SBIRT in SBHCs: A Model for Adolescent Substance Use Prevention

Introduction

Disturbingly, most adolescents don't see the use of marijuana, alcohol, illicit drugs, and tobacco as a risk. (SAMHSA, 2010)

According to the 2014 National Survey on Drug Use and Health, 10.2 percent of youth aged 12-17 years old reported that they were currently using an illicit drug. Moreover, 20.6 million persons—eight percent of the population aged 12 or older—needed treatment for drug or alcohol use problems but didn't receive treatment at a specialty facility in the past year.[1]

Substance use and misuse results in lost productivity, crime, motor vehicle crashes, fetal alcohol syndrome from pregnant teens, and death.[2] Even when substance use does not lead to death, the effects are detrimental to adolescents' emotional and cognitive development, socialization, and ability to learn. Increased injuries, school failure, mental health problems, criminal involvement, and dependence in adulthood are significant and longstanding health and academic consequences for young people using illicit substances.[3-7]

School-based health centers provide adolescents comprehensive care and counseling to prevent alcohol, tobacco, and drug use

Adolescence is the critical period to prevent substance use disorders. The striking amount of youth who engage in high-risk behaviors underscores the importance of delaying the onset of use, identifying risky behaviors, and intervening early to address misuse and deter addiction.

School-based health centers (SBHCs) are in a unique position to provide comprehensive programs and identify at-risk students before they develop substance dependence and addiction. SBHCs are health centers located in predominantly low-income areas and serve all children regardless of their race, gender, sexual identity, or socio-economic status. They provide comprehensive primary and mental health care to children and adolescents in a setting that is trusted, accessible, and avoids the potential stigma associated with visiting a mental health or substance use clinic. They can play a critical role in addressing adolescent substance use by adopting the SBIRT approach.

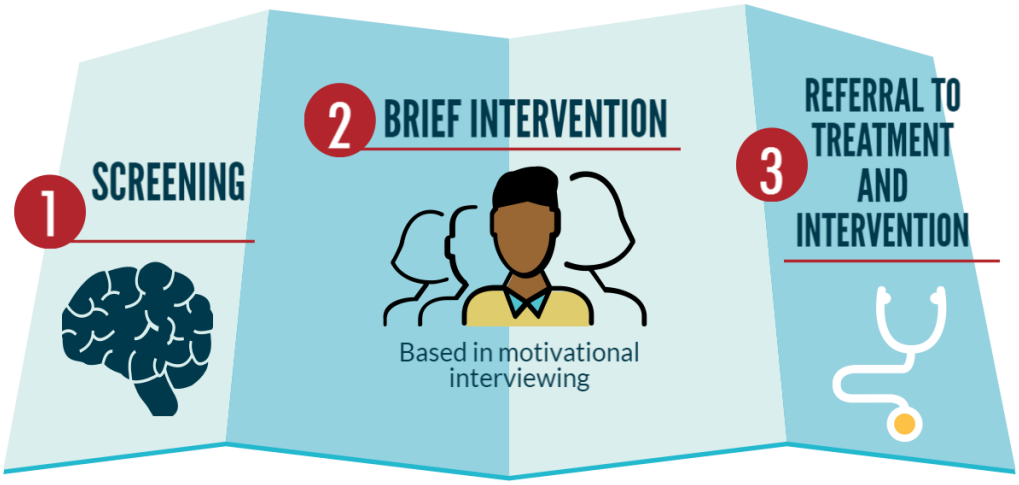
The School-Based Health Alliance is connecting SBHCs with a proven substance prevention strategy: SBIRT

In alignment with Conrad N. Hilton Foundation's vision and approach to substance use prevention, the School-Based Health Alliance launched ***SBIRT in SBHCs*** to test the adaptation of adolescent-specific SBIRT in a group of school-based interdisciplinary primary care teams to inform a strategy for large-scale implementation.

School-Based Health Alliance staff, in consultation with national adolescent substance use prevention experts and school-based health organizations, developed a comprehensive curriculum to train two cohorts of providers from ten SBHCs. Primary care and the behavioral health providers from each of the SBHCs, 20 in all, were trained to integrate adolescent-specific SBIRT services into their primary care practice, reaching an estimated 13,000 students. Armed with foundational knowledge of the SBIRT approach and techniques to conduct brief interventions and appropriate referrals, the providers tested whether SBIRT could succeed in the non-traditional setting of SBHCs.

SBIRT Defined

Inspired by Institute of Medicine recommendations and developed by the Substance Abuse and Mental Health Administration (SAMHSA), SBIRT is an evidence-based approach to identifying, reducing, and preventing substance use, misuse, and dependence. The SBIRT model consists of three components:



1) **Screening**: assess a patient for risky substance use behaviors using standardized assessment tools
2) **Brief Intervention**: engage a patient showing risky substance use behaviors in a short conversation, providing feedback and advice
3) **Referral to Treatment**: provide a referral to brief therapy or additional treatment to patients whose assessment or screening shows a need for additional services

What makes SBIRT so effective is that it takes a public health approach to alcohol and substance use and addiction. SBIRT gives providers the tools to uncover opportunities for early intervention by focusing on prevention among abstainers and low-risk users as much as treating heavy and dependent users. Clinicians are given the chance to reach at-risk substance users before more severe misuse occurs. SBIRT has proven successful with adults in multiple medical settings and workplace wellness programs, but had not been tested in SBHCs with adolescents—providing an exciting opportunity to pilot *SBIRT in SBHCs* (SAMHSA, 2013).

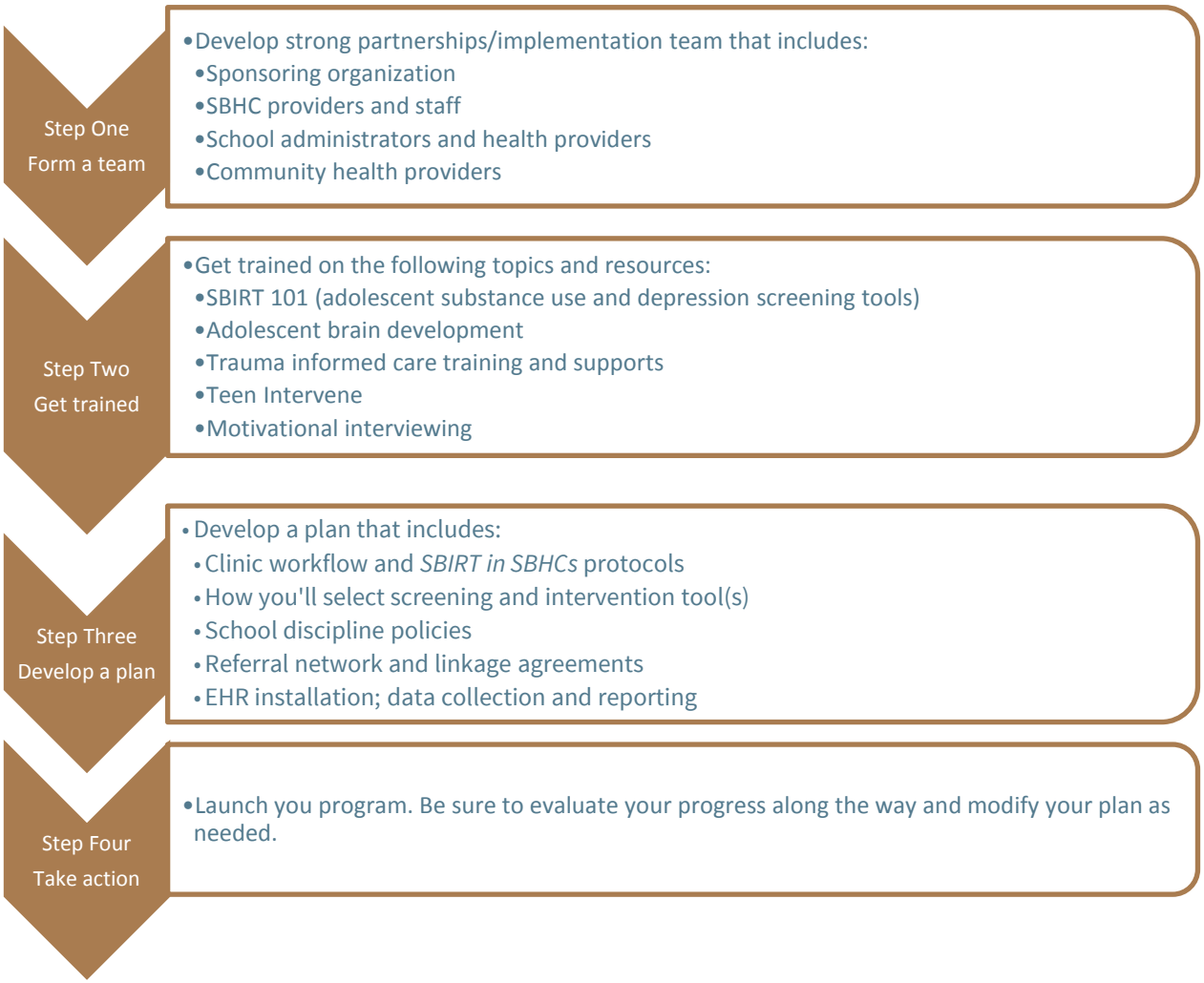
The *SBIRT in SBHCS* Model

We trained SBHC staff and school administrators on the SBIRT approach to primary and behavioral health visits and techniques to conduct brief interventions and appropriate referrals. We also provided ongoing support as clinicians adapted their practices to accommodate SBIRT. For Screening, we selected CRAFFT as the evidence-based screening tool to assess substance use in adolescents. For Brief Intervention, we incorporated Teen Intervene as the intervention program for adolescents who screened positive for drug and alcohol use. For Referral to Treatment, we advised sites on how to identify and partner with community health centers and specialized treatment programs, as well as developed a process for patient referral and follow-up.

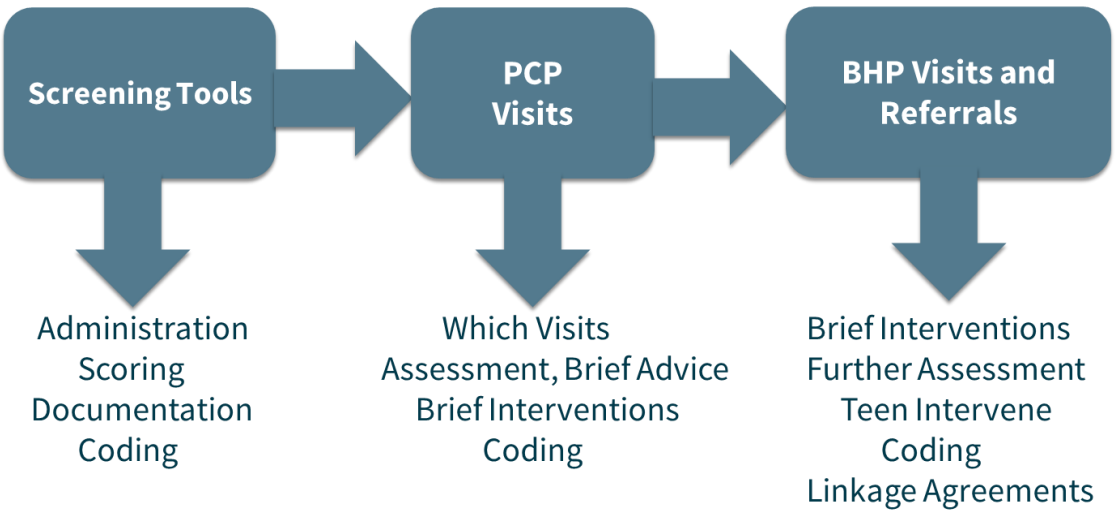
Because our participating SBHCs had behavioral health providers on staff, we had the opportunity to expand on the traditional SBIRT model by also screening for co-occurring mental health conditions. We added the PHQ-9—an evidence-based depression-screening tool for primary and behavioral health providers—to assess co-occurring conditions during the pilot project.

Before You Start

Successful SBIRT implementation begins long before a student walks into an SBHC. Planning, training, and coordination are critical to ensure the effectiveness and sustainability of building SBIRT into clinic workflow. The following chart outlines the key steps our sites took to implement *SBIRT in SBHCs,* as well as lessons we learned to improve the process.



The following section outlines the *SBIRT in SBHCs* approach and considerations for each component of the SBIRT model. These considerations are an in-depth look at Step Three from the above chart and demonstrate the process the teams in our pilot program went through to develop their plan for clinic workflow.



Screening Tools

When selecting the appropriate substance use and depression screening tools, ask:

- How will it be administered: on paper, through an electronic medical record, or on a computer?
- Who will administer and score the screening: receptionist, medical assistant, nurse, primary care provider (PCP), behavioral health provider (BHP)?
- How will it be documented in the health record?
- How will it be coded?

PCP Visits

When adolescents meet with the PCP provider, ask:

- What type of visits will receive screenings: well child, referrals from school for alternatives to suspension, emergency visits, or all visits?
- Who will do assessments and brief interventions: PCP and/or BHP?
    - If BHP, how will coordination with the adolescent occur? How and when will the PCP and BHP check-in and communicate about next steps and needed follow-up?
- How will interactions be coded and where?

BHP Visits

When assessing the level of intervention and involving the BHP, ask:

- Will the BHP do brief interventions? When?
- When will they conduct further assessment and diagnostic interview?

- How will they conduct Teen Intervene Sessions: individual, group, both; 45 or 90-minute sessions?
- How will they code these visits?

Referrals

In planning for services beyond the SBHC's scope, ask:

- With which treatment resource(s) will the SBHC have a linkage agreement(s)?
- Who will be the main contact(s) at each facility?
- Who will initiate the referral and be responsible for providing it to the adolescent?
- How and when will follow-up occur to ensure care coordination between the SBHC and outside treatment facility?
- How and when will follow-up occur with the adolescent to ensure they are receiving the appropriate care?
- How will this be documented?

Policies and Procedures

SBHC and administrators should ask:

- If policies need to be developed or changed, who is going to do that and what authority is needed to "sign off" on these changes?
- Should there be different policies and procedures based on different scenarios (e.g. a low vs. high level positive screen; referral to outpatient clinic vs. long-term treatment program).
- How and when parents should be contacted for involvement.

Positive Reinforcement

- Plan ahead to share and celebrate your successes with students, parents, the school board, partners, and the community.

Conclusion

Our experience with the *SBIRT in SBHCs* initiative proved that SBIRT is feasible and successful in an SBHC setting. We recommend that every SBHC strongly considers implementing SBIRT.

If you decide to go down this path, we have a few recommendations:

- Use valid and reliable screening tools. The following were used in our pilot program. They are evidence-based and our providers reported that they were easy to use and effective.
    - Substance use screening tool: CRAFFT
    - Depression screening tool: PHQ-9
    - Brief Intervention tool: Teen Intervene
- SBHCs should screen every child and adolescent at least once per school year.
- Contact us for guidance, training, and technical assistance with implementing SBIRT, depression screening, and other adolescent services to help students thrive.

For more information on the benefits of SBIRT, visit http://www.integration.samhsa.gov/clinical-practice/sbirt.

For more information on the Conrad N. Hilton Foundation and the substance use prevention work, visit https://www.hiltonfoundation.org/priorities/substance-use-prevention.

For guidance implementing the SBIRT in SBHCs model in your health center, contact the School-Based Health Alliance at info@sbh4all.org.

References

1. Substance Abuse and Mental Health Services Administration. *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46*, HHS Publication No. (SMA) 13-4795. Rockville, MD2013.
2. Sacks VH, et al. "School Policies, School Connection, and Adolescents: What Predicts Young Adult Substance Use? Research Brief. Publication# 2014-53." *Child Trends* Oct 2014.
3. Hingson RW, Heeren T, Jamanka A, Howland J. Age of drinking onset and unintentional injury involvement after drinking. *JAMA : the Journal of the American Medical Association*. Sep 27 2000;284(12):1527-1533.
4. Volkow ND, Li TK. Drugs and alcohol: treating and preventing abuse, addiction and their medical consequences. *Pharmacology and Therapeutics*. Oct 2005; 108(1):3-17.
5. Clark DB, Martin CS, Cornelius JR. Adolescent-onset substance use disorders predict young adult mortality. *The Journal of Adolescent Health*. Jun 2008;42(6):637-639.
6. Garnier HE, Stein JA. An 18-year model of family and peer effects on adolescent drug use and delinquency. *Journal of Youth and Adolescence*. Jun 2002; *31*(1), 45-56.
7. Janosz M, et al. Disentangling the weight of school dropout predictors: A test on two longitudinal samples. *Journal of youth and adolescence.* Dec 1997; 26.6: 733-762.

The Conrad N. Hilton Foundation was created in 1944 by international business pioneer Conrad N. Hilton, who founded Hilton Hotels and left his fortune to help the world's disadvantaged and vulnerable people. The Foundation currently conducts strategic initiatives in six priority areas: providing safe water, ending chronic homelessness, preventing substance use, helping children affected by HIV and AIDS, supporting transition-age youth in foster care, and extending Conrad Hilton's support for the work of Catholic Sisters. In addition, following selection by an independent international jury, the Foundation annually awards the $2 million Conrad N. Hilton Humanitarian Prize to a nonprofit organization doing extraordinary work to reduce human suffering. In 2015, the Humanitarian Prize was awarded to Landesa, a Seattle-based land rights organization. From its inception, the Foundation has awarded more than $1.4 billion in grants, distributing $107 million in the U.S. and around the world in 2015. The Foundation's current assets are approximately $2.5 billion. For more information, please visit www.hiltonfoundation.org.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS09738-08-00, award title "Technical Assistance to Community and Migrant Health Centers and Homeless" for $450,000. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.