected by the Hilton Foundation grantee you are working with because you have in-depth insight into how your individual site defines and implements SBIRT services for your project.

If you have any questions, please contact:

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If you would like to submit your responses via a paper form, please use this form and send it to the address above.

There are 60 questions and we request you complete of all questions to the survey. It should take approximately 25-30 minutes to complete. Please complete the survey by February 7, 2016.

Site Characteristics:

1. Respondent name: _____
2. Organization name: _____
3. Which Hilton Foundation grantee organization do you work with?: Drop-down box with the following grantees:
   - ❑ American Academy of Pediatrics
   - ❑ Behavioral Health System Baltimore
   - ❑ Center for Social Innovation
   - ❑ Children's Hospital Corporation
   - ❑ Kaiser Permanente
   - ❑ National Council for Behavioral Health
   - ❑ New Hampshire Charitable Foundation
   - ❑ Ohio State University
   - ❑ Policy Research Inc.
   - ❑ Reclaiming Futures/Portland State University
   - ❑ School Based Health Alliance
   - ❑ Treatment Research Institute
   - ❑ University of Minnesota
   - ❑ University of New Mexico
   - ❑ YouthBuild, USA
4. Respondent job title within organization: _____
5. Respondent's primary responsibilities for the Hilton Foundation grant: _____
6. Respondent phone: _____
7. Respondent email: _____
8. What is the total number clients/patients served by your organization per year: _____
9. What percent of clients/patients served through your organization are receiving SBIRT services as part of your Hilton Foundation project? _____
10. Which of the following best describes your setting?
    - ❑ Community-based program
    - ❑ Primary care or pediatric clinic
    - ❑ School
    - ❑ School based health center
    - ❑ Other: _____
11. Approximately, what percentage of your clients/patients have each of the following types of health insurance coverage:

    Private health insurance:_____

    Public health insurance (Medicaid, CHIP, Medicare, etc.):_____

    Uninsured:_____

    Don't know _____
12. When did you begin implementing SBIRT services (Date: month and year)? _____

Screening Process:

13. Please indicate the age range of youth screened through your project. Check all that apply
    - ❑ 9-11
    - ❑ 12-14
    - ❑ 15-18
    - ❑ 18-21
    - ❑ 21-25
14. Are you conducting targeted or universal screening?
    - ❑ Targeted
    - ❑ Universal

    If targeted, how is it targeted?
    _____
15. When are clients screened? _____
16. What screening instrument do you use? Check all that apply.
    - ❑ AUDIT
    - ❑ AUDIT-C
    - ❑ CRAFFT
    - ❑ CAGE
    - ❑ DAST - 10
    - ❑ GAIN
    - ❑ S2BI
    - ❑ UNCOPE
    - ❑ Other: _____
17. What substances are included in your screening? Check all that apply.
    - ❑ Alcohol
    - ❑ Prescription medications
    - ❑ Marijuana (medical or recreational)
    - ❑ Any illicit substances drugs as a yes/no question
    - ❑ If yes, please list drugs specifically asked about: _____
    - ❑ Tobacco
18. Do you also screen for the following? Check all that apply.
    - ❑ Anxiety
    - ❑ Depression
    - ❑ Eating disorders
    - ❑ Food insecurity
    - ❑ Housing issues
    - ❑ Intimate partner violence/teen dating violence
    - ❑ Legal problems
    - ❑ Neighborhood safety
    - ❑ School conduct problems
    - ❑ School performance
    - ❑ Suicidal ideation
    - ❑ Trauma
    - ❑ Other: _____
    - ❑ None
19. How often are the youth served through your project screened for substance use?
    - ❑ Every visit
    - ❑ Every 6 months
    - ❑ Once per year
    - ❑ Only at intake
    - ❑ Other: _____
20. Do you have a protocol in place that describes which screening instrument to use and how often to administer it?
    - ❑ Yes
    - ❑ No
21. Who conducts the screening? _____
22. How are screens administered?
    - ❑ Self-administered via electronic device
    - ❑ Self-administered via paper and pencil
    - ❑ Verbally administered
23. Who interprets the screening results (test score)? _____
24. Who discusses the screening results with the patient? _____
25. Where are the screening results documented?
    - ❑ Electronic health record
    - ❑ Paper chart
    - ❑ Results are not documented
    - ❑ Other: _____
26. Is there anything else about your screening process that you'd like to report? _____

Brief Intervention Process:

27. Which of the following describes how the screener determines which youth will receive a brief intervention:
    - ❑ Scoring cutoff
    - ❑ Use of any drugs or underage alcohol use
    - ❑ Substance-related consequences
    - ❑ Provider impression of risk
    - ❑ Other _____
28. Who provides brief interventions? _____
29. Which of the following brief intervention approach/models do interventionists in your program utilize most often?
    - ❑ Brief Advice
    - ❑ Brief Negotiated Interviewing
    - ❑ FRAMES: feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy
    - ❑ Manualized interventions, e.g., Teen Intervene

❑ Motivational Interviewing

❑ Other: _____

30. How do you ensure consistency in delivery of brief interventions across different staff providing brief interventions?

❑ Checklist of intervention components

❑ Observations

❑ Booster training

❑ Regular case conferences

❑ Other: _____

❑ None of the above

31. Do patients/clients receive a follow-up brief intervention (a booster) after the initial intervention?

❑ Yes

❑ No

If Yes, please describe how, when, and how many: _____

32. On average, how long is each of your brief interventions?

❑ Less than 5 minutes

❑ 5-15 minutes

❑ 15-30 minutes

❑ Greater than 30 minutes

33. What is the frequency of brief interventions?

❑ Single session

❑ Multiple sessions

❑ Both

34. Where are brief interventions documented?

❑ Electronic health record

❑ Paper chart

❑ Other: _____

35. Is there anything else about your brief intervention process that you would like to report? _____

Referral Process:

36. Do patients/clients receive a referral to substance use disorder treatment when indicated? Y/N

37. How do you determine which youth will receive a referral to treatment? _____

38. Do you have a standard or defined network of treatment providers you work with?

❑ Yes

❑ No

If you have a network, is it:

❑ Internal

❑ External

❑ Both

39. Where do you refer youth for substance use disorder treatment? Check all that apply.

❑ Behavioral health clinicians within our organization or co-located within our facility

❑ Local substance use disorder treatment providers

❑ Medication-assisted treatment provider (e.g. suboxone)

❑ Other: _____

40. Please describe your referral process: _____

41. Please describe how and where your referrals are documented:

42. Do you follow-up with patients/clients who've received a referral?

❑ Yes

❑ No

43. Does your organization communicate with local substance use disorder treatment providers to monitor progress of patient/client?

❑ Yes

❑ No

If yes, how does this happen?

❑ We have regular meetings with treatment providers to share general information about our programs and to review our referral protocols.

❑ We have a qualified services organization agreement (qsoa) in place that allows us to talk to treatment providers about individual patients.

❑ We communicate after a referral has been made.

❑ We do not communicate with local treatment providers.

44. Do you provide your patients/clients with referrals to aftercare services?

❑ Yes

❑ No

If Yes, please describe: _____

45. Do you provide your patients/clients with referrals to local recovery support services (non-clinical services that facilitate recovery)?

❑ Yes

❑ No

If Yes, please describe: _____

46. When you make a referral for an adolescent, do you inform family members?

❑ Yes

❑ No

47. Do you involve family members of adolescents in discussion of treatment plans

❑ Yes

❑ No

48. Is there anything else about your referral process that you would like to report? _____

Organizational Knowledge/Orientation to SBIRT

49. Does the staff of your organization receive information about the purpose and value of SBIRT implementation?
    - ❑ Yes
    - ❑ No

    If yes, please describe how (in what format) and when this information is provided: _____

SBIRT Training:

50. What percent of organizational staff who are responsible for service delivery receive SBIRT training?
    - ❑ Screeners: _____
    - ❑ Interventionists: _____
51. Please describe the characteristics of this training:
    - ❑ Core components of your training (techniques and topics covered): (define) _____
    - ❑ Length (define) _____
    - ❑ Manualized curriculum (define) _____
    - ❑ Training in matching clients to specific referral resources (define) _____
    - ❑ Training facilitator (define) _____
52. Does your training include a competency assessment?
    - ❑ Yes
    - ❑ No

    If Yes, does this assessment include:
    - ❑ Pre-post test of didactic knowledge
        - ❑ Yes
        - ❑ No
    - ❑ Roleplays of cases
        - ❑ Yes
        - ❑ No
    - ❑ Observations with simulated patients/clients
        - ❑ Yes
        - ❑ No
    - ❑ Observed practice with real patients/clients
    - ❑ Yes
    - ❑ No
53. Do staff receive ongoing booster SBIRT trainings?
    - ❑ Yes
    - ❑ No

    If Yes, how often do the booster sessions occur? _____
54. Does your organization utilize quality improvement activities to enhance SBIRT service delivery?
    - ❑ Yes
    - ❑ No

    If Yes, please describe: _____
55. Is there anything else about your training process you would like to report? _____

Billing and Reimbursement:

56. How do you finance screenings?
    - ❑ State grants
    - ❑ Federal grants
    - ❑ Private foundation funding
    - ❑ SBI reimbursement codes
    - ❑ Services embedded in other billable encounters
    - ❑ Other: _____
    - ❑ Not Applicable. Describe: _____
57. How do you finance brief interventions?
    - ❑ State grants
    - ❑ Federal grants
    - ❑ Private foundation funding
    - ❑ SBI reimbursement codes
    - ❑ Services embedded in other billable encounters
    - ❑ Other: _____
    - ❑ Not Applicable. Describe: _____
58. How do you finance referrals to treatment?
    - ❑ State grants
    - ❑ Federal grants
    - ❑ Private foundation funding
    - ❑ SBI reimbursement codes
    - ❑ Services embedded in other billable encounters
    - ❑ Other: _____
    - ❑ Not Applicable. Describe: _____

    If you use SBI codes (as noted in Questions 55-57), which codes are used most often? _____
59. Does your organization track reimbursement from private and public insurers for SBIRT services?
    - ❑ Yes
    - ❑ No
60. Is there anything else about billing and reimbursement for SBIRT services you would like to report? _____

The Conrad N. Hilton Foundation's
Youth Substance Use Prevention and
Early Intervention Strategic Initiative

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