WHITE PAPER

Emerging Lessons Learned from the Implementation of Screening, Brief, Intervention, and Referral to Treatment for Adolescents in School-Based Settings

Prepared by: UCLA Integrated substance abuse programs
Howard Padwa, Thomas Freese, Beth Rutkowski, & Elizabeth Teshome
UCLA Integrated Substance Abuse Programs
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CONRAD N. Hilton FOUNDATION

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Executive Summary

Though there has been significant progress in reducing substance use among adolescents in recent decades, youth substance use continues to be a major public health challenge in the United States.[1] In 2015, 21.5% of tenth graders and 35.3% of twelfth graders reported past-month alcohol use, and 16.5% of tenth graders and 23.6% of twelfth graders reported past-month drug use.[2] Approximately 5% of adolescents have substance use disorders,[3] and substance use puts other adolescents at increased risk for myriad physical, behavioral, and social problems.[4] Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in school settings have potential to address substance use and risk for substance dependence among adolescents.

As part of its work to prevent substance use disorders, the Conrad N. Hilton Foundation is sponsoring an initiative to promote SBIRT and other innovative prevention and early intervention approaches to reduce substance use among youth age 15 to 22. In February 2016, a group of Hilton Foundation grantees implementing SBIRT in schools and other national experts in school mental health and substance use prevention and early intervention convened at the Hilton Foundation's headquarters in Agoura Hills, California, to discuss SBIRT models and approaches; implementation barriers and facilitators; lessons learned about school-based SBIRT implementation; and next steps to advance the field of school-based SBIRT for adolescents.

This White Paper summarizes major themes from convening discussions, and is divided into five sections. The first section provides background information on substance use among adolescents, and the potential benefits of SBIRT services delivered in school settings. The second section provides a summary of challenges participants reported having in implementing and sustaining SBIRT for adolescents in school settings. The third section describes strategies that participants found to be helpful when implementing SBIRT, and lessons learned that can potentially inform the design and implementation of SBIRT in school settings elsewhere. The fourth section describes areas where the discussion highlighted unanswered questions about school-based SBIRT program design and implementation, and the fifth section outlines potential next steps to help advance both the science and practice of delivering SBIRT services for adolescents in school settings.

Executive Summary (cont.)

Convening discussions highlighted three major challenges to implementing SBIRT in school settings: (1) schools treating substance use as a disciplinary issue; (2) provider reluctance to discuss substance use; and (3) sustainability beyond grant funding.

Three main helpful strategies and lessons learned about SBIRT implementation in school settings emerged from convening discussions: (1) implementing SBIRT as part of a larger health and wellness program; (2) tailoring SBIRT to the local setting; and (3) incorporating peers into prevention programs.

Two unanswered questions concerning the design and implementation of SBIRT services for adolescents in school settings emerged from convening discussions: (1) what SBIRT's place in the school community should be, and (2) how to balance the needs for confidentiality and family involvement in activities related to substance use prevention.

Three next steps to advance adolescent SBIRT implementation in school settings emerged from convening discussions: (1) changing the culture around substance use and substance use prevention; (2) devising strategies to improve SBIRT's sustainability in school settings; and (3) generating data that demonstrates the benefits of SBIRT in school settings.

Appendices to this White Paper include a list of convening participant organizations and activities (Appendix A), a slide set Dr. Shannon Gwin Mitchell from Friends Research Institute, Inc. presented to convening participants on the state of the field of SBIRT for adolescents in school settings (Appendix B), and a list of resources that are currently available to support the implementation and sustainment of SBIRT in school settings (Appendix C).

Background

Though there has been significant progress in reducing substance use among youth in recent decades, adolescent substance use continues to be a major public health challenge in the United States.[5] According to the 2014 National Survey on Drug Use and Health, approximately 11.5% of adolescents aged 12 to 17 reported using alcohol in the previous month, and 9.4% reported having used illicit drugs (including nonmedical use of prescription medications) in the previous month.[6] Rates of substance use are particularly high in school settings; in 2015, 21.5% of tenth graders and 35.3% of twelfth graders reported past-month alcohol use, and 16.5% of tenth graders and 23.6% of twelfth graders reported past-month drug use.[7] Approximately 5% of adolescents have substance use disorders (SUD) that require specialty treatment,[8] and substance use puts other adolescents at increased risk for myriad physical, behavioral, and social problems.[9]

Screening, Brief Intervention, and Referral to Treatment (SBIRT) services have potential to address problematic substance use and risk for substance dependence among adolescents. SBIRT is a comprehensive, integrated, public health approach that entails screening populations for risky substance use behaviors, delivering preventative messages about the dangers associated with substance use to individuals who are not using alcohol or drugs, providing brief intervention services to reduce use among individuals who are at risk for SUD, and linking individuals in need of treatment with specialty care. The American Academy of Pediatrics (AAP) recommends the incorporation of SBIRT practices into medical care standards for adolescents,[10] and there are many screening tools that have been proven effective in identifying problematic substance use behaviors among adolescent populations.[11-13] Brief interventions, defined by the AAP as "outcome-responsive conversation(s)" that focus on "encouraging...patient(s) to make healthy choices and personal behavior changes regarding risky activity such as substance use"[14] generally include motivational enhancement discussions.[15] Evidence shows that brief interventions can lead to significant reductions in alcohol and drug use among youth,[16-17] and that certain intervention modalities (motivational interviewing) and components (decisional balances, goal-setting exercises) are associated with greater clinical benefits.[18] However, it remains unclear how to best facilitate referrals to treatment for adolescents who need specialty care for SUD, or what kinds of treatments would be most appropriate for them.[19]

As part of its work to prevent SUD, the Conrad N. Hilton Foundation is sponsoring an initiative to promote SBIRT and other innovative prevention and early intervention approaches to reduce substance use among youth age 15 to 22. Schools hold tremendous promise as venues for

Background (cont.)

these efforts, given that they are highly accessible to adolescents and that substance use is prevalent among student populations.[20] Furthermore, students visit school-based health centers (SBHCs) for behavioral health services much more than other health settings,[21] making schools ideal places to identify and serve students who face challenges related to substance use. Though the evidence base concerning SBIRT's impact when delivered in school settings is still developing, studies to date show that it can lead to significant reductions in alcohol consumption.[22] Given its potential impact, one focus of the Hilton Foundation's efforts is the implementation of SBIRT in school settings across the country.

Experience shows that it is feasible to deliver SBIRT services in school settings,[23-25] though there are also significant challenges to implementing and sustaining it.[26-27] Thus the experience of the Hilton Foundation's grantees has potential to yield invaluable lessons about SBIRT and SBIRT implementation in schools, and generate SBIRT approaches that could become models for schools across the country.

In February 2016, a group of Hilton Foundation grantees implementing SBIRT in schools and other national experts in school mental health and substance use prevention and early intervention convened at the Hilton Foundation's headquarters in Agoura Hills, California, to discuss SBIRT models and approaches; implementation barriers and facilitators; lessons learned; and next steps to advance the field of school-based SBIRT for adolescents. Given the limited knowledge about SBIRT implementation in schools, one of the convening's goals was to generate a working list of strategies that both grantees and others providing SBIRT in school settings can use to guide their efforts. The convening also featured a presentation on school-based SBIRT by Dr. Shannon Gwin Mitchell of Friends Research Institute, Inc., one of the nation's leading experts on SBIRT services for adolescents.

This paper provides a summary of challenges participants reported having in implementing and sustaining SBIRT for adolescents in school settings; describes strategies that participants reported to be helpful when implementing SBIRT, and lessons learned that can inform the design and implementation of SBIRT in school settings elsewhere; discusses areas where the participants had unanswered questions about school-based SBIRT program design and implementation; and outlines potential next steps to help advance both the science and practice of delivering SBIRT services for adolescents in school settings. Appendix A includes a list of organizations that participated in the convening, with brief descriptions of their current SBIRT services for adolescents. Appendix B includes the slides Dr. Mitchell presented at the convening, and Appendix C features a list of resources that are currently available to assist administrators, providers, and communities as they implement SBIRT in school settings.

Challenges Implementing SBIRT in School Settings

Three main challenges of implementing SBIRT in school settings were discussed during the convening: (1) schools treating substance use as a disciplinary issue; (2) provider reluctance to discuss substance use; and (3) sustainability beyond grant funding.

1 Schools treating substance use as a disciplinary issue

Participants reported that in many school environments, SBIRT is novel because it represents a dramatic shift in the way that substance use is addressed. Traditionally, participants noted, substance use has been treated as a disciplinary issue. "*It just seems like a lot of the culture is very punitive and reactionary,*" explained one participant, "*sending them straight to probation, or sending them straight to suspension.*" Even when providers are working to treat substance use differently, they fear that once students are identified as having used drugs or alcohol, they will become "*labeled for life*" and face disciplinary sanctions and stigma once their substance use is documented. As one provider summarized, "*they (providers) don't want to diagnose and label someone with this issues…because then it's in their chart indefinitely that they have this problem.*"

2 Provider reluctance to discuss substance use

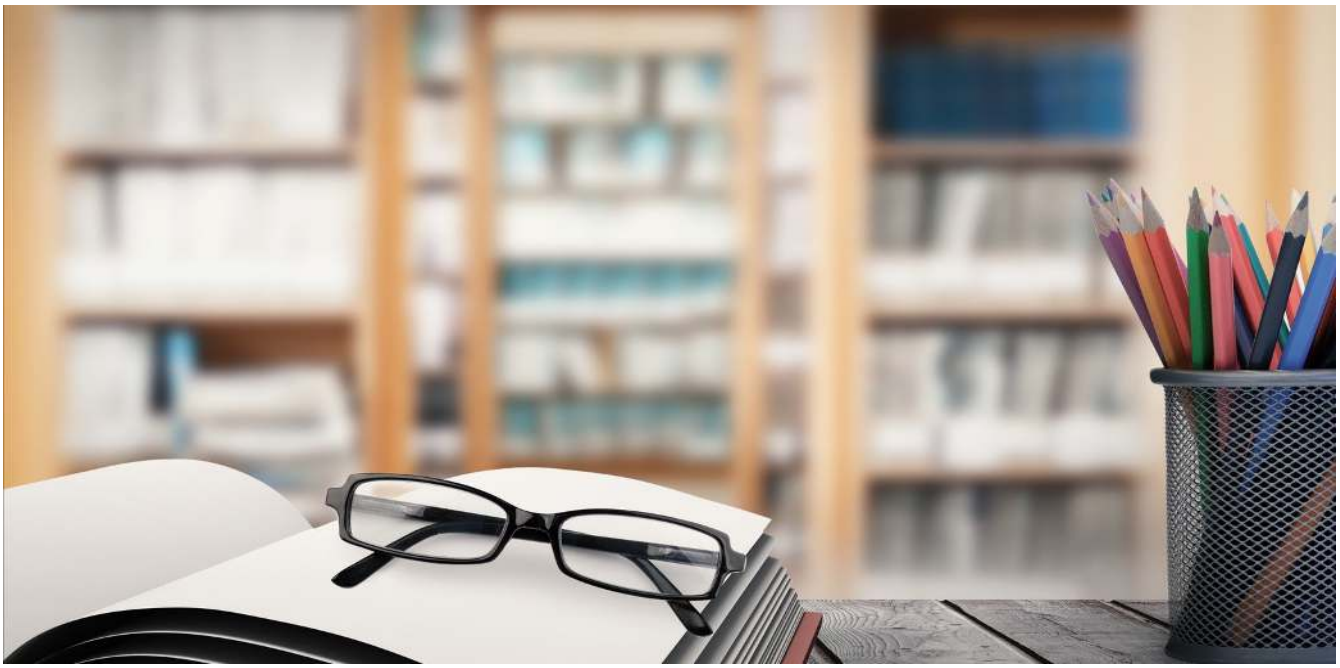
Participants reported that in many schools, providers are not comfortable having discussions about alcohol and drugs. Though they are accustomed to discussing students' medical problems, behavioral health issues like substance use require an investment of time and a willingness to delve into emotional issues. "*Getting the providers comfortable to do that,*" summarized one participant, "*is a big challenge.*"

Participants also reported that providers are often unsure of their ability to intervene when they identify students' substance use-related needs. "*Providers do not want to know because they don't believe that SBIRT's going to work, or they don't believe that whatever they're going to do is going be effective,*" explained one participant. Even behavioral health clinicians are often only prepared to address students' mental health needs, and are "*not trained, equipped, or interested in dealing with patients who have substance use issues.*" Until providers are assured that they "*have a model that works*" for addressing students' substance use-related needs, it will remain difficult to integrate SBIRT services into school settings.

Challenges Implementing SBIRT in School Settings (cont.)

3 Sustainability beyond grant funding

Participants reported significant challenges assuring that schools continue implementing SBIRT once grant or foundation support used to initiate SBIRT programs comes to an end. "*The piece that has been fundamentally missing,*" summarized one participant, "*is how do we sustain this?*" External funding often creates the perfect conditions for SBIRT implementation to succeed; it can provide for extra reimbursement, staffing, training, technical assistance, and fidelity monitoring. However, time-limited initiatives to implement SBIRT do not address the structural and financial barriers to SBIRT implementation that remain when external support ends. Schools often lack the staff needed to provide SBIRT services on an ongoing basis, and they are unable to bill third-party payers in order to make SBIRT financially sustainable. As one participant explained, while "*it's great to have a project person funded*" by grants or foundations, initiatives may "*go down in flames*" unless schools are able to devise plans to integrate SBIRT into their ongoing staffing and billing patterns. "*Sustainability*" another participant noted, "*does not mean 'let's find another grant.'*" Devising strategies to make SBIRT in school settings sustainable remains a significant challenge.



Helpful Strategies and Lessons Learned

Three main helpful strategies and lessons learned emerged from convening discussions: (1) implementing SBIRT as part of a larger health and wellness program; (2) tailoring SBIRT to the local setting; and (3) incorporating peers into prevention programs.

SBIRT as part of a larger health and wellness program

Many convening participants reported integrating SBIRT with services designed to address a variety of health, behavioral, and functional challenges adolescents face. SBIRT protocols are being blended with services designed to address medical conditions, sexual health, teen pregnancy, depression, trauma, and barriers to graduation in school settings across the country. Combining SBIRT with other services is logical, explained one participant, because "*the same kids*" face interrelated challenges in many of these areas. Thus rather than delivering services narrowly focused on substance use, participants reported integrating substance use services into broader "*wellness prescriptions*" designed to address whatever challenges are most pressing in students' lives.

Moreover, by melding SBIRT with other health and wellness promotion activities, providers who deliver SBIRT services are able to access funding streams other than those designated for SBIRT, thus enhancing its logistical and financial sustainability. "*If you're in a school-based health center, you can't SBIRT all day…that's not the only thing that needs to be done,*" elaborated one participant. "*There's other ways that these folks could be generating revenue for these school-based health centers.*"

Tailoring SBIRT to the local setting

Convening discussions highlighted the utility of adapting and designing SBIRT protocols in order to make them fit local contexts. "*Each campus we're at has different cultures and different administration and different issues that are going on,*" one participant explained. "*Figuring out that structure is really key*" to designing SBIRT protocols and planning their implementing in each school setting. Participants also emphasized the importance of ensuring that SBIRT fits in the broader vision of schools' broad, long-term goals. Thus it is critical, as one participant pointed out, to do "*visioning with the school*" to see "*what do they want… what kind of goals do [they] have for the kids on…campus,*" and tailoring SBIRT so it can help advance the school's broader aims for enhancing students' education and well-being.

Helpful Strategies and Lessons Learned (cont.)

Tailoring SBIRT to the local setting (cont.)

Similarly, participants noted that the preferences of students in different schools could vary. To gain an understanding of what students want, some participants reported eliciting input through focus groups and surveys, and utilizing students' perspectives to inform the design and implementation of their SBIRT programs. Informed by feedback, participants reported integrating discussions about substance use into health classes, and the creation of programs where young adults with lived experience with substance use and recovery serve as mentors for at-risk students. Furthermore, by incorporating student feedback into SBIRT programs, providers can make the messages they deliver to students about substance use and treatment more appropriate for each school's culture and context. "*You'd get messages that are very tailored to that school, and to some of the reasons why kids in that school… would be using*" explained one participant. Student feedback can provide invaluable insights into "*local nuances*" concerning language and norms that are needed to make SBIRT programs responsive to local needs, and ensure that messaging concerning substance use is linguistically and culturally appropriate for the school's population.

Incorporating peers into SBIRT

Participants reported that incorporating peers into substance use prevention programs can improve student buy-in and optimize their impact. Participants who elicited student input on school-based SBIRT explained how students said they wanted peers—individuals like them who may have had similar experiences with substance use and other life challenges—to be involved in designing and delivering substance use prevention services. Moreover, participants reported that students wanted to have a sense of ownership over the SBIRT program, and not simply leave the design and implementation of SBIRT to school staff. "*They want to be stakeholders in this process,*" explained one participant. "*They (students) would like to be the ones that actually take that torch and run with it.*"

Helpful Strategies and Lessons Learned (cont.)

Incorporating peers into SBIRT (cont.)

Furthermore, peer involvement in prevention activities can potentially make messages about substance use resonate with students in a powerful way. As one participant explained, students in peer-involved programs respond to messages about substance use prevention since they think that "*I can trust them because they get it…they're also from my community*." Participants with experience implementing peer-involved programs suggested that having student-run organizations that are already well established within school communities spearhead prevention efforts can be an effective way to introduce peer-involved substance use services into school settings.

By incorporating peers into the design and implementation of prevention services, schools can also potentially facilitate a broader culture change by empowering students to address challenges through self-help and mutual support. By "*instilling a framework and a structure and peers and a support network,*" explained one participant, "*whatever happens to them [students]—substance abuse, physical abuse, or otherwise…they know that there's this peer that they could talk to help alleviate their issue.*" To illustrate this point, one participant shared an aphorism pointing to the potential power of students organizing peer-run services:

> "*If you give me a fish, you have fed me for a day. If you teach me how to fish, then you have fed me until the river is contaminated or the shoreline is seized for development. But if you teach me to organize, then whatever the challenges, I can join together with my peers, and we will fashion our own solution.*"

Unanswered Questions

Convening discussions highlighted two major unanswered questions about the design and implementation of SBIRT services for adolescents in school settings; what SBIRT's place in the school community should be, and how to balance the needs for confidentiality and family involvement in activities related to substance use prevention.

SBIRT's place in the school community

Many participants believed that the implementation of SBIRT in school settings needs to involve the entire school community in order to have optimal impact. "*We can't just work like 'they're…the substance abuse providers, they'll take care of the drug part,'*" explained one participant. "*We all have to work in an integrated way and support each other*" in addressing the substance use related service needs of students. Thus, as another participant elaborated, "*everyone from the students to the parents to the administrators to the front desk person [needs to] feel comfortable with hearing things that are happening about substance use, and not have…a reflex or knee-jerk reaction*" of fear when hearing about alcohol and drugs. By incorporating everyone in the school environment into discussions about substance use, participants anticipated that they would be able to achieve a meaningful culture change, and help schools overcome the fear, stigma, and punitive attitudes that many educators and parents have concerning substance use.

Yet there are also difficulties inherent in making substance use prevention an activity that involves everyone in the school community. "*How do we make this something where it involves everybody,*" one participant asked, "*without overburdening everybody at the same time?*" Other participants reported experiences where involving the entire school community in SBIRT hampered implementation. Some reported that utilizing staff that provides other health and counseling services—such as guidance counselors, school psychologists, and school social workers—to deliver SBIRT services was problematic since students were uncomfortable discussing their substance use issues with individuals who were integrated into the regular school environment. "*We involve the broader school environment as little as possible,*" explained one participant, because "*they [students] very much see the school-based health center…as a safe place that's within the school but separate.*" Having "*that kind of boundary*" makes students much more comfortable discussing personal and potentially stigmatizing issues such as substance use.

However, cloistering SBIRT within clinical or "separate" spaces within schools can also cause problems. In particular, participants recognized the potential contradictions inherent in having clinics that provide SBIRT services when students disclose substance use while school policies mandate disciplinary measures. As one participant pointed out, it is a challenge to determine "*how [to] make sure that the two cultures of the clinic and the school are meshed together and work together, and not in competition with each other*."

Unanswered Questions (cont.)

Confidentiality and family involvement

Participants reported divergent approaches to balancing students' rights to keep their substance use behaviors and treatment private versus the parents' rights to know about their children's health and well-being. While all participants understood the importance of respecting students' privacy, they were unsure of when it is appropriate or necessary to "*break that confidentiality and talk with the parents.*" Discussions highlighted that if students have other severe health or mental health problems, it would be considered ethically necessary for providers to inform parents of the severity of their children's problems; yet with issues related to substance use, concerns over confidentiality make providers reluctant to share information with parents, even in the most severe or acute cases. Participants reported that even though there are minor consent laws in place that can be used to maintain the confidentiality of substance use services, many school administrators and providers remain confused about their obligations to share information with parents and guardians.

The question of when or how to notify family members that students are receiving services related to substance use is particularly pressing since family involvement in substance use services can potentially be beneficial or detrimental, depending on the circumstances. As some participants pointed out, family involvement in substance use services may be essential in some cases. "*Substance use with a young person doesn't exist in isolation*," explained one participant. "*You can't just work with a young person around their substance use, you've got to work with them as part of a broader construct*" that includes family life. Yet in other cases, family involvement could be detrimental, particularly if family members are misusing substances themselves or providing alcohol/drugs to their children. "*Parents can be our assets and can be our allies,*" pointed out one participant, "*but also, parents and families are sometimes the reason a lot of our youth are using (substances)…it could be harmful to bring them into the treatment.*" Moreover, family involvement could give students the impression that services are not truly confidential, and make them more reluctant to disclose their substance use behaviors. "*What I hear,*" explained one participant, "*is that if we go to the parents, we're going to lose the confidence of the kids. They're not going to come here.*"

Next Steps to Advance Adolescent SBIRT in School Settings

Based on convening discussions, future implementation and outcome research on adolescent SBIRT in school settings can advance the field by addressing the following areas:

Changing the culture around substance use and substance use prevention

Changing how both systems and individuals think about substance use and substance use prevention services is an essential step in facilitating SBIRT implementation and sustainment in school settings. Devising strategies to educate policymakers and administrators on the importance of treating substance use as a health issue rather than a disciplinary problem can help make school environments more conducive to SBIRT implementation; training providers in school settings about substance use and effective strategies to address it can overcome both the fear and discomfort providers have discussing issues related to substance use with students; and empowering students and families to think about substance use prevention as a way to enhance health and well-being can potentially impact attitudes towards alcohol and drug use, both within schools and in the community at large. By "*changing the culture and the climate*" around substance use, participants explained, SBIRT in school settings can help facilitate a broader shift in how society understands substance use and substance use prevention.

Devising strategies to improve SBIRT's sustainability in school settings

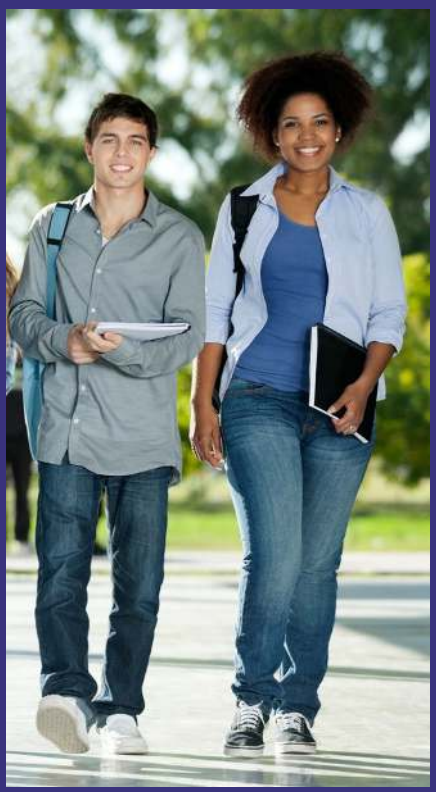
In spite of the benefits of grant and foundation support when starting adolescent SBIRT initiatives, it is essential to devise strategies to enhance SBIRT's logistical and financial sustainability. Tailoring SBIRT implementation to schools' administrative and staffing patterns and creating ways to make SBIRT services reimbursable by third-party payers will be essential in order to enhance school's capacities to deliver SBIRT on an ongoing basis.

Next Steps to Advance Adolescent SBIRT in School Settings (cont.)

Generating data that proves the benefits of SBIRT in school settings

Gathering and clearly communicating data on the benefits of school-based substance use prevention is critical if adolescent SBIRT is going to become truly integrated into the array of health and social services provided in educational settings. Information on the prevalence and consequences of substance use for local communities can illustrate to policymakers and administrators the importance of taking effective steps to address student alcohol and drug use. Participants also mentioned the importance of creating data that clearly illustrate the benefits of school-based SBIRT. As health insurers increasingly move towards value-based purchasing and reimbursement models, demonstrating measurable clinical impact or cost savings associated with school-based SBIRT will be essential if third-party payers are going to support it on an ongoing basis. Thus figuring out "*the mechanics of the nuts and bolts…within value-based purchasing*" and determining if SBIRT can lead to improvements according to measurable cost indicators will be essential to facilitate its long-term sustainability. Generating data that can help "*monetize*" the potential benefits of substance use prevention, therefore, is a critical step for the field.

Yet as several participants pointed out, it is challenging to prove that SBIRT for adolescents can achieve cost savings. "*If you're successful with prevention,*" noted one participant, "*nothing changes. How do you get money to make nothing happen?...you literally cannot put a price tag on it.*" Whereas SBIRT for adults has demonstrable health cost benefits given the proximal impact substance use has on adults' health service utilization,[28] the health service costs of adolescent substance use are often not evident until adulthood, making it difficult to document or prove adolescent SBIRT's short-term cost effectiveness.



Recognizing the challenge of proving adolescent SBIRT's health cost benefits, participants suggested that ongoing initiatives could potentially create data on the benefits of SBIRT on outcomes in other areas. By showing demonstrable impact on suspensions, expulsions, or dropouts associated with substance use, for example, SBIRT could garner support from school administrators. If SBIRT initiatives can "*budge the needle at all*" on adverse disciplinary and educational outcomes, participants suggested, schools could become interested in sustaining them as ways to improve social and educational outcomes.

Conclusion

Advancing the Future of SBIRT School-Based Settings

The innovative work being done by Hilton Foundation grantees will generate invaluable knowledge about how to implement and sustain SBIRT services in school settings. Grantees' experiences designing SBIRT procedures and protocols, integrating SBIRT into school environments, training school staff and students about substance use, and delivering substance abuse prevention and early intervention services will be instructive for schools across the country seeking to integrate SBIRT into the array of services they provide to their students. In addition, grantees' activities will create new evidence concerning the potential benefits of SBIRT in school settings, as well as a clearer understanding of what further research on substance abuse prevention and early intervention needs to focus on. Ultimately, this work will make significant contributions to the field of adolescent substance abuse prevention and early intervention, and in the process, advance the Hilton Foundation's broader goal of promoting health and wellness for the nation's youth.

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APPENDIX A

Meeting Participants and Adolescent SBIRT Activities

- Abt Associates, which is designing and implementing a monitoring, evaluation, and learning plan to evaluate the Hilton Foundation's Substance Abuse Strategic Initiative.
- American Public Health Association's Center for School, Health, and Education.
- Center for Adolescent Substance Abuse Research at the University of Minnesota, which is receiving support from the Hilton Foundation to conduct research on a SBIRT model that involves parents and is tailored for adolescents.
- CDC Foundation/Division of Adolescent and School Health, which is receiving support from the Hilton Foundation to implement SBIRT as part of a comprehensive regional SUD prevention and sexual risk behavior reduction program in Indiana, Kentucky, and Ohio.
- Children's Hospital Corporation, which is receiving support from the Hilton Foundation to conduct a research project validating outcome measures for youth SBIRT in primary care settings.
- Friends Research Institute, Inc., which has been conducting studies of SBIRT for adolescents for over seven years.
- Georgia Council on Substance Abuse, which is implementing SBIRT in schools in the Atlanta area.
- Interact for Health, a health foundation that is supporting several school-based SBIRT initiatives in the Cincinnati region.
- L.A. Trust, an organization that provides prevention and health linkage services for students in the Los Angeles Unified School District.
- Massachusetts Department of Public Health SBIRT, which supports schools across Massachusetts with SBIRT planning and implementation.
- Mosaic Group, which is receiving support from the Hilton Foundation to develop an adolescent SBIRT checklist to support effective SBIRT implementation.
- Treatment Research Institute, which is receiving support from the Hilton Foundation to enhance and expand the implementation and evaluation of SBIRT in four New York City metro area schools.
- University of California, Los Angeles, Integrated Substance Abuse Programs, which is receiving support from the Hilton Foundation to provide technical assistance and training to grantees and other stakeholders on SBIRT emerging research and best practices.
- University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions, which is receiving support from the Hilton Foundation to expand a SBIRT pilot project to school-based health clinics throughout the state of New Mexico.

APPENDIX B

Mitchell, S., Schwartz, R. P., & Gryczynski, J. (2016). Screening, Brief Intervention, and Referral to Treatment (SBIRT) in School-Based Health Settings. Presented February 24, 2016 at the Conrad N. Hilton Foundation.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) in School-Based Health Settings

Shannon Gwin Mitchell, Ph.D.
Robert P. Schwartz, M.D. & Jan Gryczynski, Ph.D.

Friends Research Institute, Inc.
Baltimore, Maryland, USA

Presented February 24, 2016 at the Conrad N. Hilton Foundation

Screening Brief Intervention Referral to Treatment

Research Overview

SBIRT

- A comprehensive, integrated, public health approach to the screening and identification of individuals engaged in risky alcohol and drug use, and the delivery of early brief interventions in order to reduce risky use
  - Recommended for adult alcohol use problems
    - US Preventive Health Task Force[1]
  - Recommended for adolescents using alcohol and other drugs
    - American Academy of Pediatrics[2]

[1] U.S. Preventive Services Task Force. May 2013. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care

[2] American Academy of Pediatrics (2012). Policy Statement: Substance use screening, brief intervention, and referral to treatment for pediatricians. Retrieved May 11, 2012 http://pediatrics.aappublications.org/content/128/5/e1330.full.html

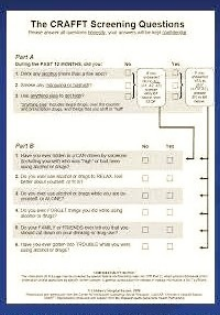
SAMHSA's SBIRT cooperative agreement emphasized:

- Early detection and intervention for at-risk alcohol and drug use
  - Find problematic use early and reduce it
  - Most empirical research focuses on S and/or BI
- Closing the treatment gap for alcohol and substance use disorders
  - Finding people in need of treatment using S, motivate treatment entry
  - Limited research focused on RT

Screening Brief Intervention Referral to Treatment

Adolescent Screening Instruments: CRAFFT[1]

- 3 pre-screening items
  - In the past 12 months did you: use alcohol, marijuana/hashish, anything else to get high
- Car (always asked)
- Relax
- Alone
- Forget
- Family/Friends
- Trouble



[1] Knight et al. (1999). A new brief screen for adolescent substance abuse. *Arch Pediatr Adolesc Med,153(6)*:591-596

APPENDIX B (cont.)

Adolescent Screening Instruments: ASSIST[1,2]

- Alcohol, Smoking, and Substance Involvement Screening Test
- Developed for the WHO to detect and manage substance use in primary/general medical settings
- Assesses use of 10 substances:
  - Ever used in life
  - Frequency of use in past 3 months
  - Urge to use past 3 months
- Recently validated with adolescents for tobacco, alcohol, and cannabis, but suggested lower risk score cut-offs compared to adults.[3]

[1] WHO ASSIST Working Group (2002). The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): development, reliability and feasibility. *Addiction, 97*(9): 1183-1194.
[2] Humeniuk et al. (2008). Validation of the Alcohol Smoking and Substance Involvement Screening Test (ASSIST). *Addiction 103*(6): 1039-1047.
[3] Gryczynski et al. (2015). Validation and performance of the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) among adolescent primary care patients. *Addiction, 110*(2): 240-247.

Adolescent Screening Instruments: BSTAD[1]

- Brief Screener for Tobacco, Alcohol, and other Drugs
- Based on NIAAA alcohol screener
- Screening questions: "Any use in the past year?"
  - 12-14 year olds asked about friends' use first, followed by personal use questions
  - Order reversed for 15-17 year olds (and 14 year olds in high school)
- If "Yes" to personal use of alcohol, drugs, or tobacco then asked about frequency of use in past 30, 90, and 365 days

[1] Kelly, et al. (2014). Validity of Brief Screening Instrument for Adolescent Tobacco, Alcohol, and Drug Use. *Pediatrics, 133*(5), 819-826.

Screening to Brief Intervention: S2BI[1]

- Based on NIDA quick screen
- Screening for use in the past year of 8 substances
  - Tobacco
  - Alcohol
  - Marijuana
  - Illegal drugs
  - Use of non-prescribed meds
  - Misuse of OTC meds
  - Inhalants
  - Herbs or synthetic drugs
- If "Yes" to any of the above, then asks:
  - Frequency of use in past year of identified substances
  - RAFFT questions (to assess problems)
  - 3 questions to assess binge drinking (from AUDIT)
  - 1 question about combining substances
  - Nicotine and cannabis use more than 2x day for 2 or more weeks
  - Use in past 30 days of other 5 substances

[1] Levy et al. (2014). An electronic screen for triaging adolescent substance use by risk levels. *JAMA Pediatrics, Sep 168*(9): 822-828.

Screening Considerations

- Different from "assessment"
  - Is there a problem and for what substance
- Universal *vs.* targeted approach
- Who does the screening
  - Self *vs.* interviewer administered
- How often
- What happens to positive screens
  - Something needs to happen in response

Screening
Brief Intervention
Referral to Treatment

Brief Intervention

- AAP = "…a screening outcome-responsive conversation that focuses on encouraging a patient to make healthy choices and personal behavior changes regarding risky activity such as substance use"[1]
- Usually includes[2]
  - Motivational Interviewing/enhancement
  - Patient-centered
  - Appropriate for developmental-age of patient
- Different from treatment

[1] American Academy of Pediatrics (2012). Policy Statement: Substance use screening, brief intervention, and referral to treatment for pediatricians. Retrieved May 11, 2012 http://pediatrics.aappublications.org/content/128/5/e1330.full.html
[2] Sterling et al. (2012). Integrating substance use treatment into adolescent healthcare. *Curr Psychiatry Rep, 14*(5), 453-461.

APPENDIX B (cont.)

Brief Intervention

- What constitutes "Brief"[1]
  - Minutes (emergency dept., primary care)
  - Sessions (school-based)
- Who conducts the BI[2]
  - Generalists (physicians, nurses, outreach workers, teachers)
  - Specialists (behavioral health experts)
  - Computer

[1] Mitchell et al. (2013). SBIRT for adolescent drug and alcohol use: Current status and future directions. *Journal of Substance Abuse Treatment, 44*, 463-472
[2] Mitchell et al. (2016). SBIRT Implementation for adolescents in urban federally qualified health centers. *Journal of Substance Abuse Treatment, 60*: 81-90.

Brief Intervention

- What do you expect to happen in response
  - Change in readiness
  - Reduction in use
  - Reduction in risks
  - Complete abstinence
    - Need to account for developmental changes with adolescents
- What happens afterwards
  - Follow-up appointment
  - Referral to Treatment
    - Positive screens may indicate further assessment is necessary
  - Screen again, and again, and again

Screening
Brief Intervention
Referral to Treatment

Referral to Treatment

- Limited research done on RT part of SBIRT
  - Direct referrals are more successful than indirect[1]
- Easier to do for adults than youth
- Easier to do for some substances, like alcohol, than others
- What kind of treatment do kids with drug use disorders need?

[1] D'Onofrio et al. (2010). Integrating Project ASSERT: A screening, intervention, and referral to treatment program for unhealthy alcohol and drug use into an urban emergency department. *Acad Emerg Med, 17*(8), 903-911

Adolescent SBIRT Settings[1]
(not including colleges)

- Hospital Emergency Departments
- Primary Care
- Schools
  - School based-health clinics
    - How to integrate it into larger school
- Other community sites

[1] Mitchell et al. (2013). SBIRT for adolescent drug and alcohol use: Current status and future directions. *Journal of Substance Abuse Treatment, 44*, 463-472

School-Based Health Center (SBHC) Overview

Physical and Mental Health

APPENDIX B (cont.)

School-Based Health Centers

- **Every child should receive high quality health care that is accessible, family-centered, culturally competent, coordinated, continuous, compassionate, and comprehensive.**
  - American Academy of Pediatrics[1]
- **Children without health insurance are less likely to access needed care than children with insurance[2]**

[1] Strickland et al. (2011). The medical home: Health care access and impact for children and youth in the United States. *Pediatrics, 127*(4), 604-611.
[2] Medical home access. (2015). Child and Adolescent Health Measurement Initiative, National Survey of Children's Health.

School-Based Health Centers

- Providing services for over 40 years[1]
  - Majority in urban settings
  - Only about 2,000 nationwide
- Located inside or on school grounds
- Most sponsored by local health care organization (CHC, hospital, health dept.)

[1] Keeton et al (2012). School-based health centers in an era of health care reform: Building on history. *Curr Probl Pediatr Adolesc Health Care*, 42(6): 132-158.

School-Based Health Centers

- Reduce transportation and scheduling barriers
- SBHCs can lead to improved:[1,2]
  - Access to medical and dental care
  - Health outcomes
  - School performance
  - Reduce emergency room visits and health care costs

[1] American Academy of Pediatrics, Council on School Health. (2012). School-based health centers and pediatric practice. *Pediatrics, 129*(2), 387-393.
[2] U.S. Department of Health & Human Services, Community Preventive Services Task Force. (2015). Promoting health equity through education programs and policies: School-Based Health Centers.

School-Based Health Centers

- Comprehensive health services
- Multidisciplinary team
  - Nurse practitioners, RNs, PAs, social workers, physicians, A&D counselors, others
- Integration within school community
- Parental consent

School-Based Health Centers

- Reasons for visiting SBHC[1]
  - 66% medical
  - 34% mental health
  - 21*x* more likely to access SBHC for behavioral health reasons than in a CHC

[1] Weinstein. (2006). School-based health centers and the primary care physician: An opportunity for collaborative care. *Primary Care*, 33, 305-315.

SBIRT in School-Based Health Centers

APPENDIX B (cont.)

School-Based Health Centers

- Comprehensive health services
  - Substance use screening as part of broader service mission
- Multidisciplinary team (Nurse practitioners, RNs, PAs, social workers, physicians, A&D counselors, others)
  - Creates opportunities for who provides S, BI, and RT (or T)
- Integration within school community
  - Waiting mode for screening or bridge to larger school
- Parental consent
  - Not always necessary for substance use services or treatment

Quasi-experimental studies of SBIRT in SBHCs

Attitudes, Perceptions, and Practice

- Harris et al (2015)[1]
  - Survey New York State SBHC program directors and clinicians in middle and high schools
  - 22% practiced SBIRT model
  - Less than 30% felt SBIRT could be effective at reducing substance use
  - 20-30% did not feel confident performing aspects of intervention

[1] Harris et al. (2015). Screening, brief intervention, and referral to treatment for adolescents: Attitudes, perceptions, and practice of new York school-based health center providers. *Substance Abuse, 16*, 1-7.

Brief Interventions in Schools

- Although not in SBHCs, studies suggest that providing substance use brief intervention in schools is feasible.[1]
- Brief intervention delivered by counselors in non-SBHC school settings have been found to be effective in randomized trials.[2,3]

[1] Curtis et al., (2014). Translating SBIRT to public school settings: An initial test of feasibility. *Journal of Substance Abuse Treatment, 46*: 15-21.
[2] Winters & Leitten (2007). Brief intervention for drug-abusing adolescents in a school setting. *Psychology of Addictive Behaviors, 21*(2):249-254.
[3] Winters et al. (2012). Brief intervention for drug abusing adolescents in a school setting: Outcomes and mediating factors. *Journal of Substance Abuse Treatment, 42*(3):279-288.

Services and Outcomes

SBIRT for substance use in a school-based program[1]

- Part of SAMHSA initiative in New Mexico
  - 2005-2008
- 13 school-based health clinics
- Masters level behavioral health counselors (BHC)
- Screened using CRAFFT
  - Direct referrals and universal screening

[1] Mitchell et al. (2012). SBIRT for substance use in a school-based program: Services and outcomes. *The American Journal on Addictions*, 21, S5-13.

Services and Outcomes (cont.)

- BI used motivational interviewing
- Brief treatment provided by BHC for those needing treatment
  - Promoting abstinence, engagement in pro-social activities, formation of +peer relationships, improving family relationships
- GPRA Questionnaire
  - Demographics and outcome data

APPENDIX B (cont.)

Services and Outcomes (cont.)

- 85% of those receiving SBIRT services got only a BI
  - Most (nearly 90%) received just one session
- 15% received BT or RT
  - Most (nearly 85%) received more than one session
- Of those screening positive
  - 32% reported using illicit drugs in past 30 days
    - 85% used marijuana only
  - 42% reported consuming alcohol in past 30 days
  - 37% reported drinking to intoxication in past 30 days

Services and Outcomes (cont.)

- Students who received an intervention (regardless of intensity) reported decreases in self-reported days of drinking
- Numerous methodological limitations
  - Possible regression to the mean
  - BHCs were also assessors
  - No control or comparison group

Effectiveness

Reducing Substance Use Among African American Adolescents[1]

- Surveyed 9th and 11th grade students from 7 public high schools in 2 waves
  - 3 schools with SBHCs and 4 without
- 598 SBHC students matched with 598 non-SBHC students
  - Ethnicity, gender, grade, health insurance status, # of parents and contextual variables

[1] Robinson et al. (2003). Reducing substance use among African American adolescents: Effectiveness of school-based health centers. *Clinical Psych: Science and Practice*, *10*(4), 491-504.

Effectiveness

- Assessments: Youth Risk Behavior Survey, demographic variables, General Functioning Scales, academic standing, Adolescent Social Stress Measure
- Grade x SBHC interactions for tobacco and marijuana
  - Cigarette use decreased in SBHC schools over time and increased in non-SBHC school
  - Marijuana use decreased in SBHC schools over time and increased in non-SBHC school
- No Grade x SBHC difference for alcohol use
- Importance of culturally and developmentally sensitive holistic care models
- What does having a SBHC on a school's campus indicate about the school?

Randomized trials of SBIRT in SBHCs

A randomized trial of SBIRT services in school-based health centers

Jan Gryczynski (PI)
Shannon Gwin Mitchell & Robert P. Schwartz (Co-Is)

Friends Research Institute, Inc.
Baltimore, Maryland, USA

NIDA 5R01DA034258-02

APPENDIX B (cont.)

A randomized trial of SBIRT services in school-based health centers

- Conducted at SBHCs embedded in two Baltimore City high schools
- Comparing nurse practitioner-delivered BI **(NBI)** *vs.* computer-delivered BI **(CBI)**
- Will also include a quasi-experimental comparison with an assessment-only cohort

Target Sample (*N*= 300)

Inclusion Criteria

- Age 14-18
- Past year alcohol or cannabis use
- CRAFFT score of 2 or higher

Exclusion Criteria

- Use of drugs other than alcohol or marijuana (may need more than BI; referred for additional assessment)
- Current enrollment in substance abuse treatment
- Pregnancy

Aims

1) Examine the comparative effectiveness of NBI *vs.* CBI on **substance use behaviors**
2) Examine the comparative effectiveness of NBI *vs.* CBI on **sex risk behaviors**
3) Conduct a focused cost-effectiveness analysis of NBI *vs.* CBI

Ongoing Implementation Research and Projects

Summary: SBIRT in SBHCs

- Good adolescent screening measures for use in health care settings
  - Put it in the EMR
  - Screen early and often
- Brief interventions can be adapted and implemented
  - MI is good fit for adolescents
- Diverse SBHC staff for BI delivery options
  - Also consider electronic BIs
- RT can be challenging
  - Is it always necessary?
  - Is behavioral health expertise already available in SBHC or larger school?

Thank you

Shannon Gwin Mitchell, Ph.D.
Senior Research Scientist
Friends Research Institute, Inc.
Baltimore, Maryland, USA
smitchell@friendsresearch.org

APPENDIX C

List of Resources

Information about SBHCs

School-Based Health Alliance: Redefining Health for Kids and Teens. 2013-14 digital census report. http://www.sbh4all.org/school-health-care/national-census-of-school-based-health-centers/

Screening, Brief Intervention, and Referral to Treatment (SBIRT) in School-Based Health Settings. Mitchell, S. D., et al., Friends Research Institute, Inc. Baltimore, MD.

Implementation Kit

Developing a Referral System for Sexual Health Services: An Implementation Kit for Education Agencies and its companion guide Establishing Organizational Partnerships to Increase Student Access to Sexual Health Services: http://www.caiglobal.co/j_con/index.php/referral-kit-download/referral-kit-download-2

School Connectedness and Parent Engagement

Fostering School Connectedness PPT: www.cdc.gov/healthyyouth/protective/pdf/connectedness_overview.ppt

Fostering School Connectedness – Staff Development Program: http://www.cdc.gov/healthyyouth/protective/pdf/connectedness_facilitator_guide.pdf

Parent Engagement Overview and Fact Sheets for School Districts and Administrators; Teachers and Other School Staff; and Parents and Families: http://www.cdc.gov/healthyyouth/protective/parent_engagement.htm

Parent Engagement – Strategies for Involving Parents in School Health: http://www.cdc.gov/healthyyouth/protective/pdf/parent_engagement_strategies.pdf

Promoting Parent Engagement in School Health – A Facilitator's Guide for Staff Development: http://www.cdc.gov/healthyyouth/protective/pdf/parentengagement_facilitator_guide.pdf

School Connectedness – Strategies for Increasing Protective Factors Among Youth: http://www.cdc.gov/healthyyouth/protective/pdf/connectedness.pdf

School Connectedness Fact Sheets for School Districts and Administrators; Teachers and Other School Staff; and Parents and Families: http://www.cdc.gov/healthyyouth/protective/school_connectedness.htm