ADOLESCENT SBIRT

Toolkit for Providers

Adolescent Screening, Brief Intervention, and Referral for Treatment for Alcohol and Other Drug Use

MAY 2015

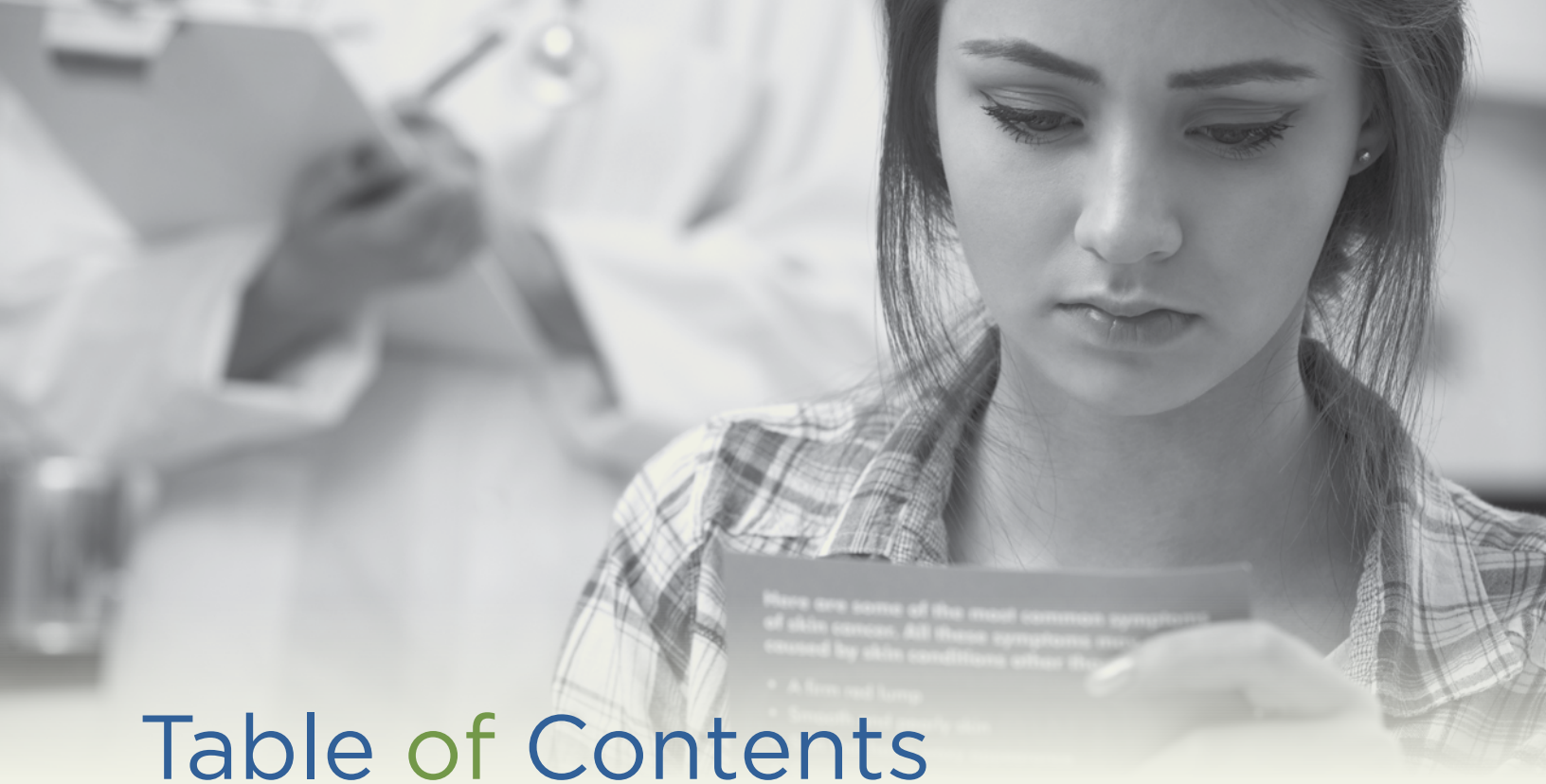
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH

MA Department of Public Health
BSAS
Bureau of Substance Abuse Services
Prevent • Treat • Recover • For Life

MCPAP
Massachusetts Child Psychiatry Access Project

Mass DMH
Department of Mental Health

Boston Children's Hospital
Adolescent Substance Abuse Program



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Attributions:

This guide was developed through a partnership of:

The Massachusetts Department of Public Health Bureau of Substance Abuse Services

The Massachusetts Department of Mental Health, Division of Child and Adolescent Services

Massachusetts Child Psychiatry Access Project

Written by:

Dr. Sharon Levy, Director, Adolescent Substance Abuse Program, Boston Children's Hospital

Dr. Lydia Shrier, Boston Children's Hospital, co-wrote the practice cases for role plays

Appendices:

The case scenarios in this Toolkit are fictional and the associated photos are not intended to represent the person in the case scenario.

The problem of adolescent alcohol and drug use

IN MASSACHUSETTS ALONE:

Use of alcohol and other drugs is widespread during adolescence and young adulthood. Among Massachusetts high school students:

ALCOHOL-RELATED:

Approximately **2 out of 3** have tried alcohol

1 out of 3 are current drinkers (within the past 30 days)

Nearly **1 out of 5** are current binge drinkers

DRUG-RELATED:

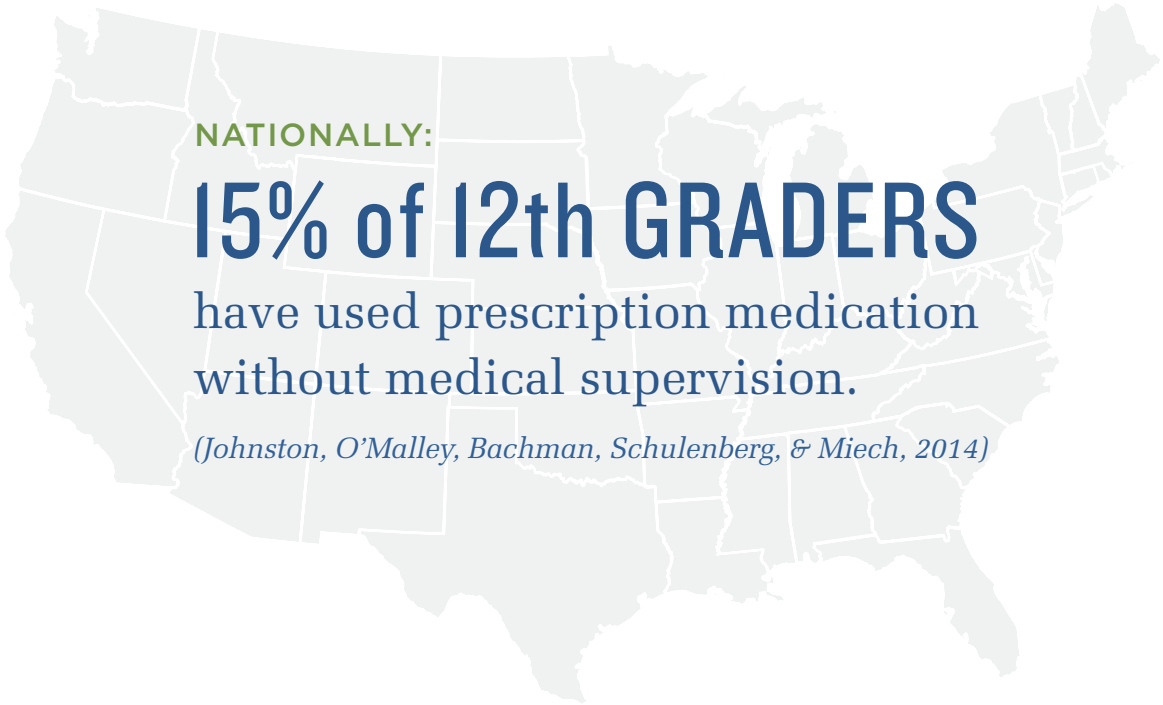
2 out of 5 have tried marijuana

about **1 out of 4** currently smoke marijuana

1 out of 3 have tried cigarettes

1 out of 5 report tobacco use (in any form)

(Kann et al., 2014)



NATIONALLY:

15% of 12th GRADERS

have used prescription medication without medical supervision.

(Johnston, O'Malley, Bachman, Schulenberg, & Miech, 2014)

Drug and alcohol use are each strongly associated with the leading causes of morbidity and mortality in adolescence (motor vehicle and other accidents, suicide, and homicide). *(National Center for Chronic Disease Prevention and Health Promotion, 2014)* Harm from adolescent substance use occurs at all levels of consumption — no amount of use is "safe."

The developing adolescent brain is particularly vulnerable to the toxic effects of alcohol and other drug use.

In addition to acute consequences, early initiation of alcohol is also associated with increased odds of developing alcohol dependence or abuse later in life. *(Grant & Dawson, 1998; Hingson, Heeren, & Winter, 2006)* Those who begin to drink before age 15 are five times more likely to develop alcohol dependence or abuse, compared to those who delay initiation of alcohol use into young adulthood. *(Grant & Dawson, 1998; Hingson et al., 2006)* Adolescents who try marijuana at age 14 or younger are six times more likely to meet criteria for illicit drug dependence or abuse later in life compared with peers who first used at age 18 *(Substance Abuse and Mental Health Services Administration (SAMHSA), 2010)*. A national study found that the younger respondents began drinking, the greater likelihood that they injured themselves or someone else while under the influence of alcohol. *(Hingson & Zha, 2009)* Marijuana use during adolescence is associated with diminished lifetime achievement. *(Meier et al., 2012)* Over 80% of adults who smoke tobacco began before age 18. Early initiation of tobacco use is predictive for use of certain other drugs, and poor health outcomes. *(Sims, 2009)* Teens who smoke report poorer health during adolescence than their peers. *(Johnson & Richter, 2002)*

Newer products such as electronic "e-cigarettes," which deliver nicotine via vapor, threaten to attract increasing numbers of youth to nicotine use with flavors such as cotton candy and bubble gum.

As advisors on health and safety matters, primary care providers are on the frontlines for preventing, identifying, and intervening to address adolescent substance use.

The vital role of primary care providers

Primary care providers (PCPs) play a vital longitudinal role in the lives of adolescent patients and are uniquely positioned to have an impact on teen substance use by providing anticipatory guidance, screening, and intervention (SBIRT) as part of their routine care, as recommended by the Massachusetts Department of Public Health (MDPH) and the American Academy of Pediatrics (AAP). *(Committee on Substance Abuse, 2011).*

A recent research study suggests that SBIRT can decrease the number of youth who initiate substance use and increase quit rates among those who have just begun to use. *(Harris et al., 2012)*

The large majority of practicing pediatricians in Massachusetts follow recommended guidelines, according to a statewide survey:

96% of pediatricians reported screening teens for alcohol and drug use at least annually.

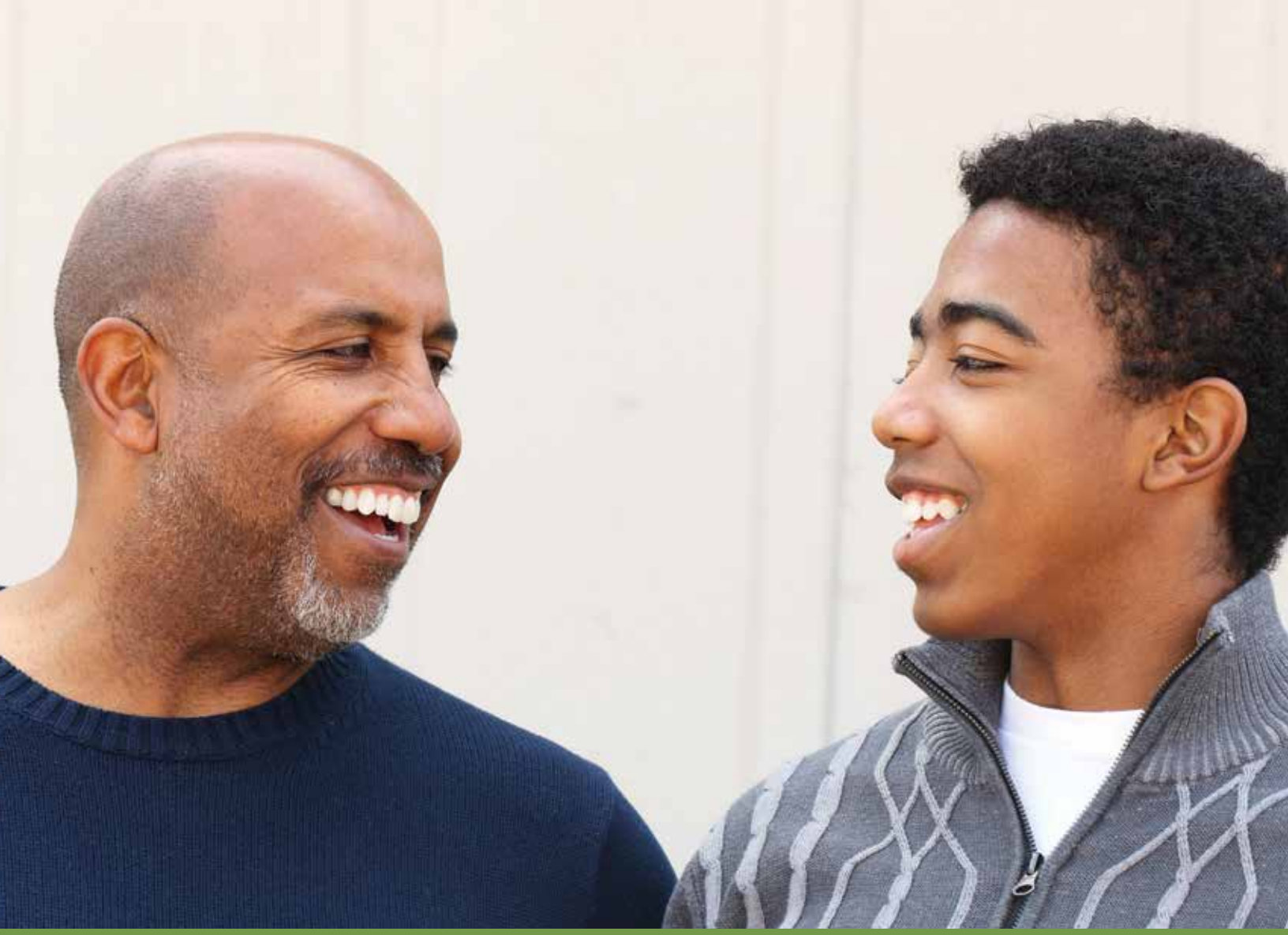
93% reported providing anticipatory guidance or giving positive feedback to teens who have not initiated substance use. *(Levy, 2014)*

However, the same survey found that some providers find it difficult to deliver screening, brief intervention, and referral for treatment (SBIRT) for adolescents. Specifically, 38% reported that they have insufficient time to screen for alcohol use during office visits, suggesting they need a more efficient format. Thirty-seven percent also said they have limited knowledge or access to treatment programs. These results underscore the need for more support in screening, brief interventions, and referral to treatment statewide.

The goal of the toolkit

The Toolkit's goal is to provide up-to-date guidance on research-informed practices to address substance use, including providing anticipatory guidance, accurate brief medical advice, brief motivational interventions, and successful referrals.

Appendices H and I in this Toolkit contain sample cases that can be used for "hands-on" practice of brief interventions and making referrals. Practice improvements are best accomplished through a multi-disciplinary team model with the entire practice staff — from administrators and front desk staff, to clinical assistants, primary care providers, and counselors — each contributing to an efficient process. Role plays provide an opportunity for staff members to practice these skills together.



Anticipatory guidance for parents: preventing substance use before it starts

Anticipatory guidance to prevent substance use is a powerful part of routine pediatric health care. Encourage parents to discuss healthy, substance-free means to express or resolve feelings such as elation, stress, disappointment, or pain.

High, yet attainable, expectations and role modeling healthy choices can have positive impacts on children. Parents should speak with their children about substance use frequently, in a developmentally appropriate manner. "Teachable moments" can help to broach the topic of substance use. Even young children can be made aware of cigarette use in a way that makes it clear that parents expect their children to stay away from these dangers. Parents of school-age children can use news media articles, television, and local stories to start a discussion. Conversations of this sort should invite children to join the discussion, ask questions, and practice ways to maintain a healthy lifestyle.

Parents may wonder if they should share their own experiences with alcohol, marijuana, and other drugs with their children. While there is little evidence on the pros and cons of this type of disclosure, one report found that teens whose parents disclosed their experiences viewed substance use more favorably. *(Kam & Middleton, 2013)* Parents are strong role models and are not obligated to volunteer personal details of their lives. If they are asked directly, they can redirect the conversation. Alternatively, if they feel they should briefly discuss their past with their children, they should include any negative consequences associated and/or explain that they hope their children can learn from their mistakes. Some parents have active substance use disorders, and their children are at particularly high risk for both trying substances and developing a disorder. Pediatricians can advise these parents that seeking their own evaluation and treatment sends a powerful message to their children.

The pre-teen visit is a particularly good opportunity to provide anticipatory guidance for parents and children, as evidence indicates the peak grades for initiating alcohol use are 7th and 8th, when most youth are 13 to 14 years old. *(Faden, 2006)* High levels of warmth and support coupled with clear rules about not using substances can be powerful deterrents.

The AAP recommends abstinence as the best health advice for teens and advises parents to set a clear "no use" policy around alcohol, tobacco, and other drug use. *(Committee on Substance Abuse, 2010)*

PCPs can be proactive in preventing alcohol and other drug abuse by sharing resources with all parents of youth age 12 or above. The free prevention materials distributed by MDPH, including "Strengthening Families Program" (DVD), "7 Ways to Protect Your Teen from Alcohol and Other Drugs," "Preventing Substance Abuse Starts at Home: Safeguarding Your Children," and other resources are based on effective evidence-based prevention programs and studies of adolescent behavior. They are available free of charge by visiting *mass.gov/maclearinghouse*.

Screening

Screening for alcohol, marijuana, and other drug use should be done at each patient's annual well visit, along with screening for injuries and other indications of high-risk behaviors (such as the diagnosis of a sexually transmitted infection), as well as whenever a teen presents with behavioral or mental health symptoms. Screening should also be considered for a youth at an acute visit when a youth has missed routine health maintenance visits.

Screening is not simply looking for teens who already have substance use disorders. The primary goal of screening is to identify each individual's experience on the continuum of substance use (i.e., from none to severe substance use disorder) in order to administer an appropriate clinical intervention to prevent or reduce substance use.

Asking screening questions is the first step toward making personalized recommendations, which can vary from positive reinforcement for abstinence to a referral to available residential treatment programs for the small percentage of youth with severe substance use disorders. Pediatric primary care providers face complicated terrain as age and developmental level impact the saliency of messages. This Toolkit can inform and simplify this process.

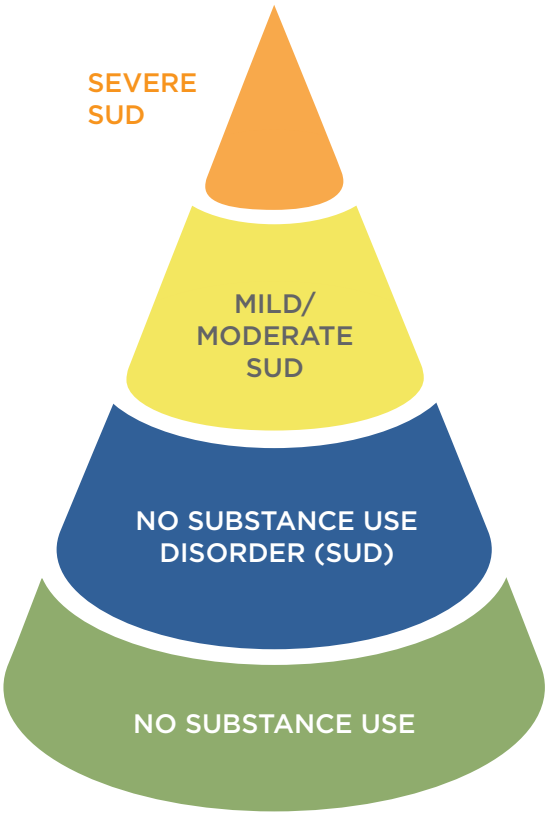
Use of validated screening tools is critical to accurately determine substance use experience and ensure that an appropriate message is delivered. Even experienced pediatricians fail to detect serious substance use disorders when relying on clinical impressions alone. *(Wilson, Sherritt, Gates, & Knight, 2004)* Recently it was found that when physicians did not use a validated screening tool, they identified only one-third of youth who engaged in "binge drinking." *(Haller et al., 2014; Levy, 2014)*

The U.S. Substance Abuse and Mental Health Services Administration estimates that less than 10% of teens in need of specialty substance use treatment receive it, and the majority who do are referred from the justice system. *(Substance Abuse and Mental Health Services Administration (SAMHSA), 2009; Substance Abuse and Mental Health Services Administration, 2013)* This is attributable, in part, to the tendency for physicians to underestimate substance use and its associated problems.

Introducing the S2BI

The clinical algorithm in this Toolkit incorporates the Screening to Brief Intervention instrument, or S2BI *(Levy et al., 2014)*, a new tool that serves as a stand-alone screening device and has been recently developed and validated for use with teens. (See next page.)

S2BI SCREENING RISK LEVELS



The proportions of adolescents at various risk levels vary across age levels, populations, etc.

Screening to Brief Intervention (S2BI)

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

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

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 right.*

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

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

Illegal drugs (such as cocaine or Ecstasy)?

- ○ 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

S2BI screening tool for substance use has a number of advantages:

- S2BI is quick and practical for short visits.
- S2BI includes questions on tobacco in addition to alcohol and marijuana.
- Research has found that the S2BI response choices correspond very well with DSM-5 diagnoses. Although S2BI does not provide a formal diagnosis, clinicians can use the result to select the appropriate level of care.
    + Kids who report use "once or twice" in the past year are very unlikely to have a substance use disorder
    + Those who report "monthly" use will generally meet criteria for a mild or moderate substance use disorder
    + Those reporting "weekly" use will most likely meet criteria for a severe substance use disorder *(Levy et al, 2014)*
- S2BI is a brief screening tool that can identify adolescents with a severe substance use disorder. This helps to quickly identify the kids most likely to benefit from a referral.
- S2BI is compatible with electronic medical records.

S2BI administration

S2BI and other screening tools can be administered in a variety of formats and platforms, including face-to-face interview by a clinical assistant or physician, or self-administered via paper and pencil, tablet, or computer. The questions can also be incorporated into other screening tools already being administered.

Remember to use the S2BI multiple choice answer options even if you are administering the screen as an interview. A recent study found that all screening questions work best when administered exactly as written. *(Levy et al., 2014)*

It is recommended that after doing the screening you tell children and younger adolescents that although physicians screen everyone, very few kids their age use substances. This strategy avoids the possible implication that drinking is common. Statements such as "I am glad to hear that like most kids your age, you have never tried alcohol" may be helpful.

Use methods that facilitate honest patient responses. For example, administer paper or computer-based screenings in a private area so that parents/guardians cannot see the answers. Conduct in-person screenings when parents/guardians are not present. If this is not possible, consider deferring screening until an opportunity for a private conversation can be arranged.

An advantage of the S2BI is that the questions can be administered by clinical staff while checking in a youth, especially during acute visits when a youth has not recently been screened.

What about the CRAFFT?

In the previous version of this Toolkit (and several other publications), the CRAFFT was the recommended screening tool with three "opening questions" administered first.

Newer research has allowed us to replace the "opening questions" and simplify the SBIRT algorithm because the S2BI can screen and distinguish between risk groups more quickly and easily than the CRAFFT. **(See Appendix B for other screening tools.)**

But don't throw your CRAFFT cards away! *(ceasar-boston.org/CRAFFT/pdf/CRAFFT_SA_English.pdf)* If your practice already uses the opening questions and the CRAFFT as a standard protocol you can continue to do so.

The CRAFFT is both a screening tool and a brief assessment instrument. The CRAFFT has screen-like properties — kids who answer yes to two or more CRAFFT questions are very likely to have a substance use disorder.

The CRAFFT is also useful as an interview guide when performing brief assessments and interventions.

It very quickly identifies topics for further discussion. When used in this way, the CRAFFT score does not change clinical decision making; rather, the conversations generated around the topics in the CRAFFT questions serve as the first step in a brief motivational intervention.

YOUTH WHO PRESENT WITH SUBSTANCE USE PROBLEMS

Some youth present to the office with substance use problems — like being caught drunk or high by parents or at school. S2BI can be useful in these situations as it will help distinguish between infrequent use (for which brief advice may be enough, though the teen has experienced a problem) and more regular use, for which further assessment and brief or more substantial treatment may be indicated. Always use your clinical judgment. Even limited use by a teen with a chronic medical condition, mental health, or developmental disorder, or by a very young teen, usually indicates a need for further assessment. In these cases, parents should usually be informed of the brief assessment and treatment recommendations. Avoid sharing small details to protect the therapeutic alliance with your patient. **(See Appendix A for information on confidentiality, records, etc.)**

Brief intervention

The type of brief intervention will be guided by the child's responses to the S2BI. Brief interventions can take anywhere from a few seconds to several minutes to deliver, with the majority requiring two to three minutes. In this Toolkit, "brief intervention" is defined as a clinician intervention delivered within a routine health care visit.

Brief intervention is intended to reduce substance use and associated risky behaviors, and in some cases, to encourage an adolescent to accept a referral to treatment. In primary care pediatrics, "brief intervention" encompasses a spectrum of responses that includes positive reinforcement for no substance use, brief advice to quit for occasional use and use that does not reach the level of a substance use disorder, and brief motivational intervention and referrals for adolescents with substance use disorders. Each intervention category is described starting on the next page.

S2BI algorithm

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

S2BI Screening Result: Never

Providing positive reinforcement to adolescents who report no use of substances may prevent or delay initiation.

"It's a great decision to avoid tobacco, alcohol, and drugs — it's one of the best ways to protect your health."

Preliminary research has found that brief advice delivered by a physician is promising for reducing adolescent alcohol initiation. *(Harris et al., 2012)* This is an important intervention because any delay allows further brain maturation and may protect against both acute and long-term consequences

For older adolescents who likely have had the opportunity to use substances, consider framing abstinence as a "decision" and give the adolescent credit for making smart choices. In addition, include advice to never accept a ride from a driver who has used alcohol or another drug.

For youth in middle adolescence who are about to start driving, you may want to discuss the "Contract for Life," a document that asks teens to pledge never to accept a ride from an impaired driver and also asks parents to pledge to always provide safe transport home. (See *sadd.org/contract.htm* for a copy.)

S2BI Screening Result: Once or Twice

Adolescents who report using a substance "once or twice" in the past year are unlikely to have a substance use disorder. Research suggests that physician-delivered advice to quit combined with a brief explanation of the negative impacts on health may encourage teens to stop. *(Harris et al., 2012)*

"I recommend that you quit because (some kids get into trouble when they use alcohol; marijuana can get in the way of your achievements; nicotine is highly addictive and people who use tobacco quickly become hooked, etc.)"

For detailed information on negative health consequences to discuss with patients, see Appendix C.

S2BI Screening Result: Monthly

Brief motivational interventions are recommended for adolescents with monthly substance use. Brief motivational interventions are short, structured conversations based on the principles of motivational interviewing (MI) in which the clinician explores problems, recognizes ambivalence, and listens for "change talk" *(Miller & Rollnick, 2013)* from the teenager. "Change talk" refers to any statement in which the adolescent expresses a willingness to quit or cut down, or acknowledges the negative aspects of substance use.

While brief motivational interventions are a complex clinical activity, use of a structured format may increase speed and efficiency.

The CRAFFT questions can be used to guide a "brief assessment." (See next page.) While the CRAFFT questions are "yes/no" format, they can quickly guide the clinician to topics that are likely to generate change talk. For example, a patient who responds "yes" to the TROUBLE question can be asked for more details. This may reveal tension with parents, problems at school, legal problems, accidents, or medical or other problems. **(See Appendix H for a case example.)** For further information on brief motivational interviewing, go to: *pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf.*

SAMPLE SCENARIO 1

Carolyn is a 16-year-old high school sophomore who reports tobacco use "once or twice" in the past year. She denies use of other substances.

During her physical, her primary care doctor reviews her screen and gives her brief advice to quit. "I see that you have used tobacco on occasion. As your doctor, it probably will not surprise you that I recommend that you quit, and now is the best time. You likely have heard that tobacco causes heart disease and cancer in addition to lots of other medical problems The good news is that if you quit right now, it will probably be easy for you. If you decide to wait until later it may be more challenging since tobacco is one of the most addictive substances there is, and once you become addicted quitting becomes much harder."

The CRAFFT questions

"CRAFFT" is a mnemonic acronym for key words in each of the six questions. The CRAFFT is a good way to quickly identify problems associated with substance use. Ask follow-up questions after each "yes" answer to learn more about problems associated with substance use. Listen for change talk.

Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

Do you ever use alcohol or drugs while you are by yourself, **ALONE**?

Do you ever **FORGET** things you did while using alcohol or drugs?

Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

Brief motivational interventions are based on the premise that adolescents who have experienced problems can identify the potential benefits of reducing substance use, though they may not want to change their behavior due to the high "cost" of giving up use. For example, an adolescent may realize that marijuana use causes tension with parents, but may continue to use because smoking is a way of socializing with their friends. The core of a brief motivational intervention involves exploring the benefits of continued substance use compared to the potential benefits of behavior change.

A summary that repeats adolescent's change talk can be used as a fulcrum to shift the conversation to asking the adolescent about plans to avoid such problems in the future. The clinician can then facilitate making a "change plan." The goal is for the youth to quit entirely, but if s/he isn't willing, s/he may agree to cut down. Regardless of the teen's decision, we recommend giving clear medical advice to quit, ensuring that the teen does not confuse the message with an implicit endorsement of continued use.

These types of interventions have been studied extensively in adults, and a body of research has found that they are effective in reducing alcohol use. *(Vasilaki, Hosier, & Cox, 2006)* Fewer studies have been done in pediatric primary care, though formative work has found that they are acceptable to both teens and clinicians. *(Levy, Vaughan, & Knight, 2002*; *Haller et al., 2009)*

SAMPLE SCENARIO 2

Hunter is a 16-year-old boy who reports monthly alcohol use without other substances on S2BI screening. He responds "yes" to the CRAFFT FORGET and FRIENDS questions.

The clinician asks for more detail, and Hunter talks about not remembering everything that happens at parties. When asked to describe further, Hunter admits that he finds the loss of control frightening. He also says that his girlfriend thinks he drinks too much. The clinician summarizes, gives Hunter brief advice, and challenges him to make a change, "It sounds as if drinking at parties is something you enjoy and you also have had some scary situations — and your girlfriend is concerned about you. As your doctor, I recommend that you don't drink alcohol at all, at least until you are older. When you have a black out, you have temporarily poisoned the brain cells that lay down new memory. As you are saying, kids often make decisions they regret and get into trouble when they use alcohol. How can you protect yourself better in the future?" Hunter says that he is not willing to quit but agrees to cut down. He agrees to come in for a follow-up visit.

Consider building a "change plan" worksheet for your practice.

Many adolescents think concretely and need help "connecting the dots." Even a sincere desire to try to cut down may not result in behavior change if the adolescent does not think through the details. The clinician can facilitate by asking the teenager for details on what specific changes s/he is planning to implement. Just like with an asthma or diabetes plan, a change plan worksheet can facilitate longitudinal follow up. Carefully document this consistent with your practice's chart documentation policy for this type of information and any applicable laws. **(See Appendix A.)** A copy of the plan can also be given to the youth as a reminder of his/her plans to change. See below for a sample change plan for "Hunter."

Abstinence vs. risk reduction

Many adolescents who report substance use, even those who report associated problems, will not be willing to completely quit. Many, however, will be willing to cut down or modify their behavior in some way. In these situations, help the adolescents make a plan that allows them to self-monitor (See below). Target high-risk behaviors, like driving after substance use or using substances before school or work. Even in these situations, include clear, brief advice to quit. Statements such as "As your physician, I recommend that you quit" can be given successfully without the patient disengaging. It is important for the adolescent to know that you recommend quitting though the decision is ultimately up to him or her. You will be supportive no matter what s/he chooses.

HUNTER'S CHANGE PLAN WORKSHEET
DATE: JULY 22, 2014

S2BI Screen Result:

SUBSTANCE	NONE	1–2 TIMES	MONTHLY	WEEKLY
Alcohol			X	
Marijuana	X			
Tobacco	X			
Other	X			

PLAN:	**My doctor recommends that I stop, but for now I will:** • Never drink more than once in a month • Limit alcohol to two drinks a night • Never drive after drinking or ride with an impaired driver. • Hunter is not interested in an alcohol counseling session with our social worker at this time.
FOLLOW UP	**In one month**

Follow up

Whenever a teen makes a change plan, it is a good idea to follow up. Ask adolescents who met their goals how it went, and discuss the pros and cons of reduced use. Many teens will not notice big changes, especially if the follow up is relatively soon after the initial appointment. In these cases, emphasize that life did not get worse with reduced substance use. Support quitting or further reductions in use.

Teens who did not meet their goals may have a more serious substance use disorder than initially suspected as loss of control is the hallmark of addiction. These teens may benefit from more extensive substance use disorder (SUD) services, such as individual counseling provided by treatment providers, e.g., addiction medicine specialist, psychiatrist, psychiatric nurse practitioner, social worker, or psychologist within the practice or in the community.

Architecture of a brief motivational intervention for use monthly and weekly or more*

COMPONENT	DESCRIPTION
"Brief Assessment"	Ask the CRAFFT questions. Follow up any "yes" answers.
Summarize	Repeat back both positive and negative aspects of substance use. Be sure to repeat back any change talk.
Brief Advice	Include brief medical advice emphasizing the negative health effects.
Change Plan	Encourage the teen to make a specific change plan. Carefully document this consistent with your practice's chart documentation policy for this type of information and any applicable laws to facilitate follow up. **(See Appendix A.)**
FOR MONTHLY USERS	
Follow-up	Invite the teen to come back to discuss how the plan went. If the teen is not willing to return, make a note to follow up at the time of the next routine visit.
FOR WEEKLY OR MORE USERS	
Offer a referral	Call Youth Central Intake and Care Coordination or the Massachusetts Child Psychiatry Access Project (MCPAP) to navigate the referral process. **(See Appendix D.)**
Consider talking to parents	Ask the teen if parents are aware of substance use and ask permission to include them in the conversation. Praise the teen wherever possible — for willingness to cut back, accept a referral, or even just for answering questions honestly.

**Adapted from http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf*

Massachusetts Child Psychiatry Access Project (MCPAP) can help with contact information for counselors who are skilled at working with teens with substance use disorders and dual diagnosis (with mental health) to facilitate referral. **(See Appendix D for referral resources.)** Youth Central Intake (617–661–3991) can also help you find an appropriate counselor. Consider completing a psychosocial interview if not completed at first visit.

The addiction potential of the substance used will inform your clinical judgment of risk.

INVOLVING PARENTS

Getting a teen to return for a follow-up visit without parental notification and support is challenging, if not impossible, so inviting a teen for a follow-up appointment requires thoughtful management.

In many cases, by the time an adolescent has begun to have problems, parents are already aware of substance use (though they may underestimate its severity or significance). This is nearly always the case when teens report trouble in school, with the police, or with their parents. In situations where parents are already aware of use, the adolescent may agree to include their parents if asked. Parents should always be included in the plan when they express concerns about their child's possible substance use.

Including parents can be rewarding for all. Give the adolescent credit for willingness to have an open and honest conversation and emphasize any positive changes that they are willing to make. Try to redirect "Who, What, Where, When" questions from parents and focus on goals and recommendations. It may be useful to invite the parent for a separate appointment without their child present to give guidance that helps them set firm limits, avoid enabling, and have reasonable expectations regarding behavior change.

Additional information on implementing brief interventions

- The BNI ART Institute's Adolescent BI materials *(bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-brief-intervention/)*
- NIAAA's Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide *(niaaa.nih.gov/publications/clinical-guides-and-manuals/alcohol-screening-and-brief-intervention-youth/resources)*

CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Many adolescents with severe substance use disorders (SUDs) will also have co-occurring mental health disorders. Every adolescent diagnosed with a severe substance use disorder should also have a mental health evaluation. Most SUD treatment programs will include a mental health evaluation as part of their intake. For adolescents who are not willing to accept a referral for an SUD evaluation, consider offering a referral for a mental health evaluation. Some adolescents will report that they use substances to treat anxiety, depression, or other mental health symptoms and may be willing to see a mental health specialist even if they are not interested in SUD treatment.

Conversely, adolescents with mental health disorders are more likely to use substances and develop a substance use disorder than their peers. Primary care providers play a key role in ensuring that these adolescents are screened routinely. If an adolescent is using substances routinely or a substance use disorder is detected, be sure to be in close coordination with the mental health provider.

S2BI Screening Results: Weekly or More

Severe substance use disorder, or addiction, is a neurologically-based disorder resulting from disruption of neurons in the reward center of the brain that occurs upon repeated exposure to a psychoactive substance. *(Ries, David, Miller, & Saitz, 2009)* There is an inverse relationship between age of initiation and risk for developing a severe substance use disorder.

Hingson et al., 2006 found that nearly 50% of kids who initiated drinking before age 14 later experienced alcohol dependence vs. nine percent of those who started drinking at age 21 or after. The good news is that treatment works: motivational interviewing, cognitive behavioral therapy, psycho-education, contingency management, and family-based therapies have all been shown effective. Unfortunately, denial, minimization, stigmatization, and other barriers may all interfere with accepting a referral to treatment.

For many adolescents, the first opportunity to discuss substance use with a professional occurs in primary care. Brief motivational interventions are a good way to encourage an adolescent and/or family to accept a referral.

Whenever an adolescent screens positive for a severe substance use disorder, the primary objective of the brief motivational intervention becomes getting the adolescent to accept a referral to treatment. Parents should be involved in treatment discussions and the referral process whenever possible because most adolescents will not have the resources to follow through on their own and in most cases will benefit from their parent's involvement.

PCPs should ask their patient's permission to involve their parents. In many cases parents will already have a sense of, or actually be aware of, their adolescent's substance use. If a teen prefers to keep the discussion, including treatment recommendations, confidential, the clinician must decide whether the alcohol and/or drug use poses a threat to the teen's physical well-being to such an extent that the threat outweighs the teen's privacy interest. When making this decision, the clinician must weigh the benefits and risks of breaching confidentiality (e.g., the risk that breaching confidentiality will make the adolescent more resistant to treatment rather than facilitate entry into SUD treatment or reduce acute risks associated with ongoing substance use). A variety of treatment settings and venues are equipped to deal with situations where adolescents seek confidential counseling without a parent's consent. Teens who are willing to participate in confidential counseling should be referred to an appropriate venue and followed closely.

In any event, you should carefully document your decision relative to maintaining or breaching your patient's confidentiality consistent with your practice's chart documentation policy for this type of information. **(Further information about protecting confidential information is provided in Appendix A.)** Legal counsel can help clarify any questions.

SAMPLE SCENARIO 3

Maya is a 17-year-old girl who reports weekly marijuana use. When asked the CRAFFT questions, she answers yes to “RELAX” and “TROUBLE.” On further questioning, Maya says that she uses it when she is stressed and she doesn’t see the harm in it. She also acknowledges that her use has caused problems with her mother, who believes that marijuana use is unhealthy. Maya was recently suspended from school when she was caught with marijuana in her bag.

The clinician summarizes and gives brief advice and challenges Maya to make a change. “It seems that you depend on marijuana to help you manage stress and at the same time, marijuana use is causing tension between you and your mother and has gotten you into trouble at school. As your physician, I recommend that you quit. Marijuana does not reduce stress in the long term. I can understand that the tension between you and your mother has been hard to manage. What do you think you would like to do about it?” Maya says that she is not going to quit smoking, and there is nothing that her mother can do about it. She is almost 18 and she plans to move out in a few months. “It sounds like things are not going well at home. In these situations I often ask patients and their parents to speak with my colleague. She is a counselor who can really help you and your mom both think through all of these issues around marijuana use.” Maya agrees tentatively. The clinician gives her positive feedback and asks her to invite her mother into the room to discuss the plan, noting that this will give Maya’s mother the opportunity to see that she is taking the concerns about marijuana use seriously. Maya agrees. Practice tip: the clinician documents the plan consistent with their practice’s chart documentation policy for this type of information, and applicable laws. **(See Appendix A.)**

Acute danger

There is a limit to the motivational interviewing approach. Some adolescents present with very high-risk behaviors, such as high levels of use per occasion, alcohol or drug-related emergency department evaluations, intravenous (IV) drug use, poly-pharmacy, extreme binge drinking, or driving or engaging in other potentially dangerous activities while impaired. These require an immediate intervention to assure their safety. These adolescents are more likely to come to attention because of a problem related to substance use than to be identified by general screening.

The first step in evaluating these patients is to determine whether active suicidal ideation is present. If so, the patient should have an immediate safety evaluation, either in an emergency department or through a mobile crisis evaluation unit. **(See Referral resources in Appendix D.)** If the patient is not actively suicidal, an urgent (i.e., within the next several days) evaluation for mental health and substance use disorders will generally suffice. Talk to the teen about avoiding the highest risk behaviors, and use a behavioral plan contract in the interim. Remember that adolescents who choose to disclose details about high-risk behavior to a clinician may be asking for help.

In almost all cases, parents should be involved in planning, even if confidentiality must be breached. **(See Appendix A.) Before informing parents, screen for domestic violence** to ensure that involving parents will not put the adolescent at heightened risk. If possible, discuss what information you will share with parents and practice the conversation. Give adolescents the option of leading the discussion with their parents, either with or without a clinician present. If the adolescent asks to speak to parents in private, be sure to follow up to make sure that the parents received and understood all of the necessary information. If you are going to lead the discussion, remember that small details (i.e., which friends are involved, where they obtained substances, etc.) generally have minimal impact on immediate safety planning and do not need to be revealed. Review with parents how to monitor their child and what to do if they become concerned.

Advice for parents

Teens engaging in behaviors that are acutely dangerous should be monitored for altered mental status, increased irritability, and suicidal/homicidal ideation.

- If an adolescent has become threatening or violent, call the police for assistance.
- If an adolescent has "altered mental status," bring him/her to the emergency department for an immediate evaluation.
- If an adolescent talks about hurting him/herself or others, bring him/her to the emergency room for an immediate evaluation, even if you think s/he "would never do it." Trained professionals should be responsible for determining whether an adolescent should be hospitalized or is safe to be at home.
- Parents should be advised to take car keys away from youth who do not agree to refrain from alcohol or drug use while driving.
- If an adolescent refuses to go to the emergency department at a parent's request, call 911, and go by ambulance.
- Parents of adolescents addicted to opioids should be trained to administer naloxone (Narcan) in case of overdose. **(See Appendix E.)**

Architecture of an acute intervention

COMPONENT	DESCRIPTION
Screen for intent to harm self or others	If a patient is an acute risk to himself or others, refer to the ED or mobile crisis team for an emergency evaluation.
Express concern	Let the teen know that substance use is putting him/her at risk of immediate harm. Briefly explain why.
Break Confidentiality	Remind the teen of the "rules of confidentiality" and explain that you must speak with a parent to help make and confirm a safety plan. **(See Appendix A.)**
Practice	Review what you will say and how you will say it to parents. Allow the teen to revise as long as the meaning of what you are saying is not changed.
Refer for an urgent evaluation	Call Youth Central Intake and Care Coordination or MCPAP for help navigating the referral process. A signed form with specific language will permit the "treatment program" to communicate with you. Both the youth and the parent should sign it if the patient is a minor. **(A sample consent form from the Legal Action Center is in Appendix A.)**
Make a "safety contract"	Discuss monitoring with parents and ensure they have a safety plan in place if anything changes.

SAMPLE SCENARIO 4

William is a 17-year-old boy who comes in for follow up after an emergency department visit for "alcohol poisoning" three days ago. He says he has been doing fine at home but his parents insisted that he keep this appointment. He reports weekly or more use of alcohol and marijuana, and monthly use of prescription medications and cocaine. He answers yes to RELAX, ALONE, and FORGET on the CRAFFT.

On follow up, he says that he uses marijuana to relax and help him sleep. He smokes marijuana alone several times a day and often drinks alone. He has a blackout every time he drinks and explains that is "the point." He recently started using opioids and benzodiazepines together with alcohol because he blacks out faster. He denies thoughts of hurting himself or others.

The clinician decides that William's behavior is an acute threat to his well-being and decides to make an immediate intervention. "I am glad you spoke honestly with me today. From what you told me, I am worried about your alcohol and other drug use. Mixing drugs can really get you into trouble, even if you only take a couple of pills. Because I am so worried I have to share some of this information with your parents (who already know some of it) and arrange an appointment for you to speak more about your drug use with my colleague who has a lot of experience talking to kids about drug use. In the meantime, can you promise me that you will not use any alcohol, pills or drugs at all before your next appointment? What do you think would be the best way to share the information with your parents?"

Referral to treatment

Deciding the appropriate level of treatment depends on availability, insurance coverage, and the preference of youth and families. As with other conditions, adolescents with substance use disorders should be treated in the least restrictive setting possible. One usually starts by referring the child/family for an assessment by a licensed practitioner or licensed youth substance abuse outpatient treatment provider.

If needed, Youth Central Intake and Care Coordination as well as most insurance carriers can help identify an outpatient provider for a comprehensive substance use assessment. **(See Appendix D.)** The family should be encouraged to access supports and utilize available support resources for themselves, even if the youth is not willing to engage in treatment. A special signed form will permit the treatment program to communicate with you. Both the youth and the parent should sign it if the patient is a minor. **(A sample consent form from the Legal Action Center is in Appendix A.)**

Depending on the severity of use, prior treatment history, and willingness to engage in services, youth can be referred to a variety of services and supports. In many cases, adolescents expressing a desire to stop using can be treated in an outpatient setting. Outpatient services, particularly for opiate use, can include medication-assisted treatment with buprenorphine, naltrexone, or methadone (for those over 18).

Several resources exist for youth assessments or substance abuse treatment and for clinicians who would like more information about substance abuse programs in the community.

(See Appendix F for a description of substance use treatment programs.)

However, youth who are heavily using marijuana, alcohol, benzodiazepines, opiates/opioids, cocaine, or other drugs should be assessed for appropriateness of referral to an inpatient level of care.

Youth using alcohol and/or other drugs and exhibiting any of the following may require inpatient detox or stabilization support:

- Daily/near daily use of alcohol or benzodiazepines, as stopping can lead to life-threatening withdrawal symptoms requiring medical supervision
- Daily/near daily use of opioids, as stopping can lead to flu-like symptoms spanning from mildly uncomfortable to very painful
- Unable to stop using despite engagement in outpatient services
- Prior inpatient and/or residential substance use treatment experience
- Co-occurring mental health disorder
- Homelessness
- Parent(s) with untreated/symptomatic mental health or substance use disorders

Physicians can be helpful with the steps of the referral process. Fortunately, a relatively small proportion of teens need intensive SUD services. However, those who do need it also need continued team management from their primary care provider.

Architecture of referral

COMPONENT	DESCRIPTION
Discuss with teen	Use brief motivational intervention strategies when discussing with the teen why you recommend a referral.
Involve parents	Ask the teen for permission to include parents. If the teen's behavior is judged to be putting him/herself or others at risk, consider breaching confidentiality and discussing with parents even if permission is not obtained. **(See Appendix A on confidentiality.)**
Determine level of care and acuity	Adolescents who are suicidal or at risk of withdrawing from benzodiazepines or alcohol should be referred to the emergency department for medical clearance and referred to youth stabilization programs for medically-supervised detoxification. Most other patients can be managed in an "urgent" (as opposed to "emergency") manner and can be referred directly to youth stabilization. *If needed, get assistance from Youth Central Intake, MCPAP, or a mental health provider. **(See Appendix D for information on these resources.)**
Select appropriate programs	Create a list of providers/programs that meet the appropriate level of care. Considerations include referrals to the BSAS Massachusetts Youth and Young Adult Substance Abuse Services Directory and Youth Central Intake and Care Coordination for options. **(See Appendix D.)** • **Age:** Teens should ALWAYS be referred to programs designed for their age/developmental level. Adolescents should not attend programs designed for adults. • **Insurance coverage:** BSAS provides many services taking into consideration the family's ability to pay. • **Location/transportation:** This is a consideration particularly for intensive outpatient and partial hospital programs, which require frequent trips from home.
Call for admission procedures	If possible, assign someone from your practice to assist parents with making the initial phone call to determine admission procedures and bed availability. • Patients may or may not need to wait at home several days until a bed becomes available. • Some insurance products require an emergency department evaluation prior to admission for "medical and insurance clearance." In these cases, a letter from the primary care provider explaining the rationale for level of care may be helpful.

Architecture of referral (continued)

COMPONENT	DESCRIPTION
Keep in touch with patients and families while they are waiting for placement	Patients and families are vulnerable while they are waiting for placement in a treatment program. Many treatment programs will offer parent or family groups while waiting for admission. Have families come for brief office visits to check in with you during this window. If this is not possible, have the practice call the family to check in. If behaviors escalate, the level of acuity may need to be reconsidered.
Continue to follow teens and parents while they are in treatment	Schedule a visit or speak with parents while their teen is in treatment to see how things are going and to advise on discharge planning. Ask for a special release of information and speak directly with program staff if at all possible. **(See Appendix A for a sample.)**
Follow up patients soon after discharge	As with any medical condition, follow up shortly after discharge from a higher level of care is warranted. Review the course of treatment and continuing care plans. Substance use disorders are not "cured," and patients should continue in a lower level of care after discharge from more intensive treatment. Ongoing recovery supports are also recommended.

Refer to Appendix G for a quick reference on matching adolescents with the most appropriate substance use disorder treatment and/or support program.

To find the right substance use disorder treatment program or other services addressing youth substance use disorders, contact your routine behavioral health provider, parents' insurance company, or Youth Central Intake and Care Coordination (YCICC) at 617–661–3991 or toll-free 866–705–2807. If you have difficulty finding a behavioral health provider, call the Massachusetts Child Psychiatry Access Project (MCPAP) **(See Appendix D)** or the member's managed care plan.

Support for families is helpful regardless of whether a teen enters treatment.

Learn to Cope *(learn2cope.org)*, a statewide, free support group for those coping with a loved one addicted to opioids or other drugs, provides free training on emergency naloxone administration at every meeting. Many outpatient providers also offer support groups for families.

Billing

Billing for SBIRT varies by payer. Please consult each insurance company for the appropriate billing process.

Thank you for all of your work to keep Massachusetts adolescents healthy.

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Appendix A: Confidentiality laws

The following are highlights of relevant federal and state laws that govern the confidentiality of personal health information related to adolescent substance abuse treatment in pediatric primary care settings. This Appendix should not be considered legal advice. For questions or further clarification, clinicians should consult legal counsel.

Federal and state laws provide important protections of personal medical information to patients, regardless of age, including health information related to substance abuse and mental health treatment. Generally these laws require that patients or their parents or guardians must authorize the sharing of protected health information for purposes other than treatment. In addition, when providers are authorized to share protected health information, these laws limit what can be shared to the minimum amount of information necessary for the intended use or disclosure of the information. Finally, federal and state laws typically impose stronger protections for health information concerning substance abuse and mental health treatment as well as special provisions for sharing health information related to minors.

42 CFR Part 2

Under the Federal Confidentiality of Alcohol and Drug Abuse Patient Records law, which is implemented by regulations commonly known as "Part 2," patients receiving substance abuse treatment from alcohol and drug treatment programs are protected by strict confidentiality rules. Specifically, the law prohibits disclosing and using drug and alcohol use records maintained by any federally assisted alcohol and drug use program without a patient's specific consent. (See 42 C.F.R. § 2.12) However, 42 CFR Part 2 only applies to alcohol and drug treatment "programs" that are both "federally assisted" and meet specific definitions of a program under 42 C.F.R. §2.11. Most primary care practices will not be considered "substance use programs," subject to 42 CFR Part 2 regulations; however you should consult with counsel concerning your status. (For a more comprehensive discussion of when a primary care provider might be considered a "federally assisted program" for purposes of Part 2, see question 10 of "Applying the Substance Abuse Confidentiality Regulations — Frequently Asked Questions" at *samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs* by the Substance Abuse and Mental Health Services Administration (SAMHSA).)

Adolescent SBIRT Services and 42 CFR Part 2:

SBIRT services would be subject to Part 2's strict consent requirement only if the entity conducting the SBIRT activities is a federally assisted "program" as defined in the regulations. (See question 11 of "Applying the Substance Abuse Confidentiality Regulations — Frequently Asked Questions" at *samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs* by SAMHSA.) Very few primary care providers meet the definition of a "federally assisted program" under Part 2.

PCPs who provide SBIRT services but who are not considered a federally assisted "program" under Part 2 must abide by the confidentiality protections of the HIPAA Privacy rule (continued).

HIPAA privacy rule

As you know, primary care physicians are required by the HIPAA Privacy Rule to protect the confidentiality of their patient's health information and prohibited from disclosing their health information without their prior written authorization. Providers should contact their facility's Privacy Officer if they have questions about the applicability of HIPAA. Important exceptions to the rule prohibiting disclosure are included in the law, however. Specifically, HIPAA permits uses and disclosures of health information for "treatment, payment, and health care operations" as well as certain other disclosures *without* the individual's prior written authorization. Disclosures not otherwise specifically permitted or required by the HIPAA Privacy Rule must have an authorization that meets certain requirements. With certain exceptions, the Privacy Rule generally requires that uses and disclosures of health information be the minimum necessary for the intended purpose of the use or disclosure.

Adolescent SBIRT Services and the HIPAA Privacy Rule:

Under HIPAA's Privacy Rule, primary care physicians are permitted to disclose an adolescent's health information to other health care providers, including information related to a substance use disorder, *without the authorization* of the patient or the patient's parents for purposes of "treatment, payment, and health care operations." HIPAA's Privacy Rule defines "treatment" as "the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another." (45 C.F.R. § 164.501)

Under HIPAA's Privacy Rule, physicians are also permitted to disclose health information to third party payers. In turn, health information that is transmitted to third party payers may be shared with a parent of a dependent child covered by the parent's health insurance policy (See 45 C.F.R. § 164.506). Therefore in situations where an adolescent patient prefers not to disclose substance use information to a parent, **primary care providers should be aware that their patient's substance use information may ultimately be shared with the parent if the adolescent is covered by their parent's health insurance policy.**

Massachusetts health privacy laws

Massachusetts' health information privacy laws generally mirror HIPAA's Privacy Rule and Part 2's stricter protections for information related to substance abuse and mental health disorders. However, federal law relies on state law to determine the extent to which the confidentiality and consent rules apply to adolescent minors. Generally, if state law requires the consent of parents or guardians for medical treatment, then parents or guardians have control over their minor child's personal health information (See 45 C.F.R. § 164.502 (g)(3)(i)(A)).

Who is a minor in Massachusetts?

In Massachusetts, the age of majority is 18 for all purposes, unless otherwise specifically provided by law (see M.G.L. c. 4, s. 7, cl. 48.) Children under the age of 18 are minors. Generally, minors must have the permission of their parents or guardians before they receive many kinds of medical treatments, so they do not have sole control over their personal health information.

Parents and guardians generally have control of and access to a minor child's protected health information except under certain circumstances:

Under HIPAA's Privacy Rule, a parent or guardian may cease to be a minor child's "personal representative" and control the child's personal health information if state law permits the minor to consent to his/her own treatment, if someone other than a parent or guardian is authorized to consent to treatment and provides such consent, or if a parent agrees to a confidential relationship between the minor child and the health provider (see 45 C.F.R. § 164.502 (g)(3)(i)).

- Instances where minors can consent to their own treatment under Massachusetts law: A minor may give consent for medical treatment if s/he is: a parent of a child; a member of the armed forces; pregnant; living separately from parents or a guardian and managing financial affairs; or suffering from a disease dangerous to public health (see M.G.L. c. 112 § 12F). Such minors control their personal health information.

- Instances where minors are authorized to consent to substance use treatment without parent or guardian authorization: In Massachusetts, a minor, 12 years or older, found to be drug dependent by two or more physicians may consent to hospital and medical care related to the diagnosis or treatment of drug dependency without consent of a parent or guardian. The parent or guardian is not responsible for payment of any care rendered under such circumstances (See M.G.L. c. 112. § 12E).

- Parents or guardians may agree to a confidential relationship between the minor child and the health care provider: Under 45 C.F.R. § 164.502 (g)(3)(i)(C), "a parent, guardian, or other person acting in loco parentis" may assent to an "agreement of confidentiality between a covered health care provider and the minor with respect to such health care service."

Licensed health care providers have discretion to withhold a minor's personal health information under certain circumstances:
Notwithstanding state law, under HIPAA's Privacy Rule, if a licensed health care provider reasonably believes that a minor child has been or may be subject to domestic violence, abuse, or neglect by a personal representative such as a parent or guardian, the provider may elect not to share information with the parent or guardian. In addition, the health care provider may elect not to treat a parent or guardian as a minor child's "personal representative" if the provider reasonably believes that it is in the best interests of the minor child to do so (See 45 C.F.R. § 164.502 (g)(5)).

This Appendix is provided as a general reference only and should not be considered legal advice. Physicians and other providers should consult legal counsel concerning specific questions and for further clarification.

Please see the sample consent form from the Legal Action Center. This signed form should permit the treatment program to communicate with you. Both the youth and the parent should sign it if the patient is a minor.

FORM 1: SAMPLE CONSENT FORM

Consent for the release of confidential information

I, _____, authorize _____

(Name of patient) *(Name or general designation of alcohol/drug program making disclosure)*

to disclose to _____ the following information:

(Name of person or organization to which disclosure is to be made)

_____.

(Nature and amount of information to be disclosed; as limited as possible)

The purpose of the disclosure authorized in this is to: _____

(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(Specification of the date, event or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____ _____

Signature of Patient

_____ _____

Signature of person signing form if not patient *Describe authority to sign on behalf of patient*

Appendix B: Screening tools

Screening tools validated for use with adolescents

TOOL	USE
S2BI	• Frequency screen • Screens for tobacco, alcohol, marijuana, and other illicit drug use • Discriminates between no use, no substance use disorder (SUD), moderate SUD, and severe SUD, based on DSM-5 diagnoses
NIAAA Youth Alcohol Screen*	• Two question screen • Screens for friends' use and own use • Not a diagnostic tool
CRAFFT	Car, Relax, Alone, Friends/Family, Forget, Trouble • The CRAFFT is a good tool for quickly identifying problems associated with substance use and framing brief intervention discussions. • Not a diagnostic tool
BSTAD**	Brief Screener for Tobacco, Alcohol, and Other Drugs • Identifies problematic tobacco, alcohol, and marijuana use in pediatric settings
GAINSS	Global Appraisal of Individual Needs • Assesses for both substance use disorders and mental health disorders
AUDIT	Alcohol Use Disorders Identification Test • Assesses risky drinking • Not a diagnostic tool

(American Psychiatric Association, 2013)

** In 2012, the National Institute on Alcoholism and Alcohol Abuse (NIAAA), and the American Academy of Pediatrics published a two-question youth alcohol screening tool. This empirically derived tool is recommended for children starting at age nine. Alcohol-only screening may be particularly useful with younger children or when alcohol use is a particular concern. The NIAAA published an accompanying resource: (pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf) and a web-based training course to guide clinicians in using this tool.*

***The Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD) is another brief screening tool, recently developed by NIDA, that can be self- or interview-administered and is compatible with the electronic medical record.*

Appendix C: Negative health effects of tobacco, alcohol, and other substances

Tobacco, electronic cigarettes, and hookah

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

Electronic cigarettes or "E-cigs" do not contain tobacco. They deliver liquefied nicotine via vapor instead of smoke. While rates of tobacco use have fallen dramatically since the 1990's, electronic cigarettes have become increasingly popular among adolescents. Because electronic cigarettes do not produce smoke, their danger is not always recognized. However, the liquid nicotine may contain toxins and contaminants. As concerning, the nicotine itself is highly addictive. E-cigs are sometimes marketed as a tobacco cessation device. They are not a safe alternative to tobacco, and threaten to attract increasing numbers of youth to nicotine use with flavors such as cotton candy and bubble gum. Currently, the FDA only regulates the marketing of electronic cigarettes for therapeutic purposes. *(Products, n.d.)*

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

Alcohol

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

- Heavy alcohol use in early to middle adolescence impairs memory function. *(Brown, Tapert, Granholm, & Delis, 2000)*

- Alcohol is particularly damaging to the hippocampus, part of the brain that is important for memory and learning. *(De Bellis, 2000)* Teens who drink heavily have poorer school performance than their peers. *(Brown & Tapert, 2004)* A "black out" occurs when the concentration of alcohol in the blood is high enough to temporarily affect brain cells that lay down new memories. *(White, n.d.)*

- Teens who start drinking at an earlier age are at high risk for motor vehicle accidents, fights, and unintentional injuries while using alcohol. *(Hingson, Heeren, & Zakocs, 2001; Hingson, Heeren, Levenson, Jamanka, & Voas, 2002; Ralph W. Hingson, 2000; Slap, Chaudhuri, & Vorters, 1991)*

- Teens who drink are also more likely to engage in risky sexual behaviors that could result in early pregnancies, STDs, etc. *(Tapert, Aarons, Sedlar, & Brown, 2001)*

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

Marijuana

In this information age, adolescents can easily obtain a large body of information about marijuana from the Internet that may influence their behavior. The inverse relationship between perceived risk of harm and use of a substance has been very well established. *(Johnston, O'Malley, Bachman, et al., 2014)* The problem is that many teens have information that is only partially correct, slanted, or misinterpreted. The good news is that research has demonstrated that adolescents support the idea of physician-initiated advice regarding substance use, *(Yoast, Fleming, & Balch, 2007)* which suggests that brief physician advice may be particularly salient. The table below lists adverse effects of marijuana use for which there is a high level of confidence in the evidence for association. *(Volkow, Baler, Compton, & Weiss, 2014)*

Marijuana use is associated with:

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

Prescription opioids

While not as common as alcohol and marijuana use, prescription opioid misuse is rising and is particularly high risk because of the powerful addiction potential of opioids. One study found that many adolescents who "misuse" opioids (i.e., use them without a prescription) do so in order to address pain, albeit inappropriately. *(McCabe et al, 2012)* These adolescents can benefit from medical assessment, pain management, and brief advice regarding the risks of opioid misuse. Parents can be referred to mass.gov/parentpower for guidance. Some adolescents misuse their own pain medications. Other teens begin using opioids recreationally in social situations in which prescription drugs are exchanged, known as "pharming" parties.

Adolescents who develop opioid use disorders are at high risk of associated complications including transition to injection drug use and fatal overdose. For these teens, access to medication-assisted treatment and psychosocial support should be provided as these treatments have proven to be effective. *(Woody et al., 2008)* See the section on referral to treatment (p. 30) for information on how to determine the appropriate level of care. Medication-assisted treatments are available for adolescents. To learn more, go to the website of the Providers' Clinical Support System for Medication-Assisted Treatment *(pcssmat.org/)* and **Appendices D and E** for resources.

Appendix D: Referral resources

Referral resources

Youth Central Intake and Care Coordination for Adolescents with Substance Use Disorder Problems (YCICC). Staff members are available to assist any family or PCP with questions and/or referrals to adolescent substance use disorder services. If it is appropriate to refer the youth to an alternative program, the staff will offer suggestions, such as outpatient treatment. The YCICC staff will coordinate all referrals to the residential treatment system for youth with substance use disorders. For additional information, please call 617–661–3991, toll-free 866–705–2807, or TTY 617–661–9051.

Massachusetts Child Psychiatry Access Project (MCPAP) is available to assist any primary care provider (PCP) who sees children or adolescents. MCPAP provides PCPs with timely access to child psychiatry consultation and, when indicated, transitional services into ongoing behavioral health care (including substance use disorder counseling or treatment). Currently, over 95% of PCPs in the Commonwealth are enrolled. MCPAP is supported by the Department of Mental Health and is free to all PCPs.

MCPAP is available to all children and families, regardless of insurance status, as long as the point of entry is through their PCP. MCPAP operates from 9:00 a.m. to 5:00 p.m., Monday through Friday, and is not meant to replace necessary emergency services.

Through MCPAP, teams of child psychiatrists, social workers, and care coordinators provide assistance to PCPs in accessing psychiatric, behavioral health, and substance use disorder services. MCPAP is regionalized to facilitate an ongoing relationship between the MCPAP team and the PCP. Each team builds relationships with the PCPs in their region to provide psychiatric telephone consultation, often immediately, but at least within 30 minutes. The consultation will result in one of the following outcomes depending upon the needs of the child and family:

1. An answer to the PCP's question;

2. Referral to the team child psychiatrist for an acute psychopharmacologic or diagnostic consultation;

3. Referral to the team care coordinator to assist the family in accessing routine, local behavioral health services (including substance use disorder counseling or treatment), with the understanding that there may be an immediate opening or a 4- to 6-week wait;

4. Referral to the team social worker to provide transitional, face-to-face care or telephonic support to the child and family until the family can access routine, local behavioral health services.

MCPAP REGIONAL TEAMS

Western Massachusetts	
Baystate Medical Center	413-794-3342
Central Massachusetts	
UMass Medical Center	508-334-3240
Northeast Region	
North Shore Medical Center	888-627-2767
Boston/Metro Region I	
Massachusetts General Hospital	617-724-8282
Boston/Metro Region II	
Tufts Medical Center Boston Children's Hospital	617-636-5723
Southeast Region	
McLean Hospital — Southeast	774-419-1184

To enroll, call the relevant regional team. For additional information, please contact the MCPAP Coordinator at *MCPAP@valueoptions.com*.

The regional MCPAP team also provides PCPs with training and behavioral health continuing education. Although much of this education will occur during telephone consultations with individual members, the team is available for "brown bag" or other types of learning sessions at the PCP's office.

Satisfaction data shows that PCPs participating in MCPAP now report that *because of MCPAP, they are able to meet the psychiatric needs of children and adolescents in their practices.*

The Massachusetts Substance Abuse Information and Education Helpline (800-327-5050, TTY MassRelay: 711 or 800-720-3480) provides free, confidential information and referrals for alcohol and other drug abuse problems and related concerns to people of all ages. The Helpline is committed to linking consumers with comprehensive, accurate, and current information about treatment and prevention services throughout Massachusetts, seven days a week. Language interpretation lines in over 140 languages are available. Information on resources and services can also be found at *helpline-online.com*.

Massachusetts Department of Public Health Bureau of Substance Abuse Services (DPH/BSAS) provides a Directory that lists specific substance use disorder treatment resources for adolescents. See *mass.gov/dph/youthtreatment*. Questions can be addressed to the BSAS Office of Youth and Young Adult Services at 617-624-5111, TTY 888-448-8321.

Suboxone providers

Suboxone (Buprenorphine) Hotline

Run by the Boston Medical Center Office-Based Opioid Treatment program, the Hotline can make referrals and offer information on opiate and heroin treatment available in doctors' offices statewide. Information regarding treatment options is available for both adolescents and adults.

Phone: 866-414-6926 or 617-414-6926
TTY: 800-439-2370 (ask for the Suboxone Clinic)

You can also call the Adolescent Substance Abuse Program (ASAP) at Boston Children's Hospital:

Phone: 617-355-2727, *TTY:* 800-439-2370

Services for substance abuse and/or mental health in emergencies

"Emergency Services Programs" (ESP) are available to the uninsured, MassHealth subscribers, and many insured Massachusetts residents of all ages. This service can address issues that involve both substance abuse and mental health. It is available 24 hours a day/7 days a week/365 days a year.

Toll free: 877–382–1609, *TTY:* 800–249–9949 (*masspartnership.com/member/ESP.aspx)*

General sources of information

Massachusetts Department of Public Health/ Bureau of Substance Abuse Services *(mass.gov/dph/bsas)* has extensive substance use disorder information and links to other Massachusetts Department of Public Health programs. For prevention and treatment referrals, consumers and professionals can contact the BSAS-funded Massachusetts Substance Abuse Information and Education Helpline (See above). For information on the required Prescription Monitoring Program (PMP), and prevention and treatment of non-medical opioid use, see *mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/dph-responds-to-opioid-epidemic.html.*

MASS 2-1-1 is a resource for finding government benefits and services, non-profit organizations, support groups, youth activities, volunteer opportunities, donation programs, and other local resources. Available 24 hours a day/7 days a week, MASS 2-1-1 can also respond to a crisis by directing callers to appropriate services in their area. All calls are confidential. If you are unable to reach 2-1-1 due to your telephone or cell phone carrier, a toll-free number is available: 877–211–MASS (6277), TTY 508–370–4890. Visit *mass211.org* for more information.

Massachusetts Health Promotion Clearinghouse offers free copies of this Toolkit, as well as other resource materials in bulk quantities. Parent and youth resources on preventing substance use disorders and many other topics are available in multiple languages. To order, go to *mass.gov/maclearinghouse*, or call 800–952–6637, TTY: Use MassRelay at 711 or 1–800–720–3480.

Learn to Cope offers naloxone (Narcan), a medication to reverse opioid overdose, and training in how to use it. Every chapter of Learn to Cope holds weekly support meetings run by experienced facilitators who have experienced opioid and other substance use in their own families. These meetings offer parents/guardians support, education, resources, and hope. Go to *learn2cope.org* or call 508–738–5148. **(See Appendix E for more information on naloxone.)**

Appendix E: Naloxone information

You can prescribe naloxone for families and individuals to have on hand as an emergency response to an opioid overdose.

Prescribe to Prevent *(prescribetoprevent.org),* a resource for prescribers and pharmacists, can provide sample prescriptions, patient materials, and videos. Many Massachusetts pharmacies now stock nasal-naloxone (Narcan) rescue kits, which include instructions. Information on detecting an overdose can be shared by visiting *mass.gov/eohhs/docs/dph/140328-opiate-advisory.pdf.*

- In addition, the Massachusetts Board of Registration in Pharmacy (BROP) issued a Pharmacy Standing Order for Naloxone Guidance to pharmacies with instructions on how to set up a standing order for dispensing naloxone. This allows family, friends, and others to obtain naloxone (Narcan) without a separate prescription. *(mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/pharmacy/dispensing-of-naloxone-by-standing-order-.html)*
  - + Check with local pharmacies to learn whether they stock naloxone kits and whether they have or are willing to set up a standing order.
  - + Prescribetoprevent.org and the BORP site also provide written instructions for naloxone administration.
  - + MassHealth covers the full cost of an nasal naloxone rescue kit.
  - + If a patient or family member is unable to afford the cost of a naloxone kit or the co-pay, they can receive a naloxone kit from one of the DPH Overdose Education and Naloxone Distribution Pilot Sites *(mass.gov/eohhs/docs/dph/substance-abuse/naloxone-info.pdf).*
  - + "Know the Signs of Overdose Save A Life" card or link can be accessed at *mass.gov/maclearinghouse* and given out when opioid use is an issue.

Parents can also find brief naloxone (Narcan) instruction and support at Learn to Cope. *(See Appendix D.)*

For information on prevention and treatment of non-medical opioid use, see *mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/dph-responds-to-opioid-epidemic.html*

Appendix F: Types of substance use treatment programs

Outpatient

Licensed, adolescent community-based outpatient programs provide assessment and counseling services for young people with a substance use problem and their families. Services offered include assessment, individual counseling, group therapy, family therapy, and often, intervention and intensive outpatient services. Families with MassHealth are eligible for additional enhanced home and community-based behavioral health services through the Children's Behavioral Health Initiative.

OUTPATIENT SERVICES	
Individual counseling	Adolescents with substance use disorders should receive specific treatment for their substance use. General, supportive counseling may be a useful adjuvant but should not be a substitute. Several therapeutic modalities (motivational interviewing, cognitive behavioral therapy, contingency management, etc.) have all shown promise in treating adolescents with substance use disorders.
Group therapy	Group therapy is a mainstay of substance use disorder treatment for adolescents with substance use disorders. It is a particularly attractive option because it is cost effective and takes advantage of the developmental preference for congregating with peers.
Family therapy	Family-directed therapies are well-validated approaches for treating adolescent substance use. Family counseling typically targets domains that figure prominently in the etiology of substance use disorders in adolescents, e.g., family conflict, communication, parental monitoring, discipline, child abuse/neglect, and parental substance use disorders. A number of family-focused modalities have all demonstrated effectiveness.

OUTPATIENT SERVICES (CONTINUED)	
Intensive outpatient program	Intensive outpatient programs (IOP) serve as an intermediate level of care for patients who have needs that are too acute or complex for outpatient treatment but do not require inpatient services. These programs allow individuals to continue their daily routines and practice newly acquired recovery skills both at home and at school. Intensive outpatient treatment works with young people in the community who have tried to control their substance use, but require more intensive support. Sometimes referred to as day treatment or structured outpatient, these programs generally include a combination of supportive group therapy, educational groups, family therapy, individual therapy, relapse prevention and life skills, 12-step recovery, case management, and aftercare planning. The programs generally range from three days per week after school with a minimum of 2.5 hours per day and last one to three months. These programs are appealing because they provide a plethora of services in a relatively short period of time.
Partial hospital program	Partial hospitalization is a short-term, comprehensive outpatient program, affiliated with a hospital that is designed to provide support and treatment for patients with co-occurring substance use and mental health disorders. The services offered at these programs are more concentrated and intensive than regular outpatient treatment, as they are structured throughout the entire day and offer medical monitoring in addition to individual and group therapy. Participants typically attend sessions for seven or eight hours a day, at least five days a week, for one to three weeks. As with IOPs, patients return home in the evenings and have a chance to practice newly acquired recovery skills.

Inpatient/Residential

INPATIENT/RESIDENTIAL SERVICES	
Detoxification and behavioral stabilization	Detoxification refers to the medical management of symptoms of withdrawal. Medically-supervised detoxification is indicated for any adolescent who is at risk of withdrawing from alcohol or benzodiazepines and may also be helpful for adolescents withdrawing from opioids, cocaine, or other substances. Massachusetts has two units specifically designed for detoxification and/or behavioral stabilization that provide short-term (average 14 days) stabilization for youth ages 13 to 17 with a substance use disorder. Individualized care is provided by an interdisciplinary treatment team of professionals, including psychiatrists, physicians, registered nurses, registered practical nurses, licensed social workers, and licensed mental health and substance abuse clinicians. Family involvement and family sessions are encouraged as part of the patient's individualized treatment plan.

INPATIENT/RESIDENTIAL SERVICES (CONTINUED)	
Acute residential treatment	Acute residential treatment (ART) is a short-term (days to weeks) residential placement designed to stabilize patients in crisis, often prior to entering a longer term residential treatment program. ART programs typically target adolescents with co-occurring mental health disorders.
Residential treatment	Residential treatment programs are highly structured live-in environments that provide therapy for those with severe substance use disorders, mental illness, and/or behavioral problems that require 24-hour care. The goal of residential treatment is to promote the achievement and subsequent maintenance of long-term abstinence as well as equip each patient with both the social and coping skills necessary for a successful transition back into society. Residential programs are classified by length of stay: less than 30 days is considered short-term; long-term is considered longer than 30 days. Adolescent substance use disorder residential treatment programs provide substance use disorder treatment services for medically stable youth between the ages of 13 and 17 and are appropriate for high-risk youth experiencing health, emotional, behavioral, family, developmental, and/or social dysfunction as a result of alcohol and other drug use, and whose issues have not been resolved in less intense, community-based levels of care. Length of stay in the programs varies based on the youth's treatment needs (45 to 90 days). Each youth participates in highly structured, developmentally appropriate individual, group, and family clinical services in addition to having his/her medical and psychiatric needs addressed. An in-house educational coordinator coordinates educational objectives with the child's school from his/her community. Transitional age/young adult residential programs provide a nurturing, structured, and safe environment for young people. These programs promote self-care, self-reliance, and community responsibility through structured activities and the experience of living in an alcohol- and drug-free residential treatment setting. An average length of stay is four to six months depending on treatment and recovery related goals. Services include: assessment; comprehensive substance use disorder treatment; mental health counseling referrals; case management and coordination; psycho-education on a variety of topics relating to health and wellbeing; life skills enhancement; vocational/educational support; recovery support; parent/care giver support; and aftercare planning.
Therapeutic boarding school	Therapeutic boarding schools are educational institutions that provide constant supervision for their students by a professional staff. These schools offer: a highly structured environment with set times for all activities; smaller, more specialized classes; and social and emotional support. In addition to the regular services offered at traditional boarding schools, therapeutic schools also provide individual and group therapy for adolescents with mental health and/or substance use disorders.

Appendix G: Youth substance use treatment and support decision tree

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

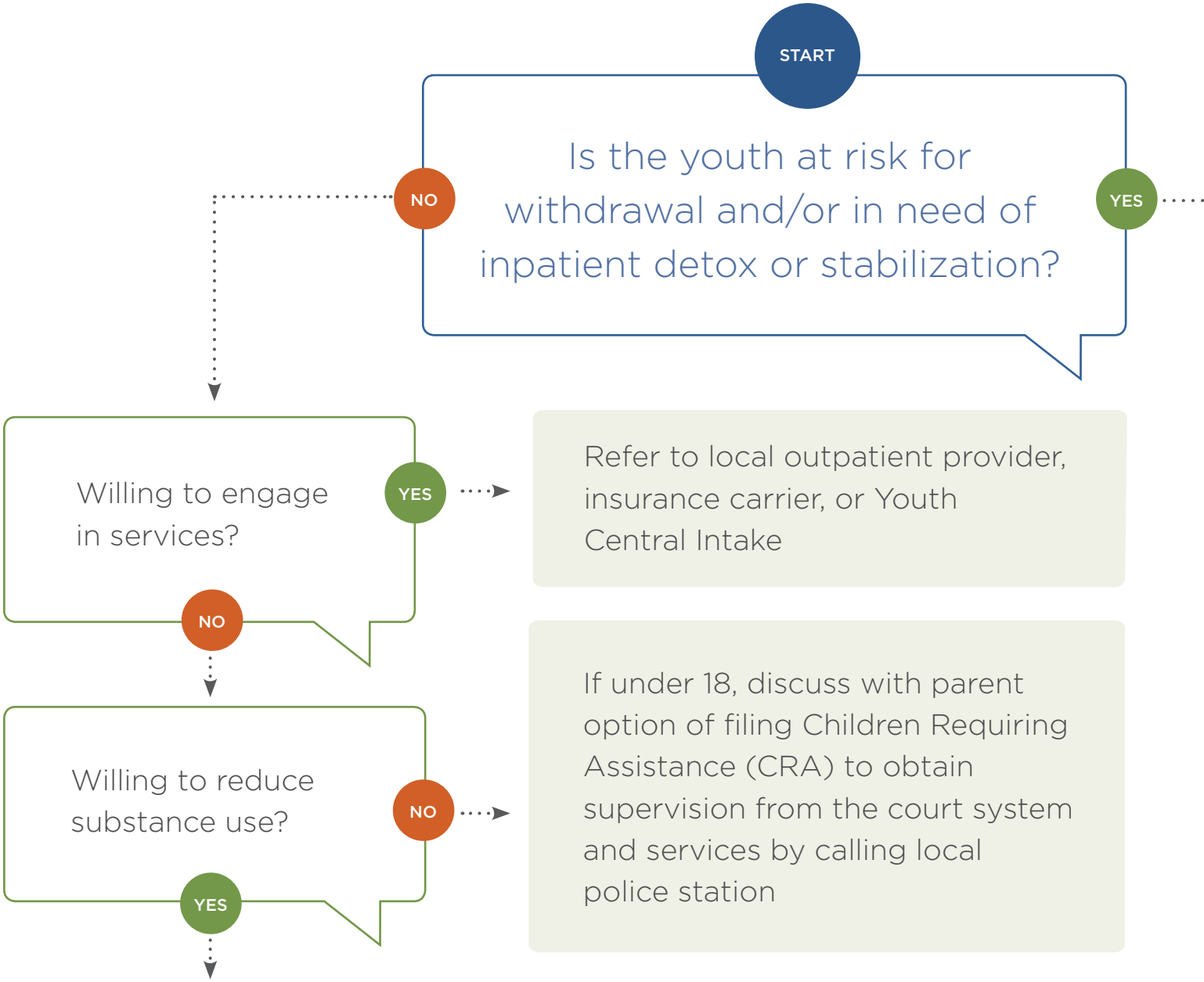
- Patients who report "weekly or more" use of any substance on the S2BI
- Patients who report monthly use of any substance and are judged to be in need of more treatment (such as very young patients, patients with known underlying medical, behavioral, or mental health disorders, or patients with a significant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

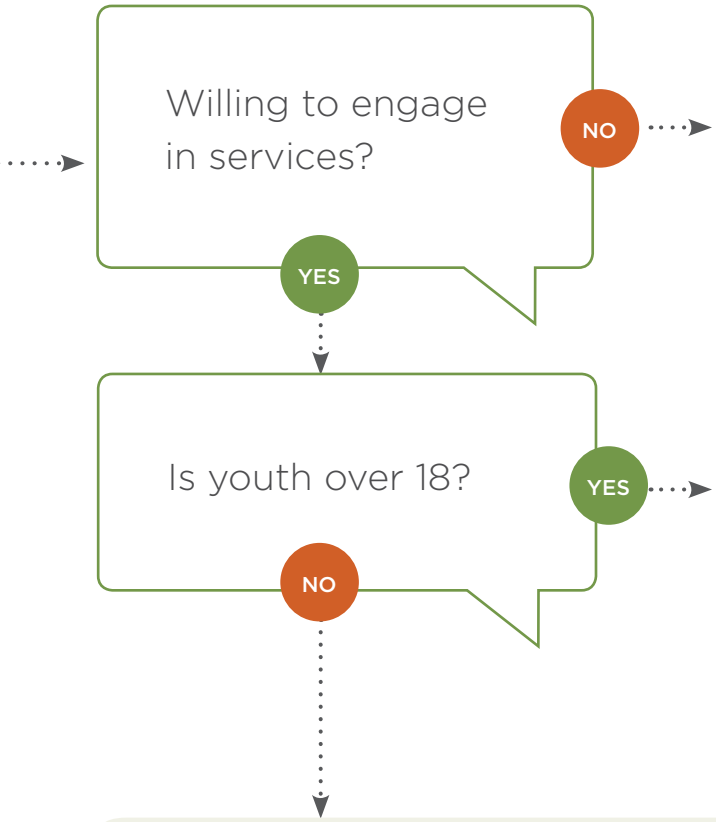
Follow up with all youth & caregivers and offer resources below post-visit:

- *Youth Central Intake and Care Coordination:* 617–661–3991, TTY 617–661–9051
- *12-step support groups:* AA, NA, Al-Anon, Families Anonymous
- *For caregiver support:* Learn to Cope (*learn2cope.org)*
- *For opioid antidote/emergency overdose treatment:* Naloxone Rx and training. *(mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/opioid-overdose- prevention.html)*

See Appendix D for referral resources.

Youth Substance Use Treatment & Support Decision Tree





Is youth at risk for harm to self through ongoing substance use that interferes with capacity to provide self care? If yes, parent/caregiver has option to civilly commit youth through Section 35 process by going to local district court. If no, provide referral info and follow up.

Contact the Helpline (for all ages)

800-327-5050
helpline-online.com

and/or call insurance carrier regarding detoxification services.

Options:

- Contact MCPAP for consultation. **(For MCPAP regional hub contact information see Appendix D.)**
- Inpatient detoxification/youth stabilization: Refer youth/family to either MYR (Worcester) 508-860-1244 or CASTLE (Brockton) 508-638-6000.
- Outpatient medication-assisted treatment for opioid dependent adolescents: Contact Youth Central Intake: 617-661-3991 or see **Appendix D.**
- **For patients at risk of withdrawal from alcohol or benzodiazepines: Refer to ED for medically supervised withdrawal.**

Appendix H: Practice vignette — the brief intervention in action

Below we have provided a complete script for a brief intervention between a PCP (Dr. Wilson) and an adolescent who is smoking marijuana (Irena). If you are working by yourself you can simply read the case through as an example of a complete brief intervention. If you have the opportunity to work in a group you can have staff members "act out" the case as an ice breaker for role playing. Feel free to change the words, ham it up, and have fun with it.

Irena is a 17-year-old girl who presents for a school physical. She has been followed in the practice since birth and was last seen one year ago. She has mild asthma that is well controlled with prn albuterol and is otherwise healthy. She has always been a solid B student whose hobbies include tennis, snowboarding, and lacrosse. She is currently in 11th grade and plans to apply to college next year.

Prior to coming into the exam room, Irena completed the office screening protocol, including the S2BI, and reported alcohol use "once or twice" and monthly marijuana use. The Medical Assistant hands Dr. Wilson the screen results for review. Note that Dr. Wilson utilizes the CRAFFT questions to explore potential problems associated with use.

After a few minutes of general interval medical history, Dr. Wilson addresses marijuana use with Irena.

DR. WILSON:

Let's review your results from this screen. I see that you reported using marijuana about once a month. Is that right?

IRENA:

Yeah, sometimes a little more, sometimes a little less, but that's about right, on average.

DR. WILSON:

Can you tell me a little more about your use? When did you start smoking?

IRENA:

I first smoked during April break last year. The first time I didn't get high and I didn't do it again for a while. Over the summer I tried it a couple more times. Actually I probably used a bit more over the summer – maybe once a week; I cut down when school started and now I use about once a month.

DR. WILSON:
What made you decide to cut down for the school year?

IRENA:
Well, I don't have as much free time to hang out with friends so it doesn't come up as much. I also don't want marijuana to interfere with school.

DR. WILSON:
Ok, so you have noticed that marijuana can get in the way of school work.

IRENA:
Well it never happened to me, but I heard it could happen.

DR. WILSON:
I agree with you. Marijuana can definitely make it harder to achieve the things that mean a lot to you.

Have you ever driven or ridden in a CAR with someone who had been drinking or using marijuana or other drugs?

IRENA:
No. I am not stupid and I would never do that.

DR. WILSON:
I am really glad to hear that you made a decision never to drive or accept a ride from an impaired driver. It is so important to protect yourself — cars can be deadly when they are in the wrong hands.
Do you ever use marijuana to RELAX?

IRENA:
Yeah, I guess so. It makes us laugh at stupid stuff when I am with my friends.

DR. WILSON:
Have you ever smoked when you were ALONE, by yourself?

IRENA:
Just once. I had left over marijuana and I just couldn't resist, so I smoked up in my room.

DR. WILSON:
So it sounds as if sometimes it can be hard for you to resist marijuana. Do you get cravings?

IRENA:
No, not really. I mean, sometimes I see kids smoking and I think I would really like to join them, but I wouldn't call that a craving.

DR. WILSON:
Are your FAMILY or FRIENDS concerned about your marijuana use?

IRENA:
My parents caught me high once or twice. I denied it, but I think they knew I had used.

DR. WILSON:
What did they say to you?

IRENA:
They told me not to use and that they would drug test me if they saw me looking high again.

DR. WILSON:
Why are your parents against you using marijuana?

IRENA:
Obviously, parents never want their kids to use drugs. My parents are constantly telling me that marijuana could be addictive and I think they are worried that I might try other things.

DR. WILSON:
What do you think? Are your parents right that marijuana could be addictive?

IRENA:
Probably, but I only smoke once in a while so I think they are overreacting.

DR. WILSON:
Did you ever FORGET anything that happened when you were smoking?

IRENA:
No.

DR. WILSON:
Did you ever get into TROUBLE because of marijuana?

IRENA:
Not really. One time, the police came to the woods and they knew all of us were smoking.

DR. WILSON:
Ok, so let me see if I got the picture right here. You smoke marijuana about once a month. You enjoy smoking with your friends and once you smoked by yourself in your room because you couldn't resist. Your parents have made it really clear that they don't want you to smoke at all. You've never gotten in trouble, but you've come close a couple of times — once when the police caught you and your friends in the woods and a couple of times when your parents caught you. You know that marijuana can be addictive, and that some kids who use marijuana do worse in school. Did I get all of that right?

IRENA:
Yeah, I guess.

DR. WILSON:
Well, it probably won't surprise you that, as your physician, I recommend that you quit completely. As you pointed out, marijuana can be addictive. Smoking can give you symptoms of chronic bronchitis and you know you already have asthma. And it really sounds like your parents are giving you a strong message that they don't want you to use marijuana and you've had to lie to them about it. I also worry that you may be finding it harder to resist marijuana when you're around it, which actually can be a sign that you are losing control. What do you think you can do to protect yourself?

IRENA:
I know all of this stuff but I think everyone is overreacting. I only use once in a while, I can definitely control it.

DR. WILSON:
Here's my recommendation — how about a "test." You are smoking about once a month. Why don't we see if you can go three months without smoking at all? Would you be willing to try that? That would be a good way for us both to see how well you can control your marijuana use.

IRENA:
I can go three months — it's definitely no big deal.

DR. WILSON:
Ok, let's try it then. I am going to write down your plan on this worksheet and give you a copy and keep another copy to remind us both at your next visit. Your mother is in the waiting room. Could we tell her that you have made a commitment to quit at least for three months?

IRENA:
I definitely don't want to discuss this with my mother.

DR. WILSON:
Alright, we'll keep this conversation just between you and me. I would like to see you back in three months to see how the "test" went. Can you come back for a follow-up appointment?

IRENA:
I don't think so. I have school, and my mom would need to drive me here.

DR. WILSON:
I usually see you in the spring to refill your asthma medications. That's about four months from now, but let's see if we can have you come in early so that we can check in then.

IRENA:
OK, I guess. But you won't tell my mom, right?

DR. WILSON:
Right. I told both you and her that I would keep our conversation private, just between us, and that is what I will do. I do think, though, that you might want to tell her at some point. It sounds as if she already knows that you have tried marijuana, and now you just agreed to quit for a few months. I bet she would be pleased. But I will leave when, whether, and how to have that discussion up to you.

Appendix I: Practice cases for role plays

Instructions for case practices: You can think through these vignettes on your own, or you can use them to role play with your colleagues. If possible, try to pull together at least four people for each exercise. If you have more, they can watch and give comments if someone gets "stuck," and their turn will be next!

Steps for practice cases:

1. Select four "volunteers"
   - Two people will be the adolescent (one actor, one coach)
   - Two people will be the PCP (one actor, one coach)
2. Everyone else forms the audience and should read both roles
3. Read your role
4. Act out the scenario by asking the S2BI questions
5. If you are playing the PCP, you can refer to "Help for PCP"
6. If you are a "coach" or audience member, feel free to jump in if an actor gets "stuck"
7. Have fun!

(See answer key on page 69.)

CASE A:

Josh

Adolescent role

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

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

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

If your PCP asks follow-up substance use questions:

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

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

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

What is your S2BI Screen Result?

- ○ No Use
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

What is your risk category?

- ○ No Use
- ○ No SUD
- ○ Mild/Moderate SUD
- ○ Severe SUD

What intervention did your PCP try with you?

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

CASE A: Josh

PCP role

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

What is Josh's S2BI Result?

- ○ No Use
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

What is Josh's risk category?

- ○ No Use
- ○ No SUD
- ○ Mild/Moderate SUD
- ○ Severe SUD

What intervention should you try with Josh?

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

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

- ○ Yes
- ○ No

If yes, what would you say to her?

Help for PCP

If you get stuck, here is some help:

SAMPLE COUNSELING LANGUAGE

Ask Josh for his own reasons to stop drinking.

What are your concerns about drinking? Why might you want to stop drinking? Tell me more... When was the last time that happened?

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

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

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

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

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

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

Give clear advice, while acknowledging agency.

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

Ask questions to empower Josh to develop a plan.

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

What else should I do?

- Ask Josh for permission to discuss the plan with his mother.
- Carefully document this interaction, consistent with your practice's chart documentation policy for this type of information and any applicable laws. **(See Appendix A.)**

CASE B:

Tracy

Adolescent role

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

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

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

If your PCP asks follow-up substance use questions:

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

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

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

What is your S2BI Screen Result?

- ○ No Use
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

What is your risk category?

- ○ No Use
- ○ No SUD
- ○ Mild/Moderate SUD
- ○ Severe SUD

What intervention did your PCP try with you?

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

CASE B: Tracy

PCP role

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

What is Tracy's S2BI Result?

- ○ No Use
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

What is Tracy's risk category?

- ○ No Use
- ○ No SUD
- ○ Mild/Moderate SUD
- ○ Severe SUD

What intervention should you try with Tracy?

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

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

- ○ Yes
- ○ No

If yes, what would you say to her?

Help for PCP

If you get stuck, here is some help:

SAMPLE COUNSELING LANGUAGE

Provide a balanced summary, using empathy.

It seems that you are trying to use marijuana to help you manage stress and, at the same time, marijuana use is causing tension between you and your mother and has gotten you into trouble at school.

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

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

Affirm consideration of discontinuing use.

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

Give clear advice, while acknowledging agency.

As your PCP, I recommend that you stop using marijuana for the sake of your health, your plans for your life, and the relationship between you and your mother. What do you think?

Make a referral.

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

What else should I do?

Propose involving the parents.

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

Make a follow-up appointment.

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

As your PCP, I will follow up with your counselor if you and your mother sign a form giving me your permission. (See Appendix A for an example.)

Carefully document this interaction, consistent with your practice's chart documentation policy for this type of information and any applicable laws. **(See Appendix A.)**

CASE C:

Anthony

Adolescent role

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

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

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

If your PCP asks follow-up substance use questions:

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

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

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

What is your S2BI Screen Result?

- ○ No Use
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

What is your risk category?

- ○ No Use
- ○ No SUD
- ○ Mild/Moderate SUD
- ○ Severe SUD

What intervention did your PCP try with you?

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

PCP role

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

What is Anthony's S2BI Result?

- ○ No Use
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

What is Anthony's risk category?

- ○ No Use
- ○ No SUD
- ○ Mild/Moderate SUD
- ○ Severe SUD

What intervention should you try with Anthony?

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

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

- ○ Yes
- ○ No

If yes, what would you say to her?

CASE C: Anthony

Help for PCP

If you get stuck, here is some help:

SAMPLE COUNSELING LANGUAGE

Ask for more information about Anthony's substance use.

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

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

It's so important that you are being honest about your use of prescription pain medications and that you have decided to quit. Tell me what made you decide that it was time for a change,

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

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

Ask questions to empower Anthony to make a plan.

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

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

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

What else should I do?

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

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

- **Make a follow-up appointment in the near future.**

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

- **Carefully document this interaction, consistent with your practice's chart documentation policy for this type of information and any applicable laws. (See Appendix A.)**

Answer key for case studies

CASE A: JOSH

S2BI result: Monthly

Risk category: Mild to Moderate SUD

Intervention choice: Assess, discuss, and and make a plan

CASE B: TRACY

S2BI result: Weekly or more

Risk category: Severe SUD

Intervention choice: Assess, discuss, make a plan, refer, and follow up

CASE C: ANTHONY

S2BI result: Weekly or more

Risk category: Severe SUD

Intervention choice: Assess, discuss, make a plan, refer, and follow up

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