Substance Use – Screening, Brief Intervention, Referral to Treatment

EQIPP Helping You Improve Care for Children Available on PediaLink

Potential Barriers and Suggested Ideas for Change

Key Activity: Screening for Substance Use

Rationale: Substance use among pediatric patients is common, identifiable, and treatable. Screening for substance use as part of routine health care can help identify and treat individuals whose patterns of substance use put their health at risk. The results of the screening can help providers develop a corresponding care plan. The SBIRT screening goal is to define the patient's experience with substance use along a spectrum ranging from abstinence to severe levels of use so that this information can be used to guide the next steps of the clinical approach, or intervention. Substance use may change over time, so physicians should be aware of the potential need to screen at every visit.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Patients ages 11–21 years of age are not screened for substance use using a recommended screening tool or within the recommended timeframe (annually at a minimum and as concerns arise).		
Clinicians and/or staff do not recognize the importance of routinely incorporating universal substance use screening into adolescent care visits.	• Recognize that screening for substance use is a necessary part of routine health care (at a minimum annually and as concerns arise) for patients ages 11–21 years to help identify and treat individuals who are putting their health and safety at risk by using substances. • Review and share with staff AAP recommendations that outline clinician responsibilities for substance use screening for pediatric patients: ✓ *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Performing Preventative Services: Adolescent Substance Use and Abuse.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017:141–144 Levy SH, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics.* 2016;138(1):e20161211; DOI: 10.1542/peds.2016-1211. Full report available at: https://doi.org/10.1542/peds.2016-1211. Accessed September 2, 2018 ✓	• Conduct lunch-and-learn sessions with staff to highlight: ✓ Data about the increasing concerns of substance use by children and adolescents in the United States, including mortality rates ✓ Patient and family member stories, which offer valuable insights that go beyond statistics and outcomes to inspire, humanize, and compel action ✓ Specific substance use gaining prevalence within the community
A recommended screening tool is not used to guide the assessment – perhaps because the clinician or staff informally asks patients about substance use or the practice does not know which screening tool to use.	• Select and implement a screening tool for the practice to guide assessment for substance use-related problems, as shown in Table 2 of the 2016 AAP clinical report. The tool should be developmentally appropriate, valid and reliable, and practical for use in busy medical offices. The screening tool combined with clinical judgment and additional assessments as needed helps physicians assess for potential substance use problems. At a minimum, the screening tool should identify substance use frequency and risk level. Also see example screening and assessment tools you may consider.	• Be aware that data has shown that relying on clinical impressions alone can result in the underestimation of substance use or failure to detect substance use disorders (SUDs). Review the article, Wilson CR, Sherritt L, Gates E, Knight JR. *Are clinical impressions of adolescent substance use accurate? Pediatrics.* 2004;114(5):e536–540

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
		Available at: www.pediatrics.org/cgi/content/ full/114/5/e536.
Clinician and staff have concerns about the amount of time substance use screening will take during patient visits.	• Brainstorm ways to administer screening effectively and efficiently within your office workflow. Clearly identify by whom, how, when, and where screening will take place. Ensure your plan for screening considers the following: ✓ Clear roles and responsibilities for all aspects of SBIRT – screening, brief intervention that includes education, referral to treatment. ✓ Patients' privacy and confidentiality of information, consistent with applicable law and as described in the Confidentiality Laws Tip Sheet shown in the Appendix. ✓ Full utilization of the skills of clinicians and staff. For example, in some practices, the workflow may include a handoff from the staff member responsible for screening to the physician equipped to conduct the brief intervention and/or referral to treatment. Education may also be provided and discussed by a trained staff member. • Consider adding brief prescreening questions to the overall health history questionnaire, which may be completed in the waiting room via a paper or tablet instrument. Then, administer the full screening in person to patients who screen positive on the brief, written prescreening questions.	• Increase the visit time allotted for patients in this age range so more time is available for substance use screening. • Consider doing a mock patient tracer, which traces the patient's experience of care through the health care delivery process to find the optimal workflow.
The age range for substance use screening within the practice does not systematically include patients as young as 11 years of age.	• Examine recent findings on the epidemiology of substance use and disorders among youth and adolescents by exploring the following: ✓ Substance Abuse and Mental Health Services (SAMHSA) provides descriptions of the most common substance use disorders in the United States. Available at: https://www.samhsa.gov/disorders/substance-use. ✓ Youth.gov provides detailed and up-to-date prevalence rates for alcohol, tobacco, and illicit drug use. Available at: https://youth.gov/youth-topics/substance-abuse/prevalence-substance-use-abuse-and-dependence. The Web site also provides links to other Web sites and data, including Monitoring the Future, the National Survey on Drug Use and Health (NSDUH), and Youth Risk Behavior Surveillance System (YRBSS). ✓ The National Institute on Drug Abuse Web site at www.drugabuse.gov/DrugPages/DrugsofAbuse.html provides information about specific drugs (including prescription medications that can be abused), commonly used names, and health effects.	• Recognize that neurodevelopment changes during adolescence confer vulnerability to addictions. Also, the age at first substance use is inversely correlated with the lifetime incidence of developing a substance use disorder.

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Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Patients decline to disclose their substance use.	• Normalize screening at a young age and introduce it even earlier to parents so that expectations for substance use screening are set early. • Introduce protection of patients' confidential health information as early as possible, eg, when the patient is first interviewed without a parent present as a preadolescent. (See example confidentiality letters for adolescents and families in the Appendix; Word versions are available on the Resources tab.) • Reassure patients that they are not being singled out. Explain that you interview all patients ages 11 and above privately, confidentially, and annually, at a minimum. Substance use and other topics that are of concern to them can be discussed without parents or other family members present. • Assess your office environment. The substance use interview should be conducted in a place where confidentiality can be ensured and where patients can feel comfortable, private, and secure. • Examine providers' attitudes and the manner in which they approach the issue. Are they comfortable? Do they put patients and families at ease?	• Have an open dialogue about why the patient does not want to disclose information. Acknowledge that the patient may not be ready to talk about substance use now and provide ways to share this information in the future if his or her mind changes. • Consult with other clinicians for ways to feel comfortable with substance use screening or your approach to substance use discussions. Consider a peer review of a role play scenario in which you screen a patient that is unwilling to share information. Incorporate peer feedback into your screening approach.
The practice's substance use screening is conducted at health supervision visits and some patients do not schedule visits annually.	• Recognize that every visit provides an opportunity for substance use screening and that substance use may change over time. Use sick visits to bridge the gap for annual health supervision visits that do not take place regularly. • Build flags for substance use screening into your electronic medical record (EMR) system to identify patients who are due for substance use screening and/or health supervision visits.	• Establish a recall/reminder system for patients who have not been screened for substance use in the past year.
Clinicians and/or staff do not know how to use the screening tool.	• Explore training curriculums, videos, role-play exercises and other resources for implementing SBIRT. Educate yourself and staff using the training materials that best fit your practice. Below are some sources to get started: ✓ SAMHSA Web site, which contains links to many organizations and training resources for SBIRT, including many state sites: Available at: https://www.integration.samhsa.gov/clinical-practice/sbirt/training-other-resources ✓ Addiction Technology Transfer Center (ATTC) Network Web site. attcnetwork.org/home/. Accessed September 2, 2018	• Collaborate with other pediatric practices and behavior health specialists for guidance on implementing substance use screening and incorporate suggestions into your practice. • Invite an expert from your AAP chapter or district or state department of addiction services to share successes with screening tools, demonstrate SBIRT techniques, and provide substance use screening role-play opportunities.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Clinicians have concerns about uncovering positive screens – perhaps due to legal concerns around confidentiality or lack of referral resources in the community.	• Explore legal resources concerning adolescent confidentiality such as the following: ✓ The Society for Adolescent Health and Medicine, American Academy of Pediatrics. Joint AAP-SAHM Policy: Confidentiality protections for adolescents and young adults in the health care billing and insurance claims process. *J Adolesc.* Health. 2016;58(3):374-377. Available at: https://www.jahonline.org/article/S1054-139X(15)00723-5/fulltext. Accessed September 2, 2018 ✓ Katz AL, Webb SA; Committee on Bioethics.Informed consent in decision-making in pediatric practice. 2016;138(2). Available at: http://pediatrics.aappublications.org/content/138/2/e20161485. Accessed September 2, 2018 ✓ State Advocacy Focus. Confidentiality for adolescents and young adults insured as dependents. AAP Web site. https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/AdolescentConfidentiality.pdf. Accessed September 2, 2018 Center for Adolescent Health Law. Consent & confidentiality protection. CAH&L Web site. http://www.cahl.org/publications/consent-confidentiality-protection/. Accessed September 2, 2018 ✓ Confidentiality for Individuals Insured as Dependents: a Review of State Laws and Policies, available at: www.guttmacher.org/pubs/confidentiality-review.pdf • Help adolescents understand their rights to privacy. See privacy information for teens available at Healthy Children.org: Information for teens: what you need to know about privacy. Healthy Children Web site. https://www.healthychildren.org/English/ages-stages/teen/Pages/Information-for-Teens-What-You-Need-to-Know-About-Privacy.aspx. Accessed September 2, 2018 • Utilize substance use and mental health services outside the community: ✓ Substance Abuse and Mental Health Services (SAMHSA) National Helpline, 1-800-662-HELP, provides free, confidential 24/7 treatment and referral and information services in English and Spanish for individuals and families facing substance use disorders.	• Reach out to adolescent medicine providers and/or your AAP chapter for local advocacy and treatment resources and legal aid. It is important to have a list of resources in place before screening.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	✓ SAMHSA Web site available at https://www.samhsa.gov/, which includes a treatment services locator. ✓ Your state and county resources as well as remote resources in other states.	
Gap: Patients' substance use frequency and risk level are not assessed and documented.		
The screening tool used by the practice does not identify substance use frequency and risk level.	• As described in row 2 of this grid, select and implement a recommended screening tool to guide assessment for substance use-related problems. At a minimum, the screening tool combined with clinical judgment and additional assessments as needed should identify the patient's frequency of substance use and risk level. • Conduct Plan, Do, Study Act (PDSA) cycles using different tools to see which yields the most useful information and fits into your practice's workflow.	• Collaborate with other pediatric practices and behavioral health specialists about screening tools that might work well with your patient population.
Staff is unclear about documentation processes for substance use screening.	• Evaluate your EMR to be sure it is set up to accommodate SBIRT documentation for **all** the following: ☐ Screening result, including abstinence or frequency and risk level ☐ Brief intervention conversation that ensued ☐ Educational materials provided ☐ Behavior change goals, if set ☐ Follow-up plan ☐ Recall/reminder alerts to verify those referred have established care or follow-up • Define clear roles and responsibilities for documentation that considers whether there are handoffs for screening, brief intervention, and referral to treatment. Assign a point person to ensure all SBIRT activities are documented for every patient.	• Audit substance use screening documentation periodically. Brainstorm reasons for lack of documentation with staff and strategize ways to overcome them. • Formalize documentation processes that consider patient confidentiality in a written policy/procedure document and ensure staff is properly trained on them.

Appendix

Recommended Substance Use Screening and Assessment Tools

The substance use screening tool should be developmentally appropriate, valid, and reliable, and practical for use in a busy medical office. The best screening tools contain the lowest number of succinct, validated questions that can elicit accurate and reliable responses. At a minimum, the screening tool combined with clinical judgment and additional assessments as needed should help identify the patient's frequency of substance use and risk level. Table 2 of the 2016 AAP clinical report for substance use lists adolescent screening and assessment tools to consider:

TABLE 2 Substance Use Screening and Assessment Tools Used With Adolescents

	Description
Brief screens	
S2BI (Screening to Brief Intervention)[38]	Single frequency-of-use question per substance Identifies the likelihood of a DSM-5 SUD Includes tobacco, alcohol, marijuana, and other/illicit drug use Discriminates among no use, no SUD, moderate SUD, and severe SUD Electronic medical record compatible Self- or interviewer-administered
BSTAD (Brief Screener for Tobacco, Alcohol, and Other Drugs)[37]	Identifies problematic tobacco, alcohol, and marijuana use Built on the NIAAA screening tool with added tobacco and "drug" questions Electronic medical record compatible Self- or interviewer-administered
NIAAA Youth Alcohol Screen (Youth Guide)[36]	Two-question alcohol screen Screens for friends' use and for personal use in children and adolescents aged ≥9 y Free resource: http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf
Brief assessment guides	
CRAFFT (Car, Relax, Alone, Friends/Family, Forget, Trouble)[40]	Quickly assesses for problems associated with substance use Not a diagnostic tool
GAIN (Global Appraisal of Individual Needs)[41]	Assesses for both SUDs and mental health disorders
AUDIT (Alcohol Use Disorders Identification Test)[42]	Assesses for risky drinking Not a diagnostic tool

Adapted with permission from American Academy of Pediatrics; Levy S, Bagley S. Substance use: initial approach in primary care. In: Adam HM, Foy JM, eds. Signs and Symptoms in Pediatrics. Elk Grove Village, IL: American Academy of Pediatrics; 2015:887–900. DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; NIAAA, National Institute on Alcohol Abuse and Alcoholism.

Source: Levy SH, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics*. 2016;138(1):e20161211; DOI: 10.1542/peds.2016-1211. Full report available at: https://doi.org/10.1542/peds.2016-1211. Accessed September 2, 2018

Example Substance Use Screening and Assessment Tool(s)

Following are the S2B1 and CRAFFT screening tools with scoring interpretations:

TABLE 3 S2BI Screen for Substance Use Risk Level

The following questions will ask about your use, if any, of alcohol, tobacco, and other drugs. Please answer every question by clicking on 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 the following questions.

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

Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?
- -Never
- -Once or twice
- -Monthly
- -Weekly or more

Illegal drugs (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

Levy SH, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics*. 2016;138(1):e20161211; DOI: 10.1542/peds.2016-1211. Full report available at: https://doi.org/10.1542/peds.2016-1211. Accessed September 2, 2018

S2BI Interpretation

Score	Substance Use Disorder (SUD)	BI Goals
No use of any substance	**None**	Positive reinforcement and encouragement to delay initiation.
Once or twice use of any substance	**None**	Brief advice to encourage cessation.
Monthly use of any substance	**Mild-moderate SUD**	Brief motivational intervention to encourage cessation or reduce use.
Weekly or greater use of any substance	**Severe SUD**	Brief motivational intervention to reduce use or risk behaviors AND accept referral to treatment. Adolescents with nicotine, alcohol or opioid addiction may also benefit from medications.

Source: Levy S, Weiss R, Sherritt L, et al. An electronic screen for triaging adolescent substance use by risk levels. *JAMA Pediatrics*. 2014;168(9):822–828

Example Screening Tools – Continued

The CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) screening tool asks a series of 6 questions to screen adolescents for high-risk alcohol and other drug use disorders simultaneously. It begins with 3 opening questions: During the past 12 months, did you:

1. Drink any alcohol (more than a few sips)?
2. Smoke any marijuana or hashish?
3. Use anything else to get high?

Using the tool as an assessment to explore "yes" responses and to reveal the extent of the patient's substance use-related problems may be more effective for gathering details for use in SBIRT intervention. If Yes is answered in Part A, it is necessary to ask questions to determine the frequency of substance use **and** to ask all 6 questions in Part B.

The CRAFFT tool and interpretation are shown on the next page.

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Box 1. The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use *anything else* to *get high*? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions in Part B**

Part B

	No	**Yes**
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX,** feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

Source: Knight J, Roberts T, Gabrielli, Hook SV. Adolescent alcohol and substance use and abuse. In the *Performing Preventative Services: A Bright Futures Handbook.* Elk Grove Village, IL: American Academy of Pediatrics; 2017:3

CRAFFT Interpretation		
Stage	**Description**	**BI Goals**
Abstinence	The time before an individual has ever used drugs or alcohol more than a few sips.	Provide positive reinforcement and education for making a healthy choice.
Substance use without a disorder	Limited use, generally in social situations, without related problems. Typically, use occurs at predictable times, such as on weekends.	Provide counseling regarding medical harms of substance use and advise to stop.
Mild to moderate substance use disorder (SUD)	Use in high-risk situations, such as when driving or with strangers. Use associated with a problem, such as a fight, arrest, or school suspension. Use for emotional regulation, such as to relieve stress or depression. Defined as meeting 2 to 5 of the 11 criteria for an SUD in the DSM-5.	Explore patient-perceived problems with use. Provide counseling regarding medical harms of substance use. Negotiate a behavior change to quit or reduce use. Set a follow-up date to reassess and check progress. Consider the need to break confidentiality if there is a risk of harm or other immediate attention is warranted.
Severe SUD	Loss of control or compulsive drug use associated with neurologic changes in the reward system of the brain. Defined as meeting ≥6 of the 11 criteria for an SUD in the DSM-5.	Refer to the appropriate level of care, involving parents in treatment planning if possible. Follow up to ensure compliance. Confidentiality may need to be broken; consider negotiating how this will happen.

Substance Use Frequency and Risk Level

Screening combined with clinical judgement and additional assessments as needed helps physicians assess for potential substance use problems. The problem or severity of substance use may be measured in a variety of ways, but for purposes of consistency for this EQIPP project, it is defined by risk level, which is measured by:

1. Frequency of use; and/or
2. CRAFFT score

Frequency identifies how often the substance has been used in the prior year; a recent research study[1] correlated frequency of use with the risk level for having a substance use disorder (SUD). Thus, if using the **S2BI** screening tool or other tool that considers frequency, risk level is expressed as follows:

FREQUENCY (in prior year)	RISK LEVEL
0 or never	None, no current risk for SUD
Once or twice	None, no current risk for SUD
Monthly or more	Mild to moderate risk for SUD
Weekly or more frequent	Severe risk for SUD

If using the **CRAFFT** tool first as a screener and then as an assessment tool to explore "yes" responses and to reveal the extent of the patient's substance use-related problems, risk level may broadly be expressed as follows (not intended as a complete CRAFFT scoring/interpretation guide):

CRAFFT SCORE	RISK LEVEL
0	None, no current risk for SUD
CRAFFT score <2	Mild risk for SUD
CRAFFT score 3–4	Moderate risk for SUD
CRAFFT score ≥5	Severe risk for SUD

Note: Current recommendations focus on measuring frequency of substance use. Therefore, when using the CRAFFT tool, it is recommended that the clinical interview also identifies the frequency of use. This combined information of frequency and risk level can contribute to decisions regarding next steps for patient care, namely, continued conversation concerning safety/anticipatory guidance issues and behavior change managed in the medical home or referral for more specialized substance use evaluation, intervention, and/or treatment.

For Your Reference

Recall that screening helps identify individuals at risk or with a substance use problem; it does ***not*** diagnose a SUD. However, to better understand SUDs, note that a DSM-5 diagnosis categorizes SUDs according to how many criteria were identified:

- Mild SUD = 2 or 3 DSM-5 SUD criteria met
- Moderate SUD = 4 or 5 DSM-5 SUD criteria met
- Severe SUD = 6 or more DSM-5 SUD criteria met

The criteria for substance use disorders summarized next are described fully on pages 483–484 of the *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition*.[2] These criteria can be considered to fit within overall groupings of impaired control, social impairment, risky use, and pharmacological criteria.

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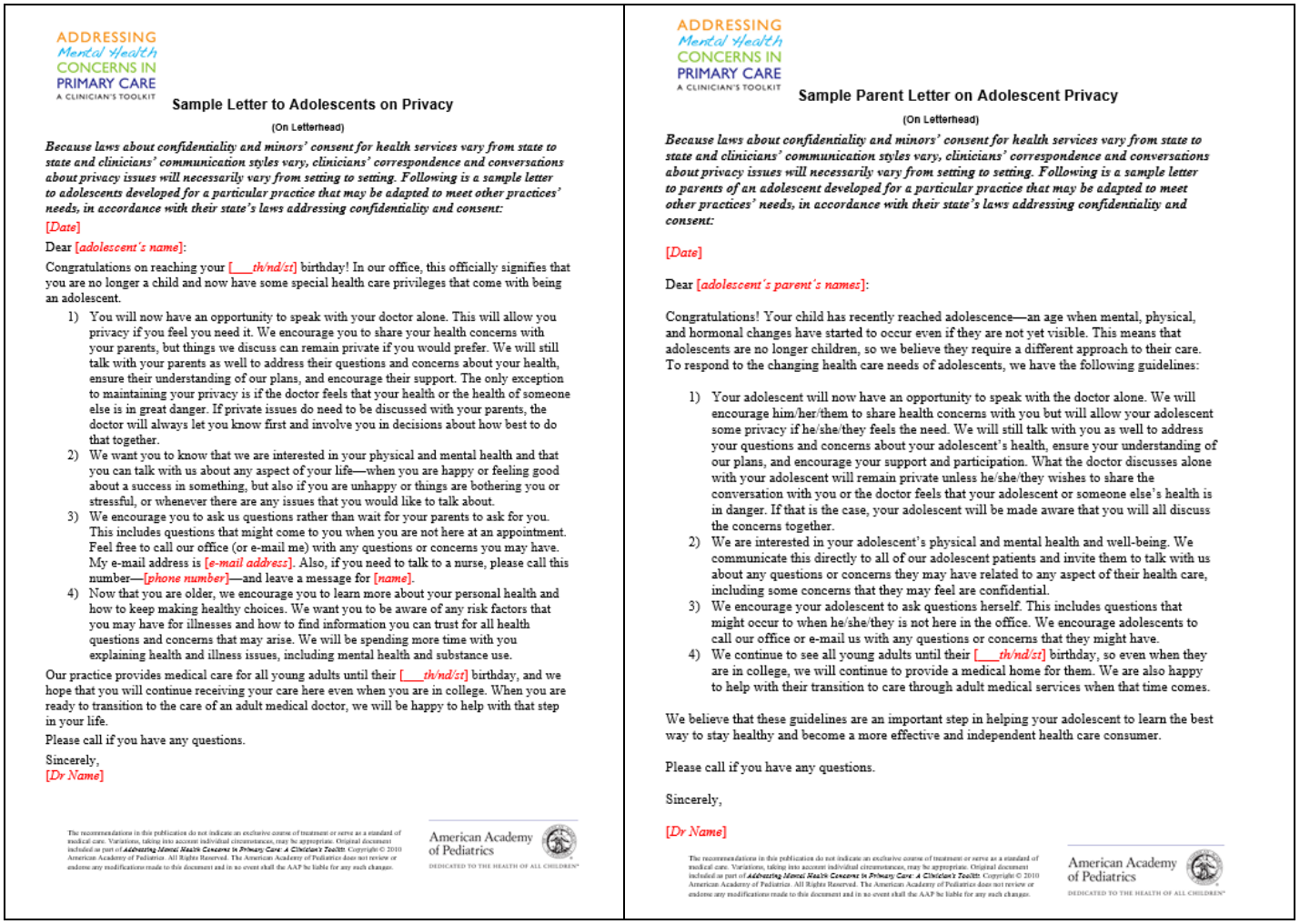
Criteria for Substance Use Disorders	
Impaired Control	1. Using the substance in larger amounts or for a longer period than originally intended
	2. Wanting to cut down or stop using the substance but not being able to
	3. Spending a lot of time obtaining, using, or recovering from use of the substance
	4. Having cravings and urges to use the substance
Social Impairment	5. Failure to fulfill major role obligations at work, home, or school because of substance use
	6. Continuing to use, even when it causes problems in relationships
	7. Giving up or reducing important social, occupational, or recreational activities because of substance use
Risky Use	8. Using substances again and again, even when it puts the individual in danger
	9. Continuing to use, even when a physical or psychological problem could have been caused or made worse by the substance
Pharmacological Criteria	10. Needing more of the substance to get the desired effect (tolerance)
	11. Developing withdrawal symptoms, which can be relieved by taking more of the substance

[1]Levy S, Weiss R, Sherritt L, et al. An electronic screen for triaging adolescent substance use by risk levels. *JAMA Pediatr.* 2014;168(9):822–828
[2]*Diagnostic and Statistical Manual of Mental Disorders: DSM-5.* 5th ed. Washington, DC: American Psychiatric Association; 2013

Click here to view Substance Use Frequency and Risk Level in a Word document or locate it on the Resources tab.

Example Confidentiality Letters

Below are letters containing example confidentiality statements for adolescents and families.



ADDRESSING Mental Health CONCERNS IN PRIMARY CARE
A CLINICIAN'S TOOLKIT

Sample Letter to Adolescents on Privacy

(On Letterhead)

Because laws about confidentiality and minors' consent for health services vary from state to state and clinicians' communication styles vary, clinicians' correspondence and conversations about privacy issues will necessarily vary from setting to setting. Following is a sample letter to adolescents developed for a particular practice that may be adapted to meet other practices' needs, in accordance with their state's laws addressing confidentiality and consent:

[Date]

Dear *[adolescent's name]*:

Congratulations on reaching your *[___th/nd/st]* birthday! In our office, this officially signifies that you are no longer a child and now have some special health care privileges that come with being an adolescent.

1) You will now have an opportunity to speak with your doctor alone. This will allow you privacy if you feel you need it. We encourage you to share your health concerns with your parents, but things we discuss can remain private if you would prefer. We will still talk with your parents as well to address their questions and concerns about your health, ensure their understanding of our plans, and encourage their support. The only exception to maintaining your privacy is if the doctor feels that your health or the health of someone else is in great danger. If private issues do need to be discussed with your parents, the doctor will always let you know first and involve you in decisions about how best to do that together.
2) We want you to know that we are interested in your physical and mental health and that you can talk with us about any aspect of your life—when you are happy or feeling good about a success in something, but also if you are unhappy or things are bothering you or stressful, or whenever there are any issues that you would like to talk about.
3) We encourage you to ask us questions rather than wait for your parents to ask for you. This includes questions that might come to you when you are not here at an appointment. Feel free to call our office (or e-mail me) with any questions or concerns you may have. My e-mail address is *[e-mail address]*. Also, if you need to talk to a nurse, please call this number—*[phone number]*—and leave a message for *[name]*.
4) Now that you are older, we encourage you to learn more about your personal health and how to keep making healthy choices. We want you to be aware of any risk factors that you may have for illnesses and how to find information you can trust for all health questions and concerns that may arise. We will be spending more time with you explaining health and illness issues, including mental health and substance use.

Our practice provides medical care for all young adults until their *[___th/nd/st]* birthday, and we hope that you will continue receiving your care here even when you are in college. When you are ready to transition to the care of an adult medical doctor, we will be happy to help with that step in your life.

Please call if you have any questions.

Sincerely,
[Dr Name]

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

ADDRESSING Mental Health CONCERNS IN PRIMARY CARE
A CLINICIAN'S TOOLKIT

Sample Parent Letter on Adolescent Privacy

(On Letterhead)

Because laws about confidentiality and minors' consent for health services vary from state to state and clinicians' communication styles vary, clinicians' correspondence and conversations about privacy issues will necessarily vary from setting to setting. Following is a sample letter to parents of an adolescent developed for a particular practice that may be adapted to meet other practices' needs, in accordance with their state's laws addressing confidentiality and consent:

[Date]

Dear *[adolescent's parent's names]*:

Congratulations! Your child has recently reached adolescence—an age when mental, physical, and hormonal changes have started to occur even if they are not yet visible. This means that adolescents are no longer children, so we believe they require a different approach to their care. To respond to the changing health care needs of adolescents, we have the following guidelines:

1) Your adolescent will now have an opportunity to speak with the doctor alone. We will encourage him/her/them to share health concerns with you but will allow your adolescent some privacy if he/she/they feels the need. We will still talk with you as well to address your questions and concerns about your adolescent's health, ensure your understanding of our plans, and encourage your support and participation. What the doctor discusses alone with your adolescent will remain private unless he/she/they wishes to share the conversation with you or the doctor feels that your adolescent or someone else's health is in danger. If that is the case, your adolescent will be made aware that you will all discuss the concerns together.
2) We are interested in your adolescent's physical and mental health and well-being. We communicate this directly to all of our adolescent patients and invite them to talk with us about any questions or concerns they may have related to any aspect of their health care, including some concerns that they may feel are confidential.
3) We encourage your adolescent to ask questions herself. This includes questions that might occur to when he/she/they is not here in the office. We encourage adolescents to call our office or e-mail us with any questions or concerns that they might have.
4) We continue to see all young adults until their *[___th/nd/st]* birthday, so even when they are in college, we will continue to provide a medical home for them. We are also happy to help with their transition to care through adult medical services when that time comes.

We believe that these guidelines are an important step in helping your adolescent to learn the best way to stay healthy and become a more effective and independent health care consumer.

Please call if you have any questions.

Sincerely,

[Dr Name]

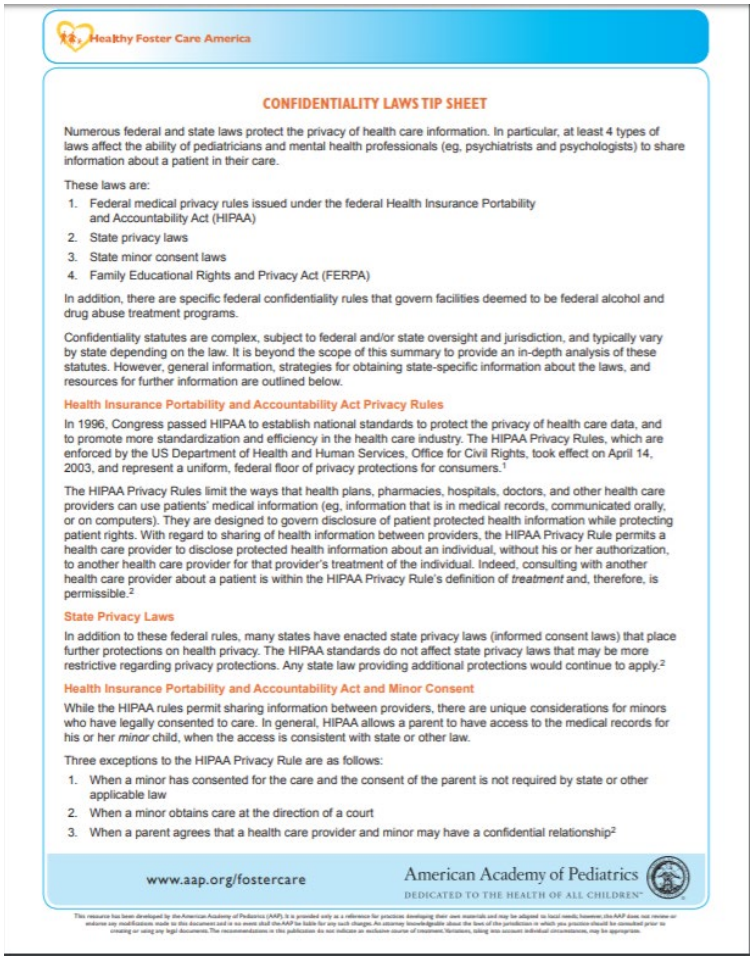
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Courtesy of AAP Mental Health Initiatives.

Click here for customizable Word versions of these letters or locate them on the Resources tab:

- Sample Letter to Adolescents for Privacy
- Sample Parent Letter on Adolescent Privacy

Confidentiality Laws Tip Sheet



Healthy Foster Care America

CONFIDENTIALITY LAWS TIP SHEET

Numerous federal and state laws protect the privacy of health care information. In particular, at least 4 types of laws affect the ability of pediatricians and mental health professionals (eg, psychiatrists and psychologists) to share information about a patient in their care.

These laws are:

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

In addition, there are specific federal confidentiality rules that govern facilities deemed to be federal alcohol and drug abuse treatment programs.

Confidentiality statutes are complex, subject to federal and/or state oversight and jurisdiction, and typically vary by state depending on the law. It is beyond the scope of this summary to provide an in-depth analysis of these statutes. However, general information, strategies for obtaining state-specific information about the laws, and resources for further information are outlined below.

Health Insurance Portability and Accountability Act Privacy Rules

In 1996, Congress passed HIPAA to establish national standards to protect the privacy of health care data, and to promote more standardization and efficiency in the health care industry. The HIPAA Privacy Rules, which are enforced by the US Department of Health and Human Services, Office for Civil Rights, took effect on April 14, 2003, and represent a uniform, federal floor of privacy protections for consumers.[1]

The HIPAA Privacy Rules limit the ways that health plans, pharmacies, hospitals, doctors, and other health care providers can use patients' medical information (eg, information that is in medical records, communicated orally, or on computers). They are designed to govern disclosure of patient protected health information while protecting patient rights. With regard to sharing of health information between providers, the HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without his or her authorization, to another health care provider for that provider's treatment of the individual. Indeed, consulting with another health care provider about a patient is within the HIPAA Privacy Rule's definition of *treatment* and, therefore, is permissible.[2]

State Privacy Laws

In addition to these federal rules, many states have enacted state privacy laws (informed consent laws) that place further protections on health privacy. The HIPAA standards do not affect state privacy laws that may be more restrictive regarding privacy protections. Any state law providing additional protections would continue to apply.[2]

Health Insurance Portability and Accountability Act and Minor Consent

While the HIPAA rules permit sharing information between providers, there are unique considerations for minors who have legally consented to care. In general, HIPAA allows a parent to have access to the medical records for his or her *minor* child, when the access is consistent with state or other law.

Three exceptions to the HIPAA Privacy Rule are as follows:

1. When a minor has consented for the care and the consent of the parent is not required by state or other applicable law
2. When a minor obtains care at the direction of a court
3. When a parent agrees that a health care provider and minor may have a confidential relationship[2]

www.aap.org/fostercare

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Courtesy of: AAP Healthy Foster Care America. Full sheet available at: Confidentiality Laws Tip Sheet. American Academy of Pediatrics Web site. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Confidentiality_Laws.pdf. Accessed September 1,2018

Potential Barriers and Suggested Ideas for Change

Key Activity: Brief Intervention (BI)

Rationale: Brief interventions encourage healthy choices so that the risk behaviors can be prevented, reduced, or stopped. Current literature supports the effectiveness of: 1) providing positive reinforcement for making the smart and healthy decision to abstain from substance use, or 2) providing clear direction and motivation to stop or reduce substance use due to the negative health and safety effects of use.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Effective brief intervention conversations tailored to the patient's frequency of substance use and/or risk level do not occur.		
The frequency and risk level for patients' substance use is not assessed or not documented in the medical record.	• Select and implement a recommended screening tool for the practice to guide assessment for substance use-related problems, as shown in Table 2 of the 2016 AAP clinical report on substance use. The tool should be developmentally appropriate, valid, reliable, and practical for use in busy medical offices. At a minimum, the screening tool combined with clinical judgment and additional assessments as needed should identify the patient's frequency of substance use and risk level. Also, see examples of screening and assessment tools you may consider. • Recognize the necessity of assessing the patient's level of substance use to develop an effective treatment plan. • Evaluate your EMR to be sure it is set up to accommodate SBIRT documentation for **all** the following: ✓ Screening result, including abstinence or frequency and risk level ✓ Brief intervention conversation that ensued ✓ Educational materials provided ✓ Behavior change goals, if set ✓ Follow-up plan ✓ Recall/reminder alerts to verify established care or follow-up • Define clear roles and responsibilities for documentation. Assign a point person to ensure all SBIRT activities are documented for every patient.	• Review the 2016 AAP clinical report on substance use, which outlines clinicians' responsibilities to screen for substance use as part of routine health care (at a minimum, annually and as concerns arise) for patients ages 11–21 years to help identify and treat individuals whose patterns of substance use put their health and safety at risk.
Clinicians have not been trained in SBIRT or do not feel comfortable with BI.	• Ensure that clinicians are familiar with Screening, Brief Intervention and Referral to Treatment (SBIRT) techniques. Explore training curriculums, videos, role-play exercises, and other resources for implementing SBIRT. (The SAMHSA Web site is a good place to start. It contains links to many organizations and training	• Collaborate with other pediatric practices and behavior health specialists for guidance on implementing substance use

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	resources for SBIRT, including many state sites: Available at: https://www.integration.samhsa.gov/clinical-practice/sbirt/training-other-resources.) Educate yourself and staff using the training materials that best fit your practice. • Explore SBIRT educational opportunities available on the Addiction Technology Transfer Center Network (ATTC) Web site. The ATTC Web site houses a calendar of events and a national registry of certified SBIRT trainers. • Provide opportunities to demonstrate confidence in SBIRT techniques, such as role play exercises.	screening and incorporate suggestions into your practice. • Invite an expert from the AAP chapter or district to demonstrate proper SBIRT techniques and provide BI role-play opportunities. • Engage a SBIRT or motivational interviewing champion to train, coach, and encourage clinicians in best practices.
A BI takes place when patients' frequency and risk level indicate a problem, but not when patients report no substance use or that they tried alcohol or marijuana once or twice.	• Recall that the goal of substance use screening is to encourage healthy choices so that the risk behaviors are prevented, reduced, or stopped. Therefore, a BI should be provided for every screening result. Simply put, every screening response gets a response. • Be prepared to match the goal of the BI to the spectrum of substance use, including no substance use or experimental use. ✓ Provide positive reinforcement to patients who make smart decisions and healthy choices when no substance use is reported. This encourages the continued delay of alcohol or substance use. ✓ Deliver clear messages about the risks of any substance use. Although it is common for youth and adolescents to try psychoactive substances, it is important to not condone or trivialize this experimentation. ✓ Be aware that substance use can change over time. Arm the patient with information to prevent future risk. ✓ Equip the patient with information that ensures the patient's personal safety or that can help a friend or family member in need.	• Invite an expert from the AAP chapter or district to demonstrate proper SBIRT techniques and provide BI role-play opportunities.
Patients or families tune out when providers give advice about substance use.	• Employ Motivational Interviewing (MI) techniques to deliver BI and throughout the SBIRT intervention. Explore information about MI from the following sources: ✓ Video clip available from the Motivational Interviewing Network of Trainers (MINT) at http://motivationalinterviewing.org/. ✓ *Pediatrics in Review* article, Promoting healthy behaviors in pediatrics, and related video clip which describes how to apply MI to support behavioral change in pediatric patients. Available at: http://pedsinreview.aappublications.org/content/33/9/e57.	• Consider MI training if additional skills practice is necessary. Note that MI can be useful in a variety of clinical scenarios—not just substance use—especially those that require behavior change. • Review the MI Reminder Card (Am I Doing This Right?) available at:

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	✓ Videos on motivational interviewing and substance use intervention available on the AAP Mental Health Initiatives Web page, available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/implementing_mental_health_priorities_in_practice.aspx. ✓ Review the MI materials available at www.mioceania.org, formed by the local members of the Motivational Interviewing Network of Trainers (MINT).	https://www.centerforebp.case.edu/client-files/pdf/miremindercard.pdf from the Center for Evidence-Based Practices at Case Western Reserve University. This quick guide contains 11 questions to build self-awareness about your attitudes, thoughts, and communication style as you conduct your work. It helps keep attention centered on the people you serve while encouraging their motivation to change.
There is no place in the medical record to document BI conversations and outcomes.	• Ensure that your EMR is set up to fully accommodate SBIRT documentation, including BI conversations as described in row 1 of this grid. • Define clear roles and responsibilities for documentation that considers whether there are handoffs from screening to BI and referral to treatment as described in row 1 of this grid.	• Audit your substance use screening documentation periodically. Brainstorm reasons for lack of documentation with staff and strategize ways to overcome them.
Gap: Educational materials tailored to the reported substance use are not given and/or discussed. *(Examples include substance use prevention or materials and resources tailored to the reported substance use.)*		
The practice does not have educational materials readily available to provide to patients/families.	• Locate or develop general and substance-specific educational materials suitable for the age, health literacy, language, and culture of your patient/family population. Materials should identify the benefits of reducing or stopping substance use and point out the harm of continued use. Consider the following sources: ○ The Resources tab of this EQIPP course. ○ The AAP substance use page for teens available at healthychildren.org in English or Spanish. • Make print-based or links to educational materials readily available for patients and families. Consider providing access to materials in the waiting room, examination rooms, and on your patient portal, where they can be accessed 24/7.	• Consult other pediatric practices and behavioral health/substance use specialists in your area about materials they use and evaluate them for your patient population. • Collaborate with the AAP chapter or district for suggested materials.

Substance Use – Screening, Brief Intervention, Referral to Treatment

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Educational materials are given, but not discussed.	• Determine the reason educational materials are not discussed. If due to lack of time: ○ Recognize the severe, costly consequences of failing to provide substance use risk and prevention education. ○ Schedule a follow-up visit or phone call to discuss substance use specifically. ○ Share visit responsibilities with trained staff members. For example, there may be a handoff from the physician who conducted the brief intervention to a nurse or physician's assistant equipped to provide resources and education. If due to concern about reimbursement: ○ Ensure the most appropriate billing strategy is used (ie, time-based or complexity-based billing) to adequately capture the services rendered. Get AAP involved. Complete the AAP's Hassle Factor Form (include link) to provide examples of reimbursement concerns so that that AAP can help with advocacy. Resolution for the Annual Leadership Forum (ALF) If due to lack of documentation: ○ Consult with staff to determine reason that materials were discussed, but not documented. Brainstorm suggestions to resolve and incorporate new and promising ideas into practice. ○ Develop scripted EMR phrases that can be used by staff to efficiently document common services. ○ Ensure that staff recognizes that services provided but not documented may not have been done and cannot be reimbursed.	• Use patient stories to create a "burning platform" to express the importance of substance use prevention and intervention efforts • Consult your AAP chapter or district for solutions regarding unresolved billing/reimbursement issues. Also visit: www.samhsa.gov/sbirt/coding-reimbursement for information on coding guidelines for SBIRT reimbursement.
The health literacy, language, and cultural barriers that affect the patient and family's comfort level in sharing sensitive information or engaging in treatment are not addressed.	• Consider the needs of your patient population with an emphasis on understanding and anticipating the health literacy, language, and cultural differences that may impact the assessment or treatment process. Brainstorm ways to ensure that clinical procedures are explained and educational materials are written to meet those needs. Implement new ideas that result from brainstorming session and reassess until the literacy, language, and cultural needs of your patient population are met. • Consider adding a patient or family member to your team to ensure that your patient population's perspective is included in your improvement efforts. • Assure clinicians and staff that using scientific language rather than slang terms is preferred. (There is no need to stay up to date with the latest terminology.)	• Engage community stakeholder groups to better understand and incorporate their perspective. • Review strength-based family materials such as those found on the Center for the Study of Social Policy Web site on the Young Children & Their Families tab.

Substance Use – Screening, Brief Intervention, Referral to Treatment

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Behavior change goals for patients with mild, moderate, or severe substance use are not set or do not include a specific plan for follow-up.		
Clinicians do not feel adequately trained to lead behavior change goal discussions with patients. Rather, they refer patients to allied behavior health or substance use professionals.	• Explore training curriculums, videos, and other resources for SBIRT and motivational interviewing as previously described in this grid. Apply techniques gleaned from these materials to role-play exercises, and when comfortable, to patients. • Develop relationships with allied behavior health professionals who can provide guidance and coaching on leading discussions with patients on setting behavioral change goals. • Use the Change Plan Worksheet to facilitate behavioral change goal discussions, while asking the patient to put their goal in writing. The worksheet helps formalize the desired change and bring clarity to it by putting measurable tasks, timeframes, and specifics around actions.	• Invite a SBIRT champion from your AAP chapter or district to demonstrate SBIRT techniques for setting behavior change goals and to provide role-play opportunities for clinicians and staff.
Patients decline to set behavior change goals.	• Begin by earning the patient's trust and establishing the bounds confidentiality. • Help patients identify the benefits of reducing or stopping substance use and the harm of continued use. Motivation increases as goals and consequences are envisioned. • Recognize that resistance is an expected part of the process of change. Attempt to meet resistance with empathy and avoid confrontation. • Offer different options for change to maximize the feeling of control over his or her own treatment. • Recognize that motivation is a dynamic state that can fluctuate over time and in relation to different situations. • Emphasize that the responsibility for change lies with the patient but that you would like to help if given the chance. Make it clear that you are available to discuss substance use at any time on request. • Ask, *"Will you at least agree to think about what I've said and come back again?"* Schedule a follow-up visit in a few weeks to facilitate the discussion.	• Consider the CRAFFT tool, which uses responses as a bridge to further dialogue. Asking about reasons for use and risks/problems associated with use heightens the patient's awareness of the severity of the problem and leads to discussing the patient's plans for avoiding such problems in the future. • Consider your approach to the goal-setting process. A helping alliance with the patient can be more effective than a confrontational or directive approach. • Use MI techniques to identify a line in the sand. For example say, "*I agree that we don't need to involve your parents at this point, but what could happen for that to change?"*

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Patients do not meet goals.	• Anticipate that not all patients will achieve goals. Help the patient explore what worked well and what did not work well, with the goal of increasing motivation to change. Ongoing follow-up is important as it helps establish trust and rapport. • Recognize that patients who are unable to meet behavior change goals may require referral to specialized services.	• Consider an in-service with a substance use professional to discuss how these conversations can be managed.
The need to establish a specific follow-up plan for patients who set behavior change goals is overlooked or its importance is not recognized.	• Recognize that establishing feasible, short-term goals is an important step in behavior change for the following reasons: ○ Follow up in the medical home after setting behavior change goals helps support the change process. ○ Determining if the patient's risk behaviors have changed will inform the treatment plan. ○ Patients who meet goals can benefit from positive reinforcement; those who do not meet goals may benefit from more extensive counseling by an allied mental health professional. • Apply the full cycle of assessment, intervention, and reassessment to understand if the intervention is working.	• Practice goal-setting using a brief role play to support practitioners to feel more comfortable with this skill.

Appendix

Recommended Substance Use Screening and Assessment Tools

The substance use screening tool should be developmentally appropriate, valid, reliable, and practical for use in a busy medical office. The best screening tools contain the lowest number of succinct validated questions that can elicit accurate and reliable responses. At a minimum, the screening tool combined with clinical judgment and additional assessments as needed should help identify the patient's frequency of substance use and risk level. Table 2 of the 2016 AAP clinical report for substance use lists adolescent screening and assessment tools to consider:

TABLE 2 Substance Use Screening and Assessment Tools Used With Adolescents

	Description
Brief screens	
S2BI (Screening to Brief Intervention)[38]	Single frequency-of-use question per substance Identifies the likelihood of a DSM-5 SUD Includes tobacco, alcohol, marijuana, and other/illicit drug use Discriminates among no use, no SUD, moderate SUD, and severe SUD Electronic medical record compatible Self- or interviewer-administered
BSTAD (Brief Screener for Tobacco, Alcohol, and Other Drugs)[37]	Identifies problematic tobacco, alcohol, and marijuana use Built on the NIAAA screening tool with added tobacco and "drug" questions Electronic medical record compatible Self- or interviewer-administered
NIAAA Youth Alcohol Screen (Youth Guide)[36]	Two-question alcohol screen Screens for friends' use and for personal use in children and adolescents aged ≥9 y Free resource: http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf
Brief assessment guides	
CRAFFT (Car, Relax, Alone, Friends/Family, Forget, Trouble)[40]	Quickly assesses for problems associated with substance use Not a diagnostic tool
GAIN (Global Appraisal of Individual Needs)[41]	Assesses for both SUDs and mental health disorders
AUDIT (Alcohol Use Disorders Identification Test)[42]	Assesses for risky drinking Not a diagnostic tool

Adapted with permission from American Academy of Pediatrics; Levy S, Bagley S. Substance use: initial approach in primary care. In: Adam HM, Foy JM, eds. Signs and Symptoms in Pediatrics. Elk Grove Village, IL: American Academy of Pediatrics; 2015:887–900. DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; NIAAA, National Institute on Alcohol Abuse and Alcoholism.

Source: Levy SH, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics*. 2016;138(1):e20161211; DOI: 10.1542/peds.2016-1211. Full report available at: https://doi.org/10.1542/peds.2016-1211. Accessed September 2, 2018

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Example Substance Use Screening and Assessment Tool(s)

Following are the S2B1 and CRAFFT screening tools with scoring interpretations:

TABLE 3 S2BI Screen for Substance Use Risk Level

The following questions will ask about your use, if any, of alcohol, tobacco, and other drugs. Please answer every question by clicking on 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 the following questions.

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

Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?
- -Never
- -Once or twice
- -Monthly
- -Weekly or more

Illegal drugs (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

Levy SH, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics.* 2016;138(1):e20161211; DOI: 10.1542/peds.2016-1211. Full report

S2BI Interpretation

Score	Substance Use Disorder (SUD)	BI Goals
No use of any substance	**None**	Positive reinforcement and encouragement to delay initiation
Once or twice use of any substance	**None**	Brief advice to encourage cessation
Monthly use of any substance	**Mild-moderate SUD**	Brief motivational intervention to encourage cessation or reduce use
Weekly or greater use of any substance	**Severe SUD**	Brief motivational intervention to reduce use or risk behaviors AND accept referral to treatment Adolescents with nicotine, alcohol, or opioid addiction may also benefit from medications

Source: Levy S, Weiss R, Sherritt L, et al. An electronic screen for triaging adolescent substance use by risk levels. *JAMA Pediatr*. 2014;168(9):822–828

available at: https://doi.org/10.1542/peds.2016-1211. Accessed September 2, 2018

Example Screening Tools – Continued

The CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) screening tool asks a series of 6 questions to screen adolescents for high-risk alcohol and other drug use disorders simultaneously. It begins with 3 opening questions: During the past 12 months, did you:

1. Drink any alcohol (more than a few sips)?
2. Smoke any marijuana or hashish?
3. Use anything else to get high?

Using the tool as an assessment to explore "yes" responses and to reveal the extent of the patient's substance use-related problems may be more effective for gathering details for use in SBIRT intervention. If Yes is answered in Part A, it is necessary to ask questions to determine the frequency of substance use **and** to ask all 6 questions in Part B.

The CRAFFT tool and interpretation are shown on the next page.

Substance Use – Screening, Brief Intervention, Referral to Treatment

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Box 1. The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use *anything else* to *get high*? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions in Part B**

Part B

	No	**Yes**
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX,** feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

Source: Knight J, Roberts T, Gabrielli, Hook SV. Adolescent alcohol and substance use and abuse. In the *Performing Preventative Services: A Bright Futures Handbook.* Elk Grove Village, IL: American Academy of Pediatrics; 2017:3

CRAFFT Interpretation		
Stage	**Description**	**BI Goals**
Abstinence	The time before an individual has ever used drugs or alcohol more than a few sips.	Provide positive reinforcement and education for making a healthy choice.
Substance use without a disorder	Limited use, generally in social situations, without related problems. Typically, use occurs at predictable times, such as on weekends.	Provide counseling regarding medical harm of substance use and advise to stop.
Mild to moderate substance use disorder (SUD)	Use in high-risk situations, such as when driving or with strangers. Use associated with a problem, such as a fight, arrest, or school suspension. Use for emotional regulation, such as to relieve stress or depression. Defined as meeting 2 to 5 of the 11 criteria for an SUD in the DSM-5.	Explore patient-perceived problems with use. Provide counseling regarding medical harm of substance use. Negotiate a behavior change to quit or reduce use. Set a follow-up date to reassess and check progress. Consider the need to break confidentiality if there is a risk of harm or other immediate attention is warranted.
Severe SUD	Loss of control or compulsive drug use associated with neurologic changes in the reward system of the brain. Defined as meeting ≥6 of the 11 criteria for an SUD in the DSM-5.	Refer to the appropriate level of care, involving parents in treatment planning if possible. Follow up to ensure compliance. Confidentiality may need to be broken; consider negotiating how this will happen.

Substance Use Frequency and Risk Level

Screening combined with clinical judgement and additional assessments as needed helps physicians assess for potential substance use problems. The problem or severity of substance use may be measured in a variety of ways, but for purposes of consistency for this EQIPP project, it is defined by risk level, which is measured by:

1. Frequency of use; and/or
2. CRAFFT score

Frequency identifies how often the substance has been used in the prior year; a recent research study[1] correlated frequency of use with the risk level for having a substance use disorder (SUD). Thus, if using the **S2BI** screening tool or other tool that considers frequency, risk level is expressed as follows:

FREQUENCY (in prior year)	RISK LEVEL
0 or never	None, no current risk for SUD
Once or twice	None, no current risk for SUD
Monthly or more	Mild to moderate risk for SUD
Weekly or more frequent	Severe risk for SUD

If using the **CRAFFT** tool first as a screener and then as an assessment tool to explore "yes" responses and to reveal the extent of the patient's substance use-related problems, risk level may broadly be expressed as follows (not intended as a complete CRAFFT scoring/interpretation guide):

CRAFFT SCORE	RISK LEVEL
0	None, no current risk for SUD
CRAFFT score <2	Mild risk for SUD
CRAFFT score 3–4	Moderate risk for SUD
CRAFFT score ≥5	Severe risk for SUD

Note: Current recommendations focus on measuring frequency of substance use. Therefore, when using the CRAFFT tool, it is recommended that the clinical interview also identifies the frequency of use. This combined information of frequency and risk level can contribute to decisions regarding next steps for patient care, namely, continued conversation concerning safety/anticipatory guidance issues and behavior change managed in the medical home or referral for more specialized substance use evaluation, intervention, and/or treatment.

For Your Reference

Recall that screening helps identify individuals at risk or with a substance use problem; it does ***not*** diagnose a SUD. However, to better understand SUDs, note that a DSM-5 diagnosis categorizes SUDs according to how many criteria were identified:

- Mild SUD = 2 or 3 DSM-5 SUD criteria met
- Moderate SUD = 4 or 5 DSM-5 SUD criteria met
- Severe SUD = 6 or more DSM-5 SUD criteria met

The criteria for substance use disorders summarized below are described fully on pages 483–484 of the *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition.*[2] These criteria can be considered to fit within overall groupings of impaired control, social impairment, risky use, and pharmacological criteria.

Substance Use – Screening, Brief Intervention, Referral to Treatment

Criteria for Substance Use Disorders	
Impaired Control	12. Using the substance in larger amounts or for a longer period than originally intended
	13. Wanting to cut down or stop using the substance but not being able to
	14. Spending a lot of time obtaining, using, or recovering from use of the substance
	15. Having cravings and urges to use the substance
Social Impairment	16. Failure to fulfill major role obligations at work, home, or school because of substance use
	17. Continuing to use, even when it causes problems in relationships
	18. Giving up or reducing important social, occupational, or recreational activities because of substance use
Risky Use	19. Using substances again and again, even when it puts the individual in danger
	20. Continuing to use, even when a physical or psychological problem could have been caused or made worse by the substance
Pharmacological Criteria	21. Needing more of the substance to get the desired effect (tolerance)
	22. Developing withdrawal symptoms, which can be relieved by taking more of the substance

[1]Levy S, Weiss R, Sherritt L, et al. An electronic screen for triaging adolescent substance use by risk levels. *JAMA Pediatr*. 2014;168(9):822–828
[2]*Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 5th ed. Washington, DC: American Psychiatric Association; 2013

Click here to view Substance Use Frequency and Risk Level in a Word document or locate it on the Resources tab.

BI Spectrum of Use and Goals

Brief intervention (BI) is a conversation that focuses on encouraging healthy choices so that the risk behaviors are prevented, reduced, or stopped. In the context of SBIRT, regardless of which screening tool is used, a BI follows as a direct response to the reported substance use frequency and risk level. The following table outlines the spectrum of use and goals for BI.

TABLE 1 Substance Use Spectrum and Goals for BI

Stage	Description	BI Goals
Abstinence	The time before an individual has ever used drugs or alcohol more than a few sips.	Prevent or delay initiation of substance use through positive reinforcement and patient/parent education.
Substance use without a disorder	Limited use, generally in social situations, without related problems. Typically, use occurs at predictable times, such as on weekends.	Advise to stop. Provide counseling regarding the medical harms of substance use. Promote patient strengths.
Mild–moderate SUD	Use in high-risk situations, such as when driving or with strangers. Use associated with a problem, such as a fight, arrest, or school suspension. Use for emotional regulation, such as to relieve stress or depression. Defined as meeting 2 to 5 of the 11 criteria for an SUD in the DSM-5.	Brief assessment to explore patient-perceived problems associated with use. Give clear, brief advice to quit. Provide counseling regarding the medical harms of substance use. Negotiate a behavior change to quit or cut down. Close patient follow-up. Consider referral to SUD treatment. Consider breaking confidentiality.
Severe SUD	Loss of control or compulsive drug use associated with neurologic changes in the reward system of the brain. Defined as meeting ≥6 of the 11 criteria for an SUD in the DSM-5.	As above. Involve parents in treatment planning whenever possible. Refer to the appropriate level of care. Follow up to ensure compliance with treatment and to offer continued support.

DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.*

Source: Levy SH, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics.* 2016;138(1):e20161211; DOI: 10.1542/peds.2016-1211. Full report available at: https://doi.org/10.1542/peds.2016-1211. Accessed September 2, 2018

Sample Change Plan Worksheet
The changes I want to make (or continue making) are:
The reasons I want to make these changes are:
The steps I will take to change are:
The people who can help me and the ways they can help are: *Who* *How* _____ _____ _____ _____ _____ _____
I will know that my plan is working if:
Some things that could interfere with my plan are:
What I will do if the plan isn't working:
As my doctor, you can help me keep these changes by:

Click here for a customizable Word version of Sample Change Plan Worksheet or locate in on the Resources tab.

Potential Barriers and Suggested Ideas for Change

Key Activity: Referral to Treatment

Rationale: Patients with reported moderate to severe substance use who have indicated an inability to generate and commit to behavior change goals, and/or have significant psychiatric or medical comorbidities should ideally receive more intensive, specialized evaluation and care.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: A recommendation for specialized substance use evaluation, intervention, and/or treatment is not made for patients who reported moderate to severe substance use.		
The practice does not know where to refer patients for more extensive substance use evaluation, intervention, and/or treatment.	*If the reason is not knowing the types of therapeutic care for treatment of substance use disorders:* • See the American Society of Addiction Medicine (ASAM) levels of care for treatment of substance use, which outlines the broad levels of treatment options on a continuum and associated intensity of services. • Review the 2015 *Introduction to The ASAM Criteria for Patients and Families* available from ASAMcriteria@asam.org. The ASAM Criteria is a collection of objective guidelines that give clinicians a way to standardize treatment planning and where patients are placed in treatment, as well as how to provide continuing, integrated care and ongoing service planning. *If the reason is due to a lack of locating substance use health services in the community or forming relationships with them:* • Use resources such as the following to create a directory for substance use specialized health services for your practice and put a plan in place to ensure it is kept up-to-date. ✓ The Substance Abuse and Mental Health Services Association (SAMHSA) Web site available at https://www.samhsa.gov/ maintains a comprehensive substance use treatment physician listing and treatment facility locater. ✓ The Partnership for Drug-Free Kids Web site available https://drugfree.org/, including a community partner resource portal. ✓ Addiction Resource Hub at https://www.facingaddiction.org. ✓ State and county Department of Human Services Web sites.	• Consult the following places to obtain treatment referral resources: ✓ The AAP chapter or district ✓ Other pediatric practices in the area ✓ Local schools ✓ State or county health department • Advocate with your clinic or system to have behavioral health clinician(s) onsite if case volume warrants it. • Explore telehealth options that enable allied providers to consult with patients remotely. • Take advantage of state Psychiatric Consultation services, if available. • Provide Web-based psychoeducational services for families while they await locating an appropriate treatment option: ✓ https://drugfree.org

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	✓ 2-1-1, sponsored by United Way, provides state-specific emergency resources including addiction counseling and crisis intervention hotlines. Available at http://www.211.org/. *If the reason is due to a lack of substance use providers or treatment programs/facilities in the area:* • Utilize substance use and mental health services outside the community: ✓ The SAMHSA Web site noted above, which includes a National Helpline, 1-800-662-HELP, provides free, confidential 24/7 treatment and referral and information services in English and Spanish for individuals and families facing substance use disorders. ✓ State and county resources. ✓ Remote resources in other states. • Ask the family or case manager to contact the payer to help locate in-network resources. *If the reason is the patient needs medication-based treatment for opioid use disorder, but there is no place to refer them:* • Physicians, advanced practice nurses, and physician assistants can receive training and obtain a waiver to prescribe buprenorphine for the treatment of opioid use disorder. Available free at: ✓ http://www.aap.org/mat for AAP members (login required) ✓ https://pcssnow.org/education-training/mat-training/ for nonmembers • Become familiar with the AAP policy statement, Medication-Assisted Treatment of Adolescents with Opioid Use Disorders. Available at: https://doi.org/10.1542/peds.2016-1893.	✓ https://teens.drugabuse.gov ✓ https://addictionresource.com/parents-and-educators • Complete the Medication Assisted Treatment (MAT) training using the resources described in the middle column of this row.
The patient and/or family are unwilling to pursue a recommendation for appropriate services.	• Create a judgement-free environment for all conversations. Attempt to meet resistance with empathy and avoid confrontation. • Respect patient autonomy and perception. Individual patients have varying insight into their substance use disorder, which can be true of any illness and, in part, be a function of developmental status. • Use motivational interviewing techniques to encourage the patient and family to accept more intensive treatment with specialized services.	• Direct families to review materials available on the Partnership for Drug-Free Kids Web site, available at: https://drugfree.org/.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

	• Attempt to uncover underlying reasons for declining the recommendation. For example:
	  ○ *I don't want my peers, neighbors, or family members to know.*
	  ○ *I can't miss any more school, work, activities, or events.*
	  ○ *I don't like the stigma of needing mental health services.*
	  ○ *I don't want the diagnosis in our insurance history…it will label us for life.*
	  ○ *This can't be happening. I'm a good a person. We come from a good family.*
	  ○ *History is repeating itself. The father/mother has substance use problems too.*
	  ○ *I can't put anything more on my plate right now…it's overloaded.*
	• Recognize that many areas of an adolescent's life may need to be evaluated and addressed at the same time as the substance use treatment (eg, trauma, sleep, anxiety, depression, and family system issues). Use motivational interviewing skills to help patients and families explore these issues and offer different treatment options (ie, mental health, which may be a more affordable and acceptable first step) to promote increased motivation to change.
	• Help the patient and family overcome barriers to treatment.
	• Offer different treatment options to maximize ownership of the patient's own treatment.
	• Recognize that motivation for change is dynamic and can change over time and in response to different situations. Listen for "change talk" – statements that suggest commitment to making behavior changes. Reinforce these comments with support and encouragement.
	• Emphasize that the motivation for change lies with the patient but that you would like to help if given the chance. Make it clear that you are available to discuss substance use at any time on request. Ask, *"Will you at least think about the recommendation I made and agree to talk again?"* Consider setting a follow-up date to reassess use and willingness to engage in behavior change.
	• Consider instances where Child Protective Service involvement or emergency evaluations may be necessary to curtail associated harm.
	
	If the patient/family accepts the recommendation:	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Provide assurance of your continued involvement of general medical care and support of collaborative care. • Set feedback expectations with the referring behavioral health service. See the example referral and feedback form in the Appendix. • Apply the full cycle of assessment, intervention, and reassessment to understand if the intervention is working. Schedule a follow-up appointment with the patient in a few weeks or as indicated.	
Treatment is not covered by insurance or is not affordable.	• Explore mental health coverage options through Medicaid and private insurance, including an appeal on coverage decisions. • Locate a sliding scale clinic whose fee is adjusted according to need. • Seek services offered by the state or local community health department. • Ask the family or case manager to contact the payer to help find in-network services. • Explore services made available through the Families First Prevention Services Act, if applicable. This legislation provides federal reimbursement for mental health services, substance use treatment, and in-home parenting skill training.	• Consider a lower level of care services such as psychoeducation and brief interventions to assist patient and family in reducing harm. As appropriate, address related issues through mental health/therapy services, which may be a more acceptable and affordable first step. • Refer to the Mental Health Parity and Addiction Equity Act (MHPAEA) to help support the patient in advocating for insurance coverage. • Contact your AAP chapter or the National Alliance on Mental Illness (NAMI) chapter or affiliate for information on the types of programs and supports available. Also communicate with them, along with your state legislators, concerning advocacy issues.
The patient previously did not respond to treatment.	• Recognize that every person is different. Anticipate that some patients will not respond to a specific treatment approach or therapist and alternative sites/options may be necessary. At any time when meeting the needs of the adolescent's substance use, the problem is outside the scope of care that can be provided by the pediatric medical home, a referral to specialty care and treatment program is appropriate and necessary.	• Help patients and families gain realistic expectations of treatment. Explain that 30 days in treatment seldom cures the patient of the disorder and that effective treatment is a journey that requires long-term work. Help them

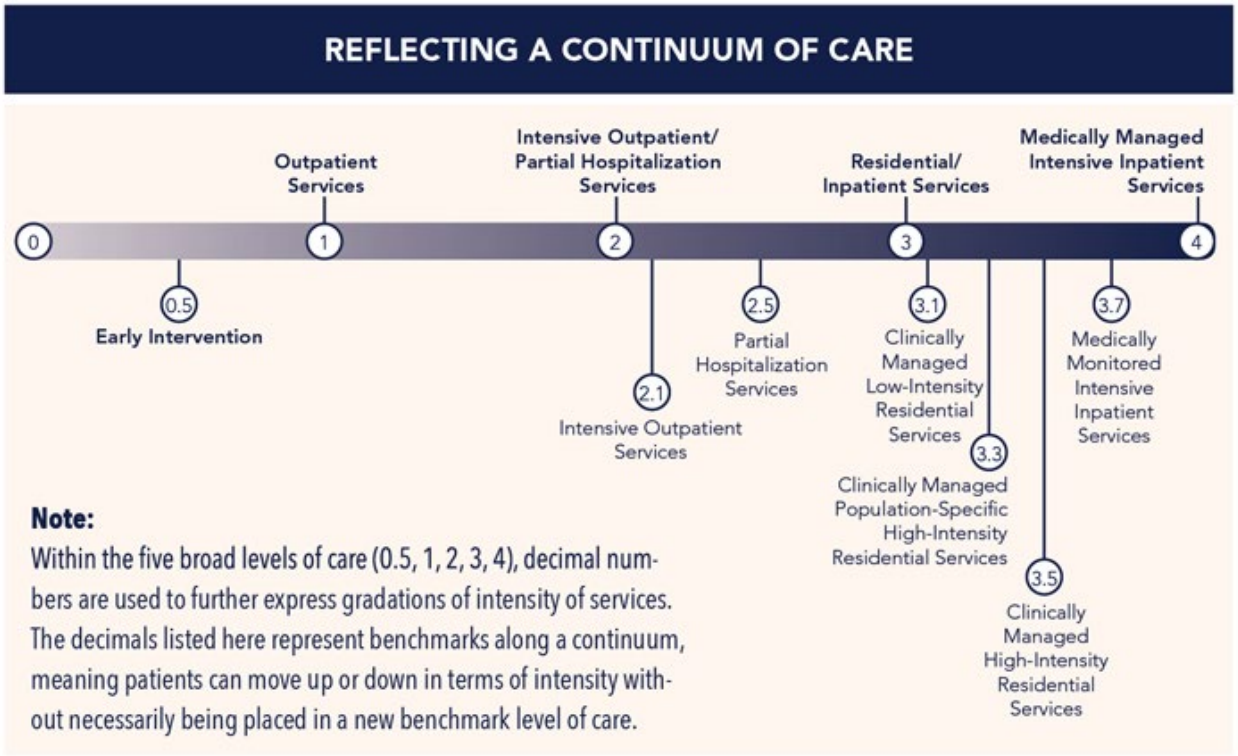
Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Understand and share with the patient/family the natural history of SUDs, including the likelihood of reoccurrences. • Screen for other mental health issues (depression/anxiety, trauma, abuse/neglect, exposure) and family system issues as appropriate.	understand that 1 treatment experience may not be enough. • Use MI techniques to increase motivation to change.
The physician views substance use and SUD as a behavior or lifestyle choice and not as a biological and psychological disorder.	• Recognize that physician bias or attitude can obstruct the path to appropriate substance use treatment, which can have severe and costly health and safety consequences. • Review literature and information on knowledgeable Web sites that support evidence of a biological basis for substance-related problems such as the following: ✓ Kelly JF, Saitz R, Wakeman S Language, substance use disorders, and policy: the need to reach consensus on an "Addiction-ary." *Alcoholism Treatment Quarterly*. 2016;34(1):116-123. ✓ The Addictionary page from the Recovery Research Institute of Massachusetts General Hospital & Harvard Medical School, dedicated to the advancement of addiction treatment & recovery Web site, available at: https://www.recoveryanswers.org/addiction-ary/.	• Engage other professionals with differing beliefs about substance use as a disease or choice in discussions while maintaining an open mind to opposing viewpoints. • Recognize that whether the problem of substance use is a choice or not, patients who use substances need help.
Gap: Recommendation information is not documented in the medical record and/or referral log.		
The practice does not have processes in place to ensure recommendation information is documented. Or, the practice does not have a registry or system to track recommendations.	• Establish a practice protocol that meets your state, local, and institution compliance requirements to obtain a signed release of information (ROI) for the referral and include all information required by the receiving office. Consider using a checklist such as the following or a referral and feedback form as shown in the Appendix. ☐ Contact information for the patient and family ☐ History ☐ Physical examination ☐ Medications, if any ☐ Summary of case (ie, impression of substance use concerns) ☐ Substance use screening assessment results ☐ Assessment of psychosocial concerns ☐ Contact information for the referring physician **Note**: Become familiar with state laws regarding adolescent confidentiality in receipt of mental health and substance use services. Also, become familiar with	• Audit your practice's referral processes periodically. Brainstorm reasons for lack of documentation and/or follow-up and strategize ways to overcome them. • Formalize your practice's referral processes in a written policy/procedure document and ensure staff is properly trained on them.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	42 CFR Part 2, a federal law governing confidentiality for people seeking treatment for substance use disorders from federally assisted programs. Discuss these legal requirements with your institution/clinic compliance team for direction. • Establish clear, bidirectional communication between the medical home and the behavioral health specialist. Consider what feedback is expected, by when, and how communication will take place. (See example referral and feedback form.) • Create a referral log to capture pertinent details for all referrals, including dates and actions for follow-up. (See example referral log.) ✓ Develop officewide procedures with clear roles and responsibilities for how the referral log will be updated, reviewed, and maintained to ensure its effectiveness. ✓ Designate an office champion to review the referral log routinely and call the patient/family and/or referral provider to determine the referral result/outcome. ✓ Put checks and balances in place to close the loop and ensure subsequent follow-up in the pediatric medical home.	
Practice continues to run into barriers to treatment that appear to be resource or system/payer-based.	• Recognize opportunities for advocacy. Are parity laws being violated? Are more funds needed to resource youth-focused services near you? Contact your AAP Chapter to share your experiences and discuss your concerns: https://www.aap.org/en-us/about-the-aap/chapters-and-districts/Pages/Chapter-Websites.aspx	• Consult with other practices in your area to share experiences and discuss concerns. Brainstorm ways to promote better and more coordinated services to youth in need.

Appendix

ASAM Levels of Care for Treatment of Substance Use

The ASAM Levels of Care describes treatment as a continuum marked by 4 broad levels of service and an early intervention level. Within the 5 broad levels of care, decimal numbers are used to further express gradations of intensity of services.

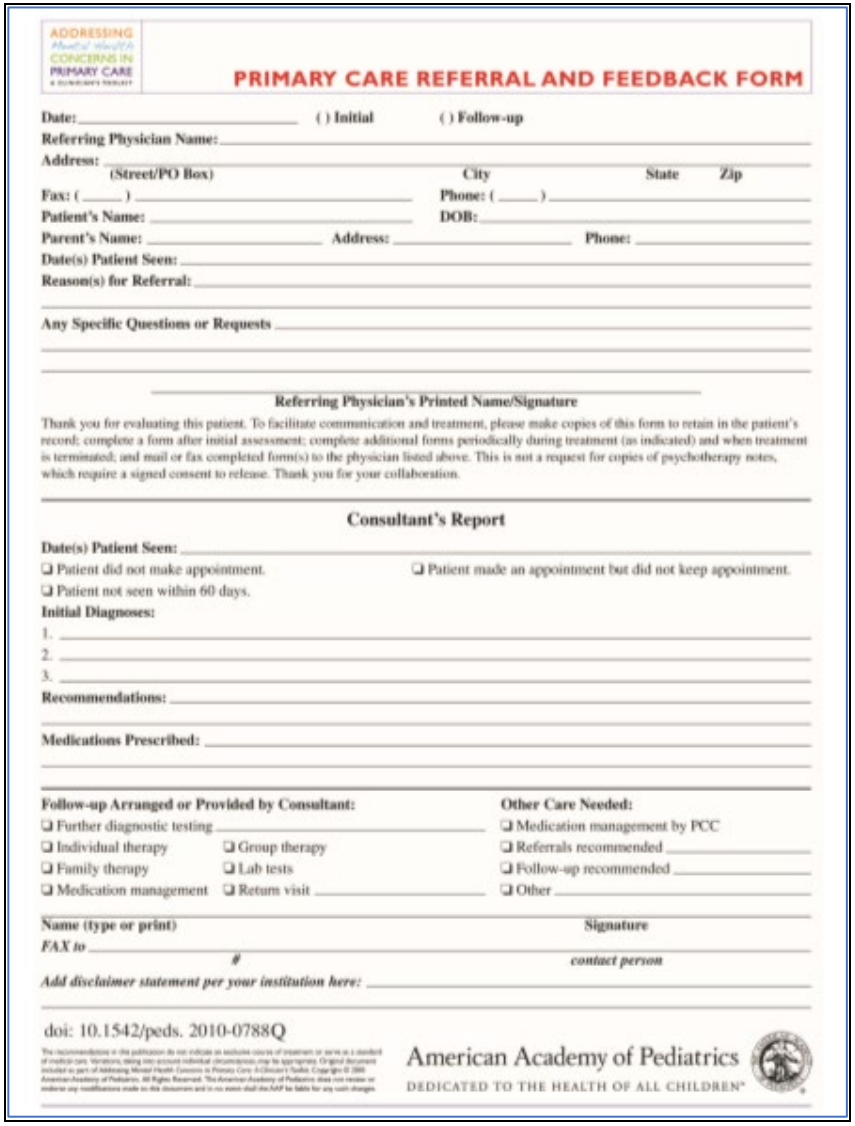


Graphic shown with permission from the American Society of Addiction medicine. For more information, see: https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/.

Additional Planning Considerations

Be aware that other associated mental health diagnoses and comorbities need to be factored into treatment planning. The ASAM criteria further structures assessment around 6 dimensions to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health, and mental health services as well as spiritual issues relevant in recovery. For further reading, an overview of the 6 ASAM dimensions can be found here: https://www.asamcontinuum.org/knowledgebase/what-are-the-six-dimensions-of-the-asam-criteria/.

Primary Care Referral and Feedback Form



ADDRESSING Mental Health CONCERNS IN PRIMARY CARE

PRIMARY CARE REFERRAL AND FEEDBACK FORM

Date: _____ **( ) Initial** **( ) Follow-up**

Referring Physician Name: _____

Address: _____
(Street/PO Box) City State Zip

Fax: ( ) _____ **Phone: ( )** _____

Patient's Name: _____ **DOB:** _____

Parent's Name: _____ **Address:** _____ **Phone:** _____

Date(s) Patient Seen: _____

Reason(s) for Referral: _____

Any Specific Questions or Requests _____

Referring Physician's Printed Name/Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of this form to retain in the patient's record; complete a form after initial assessment; complete additional forms periodically during treatment (as indicated) and when treatment is terminated; and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

Consultant's Report

Date(s) Patient Seen: _____

❑ Patient did not make appointment. ❑ Patient made an appointment but did not keep appointment.

❑ Patient not seen within 60 days.

Initial Diagnoses:

1. _____
2. _____
3. _____

Recommendations: _____

Medications Prescribed: _____

Follow-up Arranged or Provided by Consultant:

❑ Further diagnostic testing _____
❑ Individual therapy ❑ Group therapy
❑ Family therapy ❑ Lab tests
❑ Medication management ❑ Return visit _____

Other Care Needed:

❑ Medication management by PCC
❑ Referrals recommended _____
❑ Follow-up recommended _____
❑ Other _____

Name (type or print) **Signature**

FAX to _____
*contact person*

Add disclaimer statement per your institution here: _____

doi: 10.1542/peds. 2010-0788Q

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Courtesy of: AAP Mental Health Initiatives. Primary care referral and feedback form. AAP Web site. http://pediatrics.aappublications.org/content/125/Supplement_3/S172. Accessed September 3, 2018

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Patient Referral Log

SAMPLE PATIENT REFERRAL LOG

Patient Name Chart #	Referred to (Behavioral health service)	Date Referred	Date Feedback Received	Follow-up

Click here for a customizable Word version of the Sample Patient Referral Log or locate it on the Resources tab.