



IMPROVING ADOLESCENT HEALTH: FACILITATING CHANGE FOR EXCELLENCE IN SBIRT

Provider Guide

NATIONAL
COUNCIL
for Mental
Wellbeing

CONRAD N.

Hilton

FOUNDATION

ACKNOWLEDGEMENTS

This Provider Guide and the full change package, *Improving Adolescent Health: Facilitating Change for Excellence in SBIRT*, were created by the Facilitating Change for Excellence in SBIRT (FaCES) Practice Transformation Team, other subject matter experts, the National Council project team, and FaCES learning collaborative participating sites.

CONTENT

Introduction.....	1
Screening.....	2
Brief Intervention.....	4
Referral and Ongoing Management.....	8
Specialty Treatment Options.....	9
Special Considerations.....	11
Social and Cultural Considerations for SBIRT.....	12
References.....	13



This Provider Guide is an abbreviated version of the full change package, [Improving Adolescent Health: Facilitating Change for Excellence in SBIRT](#). It serves as a reference for providers who work directly with adolescents providing SBIRT in a primary care setting seeking clinical guidance and easy access to tools. Thus, it presents a condensed version of the clinical areas of action for SBIRT delivery, and omits operational considerations such as policies, procedures and change management strategies. For comprehensive clinical and operational guidance, please refer to the [full change package](#).

INTRODUCTION

WHAT IS SBIRT?

Screening, **B**rief **I**ntervention and **R**eferral to **T**reatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment for individuals at risk for adverse consequences of alcohol and other drug use and for those with problem substance use challenges (Del Boca et al., 2017).

The American Academy of Pediatrics (AAP) recommends pediatricians become familiar with adolescent SBIRT and the potential to incorporate into universal screening and comprehensive care (Committee on Substance Use and Prevention, 2016).

The SBIRT process includes:

1. **SCREENING** to identify a person's risk for a substance use challenge.
2. **BRIEF INTERVENTION (BI)** to raise a person's awareness of risks, elicit internal motivation for change, and help set behavior-change goals.
3. **REFERRAL TO TREATMENT** to facilitate access to and engagement in specialized services and coordinated care for people at highest risk.

WHY ADOLESCENT SBIRT?

Despite evidence supporting its effectiveness, youth SBIRT is not yet widely implemented. Although the intervention can be challenging, there are several key reasons for why SBIRT should be considered, including:

- The younger a person is when they start using, the more likely they are to develop a substance use disorder and continue using later in life.
- Substances can slow and impede brain development, increase health risks and have long-term financial and legal implications.
- Early substance use interventions can prevent development of more severe substance use challenges.
- Widespread SBIRT adoption is often hindered by a lack of uniform and clear implementation guidance.
- Successful models are built on agreed upon, codified and replicable screening tools, processes and interventions.

SCREENING

CHANGE CONCEPTS:

- Use the Screening to Brief Intervention or S2BI (self-administered version) to screen for substance use risk in adolescents.
- Ensure capacity for evidence-based response to screening results.

WHO SHOULD BE SCREENED?

Universal screening for alcohol and substance use should be performed with all adolescents aged 12 and older.

Substance use screening that is performed while checking for vital signs and conducting other preventive and lifestyle screenings helps normalize conversations about substance use and helps to avoid patients feeling singled out. This approach to screening can also identify other health concerns, such as depression and anxiety, and can broadly inform clinical care in the event alcohol and drug use are the source of presenting symptoms or may interfere with prescribed medications and test results.



KEY TIP

Given the rapidly changing nature of the risk of adolescent substance use challenges, it's recommended that every adolescent is screened at every clinical encounter.

THE SCREENING TOOL: S2BI

Clinicians need a tool that can accurately assess the likelihood of a substance use challenge. The S2BI (Massachusetts Child Psychiatry Access Program, 2015) is one of several valid and reliable screening tools for substance use among youth. The S2BI was introduced in 2014 as a no-cost, validated instrument and recognized by both the AAP and the Addiction Medicine Foundation (The Addiction Medicine Foundation, 2016). It offers several advantages that make it ideal for use.

The S2BI

- Is quick and practical for short visits.
- Effectively screens for alcohol, tobacco and marijuana, including among youth who vape (research indicates that if adolescents are not using one of the three, it is highly unlikely that they are using other substances (Woodcock et. al, 2015).
- Has good psychometric properties when validated against the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) diagnoses.
- Although non-diagnostic, provides an accurate way to identify those who may have substance use disorders.
- Provides results that can guide provider responses.

S2BI: SCREENING TO BRIEF INTERVENTION

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

- **Tobacco?** (Cigarettes, e-cigarettes, vapes etc.)
- **Alcohol?**
- **Marijuana?** (Smoked, vaped, edibles, etc.)

STOP if all “Never.” Otherwise **CONTINUE**

- **Prescription drugs that were not prescribed for you** (pain medication, Adderall, etc.)
- **Illegal drugs?** (Cocaine, Ecstasy, etc.)
- **Inhalants?** (Nitrous oxide, etc.)
- **Herbs/synthetic drugs** (Salvia, K2, bath salts, etc.)

Never

Once or twice

Monthly

Weekly or more

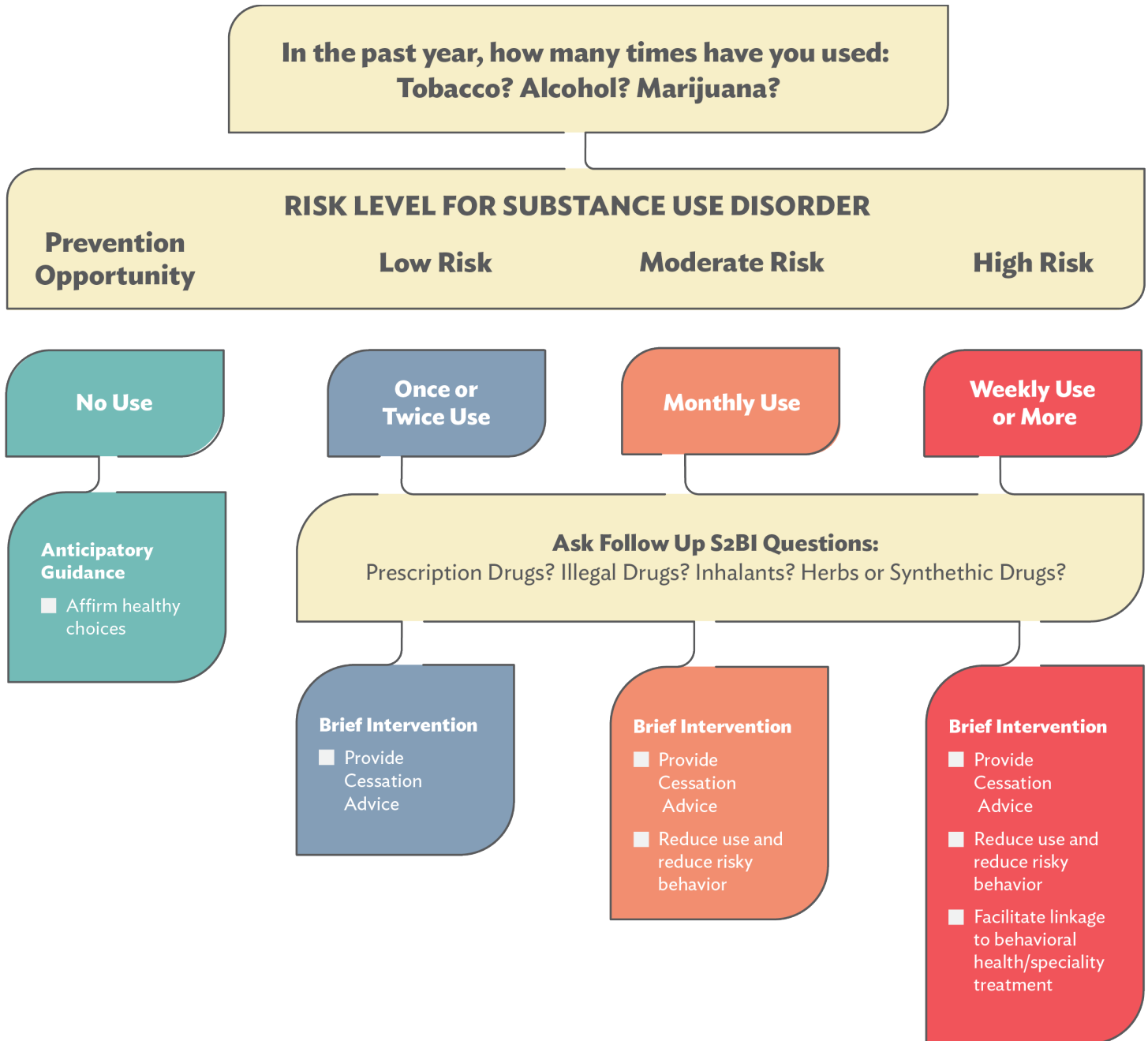
Copyright Acknowledgment: The S2BI is protected under a Creative Commons NonCommercial license, which means it is free to use and distribute as long as you are 1) not using it for commercial purposes (making any profit off of your use) and 2) the following attribution is used: © Boston Children’s Hospital 2014. All rights reserved. This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

SCREENING RESULTS INFORM BRIEF INTERVENTION

Screening results guide the intensity of BI delivery. This risk stratification chart illustrates how to respond to different levels of use, along the spectrum of anticipatory guidance to BI. (See “Guidance for Delivering BI.”)



S2BI ALGORITHM



BRIEF INTERVENTION

CHANGE CONCEPTS:

- Clearly communicate age-appropriate risks of alcohol, tobacco and substance use to health and wellbeing, with patients reporting any use in the past year (based on screening results).
- Leverage primary care team/patient relationship to negotiate behavior change and document a reasonable change plan.
- Ensure BI is responsive to screening results by training applicable staff on how to interpret results and provide age-appropriate assessment and discussion of risks.

THE ART OF BRIEF INTERVENTIONS

BI is a collaborative conversation between a health provider and adolescent to promote behavior change in order to reduce substance use.

It is a structured, goal-oriented exchange that draws from motivational interviewing (MI), including use of a non-judgmental, non-confrontational style that engages the adolescent in discussion.

Components of a BI include sharing health information, delivering cessation advice, discussing reducing use and risky behaviors and, when indicated, facilitating linkages to treatment.

Whenever delivering BI, be sure to advocate for non-use as the healthiest choice. Meet patients where they are, treating them as the expert on themselves and creating opportunities together that support all pathways to better health. For teens who are not ready or willing to attempt to quit, reducing use or risky behaviors may be a first step.

Even if a primary care physician (PCP) has less than five minutes, a BI can be both short in duration and substantial in impact. The PCP can be a positive influence by building rapport over time with adolescents and drawing upon experience with data-informed treatment of chronic conditions — vital skills for addressing substance use.



KEY TIPS

- Convey your support for the patient's autonomy in having choices and the ability to make decisions.
- All patients should be advised of potential health risks and consequences and encouraged not to use. There is no safe level of alcohol consumption for underage youth.
- With evolving changes to cannabis legalization and regulation, explore perceptions of risk and ask about method of intake (e.g., vaping, edibles) and awareness of potency.
- Address trends of increased vaping by reinforcing that, like traditional smoking, vaping can have adverse health effects due to added chemicals and high levels of nicotine.
- Share information about the impacts of substances and their harm to a developing adolescent brain and body. Clearly communicate the spectrum of risk and advise not to use.
- Conflict or resistance is often a signal that our actions are not aligned with the patient's level of readiness. Re-engage by focusing on rapport building and establishing trust.
- Change is not linear and may need to occur over time. Show your support for any steps they are willing to take and utilize the care team for monitoring and follow-up.

GUIDANCE FOR DELIVERING BRIEF INTERVENTION



This is a practical tool for staff delivering BIs by providing the appropriate level of intervention based on screening results.

No Use (Prevention Opportunity)

What is anticipatory guidance?

Anticipatory guidance is the appropriate response for a screening result of “No Use.” It is an opportunity to intervene before substance use begins. It is a process in which the health provider anticipates emerging issues that an adolescent and family may face and provides guidance by delivering information about the benefits of healthy lifestyle choices and practices that promote prevention and encourages parents or guardians to discuss healthy, substance-free lifestyles.

Provide positive reinforcement.

Affirm healthy choices. Reinforce patient’s reasons for non-use. Deliver preventative advice.

Sample Scripting:

- “It’s great that you are choosing not to use substances. Have you ever been offered?”
 - If yes, follow with: “What happened and how did you decide to say no?”
 - If no, follow with: “That’s great. It could happen in the future so it’s good to be prepared and think through what you would do.”
- “Avoiding tobacco, alcohol and drugs is an excellent choice — it’s one of the best ways to protect your health. Can I provide some information on how these substances can affect you over time?”
- “There may be times when drugs and alcohol seem tempting, especially at your age. As your doctor, I’m proud of you for making a tough choice that can also positively affect your health.”

Staff Considerations: All staff can be trained to provide positive reinforcement. Ensure staff are equipped with psychoeducational tools that are tailored to adolescents.

Once or Twice Use (Low Risk of Substance Use Disorder)

Provide cessation advice.

Recommend that no use is best for health and give accurate information on the harms of substance use. Tailor your responses based on what you know about the patient, their health and life goals.

Sample Scripting:

- “I would like to talk about your responses to the screener to find out more about your experiences with alcohol or other drugs. Would that be okay?”
- “As your health provider I recommend not using alcohol or drugs.”
- “Did you know use of (x) can impact your (grades, sports, diabetes, asthma, depression, etc.)?”

Staff Considerations:

- PCPs should ideally perform this task due to level of influence and follow the same process as providing health advice for other disease states.
- Mental health or substance use treatment providers, nursing staff and other staff can reiterate the health advice if in contact with the patient.

Monthly Use (Moderate Risk of Substance Use Disorder)

1. Provide cessation advice.

2. Reduce use and reduce risky behaviors.

Explore the ways substance use is impacting the patient's life, the perceived benefits versus downsides. Ask how the patient might go about making a change.

Sample Scripting:

“What are the good things about using (x)? What are the not so good things?”

“Have you ever quit or cut back before? What were your reasons?”

“How would you go about making a change in your use, if you decided to?”

“How can I best support you?”

Staff Considerations:

- PCPs ideally performs this task due to level of influence and relationship with the patient.
- Mental health and substance use treatment providers can perform this task if PCP is unable.

Weekly Use (High Risk of Substance Use Disorder)

1. Provide cessation advice.

2. Reduce use and reduce risky behaviors.

3. Facilitate linkage to mental health/substance use treatment.

Reinforce options and your ongoing support. Connect the patient with others who may be able to meet any needs that are outside your scope of practice. Make warm handoffs/referrals when possible.

Sample Scripting:

- “I’m concerned because (connect back to identified hook for health problems and other negative consequences [e.g., social anxiety, sleeping troubles]).”
- “I’d like to introduce you to another member of our care team who works with many of my patients. They may be helpful in discussing other services that could be of interest to you. What are your thoughts?”

Staff Considerations:

- PCPs should ideally initiate the warm handoff to build trust in the team process.
- Mental health and substance use treatment providers explore patient readiness and interest in additional services.
- Care coordination staff maintain linkages with up-to-date community resources.

Assess for imminent risk of suicide:

For suicidality, provide a safety planning intervention and discuss means restriction. If possible, include caregivers in the conversation (break confidentiality if necessary). Encourage mental health services and for imminent risk, refer for urgent services.

Resource: Training in Motivational Interviewing (MI) can be helpful for enhancing brief intervention skills. For more information: <https://motivationalinterviewing.org/motivational-interviewing-resources>

SAMPLE CONVERSATION CASE EXAMPLE

SARAH, A 17-YEAR-OLD HIGH SCHOOL SENIOR, presents on Monday morning with a severely sprained, swollen and painful left ankle. On her S2BI she reports consuming about four or five drinks about once a month, on average.

Provider: (Following a friendly check-in, engaging rapport) Can you tell me more about what happened to bring you in today?

Patient: I was walking in new boots Saturday night and wasn't used to them. I slipped on the sidewalk and twisted my ankle.

Provider: Did it hurt a lot when it happened?

Patient: Just a little, but it was a lot worse Sunday morning and I couldn't walk.

Provider: Sorry to hear that you are in pain. It's definitely swollen and I'll put in an order for an x-ray. While they set up, can we look over the questions you answered on this form?

Patient: Sure, I guess.

Provider: Thank you for filling it out and letting me know about how much and how often you drink. What do you enjoy about it?

Patient: Well it's fun because I'm hanging out with friends.

Provider: I can understand wanting to be with friends. Relationships are important! In what way, if at all could alcohol have affected your fall the other night?

Patient: I don't know. My friends gave me crap for it but I only had a couple shots.

Provider: It is common for alcohol to increase accidental injuries since it can affect our coordination and perception. My goal is not to tell you what you should do, rather to ask; if you were to cut back, or even stop drinking for some period of time, what would that look like for you?

Patient: It would be a little weird because my friends might give me a hard time. But I'm embarrassed about this. And you know what? Only one of my friends texted the next day to see if I was ok. I need a break from the others anyway.

Provider: It seems one person in the group is really thoughtful.

Patient: Right. She doesn't really drink anyway... and doesn't care what the others think!

Provider: Sounds like you've identified for yourself some reasons and some options going forward. How can I best support you?

Patient: I'm just glad you didn't lecture me. I feel stupid enough already because of my ankle.

Provider: Let's get the x-ray, then make a plan to get you feeling better. I'm glad to be a resource for you anytime.

REFERRAL AND ONGOING MANAGEMENT

CHANGE CONCEPTS:

- Establish criteria for referral to treatment that considers patient substance use, physical and mental health and developmental level.
- Develop protocol and procedures to refer patients to internal and/or external care, follow up on referred patients and leverage provider and organizational partnerships.
- Ensure capacity, protocols and documentation standards for ongoing care management (including interim management, supporting client readiness and facilitating treatment entry and follow-up).

WHEN IS REFERRAL TO SPECIALTY SUBSTANCE USE TREATMENT INDICATED?

Referral to specialty treatment is appropriate when a patient’s screening result(s) suggest high risk for a substance use disorder. Severity should be determined by the patient’s score on a validated, evidence-based screening tool (e.g., S2BI results indicate weekly or more use of any substance).

Meeting with an integrated behavioral health counselor may be appropriate when the patient’s results indicate moderate risk for a substance use disorder (e.g., S2BI results indicate monthly use of any substance).




DETERMINING WHEN A REFERRAL IS INDICATED


S2BI SCREENING RESULT	BI FOCUS	REFERRAL INDICATED
No Use (Prevention Opportunity)	Provide anticipatory guidance.	No
Once or Twice Use (Low Risk of Substance Use Disorder)	Provide cessation advice.	No
Monthly Use (Moderate Risk of Substance Use Disorder)	Reduce use and reduce risky behaviors.	Use clinical judgment.
Weekly Use or More (High Risk of Substance Use Disorder)	Facilitate linkage to mental health or substance use treatment	Yes

ASSESSMENT


Considerations for the referral will involve individual needs and circumstances and systemic capacity, such as:




Age and development levels: Adolescents should be referred to developmentally appropriate programs.



Co-occurring mental health and/or medical conditions.



Patient and family motivation, willingness and ability to engage in treatment.



The presence of high-risk behavior.

ONGOING SUBSTANCE USE SERVICES IN PRIMARY CARE

In cases where a specialty treatment referral is not warranted, or if the patient does not follow through on the recommended treatment or has a severe substance use disorder or co-occurring mental health disorder and requires additional services, there are several effective strategies for managing substance use in primary care. In fact, substance use disorders are common conditions appropriate for long-term primary care (Watkins et al., 2003).

WHY MANAGEMENT MATTERS

- Specialty substance use treatment may not be available.
- The majority of adolescents aged 12-17 classified as needing but not receiving treatment do not perceive the need for treatment (NSDUH, 2019).
- Even if a patient accepts a referral, they may not attend treatment or treatment may be short-term, creating a need for chronic management in primary care.

SPECIALITY TREATMENT OPTIONS

MEDICATION-ASSISTED TREATMENT/MEDICATION FOR ADDICTION TREATMENT

Medication-assisted treatment or medication for addiction treatment (MAT) is defined as the use of medication in combination with counseling and behavioral therapies to provide a whole-patient approach to substance use dependence. MAT can be used in the treatment of [opioid, nicotine and alcohol dependence](#) (Subramaniam & Levy, 2013). MAT is typically used in a subset of older teens.

INTENSIVE OUTPATIENT TREATMENT

During intensive outpatient treatment, adolescents typically meet with a therapist for six hours a week or less for a period dependent on progress and the treatment plan. This level of treatment is appropriate for adolescents whose assessment indicates they would benefit from a high level of support that is beyond the scope of the primary care setting yet does not rise to the level of residential treatment. Individual, group and family therapy are some of the options for outpatient treatment.

INTENSIVE OUTPATIENT TREATMENT AND PARTIAL HOSPITALIZATION

Adolescents in intensive outpatient treatment need a treatment program that can offer comprehensive services for up to 20 hours per week. For a period ranging from two months to one year, adolescents often attend in the evening or weekends but live at home. Partial hospitalization is for adolescents who have a more severe substance use disorder, but their living environment does not negatively impact their treatment. These programs are often four to six hours a day for five days a week.

RESIDENTIAL/INPATIENT TREATMENT

This high level of care is for adolescents who have not only a severe substance use disorder but also have co-occurring mental health or medical conditions (such as depression) or a family dynamic that would interfere with treatment and the ability to get and stay in recovery. Residential/inpatient treatment includes programs that provide treatment services in a residential setting and lasts from one month to one year.

MEDICALLY MANAGED INTENSIVE INPATIENT TREATMENT

This is the highest level of treatment and is most appropriate for adolescents whose substance use, biomedical and emotional problems are so severe they require 24-hour primary medical care. The length of care is dependent on the adolescent's needs and program.

IMPORTANT CONSIDERATIONS INCLUDE:

- What level of care will meet the patient's needs? What level of care is the patient willing to go to? (Some patients would benefit from acute residential treatment but are not willing or able to be away from home.)
- What quality programs are available in the community and who has space?
- What will insurance cover?

CONFIDENTIALITY AND PARENTAL INVOLVEMENT

Protecting an appropriate level of confidentiality for adolescents' health care information is an essential determinant of whether this population will access care, answer questions honestly, and develop and maintain a therapeutic alliance with their provider. Fear that clinicians will reveal private information can cause concern and lead adolescents to answer screening questions inaccurately. It is essential that providers understand confidentiality laws and how to navigate discussions with patients and parents or guardians so that they are able to screen and intervene as needed. Although privacy and minor consent laws vary by state, providers need to make a clinical judgment as to whether the circumstances for referral warrant parental involvement. In most states, confidentiality cannot be breached unless clinical judgment suggests the patient or another individual is in imminent danger because of risky behavior.

DISCUSSING CONFIDENTIALITY WITH PATIENTS AND PARENTS OR GUARDIANS

Introduce confidentiality practices. Confidentiality provisions should be introduced and defined during the initial visit for adolescents new to a practice and prior to the first time the adolescent is interviewed without a parent or guardian present. Explain the confidentiality policy — including the limits of confidentiality — to the patient and parent(s) or guardian(s) simultaneously. By doing so, the clinician can reassure parents or guardians that they will receive any information involving the immediate safety of their child, while also reassuring the adolescent that details discussed will remain confidential. The American Academy of Pediatrics' (AAP) [Information for Teens: What You Need to Know About Privacy](#) (American Academy of Pediatrics, 2010) can help adolescents understand their privacy rights and what to expect from interactions with their provider around drugs and alcohol and gives additional information regarding parental involvement.

Example messaging to introduce parents or guardians to confidential information gathering:

- Starting at age (x) all patients are seen for at least a portion of their visit without parents or guardians so they can start having opportunities to take ownership of their health.
- Our goal is to have a trusted relationship with you and your child where accurate information is shared so we can provide the best care possible. When confidentiality is not upheld, young people are less likely to talk about potentially sensitive and important information, which means they are less likely to get the care they need.
- As your teen's health care provider, it's important that I build a relationship of trust with them. While sometimes teens tell their doctor things that they won't tell their parents or guardians, I want you to trust that I will bring you in on any serious health problems or issues of personal safety.

Examples of instances when confidentiality may need to be broken include, but are not limited to:

- The patient discloses thoughts and/or attempts of suicide — "I've been thinking a lot about death and I wish I were dead."
- The patient discusses thoughts or desires to harm another person — "I was so angry that he was making fun of me that I wanted to kill him."
- The patient is at high risk for an overdose based on the severity of reported use.

Even when sensitive information such as suicidal or homicidal thoughts needs to be discussed with parents/guardians, the clinician should first discuss with the adolescent what and how information will be presented to parents. By strategizing with the adolescent ahead of time, a clinician can transmit necessary information to parents while simultaneously protecting the provider-patient bond.

Encourage parental involvement whenever possible. Even in situations where there is not an acute safety risk, adolescents may benefit from parental support in accessing recommended services. As many clinicians who provide care for adolescents can attest, teens are unlikely to follow through with referrals without the support of an adult — even more so if they are being referred for treatment of a diagnosis that they may not agree with, such as a substance use disorder. Parental participation in the health care of their adolescents should usually be encouraged but should not be mandated (Schizer et al., 2015).

In many cases, by the time an adolescent has developed a substance use disorder, parents or guardians are already aware of their use, though they may underestimate the seriousness of the problem. We recommend that clinicians ask adolescents whether their parents or guardians are aware of their substance use and encourage them to invite their parents or guardians into the conversation. This can be a rewarding experience for the adolescent if the clinician focuses on points of mutual agreement.

SPECIAL CONSIDERATIONS

CO-OCCURRING MEDICAL AND MENTAL HEALTH CONDITIONS

Alcohol or other drug use can lead to disease exacerbation and serious complications among adolescents with a chronic illness and may expose them to other risks that generally worsen health such as inadequate sleep, skipped meals, exposure to smoke and unprotected sex (a particular hazard for youth taking teratogenic or immune suppressing medicines) (Levy et al., 2016; Wisk & Weitzman, 2016; Weitzman et al., 2018).

Alcohol and other drugs may pose unique risks to the validity of diagnostic test interpretation, impacting treatment protocols derived from them, and undermine the safety of prescription medications (Jang et al., 2012). Medication interactions can result in dangerous toxicity. Many medications that are used to treat chronic diseases are hepatotoxic (or destructive to liver cells), which can be exacerbated by alcohol use. This makes alcohol and substance use vital topics to discuss and potential anchor points for screening and brief intervention (Weitzman et al., 2018).

Access to SBIRT may bolster health by encouraging behavior choices that can reduce the prevalence of physical and mental health comorbidities (Sterling et al., 2019; Parthasarathy et al., 2021). Physicians may have substantial opportunities to discuss these issues given the high frequency youth with chronic conditions interact with the health care system. Long-term rapport with specialty providers may increase the salience of health guidance and messages (Weitzman et al., 2019).

POLYSUBSTANCE USE

The term polysubstance use broadly describes the consumption of more than one drug over a defined period, simultaneously or at different times for either therapeutic or recreational purposes. In substance use prevention and treatment, it usually refers to multiple illicit drug use, but it can also include illicit and prescription medication used for nonmedical purposes. Polysubstance use is more common among adolescents than adults. Among e-cigarette users in grades 9-12, almost all (93%) reported other substance use (Gilbert et al., 2021).

PRESCRIPTION AND ILLICIT DRUGS



IN 2019,

567,000

adolescents age 12-17 were current nonmedical users of pain medication.

IN 2019,

1,754,000

youth age 18-25 were current nonmedical users of pain medication (SAMHSA, Centers for Behavioral Health Statistics and Quality, 2020)

TRAUMA

The National Institute on Drug Abuse (NIDA, 2014) asserts that **two-thirds of all those with substance use disorders have previously experienced trauma in childhood**. In 2016, it was estimated that 46% of youth ages 17 and younger experienced at least one traumatic event (Sacks & Murphey, 2018).

One of the most compelling reasons to implement a trauma-informed approach was documented by the Adverse Childhood Experiences (ACE) Study. Recent research confirms that trauma leads to brain dysregulation and chronic stress that negatively affects development, health outcomes and life expectancy (McEwan & Gregerson, 2019).

Considering the connection between trauma and substance use, it is critical that providers infuse trauma-informed practices into their SBIRT process. A trauma-informed approach prioritizes understanding life experiences and their impact on psychological wellness, physical symptoms and outcomes, treatment adherence and other behaviors to deliver more effective care to patients.

(See [Conversation Guide for Delivering a Trauma-informed Brief Intervention](#).)

SOCIAL AND CULTURAL CONSIDERATIONS

Growing evidence suggests that systems-level and area-level variables, like where adolescents live (metropolitan versus rural) and Medicaid provider acceptance rates, are not only among the most important contributors to racial/ethnic differences in treatment access and outcomes, but also have a disproportionately negative impact on certain ethnic minorities (Cook et al., 2012).

In addition to individual, familial, school, systems and area factors, some groups also face social stigma and discrimination that put them at risk for higher rates of substance use. For example, discrimination against and denial of civil and human rights of lesbian, gay, bisexual and transgender (LGBT) persons has been associated with higher rates of substance use when compared to the general population (Herek & Garnets, 2007; Ibanez et al., 2005).

When discussing substance use with minority populations, it is critical to do so in a way that is respectful of different cultural perspectives and ensures that messages about substance use and health are communicated in a manner that is responsive to patients' cultural backgrounds and perspectives.

While it is important to be aware that different groups of individuals may have different combinations of risk and protective factors, a health provider should not make assumptions about the influence of culture, gender, upbringing or other personal factors in a patient's life. Cultural humility rather than cultural competence may be a more reasonable goal as it honors the patient's lived experience and uniqueness and centers that experience as an integral component of care.



REFERENCES

- Addiction Medicine Foundation. (2016). Identifying and responding to substance use among adolescents and young adults: A compendium of resources for medical practice. Retrieved from <https://www.adolescentsubstanceuse.org/wp-content/uploads/2017/09/ABAM-Compendium-of-Resources.pdf>
- American Academy of Pediatrics (AAP). (2010). Information for teens: What you need to know about privacy. Retrieved from <https://www.healthychildren.org/English/ages-stages/teen/Pages/Information-for-Teens-What-You-Need-to-Know-About-Privacy.aspx>
- Committee on Substance Use and Prevention. (2016). Substance Use Screening, Brief Intervention, and Referral to Treatment. Official Journal of the American Academy of Pediatrics. Volume 138, Issue 1. Retrieved from <https://pediatrics.aappublications.org/content/138/1/e20161210>
- Cook, B.L., McGuire, T.G., Zaslavsky, A.M. (2012). Measuring racial/ethnic disparities in health care: Methods and practical issues. Health Serv Res, 1232e54. <https://pubmed.ncbi.nlm.nih.gov/22353147/>
- Del Boca, F., McRee, B., Vendetti, J. et al. (2017). The SBIRT program matrix: A conceptual framework for program implementation and evaluation: SBIRT program matrix. *Addiction*, 112(S2):12-22. Retrieved from: www.researchgate.net/publication/312354743_The_SBIRT_program_matrix_a_conceptual_framework_for_program_implementation_and_evaluation_SBIRT_program_matrix

Gilbert, P.A., Kava, C.M., Afifi, R. (2021). High-school students rarely use e-cigarettes alone: A sociodemographic analysis of polysubstance use among adolescents in the United States. *Nicotine & Tobacco Research*, 23(3), 505-510. <https://academic.oup.com/ntr/article-abstract/23/3/505/5735099?redirectedFrom=fulltext>

Herek, G.M., Garnets, L.D. (2007). Sexual orientation and mental health. *Annu Rev Clin Psychol*, 3:353-75. <https://pubmed.ncbi.nlm.nih.gov/17716060/>

Ibanez G.E., Purcell D.W., Stall R., Parsons J.T., Gómez, C.A. (2005). Sexual risk, substance use, and psychological distress in HIV-positive gay and bisexual men who also inject drugs. *AIDS*,19(suppl 1):49-55. <https://pubmed.ncbi.nlm.nih.gov/15838194/>

Jang, E.S., Jeong, S-H., Hwang, S.H. Kim, H. Y., Ahn, S. Y., Lee, J., Lee, S.H., Park, Y.S., Hwang, J.H., Kim, J-W., Kim, N., Lee, D.H. (2012). Effects of coffee, smoking, and alcohol on liver function tests: A comprehensive cross-sectional study. *BMC Gastroenterol*, 12,145. <https://bmcgastroenterol.biomedcentral.com/articles/10.1186/1471-230X-12-145>

Levy, S., Dedeoglu, F., Gaffin, J.M. et al. (2016). A screening tool for assessing alcohol use risk among medically vulnerable youth. Vrana, K.E., et. *PLoS One*, 11(5), e0156240. Retrieved from <https://doi.org/10.1371/journal.pone.0156240>

Levy, S.J. & Williams, J.F. (2016). Substance use screening, brief intervention and referral to treatment. *American Academy of Pediatrics*, 138(1). Retrieved from <https://pubmed.ncbi.nlm.nih.gov/27325634/>

McEwan, C.A., Gregerson, S.F. (2019). A critical assessment of the adverse childhood experiences study at 20 years. *American Journal of Preventive Medicine*, 56(6), 790-794. <https://pubmed.ncbi.nlm.nih.gov/30803781/>

National Institute on Drug Abuse (2014). Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide. Retrieved January 18, 2017, from <https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide>

Massachusetts Child Psychiatry Access Program. (2015). Screening to brief intervention (S2BI) tool. https://www.mcpap.com/pdf/S2BI_postcard.pdf

Parthasarathy, S., Kline-Simon, A.H., Jones, A., Hartman, L., Saba, K., Weisner, C., Sterling, S. (2021). Three-Year Outcomes After Brief Treatment of Substance Use and Mood Symptoms. *Pediatrics*,147(1): e202009191. <https://pediatrics.aappublications.org/content/pediatrics/147/1/e202009191.full.pdf>

Sacks, V., Murphey, D. (2018). The prevalence of adverse childhood experiences nationally, by state, and by race/ ethnicity. *Child Trends*, Publication #2018-03. <https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity>

SAMHSA. (2020). Results from the 2019 National Survey on Drug Use and Health: Detailed tables. <https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetailedTabs2019.htm>

Schizer, M., Weitzman, E.R., Levy, S. M. (2015). Medical issues in adolescent substance use: background and role of the primary care physician. In: Zucker R, Brown S, eds. *The Oxford Handbook of Adolescent Substance Abuse*. Oxford, England: Oxford University Press. <https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199735662.001.0001/oxfordhb-9780199735662-e-39>

Sterling, S., Kline-Simon, A.H., Jones, A., Hartman, L., Saba, K., Weisner, C., Parthasarathy, S. (2019). Health care use over 3 years after adolescent SBIRT. *Pediatrics*, 143(5). <https://pediatrics.aappublications.org/content/143/5/e20182803>

Subramaniam, G., Levy, S. (2013). Treatment of opioid-dependent adolescents and young adult using sublingual buprenorphine. Providers Clinical Support System. <https://pcssnow.org/wp-content/uploads/2014/03/PCSS-MATGuidanceTreatmentofOpioidDependantAdolescent-buprenorphine.SubramaniamLevy1.pdf>

Watkins, K., Pincus, H.A., Tanielian, T.L., Lloyd, J. (2003). Using the chronic care model to improve treatment of alcohol use disorders in primary care settings. *J Stud Alcohol*, 64(2):209-218. <https://pubmed.ncbi.nlm.nih.gov/12713194/>

Weitzman, E.R., Magane, K.M., Wisk, L.E. Allario, J., Harstad, E., Levy, S. (2018). Alcohol use and alcohol-interactive medications among medically vulnerable youth. *Pediatrics*, 142(4), e20174026. <https://pubmed.ncbi.nlm.nih.gov/30228168/>

Weitzman, E.R., Salimian, P.K., Rabinow, L., Levy, S. (2019). Perspectives on substance use among youth with chronic medical conditions and implications for clinical guidance and prevention: A qualitative study. Gullo MJ, ed. *PLoS One*, 14(1), e0209963. <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0209963>

Wisk, L.E., Weitzman, E.R. (2016). Substance use patterns through early adulthood: Results for youth with and without chronic conditions. *Am J Prev Med*, 54(1), 33-45. [https://www.ajpmonline.org/article/S0749-3797\(16\)00058-1/fulltext](https://www.ajpmonline.org/article/S0749-3797(16)00058-1/fulltext)

Woodcock, E.A., Lundahl, L.H., Stoltman, J.J., Greenwald, M.K. (2015). Progression to regular heroin use: Examination of patterns, predictors, and consequences. *Addictive behaviors*, 45, 287-293. <https://www.sciencedirect.com/science/article/abs/pii/S0306460315000866?via%3Dihub>