

ADOLESCENT
S B I R T

Screening, Brief Intervention & Referral to Treatment

Learner's Guide to Adolescent SBIRT

Produced in Partnership with:



National Screening, Brief Intervention & Referral to Treatment

ATTC

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

LEARNER'S GUIDE TO ADOLESCENT SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)

© 2019 NORC at the University of Chicago

This publication was prepared by and is the intellectual property of the authors. All material appearing in this publication, except that taken directly from the public domain, is copyrighted and may not be reproduced or copied without permission from the authors. The training materials contained within may be used freely to educate professionals, faculty/educators, and students, so long as acknowledgement of the authoring organizations is acknowledged during the course and on all course handouts. The development of these materials was supported by funding from the Conrad N. Hilton Foundation. For more information on obtaining additional copies of this publication, please contact SBIRTeam@norc.org.

Recommended Citation:

McPherson, T., Goplerud, E., Bauroth, S., Cohen, H., Storie, M., Joseph, H., Schlissel, A., King, S., & Noriega, D. (2019). Learner's Guide to Adolescent Screening, Brief Intervention and Referral to Treatment (SBIRT). Bethesda, MD: NORC at the University of Chicago.

Printed January 2019. Version 3.0

Table of Contents

Forward	VI
Module 1: What is SBIRT for Youth and Why Use it?	1
What is SBIRT and Why Use It?	2
Introduction.....	2
What is SBIRT?	3
Overview from “35,000 Feet”	3
Other Adolescent Substance Use Prevention Strategies.....	5
Parent Interventions.....	5
Community-level Public Health Interventions	5
Other Substance Use Prevention and Early Intervention Resources	5
Why SBIRT?	5
What is SBIRT?	6
Risky Youth Alcohol Use.....	7
Alcohol use and developmental issues	7
What is a Drink?	10
Costs of Unhealthy Drinking Patterns by Youth	12
Summary	12
Module 2: Screening	14
Screening Tools.....	16
Risky Adolescent Alcohol Use	16
Asking about Alcohol and Drug Use.....	18
Confidentiality	18
Screening Administration	19
ICD-10 Codes.....	20
CRAFFT	20
Using the CRAFFT	21
Scoring and Interpreting the CRAFFT.....	21
The CRAFFT Questionnaire (Version 2.0)	22
What is new in the CRAFFT 2.0?	22
Sample Interaction: Screening with the CRAFFT	24
CRAFFT Role Play	26
AUDIT-C and AUDIT.....	27
Using the AUDIT-C and AUDIT.....	27
Scoring and Interpreting the AUDIT-C and AUDIT	28
Sample Interaction: Asking AUDIT Questions, Interpreting Results and Providing Brief Feedback and Advice	30
AUDIT-C and AUDIT Role Play	32
GAIN-SS.....	33

Using the GAIN-SS.....	33
Scoring the GAIN-SS.....	34
S2BI	34
Using the S2BI.....	34
S2BI Role Play	35
DAST.....	36
Using the DAST-10.....	36
Scoring and Interpreting the DAST-10	36
Sample Interaction: Screening with the AUDIT and DAST-10.....	37
NIDA Modified ASSIST: Level 1 and Level 2.....	40
Other Screening Tools	41
Module 3: Brief Intervention.....	42
Brief Intervention Defined.....	43
Engagement	50
Build rapport	50
Pros and Cons	50
Explore pros and cons	50
Use reflective listening.....	51
Reinforce positives	51
Summarize	51
Feedback.....	52
Ask permission	52
Provide educational information.....	52
Substance Use Increases Risks	53
Elicit response	53
Readiness Ruler	54
Readiness scale	54
Reinforce positives	54
Envisioning change.....	54
Negotiate Action Plan	54
Write down Action Plan.....	55
Envisioning the future	55
Exploring challenges and drawing on past successes	56
Benefits of change	56
Summarize and Thank.....	56
Summarize Action Plan	56
Reinforce resilience and resources.....	57
Provide handout	57
Give an Action Plan	57
Thank the adolescent	57
Brief Intervention Observation Sheets.....	57

Sample Interaction: Screening and Brief Intervention with CRAFFT Questions	62
Brief Intervention Role Play	67
Module 4: Referral to Treatment and Follow-up	69
Referral to Treatment	70
Discussing Treatment Options	73
Treatment Settings	74
Treatment Approaches	75
Starting the conversation	76
Confidentiality	77
Effective Treatment Approaches	78
Considerations for the Referral Process	79
Motivation and Referral	80
Scheduling Treatment Appointments	83
Communicating with Referral Sources	84
Sample Interaction: A parent struggling to get their teenager to seek help for drug use	85
Referral Role Play	88
Working with Physicians in Ongoing Care Coordination ^{133,134}	89
Maintaining Communication with the Physician ¹³⁵	89
Follow-Up and Support	91
Making Phone Contact	91
Follow-up Role Play	93
Sample Interaction: Referral to Treatment, CRAFFT	94
Sample Interaction: Brief Intervention and Referral to Treatment, DAST-10 and AUDIT	98
Module 5: Motivational Interviewing Strategies	103
Motivational Brief Intervention ^{143,144}	104
Motivational Interviewing makes sense as a strategy to employ with adolescents because:	105
Examples of Confrontational Style:	105
Examples of motivated-based change statements:	106
Ready to Change? ¹⁴³	107
Motivational Interviewing Skills Used in Brief Interventions ^{143,144}	111
Motivational Interviewing Skills Role Play	113
Motivational Skill #1: Asking Open-Ended Questions ^{143,144}	114
Motivational Skill #2: Affirming Adolescents ^{143,144}	118
Motivational Skill #3: Utilizing Reflective Listening ^{143,144}	120
Motivational Skill #4: Summarizing Adolescents' Thoughts and Feelings ^{143,144}	124
Motivational Skill #5: Eliciting Change Talk ^{143,144}	126
Motivational Skill #6: Asking Permission and Giving Advice ¹⁴³	132
Motivational Skill #7: Generating Options ¹⁴³	134
Motivational Skill #8: Managing Pushback ¹⁴³	137

Sample Interaction: Brief Intervention with Moderate Risk, Non-Resistant, Contemplative Young Adult, Age 20	140
Sample Interaction: Brief Intervention with Moderate Risk, Resistant or Pre-Contemplative Adolescent, Age 16, Sports Physical/Re-injury.....	144
Sample Interaction: Brief Intervention with Moderate Risk, Resistant or Pre-Contemplative Adolescent, Age 15, Physical Injury	147
Motivational Interviewing Skills Role Play	152
Brief Intervention Observation Sheets.....	153
References	155
Appendices	166
Appendix A. Screening Tools	167
CRAFFT	167
CRAFFT 2.0 – Clinician Interview	170
CRAFFT 2.0 – Self-Administered.....	172
CRAFFT Pocket Guides	175
AUDIT-C and AUDIT	176
GAIN-SS.....	177
S2BI	179
DAST-10.....	181
CLINIC LOGO	181
NIDA Modified ASSIST Level 1.....	183
NIDA Modified ASSIST Level 2.....	187
NIAAA Youth Guide Screen.....	190
Appendix B. Standard Drink Chart.....	191
Appendix C. DSM Criteria	192
Appendix D. Goal Setting Exercise.....	194
Appendix E. Change Plan Worksheet	195
Appendix F. Mutual Support Groups	197
Appendix G. Brief Intervention Observation Sheets.....	198
Appendix H. Brief Intervention Case Studies	203
Appendix I. Sample Release Form.....	216
Appendix J. Sample Client Update Report.....	217
Appendix K. Decisional Balance Worksheet.....	218
Appendix L. Pocket Cards.....	219
Appendix M. Acronym List.....	221
Appendix N. Kognito’s SBI with Adolescents User Guide	223
Appendix O. Resources.....	225
Appendix P. Acknowledgements	229
Individual Collaborators	229
Organizational Collaborators (alphabetical order)	230

List of Exhibits

Figure A: Alcohol use among adolescents ⁵⁰	8
Figure B: Past year alcohol use among youth ⁴²	8
Figure C: Alcohol Impacts Stages of Development ⁵⁴	9
Figure D: U.S. Standard Drink Chart ⁵⁹	10
Figure E: Number of Standard Drinks by Container ⁵⁹	11
Figure F: Estimated Binge Drinking Levels for Youth ⁴²	11
Figure G: Assessing the Level of Risk and Appropriate Intervention Response ⁴²	17
Figure H: Studies and Literature Reviews	46
Figure I: BNI Adolescent Algorithm	48
Figure J: Adolescent Substance Use Treatment by Referral Source	71
Figure K: Stages of Change Model ¹⁵⁰	109
Figure L: Stages of Change: Intervention Matching Guide ¹⁵⁰	110

Forward

This Learner’s Guide was created specifically for educators and practitioners to use when training on Screening, Brief Intervention, and Referral to Treatment (SBIRT) with an adolescent population. This guide was developed in collaboration with subject matter experts and national organizations that represent educators and health professionals providing services to adolescents and young adults in a range of settings. A list of collaborating organizations are provided in Appendix P.

Dr. Tracy L. McPherson, Dr. Eric Goplerud, and the SBIRT Team from NORC at the University of Chicago (NORC) facilitate the Adolescent SBIRT Project and led the development and collaboration with organizations and expert consultants that produced this Learner’s Guide.

This Learner’s Guide would not have been possible without support from the Conrad N. Hilton Foundation (www.hiltonfoundation.org).

Module 1: What is SBIRT for Youth and Why Use it?

What is SBIRT and Why Use It?

Learning Objectives	Suggested Readings
<ol style="list-style-type: none"> 1. Learn what SBIRT stands for and what each component means. 2. Understand why SBIRT is relevant and important for use with adolescents and young adults. 3. Understand the impact of use of alcohol and other substances in the lives of adolescents. 4. Learn how alcohol use is measured—what constitutes one drink. 5. Recognize the prevalence of substance use among youth. 	<ul style="list-style-type: none"> ■ Babor TF, McRee BG, Kassebaum PA, Grimaldi PL, Ahmed K, Bray J. Screening, brief intervention, and referral to treatment (SBIRT): Toward a public health approach to the management of substance abuse. <i>Substance Abuse</i>. 2007; 28(3):7-30. ■ U.S. Preventive Services Task Force. <i>Final Recommendation Statement: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care</i>. Washington, DC: U.S. Preventive Services Task Force; 2013. ■ American Academy of Pediatrics Committee on Substance Abuse, Levy SJ, Kokotailo PK. Substance use screening, brief intervention, and referral to treatment for pediatricians. <i>Pediatrics</i>. 2011; 128(5):e1330-e1340. ■ Substance Abuse and Mental Health Services Administration. <i>White Paper on Screening, Brief Intervention, and Referral to Treatment in Behavioral Healthcare</i>. Rockville, MD: Substance Abuse and Mental Health Services Administration; April 2011.

Introduction

This Learner’s Guide will focus on Screening, Brief Intervention, and Referral to Treatment (SBIRT) for youth, which includes “adolescents” age 12-17 and “older adolescents” (commonly referred to as “young adults”) age 18 to 21. Throughout this Guide, the use of “adolescents” and “young adults” is used intentionally to draw attention to the appropriate use of screening tools, sample dialogue and interactions, role play exercises and other materials most applicable for these different segments of the youth population. Although SBIRT for adults is not the focus of this

Age Group	
Adolescent	12-17
Young Adult	18-21
Adult	22 and older

Guide, information and resources are referenced throughout to provide important and relevant content that applies to the young adult population. More information on adult SBIRT education is available from the authors and at <http://www.sbirteducation.com>.

What is SBIRT?

SBIRT is an evidence-based practice used to identify, reduce, and prevent risky, excessive, unhealthy, and harmful use of alcohol, tobacco, and other substances. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines SBIRT as “a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.”¹ Through this practice, practitioners work to identify substance use that increases the risk of physical and emotional health problems, disease, and injury as well as school, work, family, and social problems, and help to reduce its impact. SBIRT practice involves quickly screening people and using this information to assess degree of risk, conducting a brief intervention designed to help motivate people to change their behavior (typically organized around Motivational Interviewing (MI)), and referring people to treatment or other services, if necessary.

SBIRT is an effective and efficient set of services, which can be integrated into a range of health care and related settings beyond substance use specific services.² Though individuals may not self-identify or are not seeking treatment for substances specifically, alcohol and other drugs may still play a role in other issues and should be addressed.

SBIRT is used in integrated primary and behavioral health care settings (e.g., patient-centered medical homes); outpatient primary care clinics; hospital emergency departments, trauma centers, and inpatient psychiatric units; federally qualified health centers; community mental health centers; criminal and juvenile justice settings; college/university counseling and health centers; school-based health clinics; dental clinics; HIV clinics; homeless shelters; peer and recovery support programs; faith-based settings; military healthcare and the Veterans Administration; addiction and mental health counseling; employee assistance programs; and other settings.

Increasingly, behavioral and medical treatment and prevention/early intervention settings are building SBIRT into practice routines and expecting that health and affiliated professionals be skilled in SBIRT. Fortunately, some practitioners already implement components of SBIRT because they incorporate screening for substance involvement and possible problems into their practice, and routinely use MI techniques and referrals to other professionals. However, for many practitioners, screening for and having conversations specifically about risky use of alcohol and other substances is very new. Moreover, SBIRT-type tasks were not part of their formal education or training, nor incorporated into ongoing professional development and continuing education opportunities.

This Learner’s Guide aims to assist youth-serving educators and practitioners with incorporating SBIRT education into existing curriculum, including both coursework and field placement/preceptorship experience. It can also be used to train other educators, program alumni, and practitioners already in the workforce who work with youth and could benefit from SBIRT education and training.

Overview from “35,000 Feet”

There are three core components of adolescent SBIRT:

- **Screening - the process of assessing risk.**

Screening is an important component to jumpstart the SBIRT process. If you do not ask, adolescents will not tell you about their use of alcohol and other substances.

When screening those under the age of 22, there are multiple recommended screening tools, including the Alcohol Use Disorders Identification Test (AUDIT), Global Appraisal of Individual Needs - Short Screener (GAIN-SS), Screening to Brief Intervention (S2BI), the Drug Abuse Screening Tool (DAST), the NIDA Modified ASSIST (Levels 1 and 2), and the NIAAA Youth Guide Screen. Additionally, the 6-item CRAFFT is a very accurate and popular SBIRT screening tool for adolescents. Copies of screening tools are located in Appendix A of this Learner’s Guide, and screening is discussed in detail in Module 2.

- **Brief Intervention - a behavior change strategy focused on helping the adolescent reduce or stop their use of alcohol and other substances.**

Any amount of substance use (starting with mere “experimentation”) is concerning for young people due to potential health impacts as well as associated risky behaviors and future drug use.³ If screening indicates risky substance use, you may choose to provide immediate feedback on how the adolescent’s substance use compares to others his or her age and gender, offer simple advice, explore the pros and cons of substance use, and ask if he or she is willing to make a change. A brief intervention can take as little as 1-3 minutes (when providing screening score feedback, normative behavior information, or brief advice), take the form of 15-30 minutes (expanded discussion or advice), or may take place in one or several full 60-minute sessions. Substance use may be the adolescent’s primary problem and may become the focus of your interaction. However, it is very likely that substance use is a factor that complicates a primary medical or behavioral problem. In this light, as the use of SBIRT extends into a wide array of settings, it is likely that youth may not even be aware of how substance use issues are impacting other facets of their lives (e.g., physical or mental health, school or athletic performance, relationships with peers and family).

Brief intervention can help many, but certainly not all, youth to make changes in substance use. Some will not be ready to change or may need specialized substance use treatment. Further discussion of brief intervention and motivational interviewing strategies for promoting readiness and behavior change are discussed in Modules 3 and 5.

- **Referral to Treatment and Follow-up – linking the adolescent to specialized substance use treatment and staying with the adolescent to support sustained success.**

When substance use problems are more serious or complicated, intensive and specialized treatment may be a good option. “Referral to treatment” means connecting your adolescent to a physician and/or other licensed mental health professional for comprehensive assessment, medical, and behavioral health treatment, or a specialty treatment program for substance use disorders. “Follow-up” means care management and coordination according to the practitioner’s organization’s protocols as well as supporting the adolescent during treatment and post-treatment follow-up contacts. Follow-up in the form of a brief contact is appropriate for all adolescents. Referral and follow-up are discussed in more detail in Module 4.

Other Adolescent Substance Use Prevention Strategies

Parent Interventions

SBIRT is not the only intervention designed to address adolescent substance use and it may be paired with other strategies that target prevention. For instance, SAMHSA has developed a program called *Talk. They Hear You* (<http://www.samhsa.gov/underage-drinking>), which is designed to help parents and caregivers talk to their children early about the dangers of alcohol.⁴ The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has developed materials for parents to support conversations with children about alcohol (<https://pubs.niaaa.nih.gov/publications/adolescentflyer/adolflyer.htm>). Survey data show that children begin to have positive thoughts about alcohol between ages 9 and 13, which highlights the importance of starting the conversation with children early.⁵ Turrisi et al.⁶ found that parental communication about alcohol before college entry was more likely to prevent nondrinking students from transitioning to heavy drinking. Additionally, students who started heavy drinking before college and then received parental advice about alcohol were almost 20 times more likely to reduce drinking when compared to students who did not discuss alcohol use with parents.⁶ Visit the websites listed above for materials that you can distribute to parents.

Community-level Public Health Interventions

SBIRT is an intervention that should be part of a broader public health strategy that includes a range of community-level interventions. The Guide to Community Preventive Services recommends evidence-based interventions such as increasing alcohol taxes, enhancement of laws prohibiting sales to minors, school-based peer organizing interventions, and social norming campaigns, among others.^{7,8} For more information, see <https://www.thecommunityguide.org/topic/excessive-alcohol-consumption>.

Other Substance Use Prevention and Early Intervention Resources

There are other prevention and early intervention strategies and resources available. Many of these programs and tools are listed on the NORC Adolescent SBIRT website under the Resources tab at <http://sbirt.webs.com/resource-lists>. In particular, the Trust for America's Health (TFAH), a non-profit, non-partisan organization working to protect the health of communities, published a report in 2015 documenting effective strategies to reduce teen substance misuse. The report can be accessed at <https://www.tfah.org/report-details/reducing-teen-substance-misuse-what-really-works/>.

Why SBIRT?

SBIRT is simple, brief and effective. Considerable evidence demonstrates the efficacy and cost-effectiveness of alcohol SBIRT for adults⁹⁻¹³ and its effectiveness for illicit or prescription drug use is promising but mixed.¹⁴⁻¹⁷ A growing body of evidence indicates that SBIRT is also effective as a prevention and early identification approach to reduce use of youth substance use,¹⁸⁻²⁶ underage drinking,^{25,27-31} and cannabis use.³²⁻³⁵

The U.S. Preventive Services Task Force (USPSTF)¹² reviewed the research literature on screening for unhealthy alcohol use and brief counseling and recommended that primary care settings routinely provide screening to those age 18 and older. Whereas USPSTF concluded that the body of evidence for those under age 18 is insufficient to determine whether it should be routinely provided to adolescents in primary care, the use of SBIRT with teenagers is an emerging area of practice and the research literature is pointing to promising results.³¹

Moreover, numerous medical professional associations and government agencies have endorsed screening and brief counseling for youth, including adolescents. This includes initiatives to increase integration of SBIRT into behavioral and medical healthcare systems by the National Institutes of Health (NIH), SAMHSA, Health Resources and Services Administration, Agency for Healthcare Research and Quality, and the White House Office of National Drug Control Policy. Also, national and international public health agencies and medical professional associations have made formal recommendations and in some cases released formal guidance calling for health professionals to conduct screening and brief intervention for adolescents and young adults, including the American Medical Association,³⁶ American Academy of Pediatrics (AAP),³⁷ Bright Futures,^{38,39} the U.S. Surgeon General,⁴⁰ the World Health Organization,^{41,42} NIAAA,⁴² the National Institute on Drug Abuse (NIDA),³ the International Nurses Society on Addiction, the Emergency Nurses Association, the American Public Health Association, the Society for Adolescent Health and Medicine, the American College of Emergency Physicians, and others. SBIRT is part of the continuum of substance use care deemed “essential services” required of all health plans as part of the Patient Protection and Affordable Care Act⁴³ legislation starting in 2014. Moreover, under the [Early Periodic Screening, Diagnosis, and Treatment](#) statute, all states are required to provide Medicaid-eligible children with screening, “including assessment of both physical and mental health development,” which includes substance use during well-child visits.^{44,45}

What is SBIRT?

The overall aims of SBIRT for youth include:

- Increase early identification of adolescents and young adults at-risk for substance use problems.
- Build awareness and educate adolescents and young adults on U.S. guidelines for low risk drinking and the risks associated with substance use.
- Motivate those at-risk to reduce unhealthy, risky use and adopt health promoting behavior.
- Motivate individuals to seek help and increase access to care for those with (or at-risk for) a substance use disorder.
- Link adolescents and young adults at high risk to more intensive treatment services.
- Foster a continuum of care by integrating prevention, intervention, and treatment services.

Risky Youth Alcohol Use*

To further understand the need for SBIRT, it is imperative to first explore the characteristics of risky alcohol use. According to the American Academy of Pediatrics recommendations, any amount of adolescent alcohol use is deemed risky.³⁸ Yet popular models of substance use tend to focus on addiction (e.g., severe-end of substance use) and thus minimize attention to the early stages of substance involvement. Substance use and resulting problems by youth exist on various levels, not just addiction. Thus, the SBIRT model seeks to expand services for youth who have not yet advanced to addiction, but are still engaging in risky behavioral or early stage drug involvement. For example, more than half of the U.S. population over age 12 drinks alcohol,⁴⁶ and for some, alcohol use leads to a range of personal and social problems during the teenage years. These problems include:

- School problems (e.g. higher absence, poor academic performance, reduced athletic performance)
- Social problems (e.g. lack of participation in youth activities, fighting)
- Relationship problems with family and friends
- Legal problems (DUI)
- Unwanted, unplanned and unprotected sexual activity
- Memory problems
- Abuse of other drugs
- Death from alcohol poisoning
- Changes in brain development which may have life-long effects⁴⁷
- Adverse effects on maturation of reproductive system⁴⁸

Alcohol use and developmental issues

Alcohol and other substance use is common.... According to the 2016 Monitoring the Future (MTF) National Survey Results on Drug Use, 23% of 8th graders, 43% of 10th graders, and 61% of 12th graders report trying alcohol. Although drug use by adolescents is a serious concern, alcohol use is more common than cigarette, marijuana, prescription drug, or other illicit drug use in adolescents. The survey also found that one-third of high school seniors report drinking some alcohol in the last month and 85% say that alcohol would be fairly or very easy to get. Moreover, despite trends showing some improvement in perceived risk and disapproval of binge drinking as well as the continued steady decline in prevalence of alcohol use, almost 10% of 10th graders and 16% of 12th graders reported “binge drinking” (i.e., having five or more drinks in a row on one or more occasions) within the past two

*Since SBIRT was originally developed to target alcohol and tobacco use, more research has been conducted on the effectiveness of SBIRT in reducing risky alcohol consumption than with other illicit substances. For that reason, this section will focus predominantly on alcohol use. Please see <http://sbirt.webs.com/resource-lists> for more information on using SBIRT to address other illicit substance misuse.

weeks.⁴⁹ As illustrated in Figures A and B, alcohol use among adolescents increases into the later teenage years demonstrated by the increase from 8th grade to the 12th grade.

Figure A: Alcohol use among adolescents⁵⁰

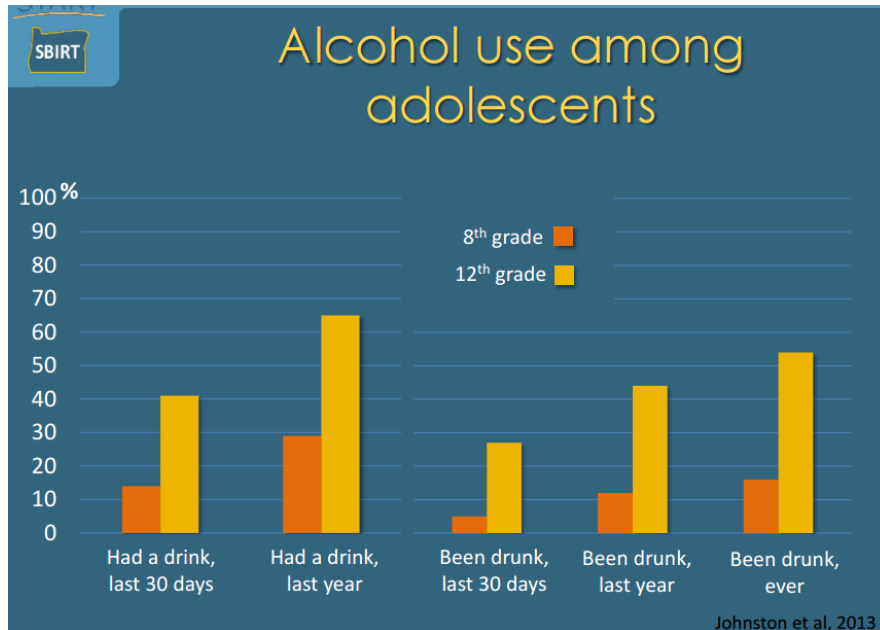


Figure B: Past year alcohol use among youth⁴²



... **And risky.** Screening for unhealthy alcohol use in adolescents is especially important because of three major reasons.

- First, **alcohol use can have lasting effects on the developing adolescent brain.** Adolescent heavy drinkers experience impaired memory, attention and quick information processing, and executive functioning.⁵¹
- The second factor is that studies have shown that the **age of first use is inversely correlated with lifetime incidences of developing a substance use disorder.** According to the National Center on

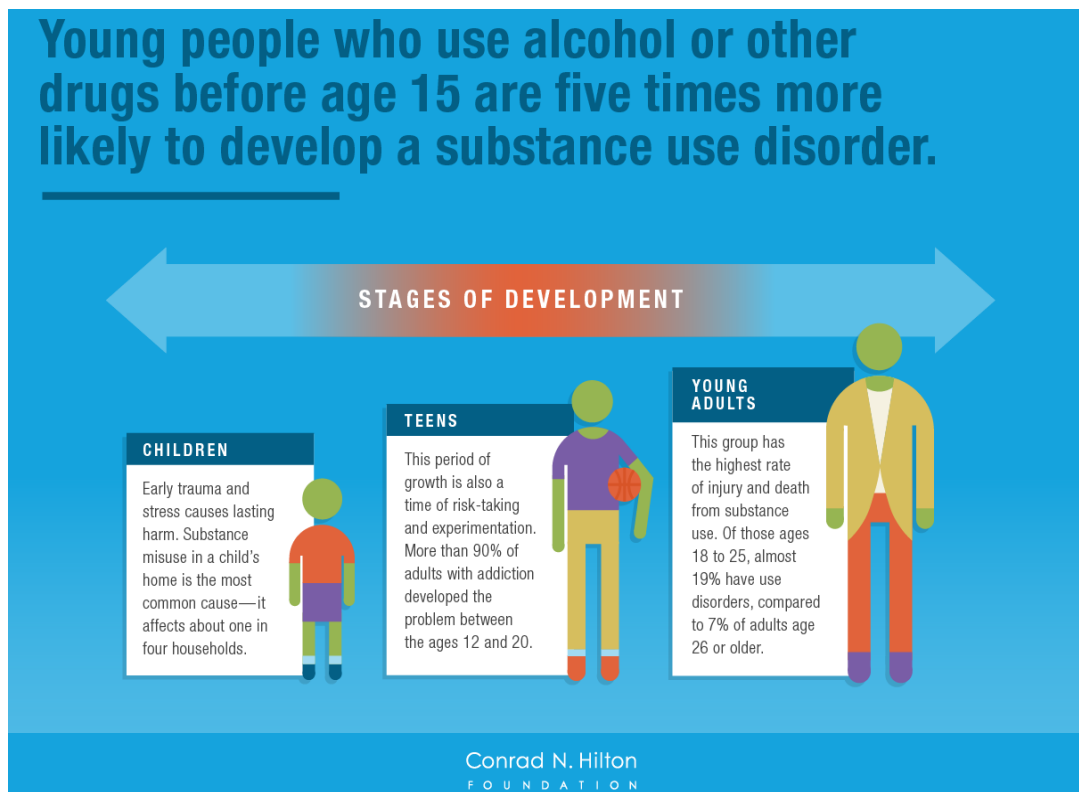
Addiction and Substance Abuse (CASA), 9 in 10 people who meet the criteria for addiction began to smoke, drink and/or use other drugs before age 18. The same CASA report found that 1 in 4 Americans who began using any addictive substance before age 18 have a substance use disorder, compared to 1 in 25 Americans who started using at age 21 or older.⁵²

- The third major reason is that **drinking during the adolescent years is associated with other unhealthy behaviors.** For example, high school students who reported binge drinking were found to be more likely than nondrinkers and non-binge current drinkers to report poor school performance and other health risk behaviors such as riding with a driver who has been drinking, being sexually active, smoking cigarettes or cigars, being a victim of dating violence, attempting suicide, and using illicit drugs.⁵³

Binge Drinking
a short period of
excessive
consumption

Additionally, alcohol misuse is strongly associated with the leading causes of death among U.S. teenagers including motor vehicle crashes, unintentional injuries, homicides, and suicides.^{52,51} In summary, youth who engage in alcohol and other drug use at a young age are at higher risk of lifelong negative personal, social, and health consequences.

Figure C: Alcohol Impacts Stages of Development⁵⁴



... **And often goes undetected.** Substance use in adolescents is common but can often go undetected which is why screening is important. A survey of health professionals indicated that only 33-43% of pediatricians and 14-27% of family practitioners routinely asked adolescent patients about alcohol use, and it is less often with patients 11-14 years old.⁴² With poor screening, it is not surprising that there is a

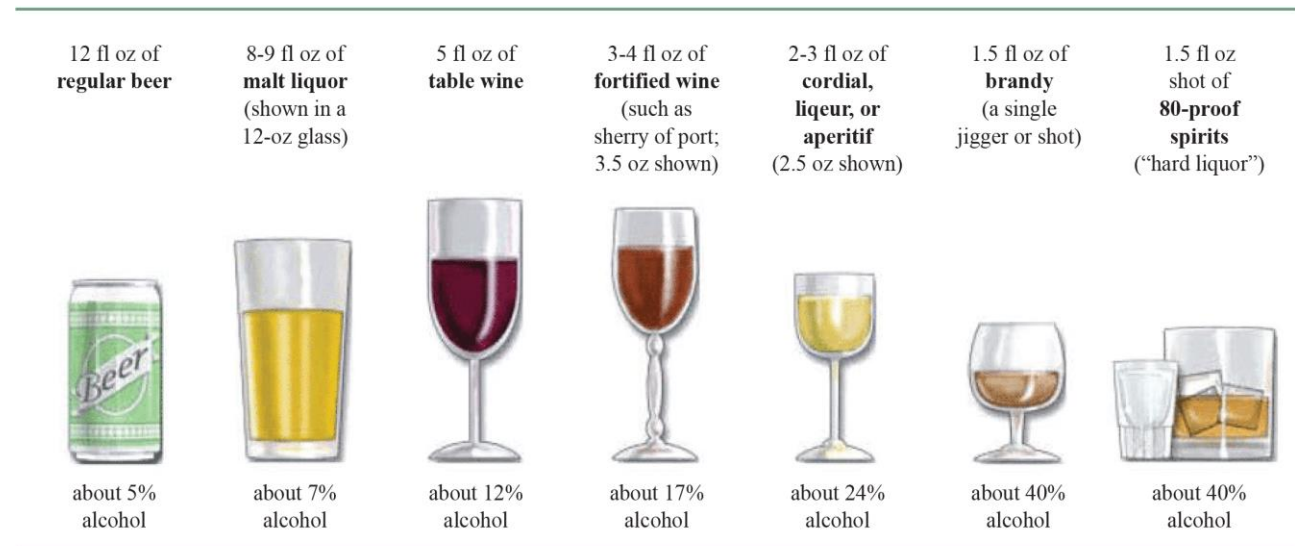
large unmet need for treatment. The National Survey on Drug Use and Health (NSDUH)^{55,56} estimates that in 2015 1.3 million (94%) adolescents age 12-17 and 5.4 million (92%) young adults age 18-25 needed but did not receive substance use treatment in the past year. A series of papers explore the unmet treatment need among youth, its consequences, and opportunities to address the gap through expansion of behavioral health services and use of evidence-based approaches in school-based settings.⁵⁷

What is a Drink?

When understanding risky alcohol use, it is important to know exactly how to measure one drink. It may seem obvious what the adolescent’s answer means to the question: “*How many drinks containing alcohol do you have on a typical day of drinking?*” But, the definition of a drink can be subjective if a definition is not explained to the adolescent. Having a standardized measure of drinks will help you to understand the risks to which the adolescent may be exposed.⁵⁸ In the United States, a “standard” drink is any drink that contains about 0.6 fluid ounces or 14 grams of “pure” alcohol. Although the drinks pictured in Figure D are different sizes, each contains approximately the same amount of alcohol and counts as a single, standard drink.

Figure D: U.S. Standard Drink Chart⁵⁹

Standard Drink Chart



The percent of “pure” alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage.

US Department of Health and Human Services. (2010). Rethinking drinking: Alcohol and your health. *NIH Pub*, (10-3770).

A copy of this U.S. Standard Drink Chart can be found in Appendix B. This chart can be made into a pocket card and used by the practitioner as a visual aid when conducting screening and brief intervention with an adolescent.

A single can or glass of alcohol can be 1, 2, or many drinks. Figure E identifies the number of standard drinks in many typical alcohol containers:

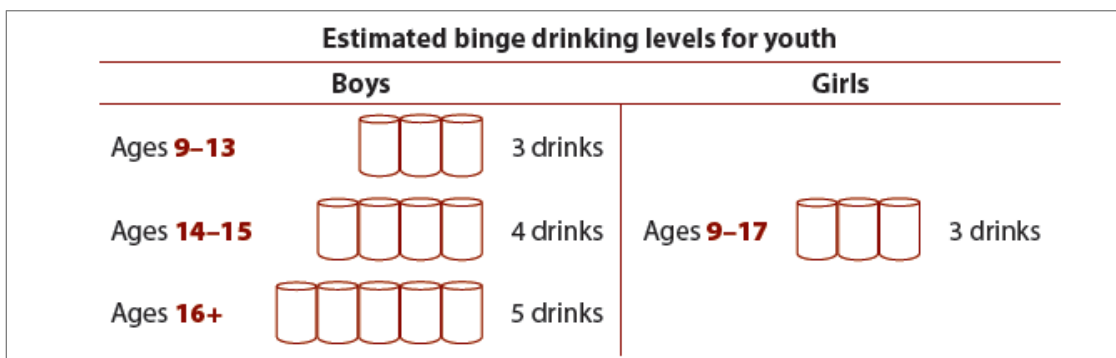
Figure E: Number of Standard Drinks by Container⁵⁹

Alcohol Type	Size of Container	Standard Drinks Equivalent
Beer	12 oz.	1
	16 oz.	1.3
	22 oz.	2
	40 oz.	3.3
Malt liquor	12 oz.	1.5
	16 oz.	2
	22 oz.	2.5
	40 oz.	4.5
Wine	750 mL bottle (25 oz.)	5
80-proof spirits/ “hard liquor”	a mixed drink	1 or more*
	a pint (16 oz.)	11
	a fifth (25 oz.)	17
	1.75 L (59 oz.)	39

It can be difficult to estimate the number of standard drinks in a mixed drink. A mixed drink can contain from 1 to 3 standard drinks. Resources such as NIAAA’s *Rethinking Drinking*[†] offers print materials and online calculators to help estimate the amount of alcohol content, calories, and the cost of one drink. Calculators can be found here: <http://rethinkingdrinking.niaaa.nih.gov/Tools/Calculators/Default.aspx>

The number of standard drinks consumed on an occasion is used to assess engagement in binge drinking. Figure F illustrates how binge drinking is defined for different age groups.

Figure F: Estimated Binge Drinking Levels for Youth⁴²



[†] This resource can be downloaded for free from: <http://rethinkingdrinking.niaaa.nih.gov/>.

Costs of Unhealthy Drinking Patterns by Youth

The estimated cost of adolescent drinking is greater than the cost of unhealthy drinking for the general population. The U.S. Department of Justice reports estimates by the Pacific Institute for Research and Evaluation that the total cost of underage drinking in 2007 was \$68 billion, including \$7.4 billion in medical costs, \$14.9 in work loss costs, and \$45.7 billion in lost quality of life. That amounts to a \$1 cost for every drink that an adolescent consumes.⁶⁰ Additional immediate costs of adolescent drinking include possible payment for alcohol treatment, medical treatment for injuries in traffic accidents, and higher insurance premiums from traffic accidents. Other costs to the adolescent drinker's family include possible money loss while driving the adolescent drinkers to appointments and treatment or taking time off work to accompany their adolescent to court dates. Long-term costs include possible loss of future earnings or contributions to the workforce since adolescent drinkers may have poor academic performance in school and difficulty finding and sustaining jobs.⁶⁰

For the general adult population age 18 and older, which includes young adults, the federal government estimates that 18.7 million Americans drink alcohol in ways that are potentially unhealthy. Their alcohol use puts them at risk of developing the medical illness of alcohol dependence. Sadly, only 3 million people get help.⁶¹ The costs of failing to help the 15.7 million people with untreated alcohol problems are staggering. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use costs at least \$223.5 billion annually, or about \$1.90 per drink. Almost three quarters of these costs are associated with binge drinking. The costs are largely due to losses in workplace productivity (72% of the costs), healthcare expenses (11% of total), law enforcement and other criminal justice expenses related to excessive alcohol consumption (9% of total), and motor vehicle crashes from impaired driving (6% of total). Excessive alcohol consumption also increases dysfunction within the family system, strains social and romantic relationships, increases health-related problems, increases financial stress and potential increases the use of other substances and/or risky behaviors. Nearly 80% of those who have a diagnosable alcohol use disorders are employed.⁶² Unhealthy drinking costs employers and employees approximately \$552 per worker per year in excess health care use. Alcohol use costs individuals in other ways too, including lost productivity due to missed work (absenteeism) or reduced or impaired work functioning (presenteeism); more accidents, resulting in increased workers' compensation and medical claims; extra hospital, emergency and other medical costs; and higher rates of job turnover.⁶³

Summary

SBIRT effectively used within healthcare and community settings can detect alcohol and other substance use problems early on with a proper screening and progression to treatment intervention. Additionally, the use of SBIRT in all points of entry into the medical and behavioral health care systems could provide needed data at a point early in the person's pattern of use that enables effective intervention strategies that could prevent possible longer-term problems and potential spiraling into more devastating addiction patterns. Early identification of risky, excessive alcohol use can potentially save billions of dollars within the total scope of the economy through reduction in health related benefit costs, destruction to family systems, and savings within the criminal justice and legal system. As we move towards integrated care,

electronic health records (EHRs), multiple screenings at multiple entry points could aid in eventual identification of problematic alcohol use, even if early attempts at intervention are not successful.

The remaining modules in this Learner's Guide provide information on how to conduct SBIRT using motivational strategies with adolescents. A companion guide, *The Health Professional's Guide to Screening, Brief Intervention and Treatment*, and other materials on conducting SBIRT with adults is also available at www.sbirteducation.com.

Module 2: Screening

Learning Objectives	Suggested Readings
<ol style="list-style-type: none"> 1. Learn how to administer, score and interpret the CRAFFT, AUDIT and AUDIT-C, GAIN-SS, S2BI, DAST-10, and the NIDA Modified ASSIST Levels 1 and 2. 2. Practice conducting screening. 	<ul style="list-style-type: none"> ■ Winters KC, Kaminer Y. Screening and assessing adolescent substance use disorders in clinical populations. <i>Journal of the American Academy of Child & Adolescent Psychiatry</i>. 2008; 47(7):740-744. ■ Winters KC. Assessment of alcohol and other drug use behaviors among adolescents. In: Allen, JP, Columbus, M, Fertig, J, eds. <i>Assessing Alcohol Problems: A Guide for Clinicians and Researchers 2nd edition</i>. Bethesda, MD: NIAAA; 2003:101-123 ■ CRAFFT: Massachusetts Department of Public Health Bureau of Substance Abuse Services. <i>Provider Guide: Adolescent Screening, Brief Intervention, and Referral to Treatment Using the CRAFFT Screening Tool</i>. Boston, MA: Massachusetts Department of Public Health; 2009. ■ AUDIT: Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. <i>The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care</i>. Geneva: World Health Organization; 2001. ■ S2BI: Levy S, Shrier L. <i>Adolescent SBIRT Toolkit for Providers</i>. Boston, MA: Boston Children's Hospital; 2014.

Risky alcohol and other substance use can be effectively managed and addressed if the pattern of use is identified. One of the biggest obstacles to effective screening and treatment is the failure to ask about substance use during screening opportunities where asking, offering brief advice and counseling can make a significant difference. In this module you will learn how to introduce the topic of risky alcohol and drug use and what questions to ask. In subsequent modules you will also learn about brief, solution-focused, motivational counseling, called brief intervention, which provides the framework and techniques for helping adolescents choose and act to reduce risks associated with substance use.

Screening Tools

Several good screening questionnaires are available for asking adolescents about alcohol and other substance use. In this module, we highlight a few validated tools that are most common for Screening, Brief Intervention, and Referral to Treatment (SBIRT).⁶⁴ The screenings covered in this module include:

Screening Tool	Target Population	Method of Administration	Cost
CRAFFT	Adolescents under the age of 21	Paper and electronic; interview	Publically available
AUDIT-C and AUDIT	Adolescents, Young Adults and Adults	Paper and electronic; interview	Publically available
GAIN-SS	Adolescents and Adults	Paper and electronic; interview	Licensing costs \$100 per agency and covers five years of unlimited use of paper assessments only. See http://gaincc.org/instruments/
S2BI	Adolescents	Paper and electronic; interview	Publically available
DAST-10	Adolescents, Young Adults and Adults	Paper and electronic; interview	Publically available
NIDA Modified ASSIST Levels 1-2	Adolescents, Young Adult and Adults	Paper and electronic	Publically available

This module will introduce the above tools along with example role plays and sample dialogue that can be used to learn how to effectively screen.

Risky Adolescent Alcohol Use

There are different schools of thought about how to conceptualize and define risk. Regardless of which school you adhere, it is important to understand how risk may play into an adolescent's use. The screening tools presented in this module are designed to help practitioners assess risk. Below we present different conceptualizations of risk offered by the American Academy of Pediatrics (AAP) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

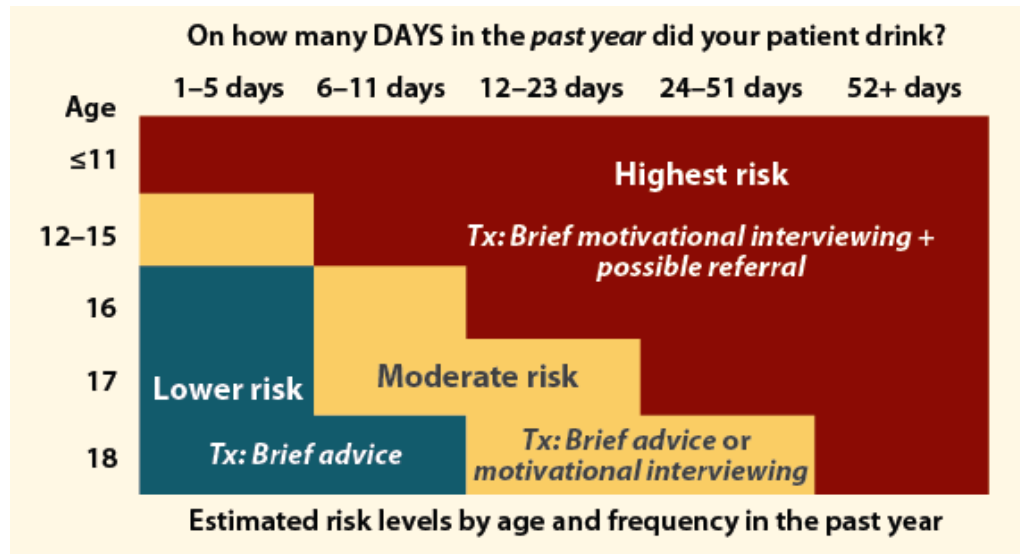
The AAP has identified four general patterns of substance use risk based on using the CRAFFT screening tool that is described in further detail later in this module:³⁸

- **Low Risk (Abstinence):** Adolescents who report no use of tobacco, alcohol or other drugs and report that they have not ridden in a car with a driver who has been using alcohol or other drugs.
- **Driving Risk:** Adolescents who report driving after alcohol or drug use or riding with a driver who has been using alcohol or other drugs.
- **Moderate Risk:** Adolescents who have begun using alcohol or drugs (CRAFFT score 0 or 1)

- **High Risk:** Adolescents who use alcohol or drugs (CRAFFT score ≥ 2)

The NIAAA assesses risk based on age and frequency of alcohol use to classify an adolescent as at **Lower Risk**, **Moderate Risk**, or **Highest Risk**. As shown in Figure G, both the number of drinking days in the past year and the age of the individual are taken into consideration to determine the level of risk.⁴² In general, the younger the individual and the more drinking days, the higher the category of risk.

Figure G: Assessing the Level of Risk and Appropriate Intervention Response⁴²



The approaches offered by AAP and NIAAA above are not the only approaches to assessing risk. In this module, other ways of conceptualizing and assessing risk are described. Specifically, we present different screening tools and how to interpret their respective “cut-off points” to determine the adolescent’s level of risk. One approach is not necessarily superior to another, but rather is meant to offer practitioners a choice in how they determine risk.

Knowing the level of risk helps the practitioner tailor the brief intervention to the adolescent’s needs. For an adolescent at “low” or “lower” risk the brief intervention may include simple advice that provides a clear personalized suggestion to quit (or cut back) on use of alcohol or other substances. For an adolescent at “driving” or “moderate” risk simple advice and brief motivational interviewing is used to engage the adolescent in a conversation about behavior change and reducing risks. At “high” or “highest” risk, in addition to simple advice and brief motivational interviewing, a referral to treatment or other health care services may be warranted. Brief intervention, referral to treatment, and Motivational Interviewing (MI) are discussed in more detail in Modules 3, 4, and 5.

Asking about Alcohol and Drug Use

Regardless of the screening tool used, asking about alcohol or other drug use may be especially difficult with adolescents who may not want to admit or discuss substance use. Successful screening can be enhanced by the memorization of the tools and practice of the conversation skills required to put the adolescent at ease. Whatever the tool and method of instruction, introducing the conversation about substance use and screening is a good skill for any nurse and social worker to practice in order to naturally transition into the suggested tools in this module. The literature also suggests that self-administered computer screening is valid and time-efficient for adolescents and that some adolescents may prefer this method.^{65,66}

How you discuss substance use with the adolescent is important.^{67,68} Practice the following conversations to introduce the topic of drinking with adolescents. To start, you may say:

“In order to help you get the correct services, I would like to ask you some questions about your health that I ask all of my clients/patients. These questions will help me to get to know you and provide you with the services you need. Is that ok?”

“As a way to help me get to know you, I would like to ask you some questions that I ask all of my clients/patients. Is that ok?”

If the adolescent questions why you are asking about substance use, you could respond:

“I ask everyone about their use of alcohol, tobacco and other substances. It helps me better understand your concerns and the things that may come up in any work we do together. The information you tell me is confidential. I will not disclose your answers to your parent.”

After the adolescent consents, you may say:

“Now I am going to ask you some questions about your use of alcohol and other drugs during this past year.”

Confidentiality

Confidentiality can play a vital role in providing health care to adolescents. Research has shown that adolescents who are aware of confidentiality are more willing to seek health care compared to their peers who may not have the same confidentiality.^{12,42} State laws govern minor patient rights to confidentiality of information shared with health care providers about alcohol and drug use, but states vary as to whether or not a minor can confidentially receive drug treatment services. Also, you should explain the full confidentiality policy regarding the disclosure of sensitive issues directly to the adolescent at the very beginning of the assessment. If the adolescent is willing, it can be helpful to explain the confidentiality policy to both the adolescent and the parent or guardian at the same time.

One example of how you might convey an assurance of confidentiality is by saying:

“Everything you tell me will be confidential unless I hear that you’re harming yourself or someone else, or you tell me you’ve been a victim of abuse. I will keep our conversation about your alcohol use between us unless you agree to include your parents. Do you have any questions for me about confidentiality and its limits?”

Here is another example of how to discuss confidentiality.

“Thank you completing the form and for your honesty on it. I’d like to tell you about our confidentiality policy. I’ll keep the details of what we discuss today confidential, which means I won’t share anything with your parents. The limit of confidentiality is safety, so if you tell me something that makes me think you are at risk of hurting yourself, hurting someone else, or someone is hurting or abusing you I would have to share that information with proper health officials to make sure everyone is kept safe. Do you have any questions about how that works?”

There are different steps that you can take to ensure confidentiality and those include establishing a private time for screening and a private time for discussing the results, keeping follow-up visits confidential, talking about referrals, discussing any procedures that may break confidentiality inadvertently, and clarifying risks of releasing medical records.¹²

Screening Administration

Substance use screening questionnaires can be verbally administered by a staff member or clinician, or self-administered by the adolescent using paper and pencil or electronic devices (e.g., iPad or other tablet). There is no one correct approach that suits all settings and situations, but there are several considerations that may favor one approach over another. Self-administered screening by the adolescent may save time and be most efficient because different members of a care team, such as front desk personnel or medical assistants, can initiate screening as part of the check-in process. In addition, the adolescent could complete self-administered screening in the waiting room or the exam/meeting room prior to the visit with the clinician as long as it is possible to create a sense of privacy. With self-administered screening, it is important to inform the adolescent and parent/caregiver (if present) that the adolescent should complete the form on their own. The clinician would then review and verify self-administered responses during the visit. Adolescents may feel more comfortable and provide more accurate responses using self-administered brief screening due to the sensitive nature of the topic. Electronic screening may be especially ideal because of the sense of privacy it confers, the widespread use of digital communication, and the tendency of adolescents to self-disclose quite freely via digital communication. When an adolescent is responding to screening questions in a language other than English, self-administered screening may also be more feasible and efficient. However, when there is concern about reading comprehension or literacy, staff or clinicians must be more involved to assist the adolescent and may need to administer the screening verbally.^{69,70}

ICD-10 Codes

There are different International Classification of Diseases (ICD-10) procedure codes that can be used when billing for screening. There is both a general screening code and also specific codes for alcohol, drug, and tobacco screening and counseling.

Code	Definition
Z13.9	Encounter for screening, unspecified
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.42	Counseling for family member of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser
Z71.52	Counseling for family member of drug abuser
Z71.6	Tobacco abuse counseling

CRAFFT

The CRAFFT tool is the most popular alcohol and drug use screening tool for adolescents 14-21 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse.^{71,72} The tool consists of six questions to screen adolescents for lifetime alcohol and other drug use disorders simultaneously. The tool is brief so that it can be easily integrated into routine care. The CRAFFT has been translated into several languages and is available as a pocket guide for quick reference (see Appendix A). Use of the CRAFFT with an adolescent younger than 14 should proceed cautiously as there are no published psychometric data on this scale for younger adolescents.

The CRAFFT is a mnemonic acronym where each first letter represents a key word in the six screening questions. In this way, it is easier to remember and apply in the field. In order to ensure accuracy of the assessment, it is important to ask the questions exactly as they are written. These screening tools have been tested using the specific wording and any deviation from the original wording may alter the type of response given by the adolescent. However, you may further elaborate and explain the question if the adolescent does not understand the question as it is written.

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

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

A-Do you ever use alcohol/drugs while you are by yourself, ALONE?

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

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

T-Have you gotten into TROUBLE while you were using alcohol or drugs?

Using the CRAFFT

The CRAFFT may be administered via interview or self-administered either electronically or in paper-form. Begin administering the CRAFFT by saying *“I’m going to ask you a few questions that I ask all my patients/clients. Please answer these questions honestly about your possible use of alcohol and other drugs. Your answers will be kept confidential.”* There are two parts to the CRAFFT. The three opening questions to be asked prior to the six CRAFFT questions are referred to as Part A:

1. During the past 12 months, did you drink any alcohol (more than few sips)?
2. During the past 12 months, did you smoke any marijuana or hashish?
3. During the past 12 months did you use anything else to get high?

If the adolescent answers “No” to all of the three opening questions, only the “C” question of the CRAFFT (referred to as the “Car question”) should be asked. If the adolescent answers “Yes” to any of the three opening questions, all six CRAFFT questions (referred to as Part B) should be asked.

The self-administered CRAFFT tool in English and Spanish and is available in Appendix A. The CRAFFT tool has also been translated into several languages, most of which can be found at <http://crafft.org/>.

Scoring and Interpreting the CRAFFT

A complete description of the CRAFFT scoring instructions is available in Appendix A. A score of 0-1 can indicate that there are no problems, however, a score of 2 or more can indicate that a more significant problem may exist and a brief intervention is indicated. Is the 2+ cut-off score a hard and fast rule? No. Whereas most of the research on the CRAFFT has identified 2+ as the optimal cut-score, some research suggests that a 1+ or a 3+ may be a better cutoff score.^{64,73,74} But since the CRAFFT serves mainly as a screening tool, it is best to favor a cut-score that minimizes false negatives (i.e., the teen is incorrectly assessed to not have a problem) compared to false positives (i.e., the teen is incorrectly assessed to have a problem). Thus, using a 3+ cut-score is not recommended as a routine policy (with one exception, as discussed below). What about setting the cut-score lower than 2? The 2+ cut-score is favored given the weight of research evidence. This recommended score provides a good balance between hits and misses, and means that you can be reasonably assured that an adolescent who scores in this range is likely to be appropriate for a brief intervention. But if an adolescent scores a 0 or 1 on the CRAFFT, and you have additional “red flag” information about the adolescent’s substance use (e.g., drinking heavily; uses marijuana regularly; presence of negative consequences resulting from substance use), a brief intervention may also be indicated.⁷⁵

Screening tools, including the CRAFFT, do not provide definitive information. Use of the CRAFFT should proceed with caution and with the recognition that other information may be useful when determining the suitability of a brief intervention for an adolescent. While the 2+ cut-score for the CRAFFT is recommended, the decision of which cut-score to use needs to be placed in the context of resources available to manage positive screens. When resources are scarce, leaning toward a higher cutpoint is worth considering.

The Center for Adolescent Substance Abuse Research (CeASAR) released an updated version (2.0) of the CRAFFT in 2016.

The CRAFFT Questionnaire (Version 2.0)

In 2016, the original CRAFFT tool was updated to create a more streamlined and easy to understand process of self-reporting. While version 2.0 has all of the same basic questions as the original questionnaire, it is more clearly formatted to be easier to follow and to allow for better interpretation of the scope of drug and/or alcohol use. For example, instead of asking simple yes or no questions, version 2.0 asks how often drugs or alcohol has been used. This enhanced item specificity is intended to allow health professionals to better understand which preventative measures to employ and/or which treatment options to offer. Just as in the original CRAFFT tool, version 2.0 has been translated into multiple languages, most of which can be found at <http://crafft.org/get-the-crafft/>.

What is new in the CRAFFT 2.0?

The CRAFFT 2.0 now incorporates opening questions inquiring about the frequency of past-12-month use of alcohol or other substances, in place of the previous opening questions that asked “yes” or “no” questions about prior use. A recent study examining the validity of these opening yes/no questions found relatively low sensitivity in identifying youth with any past-12-month alcohol or marijuana use (62% and 72%, respectively).⁷⁶ Research suggests that yes/no questions about sensitive topics may have greater potential for “motivated underreporting” and social desirability bias than questions that ask “how many” or “how often” which implicitly convey an expectation of the behavior.⁷⁷ Therefore, the opening questions were modified to ask about past-12-month frequency (“on how many days”), and include the instruction “Say 0 if none” to also normalize non-use. Item validity was tested in a screening study of adolescent primary care patients. Compared to the criterion standard of a research staff-administered confidential Timeline Follow-Back interview, results showed that the frequency questions had improved sensitivity in identifying adolescent alcohol and drug use (79% and 86%, respectively) compared with that found for the yes/no questions in the prior study.⁷⁶ For the opening questions, the highest sensitivity is preferred to avoid missing anyone who may be at risk. A copy of CRAFFT 2.0 screening tool is included in Appendix A.

Previous Questions:

During the past 12 months, did you:	Yes	No
Drink any alcohol (more than a few sips)?		
Smoke any marijuana or hashish?		
Use anything else to get high?		

CRAFFT 2.0 Questions:

During the past 12 months, on how many days did you:	# of days
Drink more than a few sips of beer, wine or any drink containing alcohol ? Say “0” if none.	
Use any marijuana (pot, weed, hash, or in foods) or “ synthetic marijuana ” (like “K2” or “Spice”)? Say “0” if none.	
Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or “huff”)? Say “0” if none.	

Sample Interaction: Screening with the CRAFFT

Setting: Mary, a 16 year old high school junior, was arrested for vandalism of school property when she was caught spray painting graffiti after school. Because this was her first offense, she was instructed to participate in a school-based diversion program for one year. During her first session in the program, Mary met with Steve, a social worker who conducted a risk assessment to identify any behavioral health issues and to connect Mary to appropriate services. In order to identify risky substance use along a broader continuum, the school-based diversion program integrated the CRAFFT screening questions into their risk assessment, replacing the assessment's standard substance use questions.

The dialogue for the in-person CRAFFT screening is presented below. Other areas of the risk assessment are mentioned in the dialogue, but are not included in this sample interaction. The scoring of the CRAFFT is calculated and noted in parentheses throughout the dialogue.

Practitioner: *Hello, Mary.*

Adolescent: *Hi.*

Practitioner: *How are you feeling today?*

Adolescent: *I'm ok.*

Practitioner: *It sounds like you aren't feeling great, but not feeling too bad either. Is this correct?*

Adolescent: *Yeah, whatever. I'm ok. I just don't feel like talking.*

Practitioner: *Well, as part of my role in this program, I ask a set of questions to everyone on their first day in the program. These questions will help me learn more about you and help you to get the most out of this program. The questions are about alcohol and drug use, anger and irritability, depression and anxiety, physical complaints, suicidal thoughts, and traumatic experiences. Is it okay if I ask you these questions? They won't take too long to complete, and you're stuck with me today anyway.*

Adolescent: *Are you going to share my answers with my parents?*

Practitioner: *No, everything you tell me today will be kept between us unless I feel that your safety, or the safety of others, is at risk. If I think I may need to share anything with your parents, then I will always talk with you about it first.*

Adolescent: *As long as you talk with me first.*

Practitioner: *Yes, I will always talk with you about it first and we would plan together exactly what I would share, if I were to share anything with them.*

Adolescent: *OK. I will answer the questions.*

Practitioner: *During the past 12 months, did you drink any alcohol (more than few sips)?*

Adolescent: *Yes.*

Practitioner: *During the past 12 months, did you smoke any marijuana or hashish?*

Adolescent: *No.*

Practitioner: *During the past 12 months, did you use anything else to get high?*

Adolescent: *No, I have only drunk alcohol.*

Practitioner: *Thank you for sharing that information. Since you told me that you drank alcohol during the past year, I would like to ask you a few more questions about your alcohol use. Would that be alright?*

Adolescent: *Yeah.*

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

Adolescent: *Yes. (1st positive answer)*

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

Adolescent: *Yes, I use it to relax and feel less anxious at school and at parties. (2nd positive answer)*

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

Adolescent: *No.*

Practitioner: *Do you ever **FORGET** things you did while using alcohol?*

Adolescent: *No.*

Practitioner: *Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking?*

Adolescent: *No.*

Practitioner: *Have you ever gotten into **TROUBLE** while you were using alcohol?*

Adolescent: *I did this time. (3rd positive answer)*

Mary scored a 3 on the CRAFFT. This is a positive screen. Steve will review the screening score with Mary and conduct a brief intervention with the goal of getting her to stop or cut down on her drinking. Steve should conduct additional brief interventions to monitor behavior changes over the course of Mary’s time in the diversion program. A dialogue of the first brief intervention, using the Brief Negotiated Interview technique, is provided in Module 3: Brief Intervention.

CRAFFT Role Play



Role Play Exercise: Partner with someone to practice conducting screening. For this situation, one person will act as the practitioner using the CRAFFT, and one person will act as the adolescent who is seeking help for some bothersome behaviors. Use a blank CRAFFT located in Appendix A to complete the role play.

Adolescent: You are a 15-year-old who is a freshman in high school and who just got caught coming home intoxicated after being at a party with your soccer team. Your grades have slipped lately and you've been grounded a lot for breaking curfew.



Role Play Exercise: Partner with someone to practice conducting screening. For this situation, one person will act as the practitioner using the CRAFFT, and one person will act as the adolescent who is seeking help for some bothersome behaviors. Use the blank CRAFFT in Appendix A to complete the role play.

Adolescent: You are a 17-year-old who has been using alcohol recently and is feeling sad and unhappy. You think it's normal to feel this way but your parents do not agree. If asked, you might say something like: "A lot of my friends and I go out and drink on the weekends, maybe on Thursday nights too. I don't want to stop hanging out with my friends, and my parents would kill me if they knew how much I am drinking."

AUDIT-C and AUDIT

The Alcohol Use Disorder Identification Test (AUDIT), and the short version, AUDIT-C, are well-known SBIRT screening tools used in the U.S. and internationally for adults including young adults over age 18; the tool has also been validated for use with adolescents.⁷⁸ Developed by the World Health Organization (WHO),⁷⁹ the AUDIT is used to detect hazardous and harmful use, as well as to identify potential alcohol dependence. Slightly longer than the CRAFFT, the AUDIT provides immediate information about level of risk for alcohol-related problems using 10 questions related to quantity and frequency of alcohol use, symptoms of dependence, and negative consequences of drinking.

The first 3 questions of the AUDIT are referred to as the AUDIT-C, where the “C” stands for “consumption.” These questions ask about quantity and frequency of alcohol use and generally take less than one minute to execute. The AUDIT-C can also be used by itself, as part of a larger set of screening questions, and to track changes in consumption over time. The score on the AUDIT-C is used to determine whether the remaining seven questions on the AUDIT should be administered.

Using the AUDIT-C and AUDIT

The AUDIT-C and AUDIT can be self-administered (paper or electronic) or administered via in-person or telephone interview. To administer the AUDIT-C and AUDIT, first let the adolescent know that “*With your permission, I am going to ask you some questions about your use of alcoholic beverages during the past year.*” Remind them that “Alcohol” refers to any form of alcohol, and a “drink” refers to a standard drink (described in Module 1). Explaining verbally what a standard drink is and using the Standard Drink Chart as a visual aid (see Appendix B) can help generate more accurate responses about quantity of alcohol use.

Here is some additional language that you could use when administering the AUDIT-C or AUDIT:

“Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be honest. Place an X in one box that best describes your answer to each question.”⁴²

For more information on the development of the AUDIT, what it is used for, and how to use it with young adults (and adults), you can read the original manual available from the WHO at <http://apps.who.int/iris/handle/10665/67205>. The manual contains the international version of the AUDIT and describes how it should be adapted for use in other countries. It is important to note that in the U.S. the wording of question 3 (i.e., the reference to “six” drinks) is adapted to reflect the U.S. standard drink size (14 grams versus 10 grams of alcohol in the international version) and U.S. drinking guidelines. A copy of the AUDIT-C and AUDIT most commonly used in the U.S. are located in Appendix A.

In 2017, an adaptation of the AUDIT emerged called The Alcohol Use Disorders Identification Test, Adapted for Use in the United States: A Guide for Primary Care Practitioners (or USAUDIT). The

adaptation of the instrument is designed to meet NIAAA’s recommended “low-risk alcohol use” guideline⁸⁰ and the severity levels recommended by the WHO. NIAAA defines “low-risk” as 4 drinks per day or 14 drinks per week for men up to age 65, and three drinks per day or seven drinks per week for men over 65 and all women. The adjustments in the USAUDIT include expansion of the number of response options in questions one to three and modifying the wording of question three (as described above). The USAUDIT aims to assist primary care practitioners in identifying patients (age 18 and older) who may use alcohol in a risky or harmful way, and patients who may have an alcohol use disorder according to the International Classification of Mental and Behavioral Diseases – Tenth Revision (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5). More information and a copy of the screening tool can be found at http://sbirt.webs.com/USAUDIT-Guide_2016_final-1.pdf.

Scoring and Interpreting the AUDIT-C and AUDIT

Responses to each question have a point value. Tally the points for each question to generate a total score. To score the AUDIT-C, add the points for questions one, two, and three.

For adolescents under age 18 who indicate any alcohol use in the first question, it is necessary to complete the remainder of the AUDIT. Otherwise, no further screening is warranted.⁸¹ For young adults age 18 and older, an AUDIT-C score of four for men and three for women indicates increased risk of alcohol-related problems and the remaining seven questions should be administered.

To score the AUDIT, add up the points for all ten questions. For adolescents aged 14-18 years old, studies by Dr. John Knight and colleagues at the Center for Adolescent Substance Abuse Research ([CeASAR](#)) indicate a cut-off score of 2 suggests problematic use and a cut-off of 3 suggests possible substance use dependence. Other studies suggest that for adolescents age 13-19 years old, a cut-off score of 4 or more indicates a possible substance use disorder.⁷⁸

- **Low risk** = 0 to 1
- **Moderate risk, any problematic use, potential harms** = 2
- **High risk, possible dependence** = 3 or more

For young adults age 18 and older, an AUDIT score of 8 or higher indicates at-risk, harmful or hazardous drinking. Scores also suggest risk ranges:

- **Low risk** = 0 to 7
- **Moderate risk, potential harms** = 8 to 19
- **High risk, possible dependence** = 20 to 40

The risk ranges can help guide the level of brief intervention and assess possible need for treatment. The risk ranges can also be useful in understanding how hazardous the drinking is and how best to proceed.

It is important to note that a score of 10 is not necessarily better than an 11, as both scores fall within the moderate risk range. **The individual AUDIT score is not as important as determining the level of risk.** Further, many cases are more complex than a single screening score can capture. You are encouraged to use your clinical judgment to evaluate whether someone needs further assessment, especially when the AUDIT score is at the cusp of the range thresholds.

The following interaction shows how to ask about drinking using the AUDIT. A caring, non-judgmental, conversational tone when discussing alcohol and the use of motivational interviewing skills (reflection and affirmations) helps build rapport. Motivational interviewing skills are discussed in Module 5.

A video of a sample interaction between a young adult and the practitioner is located at:
<http://www.youtube.com/watch?v=RHcalohcunU>.

Below is a sample interaction between a practitioner and a young adult.

Sample Interaction: Asking AUDIT Questions, Interpreting Results and Providing Brief Feedback and Advice

The practitioner and the young adult meet in person. The practitioner administers the AUDIT verbally. You will see the scoring of the screener calculated and noted in parentheses throughout the conversation.

Practitioner: *Hello, Michael. I'm Carolyn. It's nice to meet you.*

Young Adult: *Hi, nice to meet you too.*

Practitioner: *How are you doing today?*

Young Adult: *Um, not that great. Or else I wouldn't be here, I guess.*

Practitioner: *It sounds like things have been better for you. **(Reflection)** You showed up here today though, and I can provide you with some support if you'd like. This could be a great step toward changing things for the better. **(Affirmation)***

Young Adult: *Yeah, I guess so.*

Practitioner: *OK, well, I'd like to start out by asking you some questions about your use of alcohol during this past year. I ask all of my client's questions about alcohol and other substances in order to achieve the best outcomes for them. Because alcohol use can affect many areas of a client's life, it is important for me to know how much you usually drink and whether you have experienced any problems with your drinking. This should only take a few minutes. Would it be alright if I continue?*

Young Adult: *Well, I don't really think I have a problem with alcohol, but yeah, OK, that's fine.*

Practitioner: *How often do you have a drink containing alcohol?*

Young Adult: *Well, I don't drink when I'm in school. I only drink on the weekends. Usually Friday and Saturday. Sometimes Sunday too. (2 to 3 times a week = 3 points)*

Practitioner: *So, about two to three times a week. **(Reflection)** And how many drinks containing alcohol do you have on a typical day when you are drinking?*

Young Adult: *I don't drink too much. I only have a few beers, maybe four. And then a couple of shots on top of that, so probably a total of six drinks. (5 or 6 drinks = 2 points and 5 total)*

Practitioner: *Alright, it sounds like having 6 drinks is your usual routine. **(Reflection)** My next question is: How often do you have 5 or more drinks on one occasion? Based on what you're telling me, it sounds like this is weekly for you. **(Reflection)** Does that sound right?*

Young Adult: *Yeah, weekly sounds about right. (Weekly = 3 points and 8 total)*

Practitioner *How often during the last year have you found that you were not able to stop drinking once you had started?*

Young Adult: *Never. I can always stop when I want to. Like I said, I don't have a drinking problem. (Never = 0 points and 8 total)*

Practitioner: *OK, it sounds like you can decide how much you want to drink and stick with it. **(Reflection)** I just have a few more questions for you. Thanks for sharing this information with me. **(Affirmation)** How often during the last year have you failed to do what was normally expected from you because of your drinking?*

Young Adult: *Well, I did have to miss school one day and I called into work sick because I was so hung over. I guess that's considered failing to do what's expected of me. But it was just that one time. (Less than monthly = 1 point and 9 total)*

Practitioner: *Drinking interfered with your school and work responsibilities that one time, and it sounds as though this isn't a regular occurrence. **(Reflection)** How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?*

Young Adult: *Never. I'm not an alcoholic. (Never = 0 points and 9 total)*

Practitioner: *Never. **(Reflection)** My next question is: How often during the last year have you had a feeling of guilt or regret after drinking?*

Young Adult: *I only regretted drinking that one time, when I had to miss school and called in sick. That just isn't me. (Less than monthly = 1 point and 10 total)*

Practitioner: *It sounds like being on top of your school and work responsibilities are important to you. **(Affirmation)** How often during the last year have you been unable to remember what happened the night before because you had been drinking?*

Young Adult: *Never. I don't black out. (Never = 0 points and 10 total)*

Practitioner: *That's a good thing. **(Affirmation)** Have you or someone else been injured as a result of your drinking?*

Young Adult: *No, never. Nothing crazy like that. I keep it under control. (Never = 0 points and 10 total)*

Practitioner: *Keeping your drinking under control seems to be important to you. You don't want it to affect your life negatively. **(Reflection)***

Young Adult: *Yeah, that's right.*

Practitioner: *OK, I have one last question for you. Has a friend, doctor or other health worker been concerned about your drinking or suggested you cut down?*

Young Adult: *Well, my girlfriend has bugged me about it. I think she makes too big of a deal of it though. I know when it's time to be serious and when it's time to let loose and have fun.*

Practitioner: *You like to keep a healthy balance of school and fun. (**Reflection**) And when was it that your girlfriend last expressed concern about your drinking? (**Clarifying question**)*

Young Adult: *A month or so ago. That's when I missed school and called in sick to work that one time. (Yes, during the last year = 4 points and 14 total)*

The client/patient scored 14 on the AUDIT. For a young adult age 18 and older, when the AUDIT score is between 8 and 19, such as this one, a brief intervention focused on the reduction of hazardous drinking using simple advice and motivational enhancement techniques is most appropriate. For adolescents, this score indicates high risk, possible dependence and should be referred for further evaluation.

AUDIT-C and AUDIT Role Play



Role Play Exercise: Partner with someone to practice some of the techniques that you are learning. For this situation, one person will act as the practitioner using the three questions of the AUDIT-C, and one person will act as the adolescent who is seeking help for some bothersome behaviors. Use the blank AUDIT-C in Appendix A to complete the role play.

Adolescent: You are a 15-year-old adolescent who was recently kicked out of the school play for misbehaving. Your dad suggested that you talk to a counselor because you have been “moody” and “unmotivated to do your schoolwork.” You are angry that they might kick you out of the house if they found out that you are taking Xanax recreationally and drinking a lot (even on the weekdays). If asked, you might say something like: “A lot of my friends and I go out and drink on the weekends, maybe on Thursday nights too. I don’t want to stop hanging out with my friends, and my parents would kill me if they knew how much I am drinking.”



Role Play Exercise: Partner with someone to practice some of the techniques that you are learning. For this situation, one person will act as the practitioner using the AUDIT, and one person will act as the young adult who is seeking help for some bothersome behaviors. Use the blank AUDIT in Appendix A to complete the role play.

Young Adult: You are a 19-year-old woman/man who is living with her/his parents after dropping out of college three months ago. Your mom suggested that you contact someone to talk to because you have been “moody” and “unmotivated to get a job.” You are scared that they might kick you out of the house if they found out that you are drinking a lot and taking Adderall recreationally. If asked, you might say something like: “A lot of my friends and I go out and drink on the weekends, sometimes on Wednesday nights too. I don’t want to stop hanging out with my friends, and my parents would kill me if they knew I was drinking so much and taking my little brother’s Adderall. I don’t think they even know that I smoke.”

GAIN-SS

The Global Appraisal of Individual Need – Short Screen (GAIN-SS) is another screening tool recommended for adolescents, young adults, and adults.⁸² It takes approximately 3-5 minutes to administer and assesses level of risk for mental health and conduct problems, alcohol and/or drug use and crime or violence.

Using the GAIN-SS

The GAIN-SS tool includes the introduction paragraph below that should be read to the adolescent:

“The following questions are about common psychological, behavioral, and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can’t go on. After each of the following questions, please tell us the last time that you had the problem, if ever, by answering. “In the past month” (3), “2-12 months” (2), “1 or more years ago” (1), or “Never” (0).”

Each question should be asked, in order with the appropriate answer recorded. The stem for each section should be read for every individual item (ex. “When was the last time...”). The GAIN-SS may be administered in interview form or self-administered. The GAIN-SS tool is in Appendix A.

Scoring the GAIN-SS

The GAIN- SS is scored by adding up to the number of 2s and 3s for each section and then by completing the section at the end.⁸²

Below is some example language that you can use when administering the GAIN-SS.

“To help us get a better understanding of any problems you might have, how they are related to each other, and what kind of services might help you the most, I would like to spend about 5 minutes asking you some questions that we use with many of our clients. Your answers are private and will be used only to assess how to best serve you and meet your needs. If you are not sure about an answer, please give us your best guess. Please ask if you do not understand a question or a word. At the end of the interview, I will check to make sure that everything is complete, and I’ll answer any additional questions. Do you have any questions before we begin?”

The GAIN-SS is part of a family of GAIN instruments developed by Chestnut Health Systems. More extensive information about the GAIN-SS, including the administration and scoring manual, population norms, and training is available on the GAIN website at: <http://www.gaincc.org/GAINSS>.

S2BI

Created by Boston’s Children’s Hospital and introduced in 2014, Screening to Brief Intervention (S2BI) is a brief, validated electronic and paper screening tool for youth aged 12-17 years.⁸³ The S2BI can be self-administered or conducted as an interview.

This relatively new tool begins with a single question to assess the frequency of substance use in the past year. The substances screened in S2BI are categorized into eight categories including alcohol, marijuana, cocaine and prescription drugs. The tool is based off of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnoses for Substance Use Disorders available in Appendix C.

Using the S2BI

The brevity of the tool enables it to be easily integrated into routine care for adolescents with little burden to the practitioner. It should be administered to the adolescents during each visit in whichever form that is most convenient to the healthcare settings. A copy of the S2BI is available in Appendix A.

Before administering the questions, begin by reading the following statement.

“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.”

The S2BI begins with three initial questions that ask about how many times the adolescent has used tobacco, alcohol, and marijuana in the past year. If the answer to all three questions indicates they have “Never” used any of these substances, the practitioner stops the screen. If the answer to any of the three

initial questions indicates use in the last year, the practitioner should ask the remaining four questions about use of prescription drugs, illegal drugs, inhalants, herbs or synthetic drugs then provide brief intervention based on level of use as follows: ⁸⁴

No Use on Initial Questions – Provide positive reinforcement.

Once or Twice – Provide brief advice.

Monthly Use or Weekly Use – Provide brief motivational intervention (assess for problems, advise to quit, make a plan) to reduce use and risky behaviors; for weekly use provide referral to treatment.

The following table summarizes the risk level and recommended interventions based off of the adolescent’s answers to the S2BI: ⁸⁴

Frequency of using tobacco, alcohol, or marijuana	Risk Level	Brief intervention
Never	No use	Positive Reinforcement
Once or Twice	No Substance Use Disorder	Brief Advice
Monthly	Mild/Moderate Substance Use Disorder	Further assessment, brief motivational intervention
Weekly or more	Severe Substance Use Disorder	Further assessment, brief motivational intervention, referral

S2BI Role Play



Role Play Exercise: Partner with someone to practice administering the S2BI.

One person will act as the practitioner and the other will act as an adolescent seeking help for some bothersome behaviors. Use the blank S2BI in Appendix A to complete the role play.

Adolescent: You are a 13-year-old who has recently been using alcohol on the weekends and has been struggling with your new school. You don’t want to talk with someone but your parents think it could be helpful, especially since you have transitioned to a new school this year.

DAST

The Drug Abuse Screening Test (DAST-10) is a 10-item brief screening tool that can either be administered by a clinician or self-administered. Each question requires a yes or no response, and the tool can be completed in less than 8 minutes.⁸⁵ The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth.⁸⁶

Using the DAST-10

The DAST-10 can be self-administered (paper or electronic) or administered via in-person or telephone interview. To administer the DAST-10, first let the adolescent know that:

“I’m going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months. When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco. If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.”

You should remind the adolescent that the term "drug abuse" refers to the use of medications at a level that exceeds the instructions, and/or any non-medical use of drugs. In their article Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an "Addiction-ary," Kelly et al. (2016) stress the importance of appropriate language and terminology to reduce stigma and discriminatory social and public health policies with regards to substance use.⁸⁷ Along these lines, multiple providers have altered question 2 of the DAST-10 to replace the word "abuse" with "use."

A copy of DAST-10 is located in Appendix A.

Scoring and Interpreting the DAST-10

Patients receive 1 point for every "yes" answer with the exception of question #3, for which a "no" answer receives 1 point. Below is a table with scores and suggested actions.⁸⁵

DAST-10 Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1–2	Low level	Brief intervention, monitor, and re-assess at a later date
3–5	Moderate level	Further investigation, brief intervention plus brief therapy
6–8	Substantial level	Intensive assessment, brief intervention plus referral to treatment
9–10	Severe level	Intensive assessment, brief intervention plus referral to treatment

Below is a sample interaction between a practitioner and a young adult using both the AUDIT and DAST-10.

Sample Interaction: Screening with the AUDIT and DAST-10

Setting: Tim is a 20 year old college student who is visiting an outpatient mental health center for possible depression. He was referred to this program by the physician at the college health center whom he was mandated to see after getting caught drinking in his dorm room by the Resident Assistant. During this first session, the practitioner (Carl) conducted assessments to determine if a clinical problem exists and, if necessary, to develop an appropriate treatment plan for Tim. The practitioner used the AUDIT and DAST-10 screening instruments to assist in identifying if an alcohol problem or drug problem existed.

The dialogue for the in-person AUDIT and DAST-10 screening is presented below. The scoring of the instruments are calculated and noted in parentheses throughout the dialogue.

Practitioner: *Hi, Tim.*

Young Adult: *Hi.*

Practitioner: *How are you feeling today?*

Young Adult: *Not great. That's why I'm here.*

Practitioner: *We're going to discuss that. I'm glad you're here. This is the first step.*

Young Adult: *Okay.*

Practitioner: *To start, I'd like to have a discussion with you so you can help me learn more about you and how we can work together on helping you feel better. I'm going to ask you about various emotions, feelings and experiences, including anger and irritability, depression and anxiety, physical complaints, alcohol and drug use, and suicidal thoughts. Is that okay?*

Young Adult: *Sure. I fell pretty low. Maybe this will help somehow.*

Practitioner: *I'm first going to ask you a set of questions about your alcohol use. Is that okay?*

Young Adult: *Sure, why not?*

Practitioner: *Thanks Tim. Okay. How often do you have a drink containing alcohol?*

Young Adult: *Almost every day. (4)*

Practitioner: *How many standard drinks containing alcohol do you have on a typical day when you are drinking? By standard, I mean a regular beer, a glass of wine or a typical hard liquor drink.*

Young Adult: *Umm, three, maybe four. (1)*

Practitioner: *How often do you have five or more drinks on one occasion?*

Young Adult: *On weekends. I guess once or twice a week. (3)*

Tim scored an 8 on the AUDIT-C, the first three questions of the AUDIT, which serves as a pre-screen. Because this is a positive pre-screen score, Carl continues with the full AUDIT.

Practitioner: *How often during the last year have you found that you were not able to stop drinking once you had started?*

Young Adult: *Multiple times. A lot.*

Practitioner: *Would you say weekly, or more than that?*

Young Adult: *Yeah, probably weekly. (3)*

Practitioner: *How often during the last year have you failed to do what was normally expected of you because of drinking?*

Young Adult: *A bunch of times.*

Practitioner: *Weekly or more like monthly?*

Young Adult: *Monthly is about right. (2)*

Practitioner: *How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?*

Young Adult: *Never. (0)*

Practitioner: *How often during the last year have you had a feeling of guilt or remorse after drinking?*

Young Adult: *I feel that way sometimes.*

Practitioner: *About monthly? Or less often?*

Young Adult: *Monthly. (2)*

Practitioner: *How often during the last year have you been unable to remember what happened the night before because you had been drinking?*

Young Adult: *Monthly. (2)*

Practitioner: *Have you or someone else been injured as a result of your drinking?*

Young Adult: *No. (0)*

Practitioner: *Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?*

Young Adult: *Yes.*

Practitioner: *Was this in the past year?*

Young Adult: *Yes. (4)*

Tim scored a 21 on the AUDIT. This places Tim in the high risk range which warrants a referral to a treatment program for a diagnostic evaluation for alcohol dependence. Before conducting a brief intervention, Carl continues with the DAST-10 screening for drug use.

Practitioner: *Thanks for being patient Tim. The last set of questions I have for you are about drugs. Is it okay for me to continue?*

Young Adult: *Sure.*

Practitioner: *Okay, thanks. These questions refer to the past 12 months. Have you used drugs other than those required for medical reasons?*

Young Adult: *Yes. (1)*

Tim responded with a yes to the first question of the DAST-10, or the DAST-1 pre-screen. A yes response to the DAST-1 is a positive pre-screen. Carl continues with the full DAST-10.

Practitioner: *Do you use more than one drug at a time?*

Young Adult: *Yes. (1)*

Practitioner: *Are you ever unable to stop using drugs when you want to?*

Young Adult: *Yes. (1)*

Practitioner: *Have you had “blackouts” or “flashbacks” as a result of drug use?*

Young Adult: *No. (0)*

Practitioner: *Do you ever feel bad or guilty about your drug use?*

Young Adult: *Yes. (1)*

Practitioner: *Do your parents ever complain about your involvement with drugs?*

Young Adult: *Yes. (1)*

Practitioner: *Have you ever neglected your family because of your drug use?*

Young Adult: *Yes. (1) This is starting to make me look pretty bad.*

Practitioner: *Well, Tim, your honesty is very helpful here. Shall we keep going?*

Young Adult: *Sure.*

Practitioner: *Have you ever engaged in illegal activities in order to obtain drugs?*

Young Adult: *No (0)*

Practitioner: *Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?*

Young Adult: *Yes. (1)*

Practitioner: *Have you had medical problems as a result of your drug use, such as memory loss, hepatitis, convulsions, or bleeding?*

Young Adult: *No. (0)*

Tim scored a 7 on the DAST-10. He also scored a 21 on the AUDIT. These are both positive screen scores (“red flag”) and place Tim in the high risk range, which warrants a referral to a treatment program for a diagnostic evaluation for alcohol dependence. This means that Tim should receive a referral to a substance use disorder treatment program so that he can be further evaluated. Carl will review the screening score with Tim and conduct a brief intervention with the goal of getting him to accept the referral and attend the treatment program. Carl should continue to monitor the alcohol and drug use when Tim comes in to the mental health center. A dialogue of the brief intervention, using the Brief Negotiated Interview technique, is provided in Module 3: Brief Intervention.

NIDA Modified ASSIST: Level 1 and Level 2

In 2015, the American Psychiatric Association (APA) revised a set of screening tools known as “emerging measures” for use in research and clinical evaluation. The measures include self-administered screening tools for adults, adolescents (ages 11-17), and a set of screening tools for parents/guardians to administer with their children (ages 6-17). For adults, adolescents, and parents/guardians, the APA provides a pre-screening or general screen (i.e., Level 1) that asks how much certain influences are impacting the patient/client (e.g., feelings of sadness or depression, worrying, alcohol and substance use). Both the adolescent and the adult measures assess mental health domains that are important across psychiatric diagnoses and are intended to help clinicians identify additional focus areas for therapeutic interventions. These patient assessment measures were intended for administration at the initial patient interview and/or to monitor treatment progress and symptom presentation over time.⁸⁸

The NIDA-Modified ASSIST Level 1: Pre-screen/General screen⁸⁹ was adapted from the WHO’s Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0. It can be used to assess use of alcohol, tobacco, drugs, and prescription medications for non-medical reasons. A rating of mild (i.e., 2) or greater on any item within a domain that is scored on a 5-point scale may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment for that domain is needed.

The NIDA Modified ASSIST Level 2: Substance Use Screen was adapted from the NIDA Modified ASSIST and asks specifically about alcohol and substance use during the past two weeks. Each of the 15 items are rated on a 5-point scale (0=none or not at all; 1=less than a day or two; 2=several days; 3=more than half the days; and 4= nearly every day). The rating of multiple items at scores greater than 0

indicates greater severity and complexity of substance use. Scores on the individual items should be interpreted independently because each item asks about the use of a distinct substance.

Both Level 1 and Level 2 tools can be found in Appendix A and accessed at:

<http://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/american-psychiatric-association-adapted-nida>.

Other Screening Tools

As noted at the beginning of this module, the tools previously introduced do not represent all validated screening tools available for SBIRT. These tools are only the featured tools often recommended for adolescents. Other tools that may be used for screening include:

- NIAAA Youth Screening⁴² – this simple, quick, empirically derived tool is used to identify risk for alcohol-related problems in adolescents ages 9-18 years. A copy of the NIAAA Youth Guide is available at:
<http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/YouthGuide.aspx>
- NIDA Quick Screen – this is a free, online screening tool for health professionals to assess risk of use of alcohol, tobacco, prescription drugs, or illegal drugs. More information is available at:
<https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen>
- A summary of adolescent screening tools are included in the NIAAA published resource, *Assessing Alcohol Problems: A Guide for Clinicians and Researchers*.⁹⁰ See Chapter 5 for adolescent measures.
<http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/index.pdf>.

Module 3: Brief Intervention

Learning Objectives	Suggested Readings
<ol style="list-style-type: none"> 1. Learn the steps of brief intervention based on the Brief Negotiated Interview Model. 2. Practice conducting a brief intervention. 	<ul style="list-style-type: none"> ■ Levy S, Winters K, Knight J. Screening, assessment and triage for treatment at a primary care setting. <i>Clinical Manual of Adolescent Substance Abuse Treatment</i>. 2010:65-82. ■ Monti PM, Colby SM, O'Leary TA. <i>Adolescents, Alcohol, and Substance Abuse: Reaching Teens through Brief Interventions</i>. New York: Guilford Press; 2012. ■ Myers MG, Brown SA, Tate S, Abrantes A, Tomlinson K. Toward brief interventions for adolescents with substance abuse prevention and comorbid psychiatric problems. In: Monti PM, Colby SM, O'Leary TA, eds. <i>Adolescents, Alcohol, and Substance Abuse: Reaching Teens through Brief Interventions</i>. New York: Guilford Press; 2001:275-296. ■ Tanner-Smith EE, Lipsey MW. Brief alcohol interventions for adolescents and young adults: A systematic review and meta-analysis. <i>Journal of Substance Abuse Treatment</i>. 2015;21:1-18. ■ National Institute on Alcohol Abuse and Alcoholism. <i>Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide</i>. Bethesda, MD: U.S. Dept of Health and Human Services; 2011.

Brief Intervention Defined

If screening indicates alcohol use, tobacco use, or use of illicit drugs or prescription drugs for non-medical reasons, brief, solution-focused motivational interventions can be very effective in helping the adolescent or young adult reduce or stop alcohol or other substance use involvement. Usually, *brief interventions (BIs)* immediately follow screening. While a gap of a few days or a week may not dilute the effectiveness of the brief intervention, *it is desirable to avoid delays*. The likelihood that adolescents or young adults will not show for their next scheduled appointment is increased if the time interval between a screening and the BI is too great.

Brief Intervention (BI)
 a behavioral change strategy that is short in duration and that is aimed at helping a person reduce or stop a problematic behavior

BIs usually include feedback about the screening score generated from administering a validated and standardized screening tool such as the CRAFFT, AUDIT, S2BI or other tools as discussed in Module 2. BIs also typically include discussions of these issues: how the youth's level of use compares to national averages or to teenagers of the same gender or age group; concerns about the potential effects of substance use during adolescence or young adulthood; pros and cons of use; negotiating goals, including a commitment to cut back or stop use; and commitment to action.

A BI can take as little as 5 minutes or stretch to several full-length sessions. Use your best judgment to determine how to best integrate a BI into your clinical encounters.

The skills necessary to provide effective BIs for adolescent substance use are not new. Some practitioners already know and use *Motivational Interviewing (MI)* skills in their work. The information in this Learner's Guide may simply organize and sharpen existing skills to help adolescents and young adults who use alcohol and other substances. For practitioners early in their professional development, the information may be new and will complement other course work or field experience received as part of your training.

The use of Screening, Brief Intervention and Referral to Treatment (SBIRT) for adolescent alcohol and other substance use is growing across a range of medical and behavioral health settings. The SBIRT model for teenagers is attractive, given that it is an efficient and cost-conscious approach that can be taught to a wide range of service providers. Moreover, SBIRT is particularly fitting for adolescents because: the content can readily be organized around a developmental perspective; many substance-using teenagers do not need intensive, long-term treatment; and the client-centered, non-confrontational interviewing approach common to SBIRT is likely appealing to youth.

A large body of research shows the effectiveness of the BI components of the SBIRT model for adults in medical settings and the evidence for this model for youth is growing. A meta-analysis³¹ of 45 brief alcohol interventions (reported in 24 studies) found that relative to no treatment or treatment as usual, brief alcohol interventions were associated with significant reductions in alcohol use and alcohol-related problems. These favorable results were also relatively consistent across the different therapeutic approaches, delivery sites, delivery formats, and intervention length. Other meta-analyses and one systematic review found small but significant effect sizes for substance use outcomes resulting from BI and MI.^{19,27} A randomized control trial found that a computerized screening and brief advice protocol reduced substance use at three and twelve months following the intervention and also prevented initiation among those who had not started using substances.⁹¹

The U.S. Preventive Services Task Force (USPSTF) reviewed the research on screening for unhealthy alcohol use in primary care and providing brief, problem-solving counseling (brief intervention). It recommended that screening and brief intervention (SBI) be a routine practice for individuals aged 18 and

Motivational Interviewing (MI)

a communication method that is focused on the adolescent or young adult's concerns and perspectives and works to enhance their internal desire, willingness and ability to change by exploring and resolving co-existing and opposing feelings about changing

older. However, the USPSTF's review of the literature with individuals under the age of 18 indicated that, though findings were promising, there was not enough published peer-reviewed literature to determine whether SBI should be recommended as routine practice for adolescents. Nonetheless, despite no formal recommendation from the USPSTF for adolescent SBI, the American Academy of Pediatrics (AAP) and other professional medical associations and government agencies recommend incorporating SBI, and when possible a referral to treatment (RT), into routine care for adolescents.⁹² Figure H shows results from BI and SBIRT studies and literature reviews:³

Figure H: Studies and Literature Reviews

Adolescent BI and SBIRT Studies		
Study	Results- conclusions	Reference
Meta-analysis	<ul style="list-style-type: none"> Brief interventions reduced drug and alcohol use as well as problem and criminal behaviors related to substance use in adolescents 	Carney & Myers, 2012 ²⁷
Meta-analysis	<ul style="list-style-type: none"> Brief interventions to address alcohol misuse was associated with reduced alcohol use and presence of alcohol-related problems 	Tanner-Smith & Lipsey, 2015 ³¹
Meta-analysis	<ul style="list-style-type: none"> School-based individually-delivered (but not group-delivered) brief alcohol interventions were associated with significant improvements in alcohol consumption among adolescents 	Hennessy & Tanner-Smith, 2015 ⁹³
Literature review	<ul style="list-style-type: none"> SBIRT may be effective with adolescents but further study is needed 	Mitchell et al, 2013 ⁹⁴
Literature review	<ul style="list-style-type: none"> SBIRT may be effective with adolescents in acute care settings, but further study is needed particularly around intervention and implementation 	Yuma-Guerrero, et al., 2012 ⁹⁵
Primary care computerized screening and brief advice	<ul style="list-style-type: none"> Lower past-90-day alcohol use and any substance use at 3 and 12 months 44% fewer adolescents who had not yet begun drinking had started drinking during the 12 month study period 	Harris et al, 2002 ⁹¹
Community health center	<ul style="list-style-type: none"> Decrease in marijuana use Lower perceived prevalence of marijuana use and fewer friends using marijuana 	D'Amico et al., 2008 ³²
Emergency department	<ul style="list-style-type: none"> Decrease in marijuana use and greater abstinence at 12 months 	Bernstein et al., 2005 ⁹⁶
BI and SBIRT Studies with Individuals Age 18+		
Emergency department	<ul style="list-style-type: none"> Reduced DUI arrests 1 DUI arrest prevented for 9 screens 	Schermer et al, 2006 ⁹⁷
Meta-analysis	<ul style="list-style-type: none"> Adaptation of motivational interviewing reduced alcohol, drug use Positive social outcomes: substance-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems (e.g., driving under the influence) 	Burke et al, 2003 ⁹⁸
Meta-analysis	<ul style="list-style-type: none"> Brief alcohol intervention was effective in reducing alcohol consumption in primary care setting 	Bertholet et al, 2005 ⁹⁹
Meta-analysis	<ul style="list-style-type: none"> Single-session brief alcohol interventions reduced consumption among heavy drinking college students 	Samson & Tanner-Smith, 2015 ¹⁰⁰
Meta-analysis	<ul style="list-style-type: none"> Behavioral counseling interventions improve behavioral outcomes for adults with risky drinking 	Jonas et al, 2012 ¹⁰¹
Literature review	<ul style="list-style-type: none"> Interventions can provide effective public health approach to reducing tobacco and unhealthy alcohol use 	Goldstein et al, 2004 ¹⁰²
Meta-analysis	<ul style="list-style-type: none"> Brief interventions for alcohol use disorders generally found to be effective compared to control conditions and to extended treatment 	Moyer et al, 2002 ¹⁰³
Trauma center	<ul style="list-style-type: none"> 47% fewer re-injury (12 months) 48% less likely to re-hospitalize (36 months) 	Gentilello et al, 1999 ¹⁰⁴

This module presents the Brief Negotiated Interview (BNI) which is an example of an interviewing approach when implementing the BI model.¹⁰⁵ The BNI was originally developed to be used in emergency departments. Its use has expanded into a wide range of medical and behavioral health settings. We present a version of BNI developed by the BNI-ART Institute at the Boston University School of Public Health.¹⁰⁵ The BNI-ART Institute website (www.bu.edu/bniart) offers a number of supplemental resources in the public domain.

The steps of the BNI are clearly laid out in Figure I along with example dialogue that you can use when discussing alcohol or other drug use with adolescents and young adults. This resource is commonly referred to as the BNI Adolescent Algorithm.

Figure I: BNI Adolescent Algorithm

BNI Steps	Elements	Example Dialogue
Engagement	<ul style="list-style-type: none"> ■ Build rapport 	<p><i>“Before we start, I’d like to know a little more about you. Would you mind telling me a little bit about yourself?”</i></p> <p><i>“What is a typical day like for you?”</i></p> <p><i>“What do you like to do for fun?”</i></p> <p><i>“What are the most important things in your life right now?”</i></p> <p><i>“Tell me about when you first used alcohol. What was it like for you?”</i></p>
Pros and Cons	<ul style="list-style-type: none"> ■ Explore pros and cons ■ Use reflective listening ■ Reinforce positives ■ Summarize 	<p><i>“I’d like to understand more about your use of (X). What do you enjoy about (X)? What are the good things about using(X)? What else?”</i></p> <p><i>“What do you enjoy less about (X) or regret about your use?”</i></p> <p><i>“What is not so good about using (X)?”</i></p> <p><i>If NO con’s: Explore problems mentioned during the screening. “You mentioned that... Can you tell me more about that situation?”</i></p> <p><i>“So, on one hand you say you enjoy (X) because... And on the other hand you say....”</i></p>
Feedback	<ul style="list-style-type: none"> ■ Ask permission ■ Provide information ■ Elicit response 	<p><i>“I have some information about the guidelines for low-risk drinking, would you mind if I shared them with you?”</i></p> <p><i>“We know that for adolescents drinking alcohol and using other substances such as marijuana, prescription and over-the-counter medications can put you at risk for problems in school, accidents, and injuries especially in combination with other drugs or medication. [Insert medical information.] It can also lead to problems with the law or with relationships in your life.”</i></p> <p><i>“What are your thoughts on that?”</i></p> <p><i>“In what ways is this information relevant to you?”</i></p>

BNI Steps	Elements	Example Dialogue
Readiness Ruler	<ul style="list-style-type: none"> ■ Readiness scale ■ Reinforce positives ■ Envisioning change 	<p><i>“To help me better understand how you feel about making a change in your use of (X), [show readiness ruler]... On a scale from 1-10, how ready are you to change any aspect related to your use of (X)?”</i></p> <p><i>“That’s great! It mean’s your ___% ready to make a change.”</i></p> <p><i>“Why did you choose that number and not a lower one like a 1 or a 2?”</i></p> <p><i>“What would have to be different for you to choose a higher number?”</i></p> <p><i>“It sounds like you have reasons to change.”</i></p>
Negotiate Action Plan	<ul style="list-style-type: none"> ■ Write down Action Plan ■ Envisioning the future ■ Exploring challenges ■ Drawing on past successes ■ Benefits of change 	<p><i>“What are you willing to do for now to be healthy and safe? ...What else?”</i></p> <p><i>(If more than one goal is identified): “What is the most important goal?”</i></p> <p><i>“What are some challenges to reaching your goal?”</i></p> <p><i>“Who could support you with this goal?”</i></p> <p><i>“How does this change fit with where you see yourself in a year? In five years?”</i></p> <p><i>“If you make these changes, how would things be better now? In five years?”</i></p>
Summarize and Thank	<ul style="list-style-type: none"> ■ Reinforce resilience and resources ■ Provide handouts ■ Give action plan ■ Thank the patient ■ Schedule follow up 	<p><i>“Let me summarize what we’ve been discussing, and you let me know if there’s anything you want to add or change...” [Review action plan.]</i></p> <p><i>[Present list of resources, if more services are warranted]: “Which of these services, if any, are you interested in?”</i></p> <p><i>“Here’s the action plan that we discussed, along with your goals. This is really an agreement between you and yourself.”</i></p> <p><i>“Thanks so much for sharing with me today!”</i></p> <p><i>“Would you mind if we went ahead and set up a follow up appointment in [X] weeks so I can check in with you to see how things are going?”</i></p>

Additional information about each of the BNI steps and the elements that comprise the steps can be found below.

Engagement

Build rapport

Building rapport with adolescents and young adults is vital to the brief intervention. The first step in building rapport is to make sure the teenager is informed that what is talked about in the counseling session will be confidential, except if mandated reporting is required. Then, follow with a general conversation to get to know the adolescent which includes relatively benign (but still informative) topics. You can start by getting to know the adolescent and asking questions. For example, *“What is a typical day like for you? What’s the most important thing in your life right now?”*

Then the topic can move to substance use. It is important to ask permission to talk about their use of substances. You can ask:

“Would you mind taking a few minutes to talk about your [X] use? Where does your [X] use fit in your life right now?”

“Would you mind taking a few minutes to talk about your answers to your [questionnaire/form/health health screen]?”

Additionally it is important to reinforce how important it is for them to feel like they can speak with you about their substance use and ask questions at any time. Saying *“That’s great. You are showing great courage in talking about this.”* is a good way to build rapport and to also encourage open dialogue. After spending some time building rapport, you may want to ask, *“Do you have any questions for me?”*

Pros and Cons

Explore pros and cons

The next step in the BNI is to explore the pros and cons specific to their individual substance use. Exploring both positive and negative aspects about alcohol and drug use can help you further comprehend why the adolescent or young adult is using that particular substance. You should ask them about their use and what they enjoy about that specific drug. For example, *“I’m curious, what do you like about drinking alcohol? ... So it sounds like you feel relaxed and you have fun when you’re drinking with friends, and you like the taste....”*

Among adolescents and young adults, alcohol can be tied to social situations, and understanding what they like and don’t like about their alcohol, marijuana, and other substance use is important. For example, *“I’m also curious if there is anything you don’t like about drinking alcohol? ...”*

Additional example questions you can ask are:

“I’d like to understand more about your use of [X]. What do you enjoy about [X]?”

“What is not as “good” about your use of [X]? What else?”

“What are the less desirable things about your use of [X], like getting into trouble with your mom or being late for class at school because of your hangover...?”

Use reflective listening

Respond to the adolescent with a statement that guesses at what the adolescent has said. **It is especially important to use reflective listening after an adolescent responds to an open-ended question. Be wary of falling into the question-answer trap which can make the adolescent defensive. This skill demonstrates that you are listening and also provides an opportunity to clarify your understanding of what the adolescent has conveyed. Try to offer an average of one or two reflections per question.** These statements can vary from a simple repetition of what the adolescent has said to more complex reflections that attempt to continue with the adolescent’s line of thought. Using reflective listening can be especially important with adolescents and young adults. **If it feels like your conversation is repetitive and not progressing, your reflections are probably too simple.**¹⁰⁶ Module 5 discusses reflective listening in more detail and provides sample dialogue illustrating this skill (see Motivational Skill #3).

Reinforce positives

Accentuate the adolescent’s strengths. Notice and acknowledge the positive in the adolescent’s intentions and actions. Affirming the adolescent helps with engagement and can increase openness. Not all affirmation needs to come from the practitioner. You can ask the adolescent to describe his or her own strengths, successes and good efforts. Affirmation is not equivalent to praise. Avoid using the word “I” in phrases such as *“I am proud of you,”* which can come across as parental.¹⁰⁶ Instead, try phrases such as *“Thank you for meeting with me and arriving early.”* or *“Even though your test didn’t go as well as you had hoped, you studied hard and even turned down a party in order to focus on your coursework”* or *“Thank you for being so open and willing to discuss a difficult subject.”*

Summarize

Summarize the pros and cons of change that the adolescent mentions, emphasizing both sides equally. This strategy allows the adolescent to understand the dilemma and make a decision while maintaining neutrality of the practitioner. Practitioners need to check with the client as to the accuracy of the summary. Start with something like, *“What I have heard so far is... So on the one hand you said <PROS>, and on the other hand <CONS>. Did I get that right? What are your thoughts about this?”*¹⁰⁶ Module 5 discusses summarizing in more detail and provides sample dialogue illustrating this skill (see Motivational Skill #4).

Feedback

Ask permission

The next step in the BNI model is to give feedback. Prior to giving feedback, it is important that you always ask for permission to ensure that the individual is open to hearing some feedback. Asking permission helps build rapport, e.g.

“Would you mind if I provided you with some feedback about your use of alcohol?” or “As your provider, I want you to know that I’m concerned about your drinking. Would you mind if I shared some of my thoughts with you?”

Another option is to focus on sharing guidelines instead of feedback specific to their drinking. *“I have some information on low-risk guidelines for drinking, would you mind if I shared them with you?”*

Provide educational information

This step can also be used to share important educational information with the adolescent or young adult about the dangerous side effects or complications that can occur when they choose to drink, use other substances, or drive. *“When teens drink – things can go wrong, like injuring yourself....”* Education about alcohol and other substance use should be given regardless of the quantity and frequency of use.

Even though individuals over the age of 18 are considered legal adults, it is important to remember that their brain, including the prefrontal cortex which is responsible for making decisions, is not fully developed until age 25. When the prefrontal cortex is not fully developed, adolescents or young adults may make riskier choices which can be confounded by alcohol and other substance use.

An example of this is:

“We know that drinking 3 or more drinks in 2 hours, or that drinking [X] alcoholic drinks and/or use of illicit drugs can put you at risk for illness and injury. It can also cause problems with parents or friends, and school problems such as missing class or doing poorly on a test or an assignment. What do you think about this?”

This is also the step when you can utilize the screening tool to give feedback about how the adolescent or young adult’s alcohol or other substance use is putting them at risk for additional issues. The table below illustrates risks related to adolescent and young adult substance use:

Substance Use Increases Risks

Risks Associated with Adolescent Alcohol, Tobacco, and Other Substance Use	
Substance use increases the risk of:	
<ul style="list-style-type: none">■ Sexually transmitted diseases/infections■ Unwanted pregnancies■ Poor school performance■ Violence■ Falls	<ul style="list-style-type: none">■ Depression■ Suicide■ Alcohol poisoning■ Drug overdose
■ Alcohol has harmful effects on developing brains and bodies	
■ Alcohol is implicated in more than a third of driver fatalities resulting from automobile accidents	
■ Alcohol is implicated in about two-fifths of drownings	
■ Alcohol use interferes with good judgment, leading into risky behavior and vulnerability to sexual coercion	
■ Alcohol and tobacco use increase risk of using other drugs	
■ Alcohol use increases risk of developing behavioral problems, including fighting, stealing, and skipping school	

Educating adolescents and young adults about their risks of health and other problems can help them decide to change, however, it can be especially helpful to focus on the social and family impacts that the alcohol use may have on the individual rather than just the physical long-term health effects. It is also important to provide normative feedback. Adolescents and young adults tend to think that their peers use more than they actually do. Practitioners should be sure to become familiar with prevalence rates and patterns of substance use in your area (substance use norms) so that you can provide this information during the BI and compare their use to that of their peers. Fact sheets are available at <http://sbirt.webs.com/fact-sheets>.

Elicit response

Continuing a dialogue with the adolescent or young adult is very important. Asking simple, open-ended questions after you provide feedback is an easy way to elicit thoughts and feelings about your feedback. Some examples include, “*What are your thoughts on that?*”, “*What reactions do you have to the information I have just shared?*”, and “*How useful is this information?*”

One of the greatest defenses of adolescence is denial. Do not ask, “*Do you have any questions about what I have just shared?*” The easiest answer for a resistant adolescent to this question is “*No.*” It is more important to explore the feelings behind the thoughts. Asking more open-ended questions about feelings or reactions will make it easier to continue the conversation than asking about thoughts. “*What, if anything, we have discussed concerns or upsets you?*” or “*What thoughts or feelings do you have about the information we just discussed?*”

To transition from this feedback stage to negotiate an action plan, it is time to assess the adolescent’s readiness to change.

Readiness Ruler

Readiness scale

The readiness scale is used to quantify the adolescent's or young adult's readiness to change. When introducing the readiness scale, you should first define what the scale is and how it is used. An example of this is, *"The Readiness Ruler is a simple 1-10 scale we use to determine your readiness to change your (X) behavior, with 1 being not ready at all and 10 being completely ready."* The BI is tailored to the individual's readiness.

Reinforce positives

Regardless of the number chosen, it is imperative that you are positive and encouraging of whatever stage of change they are in. Especially for those who express a higher score on the Readiness Ruler, you could say, *"You marked [X]. That's great. That means you're [X] % ready to make a change."*

Envisioning change

After reinforcing that any change is good change, you should then investigate *"Why did you choose that number and not a lower one like a '1' or '2'?"* *"What would it take for you to have chosen a higher number?"* Asking for a lower number can encourage more "change talk" than asking for a higher number. Change talk is covered in more detail in Module 5. This is a good step in the BNI process to discuss what peers may be doing and what the adolescent or young adult may be able to do. An example of language you could use is *"What some people your age decide to do is to stop drinking to see what it feels like."* Or even *"How do you feel about not drinking for two months?"*

Negotiate Action Plan

The next step in the BNI is to negotiate the action plan. This includes creating options and steps that the adolescent or young adult feels are realistic and obtainable.

Ask the adolescent if they can think of ways to reduce their risk of alcohol-related problems, ways that make sense to them and that they could see themselves trying. Some of the options the adolescent might suggest (or you could prompt) include:

- reducing drinking by 1 drink per day;
- setting a limit on the number of drinking days per week;
- counting drinks;
- not driving after drinking;
- avoiding triggers for excessive drinking, such as starting early at happy hours or engaging in drinking contests;

- developing activities that are alternatives to drinking;
- eating while drinking so the alcohol is absorbed more slowly;
- going for a walk or exercise when feeling stressed instead of having a drink;
- not giving in to social pressures to drink;
- drinking only during evening meals; and
- alternating alcoholic beverages with non-alcoholic beverages.

For adolescents whose drinking puts them in the moderate or high risk categories, simple advice to reconsider their drinking patterns, cutting back or abstaining from alcohol can be powerful. Non-confrontational advice expressed with concern can motivate many people to change or rethink their use. You might say, *“Have you considered cutting back your drinking? Reducing your alcohol use could reduce your risk of problems, and cutting back could really help you concentrate on the issues that led you to come in today. I am concerned that your continued drinking at this level may make things worse. I think following the recommended drinking guidelines would help make things better. If you are not ready to change, you might consider doing one or more of these things....”*

- *keep track of how often and how much you are drinking.*
- *notice how drinking affects you.*
- *list pros and cons of changing your drinking.*
- *deal with things that may get in the way of changing.*
- *ask for support from your doctor, a friend or someone else you trust.*⁵⁹

You can use the *Setting Goals for Change Exercise*, which is located in Appendix D of this Learner’s Guide, and the *Change Plan Worksheet*, located in Appendix E, to help develop cutting back goals with the adolescent.

Write down Action Plan

As you discuss what the action plan could include, it is always a good idea to write down the steps and ideas you discuss. Some example dialogue that you can use is *“Those are great ideas! Is it okay for me to write down your plan, your own prescription for change, to keep with you as a reminder?”*

Envisioning the future

The action plan should be focused on steps for the future and be action-oriented. Example language could be, *“What do you think you can do to stay healthy and safe?”* or *“What will help you to reduce the things you don’t like about using (x, y, z)?”* or *“Who can help or support you with the goal?”* While the action plan should be focused on the future, it should include some immediate steps to help the adolescent or young adult achieve their goals.

Exploring challenges and drawing on past successes

Identifying challenges that the adolescent or young adult have already faced can help to both build confidence and to come up with contingency plans in case those situations may arise again. *“What are some of the challenges to reaching your goal?” “What situations may be difficult for you to maintain the goal of reducing drinking?” “How can you address these challenges?”*

Past successes in dealing with challenges may reinforce new challenges. *“Tell me about a time when you overcame challenges in the past. What kinds of resources did you call upon then? Which of those are available to you now?”*

If the adolescent or young adult does not come up with any challenges, you can inquire about challenges in other aspects of their life and how they overcame those challenges. *“What have you planned/done in the past that you felt proud of?” “What challenges do you face?” “Who/what has helped you overcome these challenges and succeed? How can you use that (person/method) again to help you with that challenges of changing now?”* Ask the adolescent, *“What things would make it easier for you to not drink?”* and make sure to enquire *“Is there anybody in your life who could support you in not drinking?”*

Benefits of change

Start by asking the adolescent to identify the possible benefits of change. For example, *“If you make these changes, in what ways would things be better?”* Remind the adolescent or young adult about all of the benefits of changing their behavior, regardless of their individual action plan. Ask, *“How will some of the ‘cons’ you noted be reduced or eliminated?”* or *“What will be the signs of change that you, your family or friends might notice?”*

Summarize and Thank

The brief intervention should end with summarizing and reviewing what was discussed, going over the action plan and ensuring that all questions have been answered. Reinforce resilience by summarizing the discussion and in particular focusing on the adolescent’s strengths, their interest in problem solving, and their openness to engage in a difficult discussion.

Summarize Action Plan

“Will you summarize the steps you will take to change your [X] use?”

“Let’s summarize the steps you will take to change your [X] use?” “I’ve written down your plan, a prescription for change, to keep with you as a reminder...Do we have this correct?”

“And we talked about possible challenges and way to address them.”

Reinforce resilience and resources

At the end of the brief intervention, it is important to reinforce resilience and remind the adolescent or young adult of the resources they have available while making this change. These resources may include friends, teachers, parents, school or community-based groups, further assessment, intensive substance use treatment, mental health treatment, or self-help groups, among others. Through the assessment, you should gain an idea of the quality of the adolescent's relationships, and whether they are a resource or obstacle to change. As a practitioner, you should become familiar with each type of resource so that you can discuss what these options are with the adolescent. This is done by focusing on the adolescent's strengths for making this change. You might ask, "Which of these services, if any, are you interested in?"

Provide handout

Provide the adolescent with handouts or additional information on outpatient counseling, self-help groups including Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, primary care or mental health providers. If a referral is part of the plan, conduct a warm hand-off to the referral source. Set a follow-up appointment to check in with the adolescent at a later date. For more information on referrals, conducting warm hand-offs, and effective treatment approaches for adolescents, see Module 4. Additional information about mutual support groups can be found in Appendix F. You might ask, "Which of these services interest you at this point?"

Give an Action Plan

One of the final steps of the BNI is to hand the adolescent or young adult a copy of the finalized Action Plan. You might say, "*Here's the action plan we discussed along with your goal. This is really an agreement between you and yourself.*"

Thank the adolescent

Finally, thank the adolescent or young adult for taking the time to speak with you and, if applicable, notify the adolescent that you are a resource that they can feel free to contact in the future. For example, "*Thanks so much for sharing with me today! I would like to follow up with you in a few weeks and check in on your progress towards reaching your goals.*" The offer of follow-up is often seen as an offer of continued support.

Brief Intervention Observation Sheets

Brief Intervention Observation Sheets (BIOS), such as the BNI-ART Institute BIOS below, can be used by an observer to assess the use of brief intervention using key motivational interviewing skills throughout a role play. The observer listens for examples of each element of the brief intervention and places a check mark in the appropriate box. The observer also rates specific skills. The information recorded by the observer is used to provide helpful feedback following the role play or during simulated exercises. A BIOS for Kognito's *SBI with Adolescents Simulation Program* is also presented. This BIOS

is designed for observers to use with Kognito's online simulation program. The BNI-ART and Kognito BIOS are based on the BNI model.

Alternative BIOS are offered in Appendix G. These BIOS are based on the BI Adherence/Competence Scale, created by D'Onofrio et al.¹⁰⁷ for Project ED Health, and the Oregon Brief Intervention Observation Sheet.

Other BIOS are available such as the Clinical SBIRT Proficiency Checklist (CSPC) which assesses competency.^{108,109} A copy of the Proficiency Checklist can be found in Appendix O: Resources. Also, the SBIRT Checklist for Observation in Real-time (SCORE) which assesses adherence based on the FRAMES model can be found at <http://onlinelibrary.wiley.com/doi/10.1111/add.13657/full>.¹¹⁰

BNI-ART Institute
Youth Brief Intervention and Referral: Interview Scoring Sheet

Date _____ Interviewer Initials _____ Evaluator Initials _____

CRITERIA	Y	N
Engagement <ul style="list-style-type: none"> • ask permission for talk about alcohol/drugs • ask about a day in the person’s life • ask how drinking and marijuana fits in with life • ask about patient’s values, (what’s important to them) 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Decisional Balance: Pros and Cons of alcohol/drug use <ul style="list-style-type: none"> • elicit good things about alcohol/drug use • elicit less good things about alcohol/drug use • draw upon screening answers • sum up and restate in patient’s own words (reflective listening) 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Feedback <ul style="list-style-type: none"> • Ask permission to share information • NIAAA guidelines or salient information • Elicit response from patient 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Readiness Ruler <ul style="list-style-type: none"> • use general readiness to change question (ruler) • ask, why not less? • elicit other reasons for changing 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Negotiate Action Plan <ul style="list-style-type: none"> • elicit specific steps • write steps on the prescription for change form • ask about future goals (discrepancy) & how change fits in • ask about challenges to change • ask about past successes <ul style="list-style-type: none"> ➢ what they did ➢ who/what helped them (social support) ➢ community/resources that helped • explore benefits of change 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Summarize & Thank (Referrals) <ul style="list-style-type: none"> • summarize action plan • offer referrals <ul style="list-style-type: none"> ➢ to primary care ➢ for substance abuse treatment if necessary ➢ to mental health if depression or past psychiatric problems are mentioned • Review/ make additions to prescription for change • Sign/Give prescription for change to patient • Thank patient 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Each “Yes” check = 4 points, Maximum score = 100 points Score _____
 General Performance Feedback (20 points—5=2 points; 4=1 point;<4=0)
 PART 2 SCORE = _____ TOTAL SCORE (PARTS 1 & 2) = _____

- Language appropriate Not appropriate Appropriate

0	1	2	3	4	5
- Open Questions More Closed More Open

0	1	2	3	4	5
- Reflective listening Not reflective Reflective

0	1	2	3	4	5
- Percent of talking by patient compared to interviewer (Voice)

0%	20%	40%	60%	80%
(1)				(5)
- Respect Disrespectful Respectful

0	1	2	3	4	5
- Negotiation(Choice) One-sided Agenda Shared Agenda

0	1	2	3	4	5
- Affirmations Not Encouraging Encouraging self-change

0	1	2	3	4	5
- Knowledge of facts/resources Low High

0	1	2	3	4	5
- Allowing for silence and duration of pauses before jumping in
 No pause Uses silence effectively

0	1	2	3	4	5
- Listening for cues Misses opportunities Uses opportunities to go deeper

0	1	2	3	4	5

Comments/Examples

Brief Intervention Observation Sheet (BIOS)
for Kognito's *SBI with Adolescents* Online Simulation

Date: _____

Person Conducting the Brief Intervention: _____

Observer: _____

Observer Instructions: Place a ✓ in the Yes/No column corresponding to the components utilized in the role play or standardized patient simulation.

CRITERIA	YES	NO
BUILD RAPPORT		
• Ask about life	<input type="checkbox"/>	<input type="checkbox"/>
• Ask permission to raise subject	<input type="checkbox"/>	<input type="checkbox"/>
• Discuss drinking/drug use	<input type="checkbox"/>	<input type="checkbox"/>
ELICIT PROS AND CONS		
• Elicit pros	<input type="checkbox"/>	<input type="checkbox"/>
• Elicit cons	<input type="checkbox"/>	<input type="checkbox"/>
• Summarize	<input type="checkbox"/>	<input type="checkbox"/>
PROVIDE FEEDBACK		
• Ask permission to share information	<input type="checkbox"/>	<input type="checkbox"/>
• Provide salient info	<input type="checkbox"/>	<input type="checkbox"/>
• Elicit response	<input type="checkbox"/>	<input type="checkbox"/>
ASSESS READINESS		
• Ask about readiness	<input type="checkbox"/>	<input type="checkbox"/>
• Make recommendation for abstinence	<input type="checkbox"/>	<input type="checkbox"/>
• Ask, Why not less? Or What would have to change?	<input type="checkbox"/>	<input type="checkbox"/>
NEGOTIATE AN ACTION PLAN		
• Elicit a specific goal	<input type="checkbox"/>	<input type="checkbox"/>
• Collaborate on specific steps	<input type="checkbox"/>	<input type="checkbox"/>
• Explore challenges to change	<input type="checkbox"/>	<input type="checkbox"/>
SUMMARIZE AND THANK		
• Summarize an action plan	<input type="checkbox"/>	<input type="checkbox"/>
• Offer referrals (as needed)	<input type="checkbox"/>	<input type="checkbox"/>
• Schedule a check-in	<input type="checkbox"/>	<input type="checkbox"/>

© 2016 Kognito. All Rights Reserved.

Developed to accompany Kognito's *SBI with Adolescents* Online Simulation. Adapted from the Brief Negotiated Interview (BNI).

Sample Interaction: Screening and Brief Intervention with CRAFFT Questions

Setting: Mary, a 16 year old high school junior, was arrested for vandalism of school property when she was caught spray painting graffiti after school. Because this was her first offense, she was instructed to participate in a school-based diversion program for one year. During her first session in the program, Mary met with the practitioner (Steve) who conducted a risk assessment to identify any behavioral health issues and to connect Mary to appropriate services. The practitioner conducted a screening using the CRAFFT questions and Mary scored positive, indicating the need for further intervention.

The dialogue below presents the brief intervention.

Practitioner: *Thanks for bearing with me and answering all of those questions. Now, I'd like to learn a little more about you. What is a typical day like for you?*

Adolescent: *It's boring. I wake up, go to school, and sit through very long classes. Then I go home and watch TV. Some days I stay after school for my art class. My mom comes home at some point. After dinner I do my homework. Then it starts all over again the next day.*

Practitioner: *That sounds like a typical day for a high school student. What's the most important thing in your life right now?*

Adolescent: *My grades. I really want to get into art school. That is why I sometimes stay after school. To continue working on my assignments. My teacher also lets me work on some new projects if I finish the assigned ones early.*

Practitioner: *So you're interested in art. What kind is your favorite?*

Adolescent: *My painting and drawing class.*

Practitioner: *That sounds like fun. I'm glad you enjoy that. Based on your responses to some of my questions, I was wondering if you'd mind taking a few minutes to talk about your alcohol use? How does your use fit into your typical day?*

Adolescent: *Well I don't drink every day. As I said, my days are usually same old same old. I focus on my studies and don't have much of a life outside of school. My mom noticed that something was bothering me and encouraged me to spend time with friends. But I'm not that comfortable socially. So, I went to a party with a couple of friends from my class and there was drinking. I drank as well, so I'd fit in. I met some new friends who showed me some of their awesome graffiti art when I was there. So I like to drink when I'm with these friends because we have the same interest in art and we can share ideas.*

Practitioner:	<i>How much do you drink when you're with your friends?</i>
Mary:	<i>Three or four drinks. Just something sweet, like Smirnoff Ice or hard lemonade. Beer doesn't taste good. And, it's just on the weekends, two or three days a week.</i>
Practitioner:	<i>Is that every weekend, or just on some?</i>
Adolescent:	<i>Not every weekend! Just 2 or 3 weekends a month.</i>
Practitioner:	<i>I'd like to understand more about your alcohol use. What do you enjoy about drinking?</i>
Adolescent:	<i>I'm a whole different person when I drink. I can let loose and I'm much more fun. It is easy for me to be social when I'm drinking. I'm in the moment and I'm having fun. I'm not just the studious one anymore. I fit in.</i>
Practitioner:	<i>What is not as good about your drinking?</i>
Adolescent:	<i>Oh, I don't know. Sometimes the day after I drink, I have a bad headache and I spend a lot of time sleeping. I've had less time and energy to study and to do my homework. When we drink on a Sunday and I have school the next day, I can be very tired and can't concentrate in class. My grades have dropped.</i>
Practitioner:	<i>Anything else?</i>
Adolescent:	<i>I haven't felt like working on my paintings. I had a good friend in that class, and we used to stay after together to work on assignments. We're not really friends anymore. She doesn't fit in with my group.</i>
Practitioner:	<i>So on the one hand you said that drinking relaxes you, makes you feel more social, and helps you to fit. On the other hand it is having an impact on you academically. Your grades are dropping because you're less able to concentrate on studying and doing your homework. You also have lost some interest in your painting and drawing and lost a good friend of yours as a result. What do you think about that?</i>
Adolescent:	<i>If I don't drink I won't be welcomed in my group of friends. There's not really a choice. My choice is whether I want to have friends or whether I want to do well in school and get into a good college. It's hard not having friends.</i>
Practitioner:	<i>What about the friend in your painting class? This friendship didn't require you to drink.</i>
Adolescent:	<i>Right. We spent time after school working on our projects. And we talked. I guess I could be myself. I didn't get into trouble trying to fit in.</i>
Practitioner:	<i>I have some information on drinking. Would you mind if I shared it with you?</i>
Adolescent:	<i>What, that I should stop? Okay, what is it?</i>

Practitioner: *Drinking three or four alcoholic drinks at one time is binge drinking. It can impair your judgment. It has been associated with risky behaviors. In fact, teens who drink in excess are more likely to have unwanted pregnancies or to contract a sexually transmitted disease. They have also gotten into car accidents. Of course, drinking also has a negative impact on grades. Not to mention, extended use will put you at risk for illness. What are your thoughts on that?*

Adolescent: *I was really just focusing on the fitting in part of drinking. And I didn't think much of the number of drinks I was having. They're just sweet drinks I guess vandalizing the school was pretty stupid. The drinking must have "impaired my judgment."*

Practitioner: *You may be surprised to hear that your peers are drinking less than you think. Only 10% have had three or more drinks at one time. Less than 30% have had any alcohol in the past 30 days. What do you think about that?*

Adolescent: *Really? I thought most of the people in my school drink. Everyone was drinking at the party. We drink every time my friends and I get together. I drink so that I fit in. But really most people my age don't drink?*

Practitioner: *That's right. Teens often think that their peers are drinking more than they really are. They're always surprised when I provide them this information.*

Adolescent: *So my drinking is actually making me less like my peers?*

Practitioner: *That's a good way to look at it. Let's talk a bit about how you want to address your drinking. This readiness ruler is like the pain scale that many doctors use in their offices. On a scale from one to ten, with one being not at all ready and ten being completely ready, how ready are you to change your alcohol use?*

Adolescent: *Um, I don't know. Maybe a 5?*

Practitioner: *5? That's good. You're 50% ready to make a change. Why a 5 and not a lower number like a 3?*

Adolescent: *Well my peers aren't really drinking like I thought they were. I was more like everyone else than I thought. Plus, I really did something stupid when I was drinking and I got in trouble. I never would have done those things if I weren't drinking or hanging out with this group of friends. The only problem is that I was pretty lonely before I started drinking. It's really tough to feel like an outsider.*

Practitioner: *I understand what you're saying. But you did have a friend in your painting class – with similar interests. And you could be yourself with this friend. And you certainly have goals and interests – like your grades and getting into art school.*

Adolescent:	<i>That's true.</i>
Practitioner:	<i>So, let's make a plan to help you reduce, and possibly stop, your drinking. What will help you reduce the things you don't like about drinking?</i>
Adolescent:	<i>Well, not going out to the parties. But I don't know about my friends. They all drink.</i>
Practitioner:	<i>Are there alternative things to do? Or places to go? And what about the friend in your painting class?</i>
Adolescent:	<i>I can try to see if she would go to the movies or to the mall, or just get together to paint.</i>
Practitioner:	<i>That's a good idea. Anything else?</i>
Adolescent:	<i>Well I'm not sure. Maybe I can tell my other friends that I'm not drinking so that I can do well on the SAT and get into my top choice for art school. I could try to do something with my art friend outside of school. I just don't like being alone all the time after school and on weekends.</i>
Practitioner:	<i>These are all good ideas. What can help you to carry out this action plan? Sometimes, looking at what worked well in other situations can help us figure out how to be successful in new ones. Tell me about a time when you overcame a challenge in the past. What kinds of resources did you call upon then?</i>
Adolescent:	<i>When my parents got divorced it was really hard. My dad moved out and then moved across the country to be closer to his brother. He's remarried now and has a whole new family. My mom was very supportive then. So was my aunt, her sister. My teacher at the time was understanding and took extra time with me to make sure everything was okay and to support me in the classwork.</i>
Practitioner:	<i>Which of these supports are available to you now?</i>
Adolescent:	<i>My mom is, but she doesn't know about my drinking. She just found out about my getting caught vandalizing school property. She was surprised and very angry. Before, she just thought it was great that I was socializing and had a new group of friends. I don't think she realizes my grades have dropped. My aunt is cool though. Maybe I can tell her. And my painting and drawing teacher is pretty supportive, too. It is usually pretty quiet in the classroom after school.</i>
Practitioner:	<i>So it sounds like you do have some people you may be able to count on. And your mom may be understanding if you talk openly to her.</i>
Adolescent:	<i>Right...maybe.</i>

Practitioner: *Let me summarize what we've been discussing, and you let me know if there is anything else you want to add or change. Your goal is to do well on the SATs and get into the art school of your choice. But you feel that your life is pretty dull and you don't have friends to socialize with. You feel uncomfortable socializing. You started drinking to make socializing easier and to fit in. However, you got caught vandalizing the school, which you related to your drinking and how it might have impaired your judgement. You said that you'd try to explain to your friends that you're not drinking to improve your chances on the SAT, and to suggest going to the mall or to the movies instead of to parties. You also said you can ask your friend from painting class to do things outside of school.*

Adolescent: *That sounds about right.*

Practitioner: *Good. You're scheduled to attend this program once per week. Let's touch base again in two weeks to see how you're doing.*

Adolescent: *Okay, that sounds like a plan.*

Practitioner: *Thank you Mary.*

Brief Intervention Role Play



Role Play Exercise: Partner with someone to practice conducting a brief intervention. One person will act as the young adult and the other as the practitioner who has administered the AUDIT and determined, based on an AUDIT score of 25 that the young adult is at high risk of alcohol-related problems. Practice engaging/establishing rapport, exploring pros and cons, giving feedback, using the readiness ruler, negotiating an action plan, summarizing and thanking the adolescent.

Young Adult: You are a 18-year-old young adult who seeks some help because you feel like you have very little energy and feel depressed and blue. If asked about alcohol use, you might say something like: *“I drink 4 or 5 drinks most days after school at my friend’s house and a few more on the weekends at parties. It is really the only way I relax. I have a lot of stress in my life, and it is just my release. I don’t see any problem with it.”*



Role Play Exercise: Partner with someone to practice conducting a brief intervention. One person will act as the adolescent and the other as the practitioner who has administered the CRAFFT and the adolescent scored a 4. Practice engaging/establishing rapport, exploring pros and cons, giving feedback, using the readiness ruler, negotiating an action plan, summarizing and thanking the adolescent.

Adolescent: You are a 16-year-old adolescent who is worrying all the time about failing out of school. You have had several acute feelings of panic and doom, which also worries you a lot. You know that your teacher has contacted your parents about performing poorly on recent assignments and tests. Sometimes you just feel like blowing up, the pressure of school gets so high. You feel you have to work harder in school than your friends. If asked about your drinking, you might say something like: *“I don’t think I need to stop drinking. I only have a couple of shots of vodka or maybe a beer or 2. My health is good and besides, you’re only young once.”*



Role Play Exercise: Partner with someone to practice conducting a brief intervention. One person will act as the practitioner and the other will act as an adolescent seeking help for some bothersome behaviors. The adolescent has scored at risk on the S2BI.

The practitioner can assume for this role play that the adolescent has been handed off to you by another professional (e.g., medical assistant, physician, nurse, office staff, and health educator).

You might start providing feedback about screening, by saying:

“Hi, my name is _____ and I am a <job title> here. Is it okay if I took about 10 minutes of your time to discuss the results of the screen you just completed? Let’s start by talking about your responses on the screen and exploring more about your experiences with alcohol or other drugs. I’m not going to lecture you or tell you what to do about alcohol and drugs; you’re in charge of you and only you can make those decisions. I just want to think with you about your use and how it fits into your life. Would this be okay?”

Adolescent: You are a 13-year-old adolescent who has recently been using alcohol on the weekends and has been struggling with your new school. You don’t want to talk with someone but your parents think it could be helpful especially since you have transitioned to a new school this year.

Case studies included in Appendix H can be used for additional role play exercises.

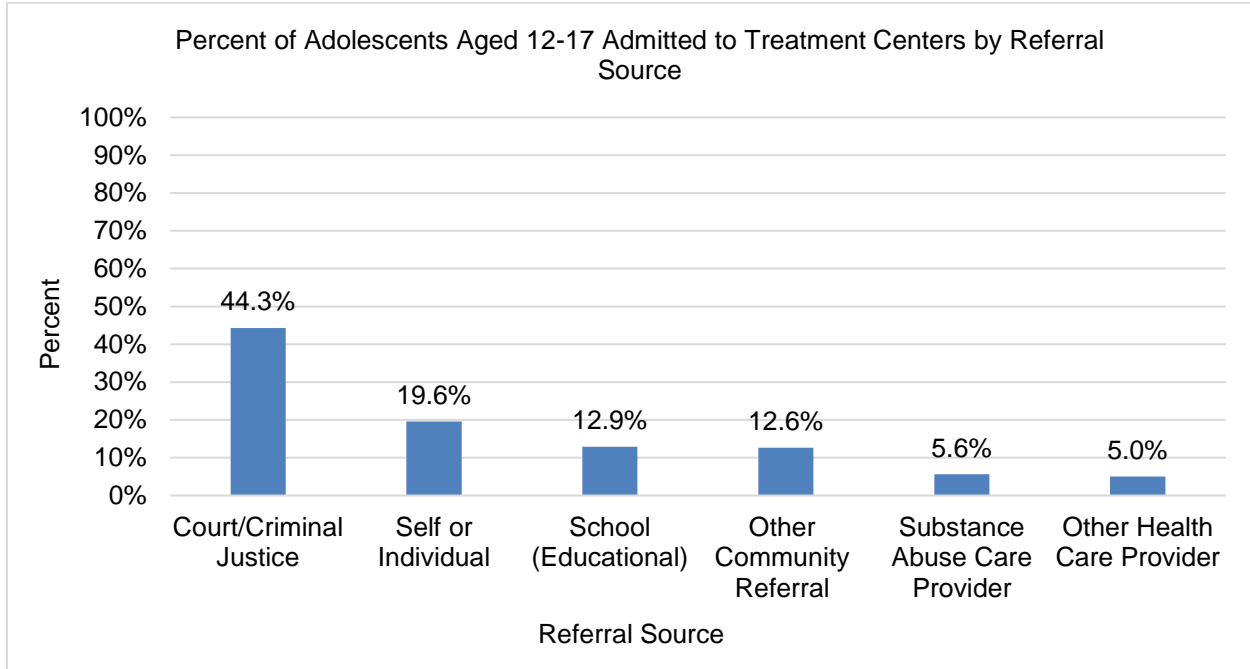
Module 4: Referral to Treatment and Follow-up

Referral to Treatment

Learning Objectives	Suggested Readings
<ol style="list-style-type: none"> 1. Learn which substance use disorder treatment options are best suited to address the needs of adolescents. 2. Understand unique challenges that you will encounter when referring adolescents to treatment, relating to confidentiality and push back. 3. Recognize what constitutes a warm hand-off when referring adolescents to treatment. 4. Understand the importance of follow-up and learn what to cover during these encounters. 	<ul style="list-style-type: none"> ■ National Institute on Drug Abuse. <i>Principles of Adolescent Substance Use Disorder Treatment: A Research-based Guide</i>. Bethesda, MD: NIDA; 2014. ■ Williams RJ, Chang SY. A comprehensive and comparative review of adolescent substance abuse treatment outcome. <i>Clinical Psychology: Science and Practice</i>. 2000;7(2):138-166. ■ Meyers K, Cacciola J, Ward S, Kaynak O, Woodworth A. <i>Paving the Way to Change: Advancing quality interventions for adolescents who use, abuse or are dependent upon alcohol and other drugs</i>. Philadelphia, PA: Treatment Research Institute; 2014. ■ Winters KC, Tanner-Smith EE, Bresani E, Meyers K. Current advances in the treatment of adolescent drug use. <i>Adolescent Health, Medicine and Therapeutics</i>. 2014;5:199.

A very small number of adolescents will require a level or intensity of treatment beyond that of which you may be able to provide. Those adolescents may be referred to a treatment facility that offers inpatient and/or outpatient treatment programs. Adolescents who enter treatment are referred from a variety of sources. The 2016 Treatment Episodes Data Set (TEDS) reports that 78,018 adolescents aged 12-17 were admitted to treatment centers in 2014. Of those admitted, 44% were referred from the court/criminal justice system, but nearly 20% of admissions were self-referred (see Figure J).¹¹¹ This percentage of self-referred admissions underscores the importance of the brief intervention, which encourages youth to take positive actions around their alcohol and/or substance use. Through SBIRT, adolescents in need of treatment can be identified and given the information they need to enter treatment from school, medical and community sources.

Figure J: Adolescent Substance Use Treatment by Referral Source



SOURCE: 2004-2014 Treatment Episode Data Set¹¹

Of course, the adolescent must be agreeable to participating in treatment. How you broach and discuss referral contributes to the likelihood of successful treatment. In contrast to adults, adolescents are less likely to feel that they need help or seek treatment on their own. Developmentally, adolescents have a harder time recognizing their own behavior patterns than adults. Since they are young, they have shorter histories of substance use and therefore are unlikely to have experienced as many adverse consequences from their use as adult users. Fewer adverse consequences can mean less of an incentive to change or begin treatment.⁴² Engaging adolescents requires patience, and an open and empathetic therapeutic stance.

Depending on the age of the adolescent, the degree of acute risk, and state regulations regarding access to health care by a minor, it may be necessary to involve the parents/guardians of the adolescent regardless of whether the adolescent consents.⁴² Resistance and denial (lack of insight) are characteristic of substance use disorders at this stage of the disease, therefore the adolescent and/or family may be unwilling to pursue treatment even when it is clearly indicated^{38,42} Though breaking confidentiality in this situation can be challenging, it is important for you as the practitioner to be supportive during conversations with the family about the adolescent's care options. Motivational Interviewing (MI) strategies (see Module 5) can be used to encourage an adolescent and/or family to accept a referral.³⁸ See Confidentiality section later in this module for a discussion of legal issues associated with maintaining and breaking confidentiality.

When considering referring an adolescent to treatment, keep in mind that the National Institute on Drug Abuse (NIDA) indicates that adolescents can benefit from substance use intervention even when they are not revealing a severe substance use disorder.³ Any amount of substance use (starting with mere

“experimentation”) is concerning for young people, due to the increased risk of motor vehicle accidents, other injuries, and unwanted pregnancy and contraction of sexually transmitted diseases (STDs) as a result of sexual risk taking, all of which can be a consequence of first time use. Adolescent use is also associated with increased risk of chronic disease, poor school performance, depression, suicide and future dependence.^{3 112-114}

Referrals, or “hand-offs,” for a level or intensity of treatment beyond that of which you can provide are challenging in virtually any endeavor, particularly when working with individuals with substance use problems. David Gustafson has studied the characteristics of handoffs in activities as diverse as daycare drop-off and pick-up, surgery and post-operative care, air traffic control, relay races, 911 calls, railroad dispatch, professional football and automobile racing. These studies found that all situations require a smooth hand-off, and a failed hand-off disrupts service delivery and introduces errors, sometimes with disastrous consequences.¹¹⁵

According to a 2004 Treatment Episode Data Set (TEDS) analysis of adult populations (age 18 and older), only 16% of clients discharged from detoxification programs start a new level of care. Only 30% of clients discharged from residential care start a new level of care, and only 50% of those who start outpatient care complete their regimen.¹¹⁶ Far too many clients are lost to the system during hand-offs from one level of care to another.

Data on referral patterns for adolescents are not available in the literature. However, recent TEDS data provides information on referral sources for adolescents entering substance use treatment. Figure J demonstrates the number of adolescents admitted to substance use treatment grouped by referral sources, according to the 2008 TEDS data.

Gustafson suggests eight principles, that if followed could dramatically improve the transition of clients with substance use disorders between levels of care.¹¹⁵ Also, given the unique situation with adolescents and parents with respect to health care access, it is likely that a hand-off involving an adolescent will require that both the adolescent and parent mutually agree to the referral decision.

1. **Commitment** - The practitioner who makes referrals must believe that handoffs are essential for each patient/client and for the organization as a whole. As a practitioner, you play a critical role in successful handoffs, but this commitment must be felt throughout the entire process.
2. **Responsibility** - Adolescents do not always follow instructions. Many patients/clients do not follow doctors’ instructions for other types of medical treatment either. However, we do not blame a failed hand-off in a relay race on the baton. Noncompliance is the reason we should devote more attention to successful handoffs, not an excuse for failing to do so. It is your responsibility to ensure that patients/clients with complicated chronic diseases, such as alcohol or drug dependence, transfer to the appropriate care.
3. **Understanding the client** - We are not handing off an inanimate object, such as a football or an airplane. We must respect and incorporate both the unique needs and circumstances of patients/clients in managing the referral.

4. **Designation and clearly defined roles** - For a successful hand-off, responsibilities of the individual “giving” the patient/client to the next level of care and the person “receiving” the patient/client are clearly defined. In a smooth hand-off, the receiver is fully informed of the patient/client and demonstrates that they have understood what the patient/client has experienced before responsibility can be passed on.
5. **Presence** – Patients/clients are not “sent” but are “delivered.” They could be viewed in the same way as unaccompanied minors are in the airline industry - they need to be “handed off” by one supervising airline employee to another when boarding, making a connection and arriving at the final destination.
6. **Common language for handoffs** - A common language is crucial to activating any successful hand-off process. Organizations in virtually every field have specific, unequivocal, highly clarified language that all “players” understand. Make sure that you understand each other’s language.
7. **Practice** - A smooth handoff is standardized, synchronized and practiced over and over again. Every field that performs good hand-offs engages in incredible amounts of practice to make them happen. Handoffs can be hard to practice in a setting where they are done infrequently. All clinicians who encounter these types of referrals, on a frequent or infrequent basis, are encouraged to keep abreast of the changes in providers and treatment services in their area, so that they have a current set of information when the need arises.
8. **Monitoring, evaluation and improvement** - In sports, team members are constantly graded on how well they are playing their roles, and they retain or lose their spots in the line-up based on performance. Grading also identifies areas where teaching can improve performance. When integrating SBIRT into practice, we need to establish mechanisms for monitoring the success of our handoffs from one level of care to another and use those results to improve.

Discussing Treatment Options

For adolescents and young adults who score at high risk on the CRAFFT, AUDIT, S2BI or other validated screening tool, you may wish to suggest that they seriously consider more intensive treatment than can be provided in your practice settings. Additionally, it may be advisable to pursue more intensive treatment when a co-occurring medical or mental health problem (e.g., PTSD, ADHD) exist. As you work with adolescents and their families to develop the steps of a plan, options for treatment will probably come up. After gaining permission from the adolescent and/or family to do so, suggest and describe some treatment options that best fit the adolescent’s situation.

The American Society of Addiction Medicine (www.asam.org) suggests the following guidelines to determine the appropriate intensity and length of treatment for adolescents with a substance use disorder:

1. Level of intoxication and potential for withdrawal, currently and in the past.
2. Presence of other medical conditions, currently and in the past.
3. Presence of other emotional, behavioral or cognitive conditions.
4. Readiness or motivation to change.
5. Risk of relapse or continued drug use.
6. Recovery environment (e.g. family, peers, school, legal system)¹¹⁷.

Other Associated Risky Behaviors

Take the time to find out about the adolescent's level of risk. Risk factors may include individual, family and environment. Violence, physical or emotional abuse, mental illness or drug use in the neighborhood and household can all contribute to an increased likelihood that an adolescent will use drugs.³ Based on the National Survey on Drug Use and Health (NSDUH) in 2013, 1.4% of adolescents age 12 to 17 experienced substance use disorder (SUD) and major a depressive episode. The prevalence rises to 3.2% for those 18 and older experiencing SUD and any mental illness.¹¹⁸ Consider screening for Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, Suicide/Depression, Anxiety and Post-Traumatic Stress Disorder (PTSD). Taking into consideration the adolescent's family environment, known co-occurring disorders, and results from screening for other behavioral health conditions can help you make the most appropriate referral(s).

Additional resources regarding co-occurring mental health and substance use problems in adolescents:

- Concurrent Disorders Knowledge Exchange Area. Screening for Concurrent Substance Use and Mental Health Problems in Youth. 2009. <https://www.porticonetwork.ca/web/knowledgex-archive/amh-specialists/screening-for-cd-in-youth>
- Substance Abuse and Mental Health Services Administration. (2011). Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations (HHS Publication No. SMA 12-4670). Rockville, MD: Author. <https://store.samhsa.gov/product/identifying-mental-health-substance-use-problems-children-adolescents-guide-child-serving>

Possible screening tools:

- HEADSS Psychosocial Interview for Adolescents. <http://www.bcchildrens.ca/Youth-Health-Clinic-site/Documents/headss20assessment20guide1.pdf>¹¹⁹
- Patient Health Questionnaire modified for Adolescents (PHQ-A) <https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures>
- Child Measures of Trauma and PTSD <http://www.ptsd.va.gov/PTSD/professional/assessment/child/index.asp>
- Massachusetts Child Psychiatry Access Project (MCPAP) Toolkit for Primary Care Providers <https://www.mcpap.com/pdf/PCCScreeningToolkitFINAL331909.pdf>

Treatment Settings

The most common Treatment Settings in which adolescent substance use treatment occurs includes:

- **Outpatient/Intensive Outpatient** -- The most commonly offered treatment setting for adolescent drug abuse treatment. It can be highly effective and is traditionally recommended for adolescents with less severe addictions, few additional mental health problems and a supportive living environment. Studies have demonstrated that more severe cases can be treated in outpatient settings as well.
- **Partial Residential** -- Suggested for adolescents with more severe substance use disorders who can be safely managed in their home living environment. Adolescents participate in 4-6 hours of treatment per day at least 5 days a week in this setting while still living at home.
- **Residential/Inpatient Treatment** -- Offered to adolescents with severe levels of addiction, mental health and medical needs and addictive behaviors, which require a 24-hour structured environment. Treatment in a residential setting can last from one month to one year.¹²⁰

Treatment Approaches

Research evidence supports the effectiveness of various behavioral-based substance use Treatment Approaches for adolescents. One or more of the options below could form a reasonable action plan.³ Under treating a substance use disorder will increase the risk of relapse. Medication-assisted treatment for substance use disorders has proven effective with adults, but are not approved for adolescents. A review of effective treatment approaches for adolescents are available elsewhere.³ Most adolescent treatment program use an eclectic treatment approach employing multiple therapeutic models listed below.¹²⁰

- **Behavioral Approaches** work to address adolescent substance use by strengthening the adolescent’s motivation to change. The following behavioral interventions help adolescents to actively participate in their recovery from alcohol and/or drug abuse and addiction and enhance their ability to resist alcohol and/or drug use:
 - ▶ Adolescent Community Reinforcement Approach (A-CRA)
 - ▶ Cognitive-Behavioral Therapy (CBT)
 - ▶ Contingency Management (CM)
 - ▶ Motivational Enhancement Therapy (MET)
 - ▶ Twelve-Step Facilitation Therapy (12-Step)
- **Family-based Approaches** seek to strengthen family relationships through improving communication and developing family members’ ability to support abstinence from alcohol and/or drugs.³ Involving the family can be particularly important in adolescent alcohol and/or substance use treatment. These approaches include:
 - ▶ Brief Strategic Family Therapy (BSFT)
 - ▶ Family Behavior Therapy (FBT)
 - ▶ Functional Family Therapy (FFT)
 - ▶ Multidimensional Family Therapy (MDFT)
 - ▶ Multisystemic Therapy (MST)
- **Addiction Medications** are shown to be effective in treating addiction to opioids, alcohol and nicotine in adults. Some preliminary evidence indicates effectiveness and safety for use with minors. The only FDA approved medication for use with this population in treating opioid addiction is Buprenorphine which is approved for use with 16-65 year olds.
 - ▶ Opioid Use Disorders
 - ▶ Alcohol Use Disorders
 - ▶ Nicotine Use Disorders
- **Recovery Support Services** aim to improve quality of life and reinforce progress made in treatment.
 - ▶ Assertive Continuing Care (ACC)
 - ▶ Mutual Help Groups
 - ▶ Peer Recovery Support Services

► Recovery High Schools

Resources to Find Substance Use Recovery Help for Teens and Young Adults:
<ul style="list-style-type: none">■ Recovery high school resources : https://www.recoveryschools.org/■ Recovery schools for higher education: http://collegiaterecovery.org/programs/■ Substance Abuse and Mental Health Services Administration’s Guide to Peer Recovery Support Services: https://store.samhsa.gov/system/files/sma09-4454.pdf■ Mutual Support Groups: 12-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) for teens, and non-12-step programs such as SMART Recovery Teen & Youth Support Program age 14-22 (http://www.smartrecovery.org/teens/)

For additional information about different treatment options, please review the following:

National Institute on Drug Abuse. *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide*; 2014.³⁸ <http://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/acknowledgements>

HBO Addiction: Drug Treatment for Adolescents
https://www.hbo.com/addiction/treatment/35_treatment_for_adolescents.html

Starting the conversation

When discussing these options with the adolescent, set the tone by displaying a non-judgmental demeanor and explain your role and concern. Also, connect the adolescent’s screening results and current visit to the need for specialized treatment.

Here are some examples of what you might say:

“Stacy, we have talked a bit about your struggles at home, at school and with your health, and I think some changes around alcohol could help with the issues you identified. Your score of 13 out of 40 on the AUDIT indicates that you might benefit from some help with cutting back on drinking. Working on this through outpatient counseling with a counselor or other health professional like myself could be really helpful. What do you think of this idea?”

“I’m glad that you want to make significant changes in your health by decreasing the amount you drink. You know, adolescents in your situation are often more successful if they also see a counselor who specializes in this topic. We have some excellent programs in our area that have helped many people in exactly your situation. Would you be willing to see one of these counselors to assist you with your plan of recovery?”

“Your score of 32 out of 40 on the AUDIT indicates that you are at great risk of developing alcohol dependence. I am very concerned for you and your health. I understand your desire to want to quit drinking on your own and applaud your determination. However, your heavy use of alcohol can be dangerous and you might have problems with alcohol withdrawal too. The best response is to admit you to a residential program that can safely manage your possible withdrawal and help you deal with

your alcohol abuse. I would be really worried if you were to just stop drinking (go “cold turkey”) on your own without the care of a health professional. This could be dangerous to your health” ¹²¹

“John, we’ve talked about the impact that the use of marijuana has had at school and playing sports, and I think some changes around marijuana could help with the issues you’ve identified. Your score indicates that you might benefit from some help reducing your marijuana use. Working on this with a counselor or a nurse like myself could be really helpful. What do you think of this idea?”

Confidentiality

Federal Confidentiality Regulations: SAMHSA Guide to Screening and Assessing Adolescent Substance Use Disorders

Information that is protected by the Federal confidentiality regulations may always be disclosed after the adolescent has signed a proper consent form. (Parental consent must also be obtained in some States.) The regulations also permit disclosure without the adolescent’s consent in situations such as medical emergencies, child abuse reports, program evaluations, and communications among staff.

Any disclosure made with written client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations (§2.32).

When a program that screens, assesses, or treats adolescents asks a school, doctor, or parent to verify information it has obtained from the adolescent, it is making a client-identifying disclosure that the adolescent has sought its services. The Federal regulations generally prohibit this kind of disclosure unless the adolescent consents.

Programs may not communicate with the parents of an adolescent unless they get the adolescent’s written consent. The Federal regulations contain an exception permitting a program director to communicate with an adolescent’s parents without her consent when:

1. The adolescent is applying for services.
2. The program director believes that the adolescent, because of an extreme substance use disorder or a medical condition, does not have the capacity to decide rationally whether to consent to the notification of her guardians.
3. The program director believes the disclosure is necessary to cope with a substantial threat to the life or well-being of the adolescent or someone else.

Other exceptions to the Federal confidentiality rules prohibiting disclosure regarding adolescents seeking or receiving substance use disorder services are:

- Information that does not reveal the client as having a substance use disorder
- Information ordered by the court after a hearing
- Medical emergencies
- Information regarding crimes on program premises or against program personnel
- Information shared with an outside agency that provides service
- Information discussed among people within the program
- Information disclosed to researchers, auditors, and evaluators with appropriate Institutional Review Board review and approval to ensure the protection of program participants

The issue of client-therapist confidentiality when a client is a minor is complicated. Whereas clinical practice and ethics are relevant,^{122,123} practitioners must be conversant with state laws in this area. States vary as what age defines a minor and what type of information is or is not considered confidential. Most state laws give the parent access to the child's treatment until the child is age 18 years but exceptions exist (e.g., some states allow those age 16 or older to seek health care services without parental consent).

Effective Treatment Approaches

Just as timing is important for adolescents to initiate treatment, the methods used to introduce their options are equally important. Meta-analyses demonstrate that established treatment options are effective for adolescents, but not enough treatments have been evaluated for a comparative effectiveness study to rank these options.¹²⁴ For example, brief alcohol interventions lead to significant reductions in drinking and alcohol-related problems for adolescents and young adults, the effects of which lasted for up to one year after the intervention.^{19,24,27,31} Motivational interviewing has been shown to have a larger effect on alcohol consumption than other brief interventions for this age group.³¹ Motivational interviewing has also been shown to be effective for adolescents across a variety of substance use behaviors with its effect retained over time.²⁵ Module 5 provides greater detail on Motivational Interviewing.

When brief interventions were delivered to adolescents individually over multiple sessions, they were found to be the more effective in reducing the frequency of alcohol and cannabis use as well as reducing associated criminal behaviors (compared to group and single session brief interventions).²⁷ Compared to various outpatient substance use treatment, adolescents showed greatest improvements from family therapy, mixed and group counseling.¹²⁵

The American Academy of Pediatrics (AAP) recommends that practitioners manage adolescents with alcohol or other drug use disorders collaboratively with adolescent mental health or addiction specialists.³⁸ They also recommend that practitioners schedule medical home office visits throughout the recovery process whenever possible.³⁸



Self-assessment Exercise: What are the treatment approaches most frequently used in the settings in which you would work as a health professional?

Considerations for the Referral Process

Typically, the referral process includes:

1) **Determining the specific needs of the client to determine the most appropriate referral sources.**

Every adolescent is different and has varying needs when obtaining assistance. Practitioners consider the many multicultural factors that impact the treatment process, such as race, gender, religion/spirituality and primary language spoken, as well as geographical constraints and financial factors, such as insurance coverage and out-of-pocket expenses, when making a recommendation so the adolescent can be matched with the most appropriate referral resource for his or her needs. SAMHSA offers online sources of information for persons seeking substance use and/or mental health treatment services in the United States or U.S. Territories including the Behavioral Health Treatment Services Locator, Buprenorphine Physician & Treatment Program Locator, and Opioid Treatment Program Directory (see <http://www.samhsa.gov/treatment/index.aspx>).

Practitioners should become acquainted with the available local community options for teenagers, including mental health services because for some communities, specialized drug treatment programs may not be available.³⁸ Contact your state agency for substance use to identify adolescent-specific treatment programs near you. Education and prevention programs for youth in the early stage of substance use should also be considered when locating services and resources. Practitioners who work with substance use issues would do well to create and maintain a current list of substance use treatment options available in their local and surrounding area. Creating personal connections with intake personnel, and taking tours of treatment facilities will ease the referral process and enhance the practitioner's credibility with the client and the treatment program.

2) **Evaluating and, whenever possible, removing potential barriers to successful engagement with the helping resource.**

Potential barriers can include lack of insurance or financial resources, transportation needs, fear that others will find out, lack of family support, parent/guardian's lack of access to child care or elder care, legal complications, and/or medical needs, to name a few. Identifying and addressing these barriers can help ensure the adolescent accesses the assistance or treatment resource available to them.

Treatment Referral Resources

- Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Locator: 1-800-662-HELP or search: <https://www.findtreatment.samhsa.gov/>
- The Physician Locator of the American Society of Addiction Medicine (ASAM): <https://www.asam.org/resources/patient-resources>
- The Patient Referral Program of the American Academy of Addiction Psychiatry: <https://www.aaap.org/patients/find-a-specialist/>
- The Child and Adolescent Psychiatrist Finder of the American Academy of Child and Adolescent Psychiatry: https://www.aacap.org/AACAP/Families_and_Youth/Resources/CAP_Finder.aspx

3) Explaining to the adolescent in clear and specific language the necessity for and process of referral to increase the likelihood of understanding and follow through with the referral.

Listening and responding openly to client questions and concerns will help minimize denial and resistance.

4) Arranging referrals to other professionals, agencies, community programs, support groups or other appropriate resources to meet the adolescent’s needs. The American Academy of Pediatrics recommends that practitioners establish working relationships with alcohol and other drug treatment providers in their communities to ensure their adolescents have treatment options that are developmentally appropriate.³⁸ It is preferable for the referral to be arranged immediately using a “warm transfer” where the addiction professional connects the adolescent directly with the treatment provider by telephone while the adolescent is still in the office. However, if impossible, the practitioner must contact the adolescent within 24 hours to arrange the referral. At a minimum, the adolescent, and in most instances the parent, must be provided with a written referral with the treatment provider’s contact information, address and date and time of the first appointment or meeting.

The speed at which you can link an adolescent to treatment dramatically impacts their likelihood to show up, remain in treatment and experience positive outcomes. Offering a treatment appointment date immediately¹²⁶ and reminding the adolescent of their initial scheduled appointment usually improves the rate at which adolescents will begin treatment.¹²⁷ The first 24 hours after an adolescent’s initial contact is a critical period in initiating treatment.¹²⁸ Research shows that if the gap between your session and first appointment for a different level of care is more than 14 days, failure is virtually certain.¹²⁹⁻¹³¹

Motivation and Referral

For adolescents who express little motivation to go into more intensive treatment, the primary task is to engage them in a discussion that allows you to get a good understanding of how they see substance use which explains their decision not to choose treatment. When adolescents hear themselves describe their thoughts and feelings about their substance use to a non-judgmental listener, they are more likely to understand their mixed feelings, which serve to increase their level of motivation for treatment. You can facilitate this process by asking open-ended questions, making empathic reflections and using summary statements. The following is an example that shows how these three strategies can be used together:

“So you’re saying that you know that drinking is bringing you down and messing up your relationships with your family, but you are just so tired and you feel like ‘what is counseling gonna do for me?’ You think it’s possible that it’s partly the drinking itself that’s got you feeling this way, but you just don’t feel ready to commit to treatment yet. Is that what you’re saying?”

After you make reflective listening statements that express an understanding of why the adolescent does not want to go to treatment, then you can move on to the next steps. You might ask what would need to happen to raise their level of motivation. If the initial response is something vague or noncommittal like “I don’t know,” try saying something like:

“It’s hard to know what could happen that could make you feel more motivated for counseling. Sometimes people get more motivated because some things in their life get worse, like health problems or getting poor grades in school. Sometimes people get more motivated to go into counseling because something good happens that makes it easier for them, like they find out that they can get transportation there or their parents are supportive. Do you relate to any of these?”

If the adolescent is willing to consider treatment options at this point, you could move to discussion of barriers to treatment and linkage to treatment. If the adolescent is not willing, you might close the discussion with a summary statement that conveys that the option is open for more intensive treatment in the future.

“You’re saying that you know that counseling can help people, and has even been helpful to you, but you just don’t want to go back to it at this time in your life because you don’t feel ready to give up drinking yet. You feel like you’ll know when you’re ready, and you’ll get treatment then. Did I get that right?”

For an adolescent who expresses moderate motivation to go into more intensive treatment, the primary task is to express understanding of their ambivalence and elicit change talk that will tip the balance in favor of the adolescent agreeing to treatment. This can be done by exploring ambivalence, expressing empathy and reflecting:

“Tell me about some of the reasons why you would be motivated to get counseling.”

“Tell me about some of the reasons why you would not be motivated to get counseling.”

“What would need to be different for you to go to counseling?”

Use reflections to express empathy toward their responses. For example:

“So, you’re saying that you want to go to treatment because you’re sick of being tired and grouchy. You really sound tired of that life.”

“I see the way you light up when you talk about how you’d like to be a better friend.”

You will experience more success by accepting the fact that the adolescent is ambivalent and that sometimes they will not feel like acknowledging the potential benefits of treatment. Always remain patient and express empathy. Double-sided reflections that include both sides of the adolescent’s ambivalence show that they are understood:

“So, what I’m hearing is that you don’t really feel like getting counseling now because of how much work it is, even though you think it would make things better for you and your family.”

Ask questions that invite the adolescent to describe the potential benefits of treatment:

“How do you think it would affect your life if you got counseling?”

“It sounds like you feel that going to treatment could help your health. Tell me more about what causes you to say that.”

For adolescents who express high motivation, avoid trying to convince them that they are making a good choice, because such a response could run the risk of raising pushback in someone already motivated. Instead, allow the adolescent to explain their reasons for that motivation:

“You indicated quite a bit of motivation to get treatment for your alcohol use right now.”

“Tell me some of the main reasons for that... You mentioned some health concerns.”

“Is that also related to why you want to get treatment? How so?”

Explore possible ambivalence. This is helpful because it allows the adolescent to know it is OK to talk about their reservations. A motivated adolescent may not know it is OK to have such concerns, and may deny them to please the counselor or parents. The reason to discuss ambivalence is to decrease the likelihood that these reservations will result in not following through. You might approach discussing ambivalence in a highly motivated adolescent by saying:

“You’re describing a lot of reasons why it would be a good idea for you to get counseling for your alcohol dependence. Sometimes even when someone is really motivated to get treatment, they might have some negative feelings or concerns about doing that. How do you feel about it?”

Support change talk, expressing recognition and appreciation that the adolescent is committing to do something that a) is not easy; b) is a positive step to improve their life; and c) is taking this step willingly and openly.

“I appreciate that you’ve been so open in looking at the ways alcohol has been complicating things for you. Now you’re planning to take back control of your life by going to treatment (or involvement in a support group). That’s a really positive step you’re taking, and I know it’s not easy.”

There are several barriers to seeking treatment. A SAMHSA survey found that the most often reported reason for not receiving treatment among adults and adolescents who felt a need for treatment and made an effort to receive treatment was not being able to afford it (37%).¹³² Among individuals 18 and older, 9% feared that seeking treatment would negatively impact their jobs.¹¹⁸ When discussing treatment options, explore insurance coverage, and concerns about costs and take care to discuss resources that are free or have a sliding fee scale.

SAMHSA's online treatment locator is available at <https://www.findtreatment.samhsa.gov/> and National Help Line 800.662.HELP (4357) offers confidential, free, 24-hour-a-day, 365-day-a-year, information services in English and Spanish for individuals and family members facing substance use and mental health issues. The Help Line service provides free referral to local treatment facilities, support groups and community-based organizations. If the adolescent has no insurance or is underinsured, provide a referral to the local state office responsible for state-funded treatment programs, as well as offer referral to facilities that charge on a sliding fee scale or accept Medicare or Medicaid. In areas that experience a geographic shortage of providers, such as rural areas, practitioners should become knowledgeable about proximate alternative solutions.

If the adolescent simply is not interested in treatment at this time, rather than push them and jeopardize future opportunities, it is important for you to accept and respect their decision in a non-judgmental manner. They may be more willing to accept the notion of treatment during future sessions or at some later time. A follow up conversation with the reluctant adolescent (and perhaps include the parent) is essential, as your initial conversation could have ignited some thoughts of change.

Scheduling Treatment Appointments

When a referral to another health professional, behavioral health practitioner or treatment program is appropriate, there are several steps you can take to facilitate a successful link. Consider making a three-way call involving you, your patient/client, parents/guardians (as appropriate), and the treatment program or provider immediately after the adolescent consents to treatment. The purpose of the call is to:

- inform the treatment staff or clinician of the adolescent's substance use, treatment barriers or ambivalence;
- agree on whether the program or some other treatment option is best;
- gain support from the program to solve or remove some of the treatment barriers (e.g., transportation, cost, insurance coverage, child care, evening appointment); and
- schedule an appointment.

As noted earlier, it is important to have this call within three days of gaining the adolescent's consent is best; after that, no show rates climb steeply. After 14 days, about 50% of clients will not show for treatment, regardless of their motivation. Making a referral that adolescents do not reach wastes their time and yours.

Communicating with Referral Sources

It is essential that you and the treatment program or provider be able to share information and share responsibility for helping the adolescent. A *Sample Release of Information* form is included in Appendix I of this Learner's Guide. These are only examples. Make sure that your release forms comply with your state and federal substance use medical record confidentiality laws and The Health Insurance Portability and Accountability Act (HIPAA). A *Sample Client Update Report* is also located in Appendix J of this Learner's Guide to help facilitate quick communication between professionals so everyone involved can stay informed of the adolescent's progress, status and additional needs.

Video Resources

- Boston University's BNI-ART Institute produced several excellent brief videos that might be helpful to you when discussing referral. These videos are located at: <http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/>
 - Video 1 - insensitively confronting a young adult with an alcohol-related injury
 - Video 2 - an alternate, respectful brief intervention with the same young adult
 - Video 3 - an exceptionally sensitive video of a clinician helping an ambivalent patient/client make his own decisions and plan to get intensive treatment
 - Video 4 – SBIRT for alcohol use with a college student
- SBIRT Oregon produced several other strong examples of SBIRT in practice, including a video entitled "Clinical workflow with behavioral health specialist" which demonstrates a warm hand-off. These videos are located at: <http://www.sbirtoregon.org/video-demonstrations/>
- University of Florida Institute for Child health Policy & Cherokee National Behavioral Health produced a video entitled "The Effective School Counselor With a High Risk Teen: Motivational Interviewing Demonstration." The video is located at: <https://www.youtube.com/watch?v= TwVa4utpII>

Sample Interaction: A parent struggling to get their teenager to seek help for drug use

Setting: A single mom, Sheila, has discovered that her 16-year-old son, Tom, is using drugs. Her efforts to get help for Tom have not been fruitful. She does not know where to turn. Sheila ruminates about these issues: ‘Does my son have a drug problem? Maybe he is going through a phase and will grow out of it?’ She is asking the kinds of questions typical of most parents. Her health care provider recommends that she call a local adolescent drug treatment program and talk to an intake worker.

Practitioner (Intake Staff - Carrie): *Hello, this is Carrie from the Adolescent Treatment Center. How can I help?*

Parent (Mom): *Hi, I am Sheila. I am concerned and worried. I think my son, Tom, is using marijuana. Lately he’s been coming home smelling like weed. Every time I enter his room I can smell weed. Do you think he needs treatment?*

Practitioner: *I can see why you are concerned. It’s good that you gave us a call. Maybe we can help. But before we talk about next steps, tell me more about your concerns.*

Parent: *He doesn’t seem to be very conscious every time I talk to him. It seems like he’s high and not alert. And I am worried about him driving under the influence, which might cause danger to him and other people.*

Practitioner: *Sheila, this must be very frustrating for you. It sounds like you want to take steps to stop what you see is happening.*

Parent: *Yes, I am! What makes it so frustrating is that he doesn’t think using marijuana is a problem. I get no sign from him that there is anything wrong here. He even tries to convince me that marijuana is not addictive. Is this true?*

Practitioner: *That’s a common myth by teenagers – and even many adults. Marijuana can be addictive, like all other drugs that get a person high. Does Tom also say this to you? ‘All my friends do it. I’m just having fun.’*

Parent: *Yes. All the time. (Eyes roll.)*

Practitioner: *I understand! How about this one? ‘Weed is not harmful.’*

Parent: *Yea. He throws that at me all the time. ‘Marijuana is safer than alcohol.’ Is that true?*

Practitioner: *I do not want to over-state things – it is unlikely that a person would get addicted if they used just a little and very infrequently. But anyone who is a regular user is at great risk of becoming addicted. And it’s not safer than alcohol.*

Parent: *I hope Tom is just experimenting with it.*

Practitioner:	<i>You are worried that he might be a regular user.</i>
Parent:	<i>Yea - definitely. It's so difficult to know about Tom. I cannot be sure what he is doing during most hours of the day. So much of his free time is outside what I see.</i>
Practitioner:	<i>Sheila, it is to your credit that you are concerned about Tom and his marijuana use. Your efforts to seek help show me that you are a caring parent. I also hear from you that you are frustrated because Tom is not taking this issue seriously, despite your efforts.</i>
Parent:	<i>Exactly. I feel like I am dealing with a younger version of my ex.</i>
Practitioner:	<i>(laughs) Well, it can be quite normal for a teenager to minimize drug use and to reject parents' efforts to reach out.</i>
Parent:	<i>So it's normal for a teen to basically say, 'leave me alone and to ignore me when I want to discuss an important topic?'</i>
Practitioner:	<i>In many ways, yes. This does not mean that you stop trying. Many parents do not realize that even when it seems futile, teenagers typically appreciate that they have a parent who cares. But it would help me to know more about what it's like when you try to talk to Tom.</i>
Parent:	<i>He doesn't listen. Or he swears at me. It seems every time I try to talk to him, we just argue.</i>
Practitioner:	<i>Sounds like a common experience for parents. But you try – that's important. Describe where you have these chats.</i>
Parent:	<i>Usually in his room. I can't find time when he's not playing video games or has headphones on.</i>
Practitioner:	<i>This is excellent to hear that you are trying!! Even if you are not getting any clues, Tom knows you care. And this is important role of a parent – give continuous signs to your teenager that you care.</i>
Parent:	<i>But what do you think – does my kid have a problem? What do you suggest?</i>
Practitioner:	<i>Okay, allow me to offer some guidelines. What I am suggesting is that you try another talk. This can be... (interrupted).</i>
Parent:	<i>Are you sure? I have already tried this!</i>
Practitioner:	<i>I know. But I am going to offer some Tips that are important when having a heart-to-heart talk with a teenager. You may have already tried them, but let's see. First thing – or Tip #1. You need a proper setting. Avoid his room – that gives him too many ways to ignore you. A great opportunity is at meal time or when you both are running an errand in the car.</i>

Parent:	<i>The one thing we still do is have dinner together. That might work.</i>
Practitioner:	<i>Okay. What does small talk at dinner go like?</i>
Parent:	<i>(Sarcastically) It's great bonding! He opens up about his many private thoughts - he needs more money, has to use the car that night, and to tell me that he won't be home much! Then we really get close when we share our wonderful views about him wanting to spend more time with his Dad.</i>
Practitioner:	<i>(Laughing). Great! So after you have settled in and enjoyed some of this enjoyable small talk, you will want to try Tip #2: Tell Tom that you care about him. It might go something like this. 'Tom, I have something important to talk to you about. Let me start first and then I will listen to you. My concern is that I am worried about your use of marijuana. I care about your health and well-being. This is not about my personal view of marijuana – it's about me caring about you.'</i>
Parent:	<i>Hmmm. I see. I am to emphasize that I care about him. Hey I am his Mom, after all!!</i>
Practitioner:	<i>Yes, by starting this way you hopefully avoid Tom getting defensive. You remind him that there is a reason for this chat and that you are not trying to be the fun police. Next up is Tip #3: You give Tom permission to talk and you just listen.</i>
Parent:	<i>Okay, I can do that.</i>
Practitioner:	<i>Let him talk. Just listen. You can even affirm what he says. Something like this: 'I understand your point of view. I do not agree with everything you said it but I understand.'</i>
Parent:	<i>This sounds like I am approving of using.</i>
Practitioner:	<i>No, showing understanding is not approval. It shows that you respect his point of view.</i>
Parent:	<i>Okay, then I assume the next thing from his mouth is "Mom, drive me to rehab!"</i>
Practitioner:	<i>(Laughing). Yes, it always works like that! Seriously, here is Tip #4: Ask him to consider the idea of getting an assessment from a professional. Describe the request this way: 'What I would like you to consider is a small commitment on your part. I want you to agree to get an assessment from a professional. This is not treatment. It's an opportunity in a no-pressure situation where you can talk about your life and to learn a little about yourself. If there is a recommendation that it's best that you get treatment, that decision will be yours. I cannot tell you what to do.'</i>

Parent: *Interesting. Perhaps this will work – I will give it a try. This is a new approach for me. My son had always been a good kid. He is a great student who finishes his homework. He has a big heart. I think he is popular with his friends.*

Practitioner: *You are hopeful and you have good reason to be. You have some next steps to try. Also, perhaps you will want to discuss these issues with your ex. He might be an important ally in this effort. And feel free to call me after the talk. Perhaps we will see you and Tom if he agrees to an assessment.*

Parent: *Thanks, you have been very helpful.*

Referral Role Play



Application Exercise: *What treatment options would you recommend to the adolescent?*

Role Play Exercise: You are a 16-year-old adolescent who is worrying all the time about failing in school. You have had several acute feelings of panic and doom, which also worry you a lot. You know that the school has notified your parents that you are on academic probation due to your low performance. Sometimes you just feel like blowing up, the pressure gets so high. You feel you have to work harder than other students your age. If asked about your marijuana use, you might say something like: *“I don’t think I need to stop smoking. I only smoke weed a few times a week with my friends. My health is good and besides, I’m only 16, it can’t hurt.”*

CRAFFT score of 5

S2BI score of Weekly Use of Marijuana

Role Play Exercise: You are a 20-year-old young adult who seeks some help because you feel like you have very little energy and feel depressed and blue. If asked about alcohol use, you might say something like: *“I drink four or five drinks most days after classes and a few more on the weekends. It is really the only way I relax. I have a lot of stress in my life, and it is just my release. I don’t see any problem with it.”*

AUDIT score of 25

S2BI score of Weekly Use of Alcohol



Role Play Exercise: Partner with someone to practice conducting referral. One person will act as the practitioner who has administered the AUDIT. Your partner will act as the young adult who scored a 17 on the AUDIT and has sought help for stress and depression.

Young Adult: You are an 18-year-old adolescent who called with concerns about feelings of stress and depression. You are concerned about poor performance at school. If asked about your alcohol use, you might say something like: *“I stopped going out to drink with my friends as much as soon as I started getting D’s at school. Sometimes I will have a beer, never more than two and I don’t do it every night. I heard that beer is okay. It’s not the hard stuff. I don’t smoke. I don’t do drugs. I wouldn’t do anything that would get me into trouble.”*

Working with Physicians in Ongoing Care Coordination^{133,134}

Adolescents who are identified as having risky alcohol, tobacco and other substance use patterns and/or are in need of mental health services may need to be referred to a physician for additional care. The need for medical services for an adolescent that are identified during the SBIRT protocol could be related to:

- alcohol-related physical illnesses or impairments;
- detoxification necessity;
- psychiatric conditions; and/or
- pharmacotherapy options.

Maintaining Communication with the Physician¹³⁵

It is imperative for you to coordinate these services with the physician, follow-up with the adolescent or young adult to ensure services are being received and share information so that you and the physician are working together (with a signed Release of Information, of course - A *Sample Release of Information* form is included in Appendix I of this Learner’s Guide). Below are some tips for you when referring to a physician to ensure that needed care is effective and consistent:

- **Locate a knowledgeable prescriber.** It is not uncommon for an adolescent or young adult to not have a primary physician. If the adolescent does not already have a relationship with a qualified physician who is knowledgeable about addiction medicine, you can recommend one. The American Academy of Addiction Psychiatry (AAAP) and the American Society of Addiction Medicine (ASAM) are organizations of medical professionals who have been specially educated and trained in the field of addiction medicine. You and the adolescent can contact either of these organizations to locate a physician in your client’s area. The American Academy of Addiction Psychiatry’s (AAAP) physician locator program is located at <https://www.aaap.org/patients/find-a-specialist/>. The American Society of Addiction Medicine’s (ASAM) physician locator system is at <http://www.asam.org/>.

- The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a searchable directory of drug and alcohol treatment programs. It shows the location of specialty substance use treatment programs around the country that treat alcohol use disorders and drug use disorders. The SAMHSA Locator includes more than 11,000 addiction treatment programs, including residential treatment centers, outpatient treatment programs and hospital inpatient programs for drug addiction and alcoholism. The SAMHSA Locator does not list individual physicians, advance practice nurses, psychologists, social workers or other addictions specialists who do not practice within licensed treatment programs. This service is located at: <http://findtreatment.samhsa.gov/>. SAMHSA maintains a list of state agencies in the Directory of Single State Agencies (SSA) for Substance Abuse Services https://www.samhsa.gov/sites/default/files/sites/default/files/ssa_directory_4-9-2018.pdf. It is a good idea to develop a list of addiction-focused physicians and other specialists in your area who provide specialized behavioral and mental health services for adolescents, especially if your clientele lives in a small community or rural area where knowledgeable physicians are scarce. Local services may specialize in substance use treatment for adolescents, but in many communities, this type of care only occurs in a mental health setting. The more familiar that you are with these physicians and with their practices, the more smoothly your handoffs will be and the better the treatment will be for the adolescent.
- **Send a written report.** Maintain consistent communication with the adolescent’s physician so any concerns that arise during a session with you can be addressed by the physician (or vice versa). Significant clinical issues encountered or addressed by either you or the physician need to be included in the adolescent’s medical record. When information is in a medical record, it is more likely to be acted on. The most efficient way to update a physician on the status of the adolescent or significant changes potentially impacting care is to submit a written report to the physician’s office. This report can be submitted via fax, mail or email, depending on the communication preferences of the prescriber and must be in accordance with 42 C.F.R. § 2 The Confidentiality of Alcohol and Drug Abuse Patient Records at <http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol1/pdf/CFR-2010-title42-vol1-part2.pdf>. Making your release of information mutual, allows the physician to communicate back to you on the client’s progress as appropriate. You may still have to contact the physician’s office to obtain such feedback.
- **Make it look like a report - and be brief.** Since physicians maintain caseloads of hundreds of clients at a time, it is important that your written report be brief, concise and official. A report should include the date, the adolescent’s name and date of birth, your contact information and any relevant information that needs to be conveyed to the physician so he/she may remain informed of the adolescent’s progress and current status. Adolescent update reports should not be longer than one page. Reports that include extensive details and are longer than one page will probably not be read.
- **Keep the tone neutral.** You can provide brief detail about the adolescent’s use or abuse of alcohol, prescription medications or illicit drugs. Avoid making direct recommendations about prescribing medications, as doing so could be practicing beyond the scope of your license/credential. The physician will use their clinical judgment to draw their own conclusions. Providing “just the facts” will enhance your alliance with the adolescent’s physician and make it more likely that he/she will act on your input.

Follow-Up and Support

From your first encounter with the adolescent, discuss that you would like to *follow-up* with them, regardless of their decisions about continuing to meet with you, cutting down or abstaining from unhealthy drinking or other substance use, or getting additional treatment. Adolescents and adults generally do not know what to expect from counseling or treatment. If follow-up is presented as the standard of care and what you do for all of your adolescents and adults, very few will refuse.

Follow-up
contacting the adolescent at a later time to provide additional support, if needed

Reconnect with the adolescent after a couple of weeks to see if she got what she needed from you, to ask how things are going and to check-in to see if any additional services are needed. Treat relapse as an opportunity to engage in additional or different treatment rather than a failure.³ There are two overlapping types of follow-ups that are distinguishable mainly by how soon they occur after your session and the amount of information that you collect:

- **Booster and linkage follow-up** – Controlled research studies have shown that a brief telephone call within a few days or weeks to an adolescent who received a brief intervention for unhealthy alcohol use dramatically reduces alcohol intake, unhealthy drinking practices, alcohol-related negative consequences and alcohol-related injury frequency.¹³⁶⁻¹³⁸ The booster and linkage follow-up reinforces the action plan made, demonstrates your concern for the adolescent’s health and well-being, and gives you both an opportunity to resolve barriers or ambivalence through additional brief intervention. A booster follow-up also gives you an opportunity to re-administer the CRAFFT, S2BI, AUDIT-C, AUDIT or other screening tools to assess change in alcohol use consumption and other substance use since the last interaction.
- **Recovery management follow-up** – This type of follow-up generally occurs several months after your last interaction with the adolescent. These are primarily booster and linkage reconnections that give you and the adolescent opportunities to assess whether issues have been resolved, assess need and motivation for additional services, and to reinforce changes that have been made since your first contact. They also give you an opportunity to measure change and gather feedback for improving your services. These follow-ups can occur quarterly or six months after the initial contact with the adolescent.¹³⁹⁻¹⁴²

Making Phone Contact

Follow-ups are brief contacts, generally not more than 15 to 20 minutes and should always utilize Motivational Interviewing techniques outlined in Module 5. The follow-up may begin with a brief, casual conversation as a way to get reacquainted. You could also remind the adolescent that you had told them you planned to follow-up.

If you reach the adolescent, you might say:

“Hi, [name of adolescent]. This is [your name], and I’m following up on the conversation we had on [date]. This will only take a few minutes. Is this a good time to talk?” If yes, continue; if no: “OK, that’s not a problem. We can schedule an appointment to talk another time. I am available [day, times]. Which time would work best for you?”

“You may recall that when we spoke some time ago, I stated that I would try to check back in with you to see how you are doing. Is this OK with you? Do you have any questions?”

Confidentiality is an essential element of any outreach to an adolescent. If you call and get voicemail, you might say:

“Hello. This message is for [the adolescent’s name]. This is [your name]. I’d like to take a few minutes to speak with you. Please call me at [your work number] between the hours of [time]. If I don’t hear from you, I will try back again on [date].”

If client does not agree to a time, you might say:

“I understand how hard it is to find a good time. Did you have any questions about why I’m calling? [pause for response] OK, I’ll go ahead and leave my number with you. I look forward to talking with you soon.”

The goal of the call and of the practitioner is to help adolescents solve the problems for which they initially contacted you and to link people to supports and services that they may need now before they experience any other problems. The follow-up is also an opportunity to address concerns that were identified during the interaction (e.g., risky alcohol or marijuana use) and to measure change (e.g., reduction in alcohol consumption) since their last contact with you. You can ask some of the same questions (e.g., CRAFFT, S2BI, AUDIT, or AUDIT-C) that the adolescent was asked when she first sought help, so that you both can see what has improved, what still might be troubling her and how you can offer additional services.

The CRAFFT Provider Guide recommends re-screening at follow-up. The table below is extracted from the guide to provide guidance on follow-up based on the CRAFFT score:

Extracted from CRAFFT Provider Guide Recommendations for Screening at Follow-up 2

- Adolescents whose CRAFFT score is 0 or 1 who receive brief advice should be asked about continued substance use at the next health care visit. Those who have continued to use should be re-screened with the CRAFFT. Those who have stopped should be given praise and encouragement.
- Any adolescent who answers “yes” to the car question and contracts with the provider not to drive or ride with an intoxicated driver should be given a follow up visit to ensure they have been successful.
- Adolescents with a CRAFFT score of 2 or more who receive a brief intervention in the office should be followed to determine whether they have been able to make progress towards the goals defined in the intervention.
- Adolescents who are referred for substance use treatment should be followed to track their progress and keep them connected with their medical home. Providers should ask them what they do in treatment, how it is going, and what is planned once the treatment program is completed. Many practices can use their electronic health record (EHR) or a tickler file to remind the practice to check on progress either through a telephone call or follow-up visit.

Follow-up Role Play



Role Play Exercise: With a partner, practice conducting follow-up. Your partner will act as the adolescent who scored a 4 on the CRAFFT and was referred to a treatment provider for alcohol and marijuana use, and feelings of anxiety and depression.

Adolescent: You are a 16-year-old adolescent who originally presenting with concerns about feelings of anxiety and stress. During the initial visit with the practitioner you screened positive for risky alcohol use and weekly marijuana use. You have been receiving care with a treatment provider for your alcohol and marijuana use as well as your concerns about feelings of nervousness, sadness, and difficulty concentrating in class. If asked about your substance use, you might say something like: *“I’ve been going to my appointments. I’ve stopped drinking alcohol. And now I’m only smoking weed after school once in a while. I’ve stopped smoking before school and I don’t smoke anything that would really hurt me. Smoking weed makes me feel less anxious. I’m not driving while high anymore. Last weekend my friend got pulled over and arrested for drugged driving. He lost his license and now it’s on his record. This has been really hard.”*

Sample Interaction: Referral to Treatment, CRAFFT

SBIRT works particularly well with teens who are risky users but are not yet in need of treatment. For those who are, however, the brief intervention may be used to encourage the teen to accept a referral to treatment.

Setting: Imagine that Mary, a 16-year old high school junior who was arrested for vandalism of school property when she was caught spray painting graffiti after school, scored a 5 on the CRAFFT. In this scenario, Mary also answered that she forgets things as a result of her drinking and that her mother has told her that she should cut down (Yes to the “FORGET” and “FAMILY and FRIENDS” questions). A dialogue of the first brief intervention with the practitioner (Steve), using the Brief Negotiated Interview technique, is provided below.

Practitioner: *Thanks for bearing with me and answering all of those questions. Now, I'd like to learn a little more about you. What is a typical day like for you?*

Adolescent: *It's boring. I wake up, go to school, and sit through very long classes. Then I go hang out with friends. I usually go home sometime around dinner. After dinner I do my homework. Then it starts all over again the next day. Hanging out with friends is the only interesting part of the day.*

Practitioner: *That sounds like a typical day for a high school student. What's the most important thing in your life right now?*

Adolescent: *My grades. Well, at least to my mom. There's a lot of pressure on me to do well in school and go to a good college. My mom enrolled me in an SAT prep class. But, I really want to go to art school. I met a friend in my art class, and I've been hanging out with her and her friends. We listen to music and go to parties and stuff.*

Practitioner: *So your grades are important to you or to your mom?*

Adolescent: *They used to be important to me, but I'm 16 now. I have a life of my own. Some of my friends have their drivers' licenses, so we can go out whenever we want and they do some awesome painting and graffiti art.*

Practitioner: *So it sounds like you enjoy spending time with your friends and that your school work has taken more of a backseat. Based on your responses to some of my questions, I was wondering if you'd mind taking a few minutes to talk about your alcohol use? How does your use fit into your typical day?*

Adolescent: *I started drinking when I began hanging out with this new group of friends. They were drinking so I joined in. I didn't want to stick out. We all drink after school at someone's house. My mom thinks I'm at my SAT class. We also drink on weekends, usually more. When we go to parties. It's really just social.*

Practitioner: *How much do you drink when you're with your friends?*

Adolescent: *Three or four drinks on the weekdays. Beers mostly but sometimes hard liquor. Not every weekday. Just Tuesdays and Thursdays when I'm supposed to be at the SAT class. I drink more on the weekends when I'm at a party. Usually five drinks.*

Practitioner: *I'd like to understand more about your alcohol use. What do you enjoy about drinking?*

Adolescent: *My whole social life centers around drinking. We do a lot of fun things and meet some cool people. We're popular. And I'm a different person. I don't have to worry about my grades.*

Practitioner: *What is not as good about your drinking?*

Adolescent: *Not much. My grades have dropped. But I'm still doing better than my friends. My grades aren't that bad. I sometimes forget things that happened at the parties. But my friends fill me in.*

Practitioner: *Anything else?*

Adolescent: *My mom is always mad at me for something or other.*

Practitioner: *You told me earlier that your mom told you to cut down on your drinking.*

Adolescent: *Yeah, she's said that a number of times. That's one of the many reasons she gets angry at me.*

Practitioner: *How do you feel about that?*

Adolescent: *Well, it's annoying, but I am a teenager. Teenagers always fight with their parents. I'm no exception. And she doesn't understand what people my age do to have fun. She's too old to get it.*

Practitioner: *So on the one hand you said that drinking is really the center of your social life and it helps you to fit in with your group of friends. On the other hand it is causing your grades to drop, you forget things that happen at parties, and you are constantly getting into fights with your mom. What do you think about that?*

Adolescent: *Like I said, I'm having fun with my group of friends, and my mom's just worried about my grades. They're not that bad. And the forgetting thing hasn't gotten me into trouble yet.*

Practitioner: *I have some information on drinking. Would you mind if I shared it with you?*

Adolescent: *What, that I should stop? I guess so, what is it?*

Practitioner: *Drinking three or four alcoholic drinks at one time is binge drinking. It can impair your judgment. What do you think about that?*

Adolescent: *Maybe when you're not used to it. I'm used to it now. My judgment is fine.*

Practitioner: *What about the reason you're here with me today? You were caught vandalizing school property with graffiti. Were you drinking at the time?*

Adolescent: *Yes.*

Practitioner: *Drinking can make you do things that you wouldn't normally do. Things that will get you into trouble. Worse trouble than this. Luckily this was only a first-time offense and the punishment was only this diversion program.*

Adolescent: *I think the real problem is that I got caught.*

Practitioner: *There are also other consequences of drinking. It has been associated with risky behaviors. In fact, teens who drink in excess are more likely to have unwanted pregnancies or to contract a sexually transmitted disease. They have also gotten into car accidents. Of course, drinking also has a negative impact on grades. Not to mention, extended use will put you at risk for illness.*

Adolescent: *Yeah, yeah. And my grades are dropping. But that's what we do as a group. And everyone is drinking at these parties.*

Practitioner: *You may be surprised to hear that your peers are drinking less than you think. Only 10% have had three or more drinks at one time. Less than 30% have had any alcohol in the past 30 days. What do you think about that?*

Adolescent: *Really? 100% are drinking at these parties.*

Practitioner: *That's right. Teens often think that their peers are drinking more than they really are. They're always surprised when I provide them this information.*

Adolescent: *Well I guess I'm drinking a lot then.*

Practitioner: *Mary, you're drinking at a level which concerns me. Tell me, using this readiness ruler, on a scale from one to ten, with one being not at all ready and ten being completely ready, how ready are you to change your alcohol use?*

Adolescent: *Probably a 2.*

Practitioner: *2? That's good. You're 20% ready to make a change. Why a 2 and not a 1?*

Adolescent: *My mom can be a nag at times. My drinking is causing us to fight more than usual. But I'll get over it.*

Practitioner: *My advice as a clinician is that you would benefit from treatment for your alcohol use. I would like to incorporate attending a treatment program into your participation and successful completion of this diversion program.*

Adolescent: *Aww seriously? I'm fine.*

Practitioner: *Well, attendance is going to be required. You will not be able to complete this program otherwise.*

Adolescent: *Okay then.*

Practitioner: *But it's still important that you attend treatment regularly and get the most out of it. So let's make a plan to help you get the most out of treatment. What will help you to be able to do this? Can you tell me about a time when you overcame a challenge in the past? What kinds of resources did you call upon then?*

Adolescent: *When my parents got divorced it was really hard. My dad moved out and then moved across the country to be closer to his brother. He's remarried now and has a whole new family. My mom was very supportive then. So was my aunt, her sister. My teacher at the time was understanding and took extra time with me to make sure everything was okay and to support me in the classwork.*

Practitioner: *Which of these supports are available to you now?*

Adolescent: *My mom is, but like I said, we're always fighting.*

Practitioner: *But the fighting is around your drinking, and she has told you to cut down on your drinking. Would she be supportive if you told her you were seeking help?*

Adolescent: *Actually I bet she'd be very supportive. I don't know what my friends will think though. But you said I had to go. I can tell them that. Attending treatment is a punishment for what I did.*

Practitioner: *That's a good way to frame it with them. So I think we have a plan. I'd like you to attend the treatment program a few miles from here. It is very easy to get to with public transportation if you can't get a ride. I will place this in your file and will schedule the first appointment for you. I also think you should talk to your mom about this. What do you think?*

Adolescent: *I don't know.*

Practitioner: *We can always talk to her about it together. What do you think about that? She can come with you next week for our next session. Then we can schedule the appointment with the treatment program after we've all talked together.*

Adolescent: *Okay.*

Practitioner: *Great. So I will see both you and your mom next week. I think we're making good progress.*

Adolescent: *Okay, see you then.*

Sample Interaction: Brief Intervention and Referral to Treatment, DAST-10 and AUDIT

Setting: Tim is a 20 year old college student who is visiting an outpatient mental health center at his University for possible depression. He was referred to this program by the physician at the college health center whom he was mandated to see after getting caught drinking in his dorm room by the Resident Assistant. The practitioner (Carl) conducted a screening using the questions from the AUDIT and DAST-10. Tim scored a 7 on the DAST-10. He also scored a 21 on the AUDIT. These are both positive screen scores and indicate a need for brief intervention and referral to treatment.

Practitioner: *Thanks for bearing with me and answering all of those questions. Now, I'd like to learn a little more about you. You came in to the center, with your parents' coaxing, because you have been feeling overly hostile, aggressive, and irritable. Tell me about a typical week for you.*

Young Adult: *I'm a sophomore in college. I have classes four times a week and am on the football team.*

Practitioner: *Where does your current alcohol and other drug use fit in with a typical week?*

Young Adult: *There are a lot of parties at school, usually four or five nights a week. I usually go out with a few buddies from the team on Thursday, Friday, and Saturday. We have a drink or two before heading out, kind of a "pre-game", and then have a bunch of drinks when we're at the party.*

Practitioner: *How about other days of the week? Is your drinking limited to the party nights?*

Young Adult: *Well, not really. I drink on the other nights as well.*

Practitioner: *Is this with the football team, too?*

Young Adult: *No, this is by myself.*

Practitioner: *And how about your drug use? Where does that fit in?*

Young Adult: *Sometimes at the parties there are a bunch of prescription drugs.*

Practitioner: *Is that it? You said earlier that you use more than one drug at a time.*

Young Adult: *Well, not really. Last year, during a game, I got tackled real hard and hurt my shoulder. The doctor put me on prescription pain medication. It hurt so badly, and the drugs took a lot of the pain away. But I couldn't stop using them. The doctor wouldn't give me more when I ran out. But this buddy of mine said he had a friend who could help. That's how I got started with smoking heroin. My friends on the team don't know about it. My parents recently found out though.*

Practitioner: *How did your parents react?*

Young Adult: *They were first mad, but then they got concerned. They are worried that I have a serious drug problem.*

Practitioner: *Help me understand more about what you like about using alcohol and other drugs.*

Young Adult: *The alcohol helps calm down my irritability and hostility. I've been so angry since my football injury. I haven't been able to play in a game since. When I drink I have fun, and I fit in with the team, even though I haven't been playing. It makes me feel like I'm still part of the group. When I'm alone, sometimes I'm sad. When I drink then, it helps me to forget.*

Practitioner: *And how about the drugs? What is good about using them?*

Young Adult: *Oh, well I need them. It helps me deal with any after-effects of my drinking. These hangovers are pretty uncomfortable. I can get my hands on prescription pills at some parties, but not often enough. The heroin helps on a regular basis.*

Practitioner: *What are some of the not-so-good things about using alcohol and the other drugs?*

Young Adult: *It's a lot of drinking, and sometimes I feel sick later. And it's hard to get to class if I had been drinking the night before. Not to mention my grades. My parents are upset. I'd worry about getting kicked off the football team, but I haven't played in a while anyway. For the drugs? I know it's bad, but I can't stop. I get stuff, and I don't know what's in it. But I need it.*

Practitioner: *So on the one hand, the alcohol helps to calm you down so you're not as angry. And when you're alone, it makes you feel less sad. The drugs prevent you from getting sick as a result of not taking them. On the other hand, the drinking can get you sick, it is impacting your ability to get to class, and is hurting your grades, and your parents are upset. The heroin is making you worried for your health.*

Young Adult: *That sounds about right.*

Practitioner: *I have some information about low-risk guidelines for drinking as well as some information about drug use. Would you mind if I shared them with you?*

Young Adult: *I suppose.*

Practitioner: *Let's look at your recent pattern of drinking. On average you are drinking more than 14 drinks per week and typically 5 or more drinks in a two hour period. That amount puts you above 96% of the adult population in terms of drinking. And at this level, you are at risk for a lot of consequences, including alcohol poisoning, motor vehicle accidents, other injuries, poor school performance, and drop out. And heroin use is dangerous. As you may know, it's a highly addictive drug. You are already feeling the effects of addiction and there is a big risk of overdose with heroin use. Together, these can put you at risk for social or legal problems as well. What are your thoughts on that?*

Young Adult: *I know that heroin is dangerous. And I know I'm drinking a lot. But I'm also angry and feeling like I want to hurt someone. And sad sometimes too. The alcohol and drug use helps with that. So it's one thing or the other thing.*

Practitioner: *Remember when we were talking about some of these feelings before we started talking about your alcohol and drug use?*

Young Adult: *Yeah.*

Practitioner: *Well, those feelings are related to the reason you are here- the depression and anger. I can appreciate that you get short-term relief from these feelings when using. But do you think that continued use is a long-term solution?*

Young Adult: *I see your point. Continuing on this path seems risky.*

Practitioner: *So you are also seeing this perspective of what may be important to your health. Here is something I would like you to review with me. This readiness ruler is like the pain scale we use in the hospital. On a scale from 1-10, with 1 being not ready at all and 10 being completely ready, how ready are you to change your alcohol use? And your drug use?*

Young Adult: *Probably a 2 for both.*

Practitioner: *A 2. That is great that it's not a 1! So there is some interest in change. Tell me about why you gave a 2.*

Young Adult: *Well, because you say there is something that you can do for my hostility and my sadness, other than using alcohol and drugs. And that there are quite a few people my age who are dealing with this. But a score higher than a 2 is not how I feel. The pain is really bad, and I need the alcohol and drugs for that. I can't change it now.*

Practitioner: *Tim, it is a good time to summarize. Here is how I size-up the situation. I am concerned about the amount you are drinking and about your heroin use. Given the level of your use, it is important for your wellbeing, and for your mental health, that you go to a substance use disorder treatment program for further evaluation. You may not know this, but alcohol and drug use often makes the depression worse. This is very common. Kind of like what I said before, one in three who struggle with alcohol and drug abuse also suffer from depression. What are your thoughts?*

Young Adult: *More treatment? It took me a while to finally come here.*

Practitioner: *I know it's a lot, but it's important for us to come up with a plan that can work for you. We do not have staff here with the expertise to conduct a full diagnostic assessment and to treat patients with possible substance use disorders and a co-occurring problem, such as depression. What supports do you have that will help you to attend treatment? Tell me about a challenge you overcame in the past. How can you use those supports or resources to help you now?*

Young Adult: *Like I said, coming here for my depression. My parents were really helpful. They're angry with me right now though. But I guess they're angry about my alcohol and drug use. I can ask them to support me in treatment, so I can stop these problems. I still don't know about all of this. It seems pretty intense.*

Practitioner: *It's OK to have concerns and we can address them as we move along. I agree that it would be good to seek your parents' support. It might help you begin to repair your relationship with them at the same time. There's a program that merits more attention by professionals. Can I call them and make an appointment for you?*

Young Adult: *Yes, that'd be easier for me. Otherwise I might not make it myself.*

Practitioner: *Okay. I'll get you an appointment for next week on the day you don't have class.*

Young Adult: *Friday.*

Practitioner: *Great. I also have some additional resources that people sometimes find helpful. Would you like to hear about them?*

Young Adult: *Sure.*

Practitioner: *Here is some information about alcohol use. And here is something else about prescription opioids and heroin. AA also holds sessions near here, if you're interested. AA can be a supportive, non-threatening place where you can feely talk about what is going on with you.*

Young Adult: *Thanks. I'll take a look at those brochures. But for now I'm going to hold off on the AA. I want to go to the treatment program first, see what they have to say.*

Practitioner: *That sounds reasonable. Thank you for talking to me today, Tim. Before you leave, the scheduler will work with you to set up an appointment at the substance use disorder treatment center. They're just going to do a diagnostic evaluation, see how they can help.*

Young Adult: *Okay.*

Practitioner: *And I will see you next week. We'll get to work.*

Young Adult: *Okay, thanks Carl.*

Practitioner: *Thank you, Tim. It was an important step you took today.*

Module 5: Motivational Interviewing Strategies

Motivational Brief Intervention^{143,144}

Learning Objectives	Suggested Readings
<ol style="list-style-type: none"> 1. Learn to use motivational interviewing strategies as part of conducting brief interventions, specifically: <ol style="list-style-type: none"> a. Assess readiness to change b. Ask open-ended questions c. Affirm d. Utilize reflective listening e. Summarize thoughts and feelings f. Elicit change talk g. Ask permission and give advice h. Generate options i. Manage pushback 	<ul style="list-style-type: none"> ■ Jensen CD, Cushing CC, Aylward BS, Craig JT, Sorell DM, Steele RG. Effectiveness of motivational interviewing interventions for adolescent substance use behavior change: A meta-analytic review. <i>Journal of Consulting and Clinical Psychology</i>. 2011;79(4):433-440. ■ Gold MA, Kokotailo PK. Motivational interviewing strategies to facilitate adolescent behavior change. <i>Adolesc Health Update</i>. 2007;20(1):1-10. ■ Naar-King S, Suarez M. <i>Motivational Interviewing with Adolescents and Young Adults</i>. New York: Guilford Press; 2011. ■ Center for Substance Abuse Treatment. <i>Enhancing Motivation for Change in Substance Abuse Treatment</i>. Treatment Improvement Protocol (TIP) Series, No. 35. Rockville, MD: Substance Abuse and Mental Health Services Administration; 1999. ■ Grenard JL, Ames SL, Pentz MA, Sussman S. Motivational interviewing with adolescents and young adults for drug-related problems. <i>International Journal of Adolescent Medicine and Health</i>. 2006;18(1):53-67.

Change can be difficult for individuals of all ages, and perhaps especially so for adolescents. Brief interventions are designed to help adolescents take the first steps towards making healthy changes, and a key brief intervention ingredient to the change process is Motivational Interviewing (MI). Adolescents have to choose to change and to do the work, but a brief intervention, with MI as a core component, is a valuable technique to help adolescents reduce or stop their alcohol or other drug involvement. MI can promote positive change by strengthening a person’s self-confidence and competence, and provide guidance to generate self-change options and plans.

Motivational Interviewing makes sense as a strategy to employ with adolescents because:

- 1) It is non-confrontational;
- 2) It promotes insight, self-understanding and self-efficacy (all critical skills to develop at this stage of life); and
- 3) It helps empower the adolescent to own their decisions which can be beneficial for many other challenging choices and decisions that they may face.

You, the practitioner, cannot provide the motivation to change by directing, browbeating or humiliating adolescents to change. A confrontational style addresses adolescents as if they are “out of touch with reality, dishonest, incapable of responsible self-direction, deficient in knowledge and insight and pathologically defended against change.” When working with adolescents, practitioners may fall into a trap of taking on a parental role with a directing, judgmental or moralizing tone. These assumptions place the practitioner in a role of “correcting error[s], combating delusion, taking charge, educating, breaking down defenses and being the [adolescent’s] link to reality.”¹⁴⁵

Examples of Confrontational Style:

“You’re going to hurt your parents/family if you don’t stop drinking.”

“You’re going to get kicked off the soccer team if you don’t stop going to practice hung over.”

“You’re wrecking your life because of your drinking. You have to stop. It’s going to kill you.”

“You’ll never get into college if you don’t stop smoking pot.”

“Why don’t you stop drinking? If you really wanted to you would.”

“If you don’t stop smoking now, when you’re 25 you’ll look 100 from all the wrinkles.”

“You’re depressed and your drinking makes it worse. You aren’t going to feel better until you stop. Just do it!”

“Your denial that you have a drinking problem tells that you really have a problem.”

This approach is rarely effective. In fact, “four decades of research have failed to yield a single clinical trial showing efficacy of confrontational counseling, whereas a number have documented harmful effects, particularly for more vulnerable populations.”¹⁴⁵ (There is a concept in MI of “light confronting.” We will address this style in a subsequent section, Motivational Skill #8—Managing Pushback.)

Not all adolescents want to change their behavior. They may not feel that they have a problem with alcohol or drugs, or that it’s their first priority to address it. Even when an adolescent knows the potential consequences if change is not made and sustained, the choice to change is the adolescent’s. Your role with adolescents is to ignite the internal motivation and help them find their own best reasons and methods to change. Motivation can best be described as:

Motivation - internal and external forces and influences that move an individual to become ready, willing and able to achieve certain goals and engage in the process of change.

Adolescents either at-risk for or are already experience substance-user related problems (e.g., school, health and social) are much more likely to change their behavior if you use an empathic, person-centered, strength-based, motivationally enhancing style, focused on identifying and solving the adolescent's problems.

Motivational counseling– a method of communicating that uses the perspective, ideas, beliefs and strengths of an individual to evoke internal motivation to change behaviors.

Motivational Interviewing (MI) is a collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a target behavior change by eliciting and exploring an individual's own arguments for change. Motivational Interviewing is not therapy in and of itself. It is a preparatory step for encouraging change behavior.

Brief motivational counseling is not a set of techniques or tricks for getting an adolescent to do what you want. Rather, according to Drs. William R. Miller and Stephen Rollnick, the developers of the modern MI counseling approach, it is "a skillful clinical style for eliciting from clients their own good motivations for making behavior changes."¹⁴⁴ The goal is for adolescents to arrive at the reasons for change that will be most influential to them, to create realistic plans to change and to monitor steps taken to correct or reinforce change. The aim is to help adolescents generate their own motivators to change their substance use in the direction of reducing or stopping use.

Examples of motivated-based change statements:

"I don't want to fail my next exam because I was hung over. I like high school and I want to go to college, but school is seriously stressful. Most of the time, I drink with my friends after school just to relax, chill for a while. It takes the pressure off. Yeah, probably not a good idea to get drunk the night before an exam."

"I know I have to stop smoking weed. My dad is starting to suspect that something isn't right with me. He keeps asking me why my eyes are always red and why I don't hang out and eat dinner with them anymore. I don't want him to see me as a pot head."

"I really thought I had my drinking under control. I only drink a couple of 6-packs on the weekends, but I still feel so anxious. At first it helped me feel less nervous but I think it's getting worse. Maybe I'd feel better if I got this drinking under control."

MI also helps resolve **ambivalence**. Ambivalence is a hallmark of the change process. Even with wanted or positive changes, ambivalence is often present. It can impede progress if we do not address it. Practitioners need to pay special attention to normalizing adolescent ambivalence through the use of empathic responses that normalize the experience.

Ambivalence
having positive and negative considerations that have about equal weight and shift back and forth, keeping an individual from making a decision

Ready to Change?¹⁴³

People change their behaviors when:

- they become interested in or concerned about the need for change;
- they become convinced that the change is in their best interest or will benefit them more than cost them; and
- they organize a realistic, feasible plan of action and take the actions that are necessary to make the change and sustain it.¹⁴⁶

“In a representative sample across more than 15 high-risk behaviors, it was found that fewer than 20% of a problem population is prepared for action at any given time. And yet, more than 90% of behavior change programs are designed with this 20% of the population in mind.”¹⁴⁷

Your clinical task is to promote the behavior change process in the 1 in 5 people who are ready to make changes right now, and for the 4 out of 5 others, to support efforts to increase recognitions that change is needed.

Stages of Change model - a way to identify the important tasks needed to make change happen, better understand the health care or treatment needs of that adolescent and identify which options are most appropriate given the adolescent’s level of motivation to change.

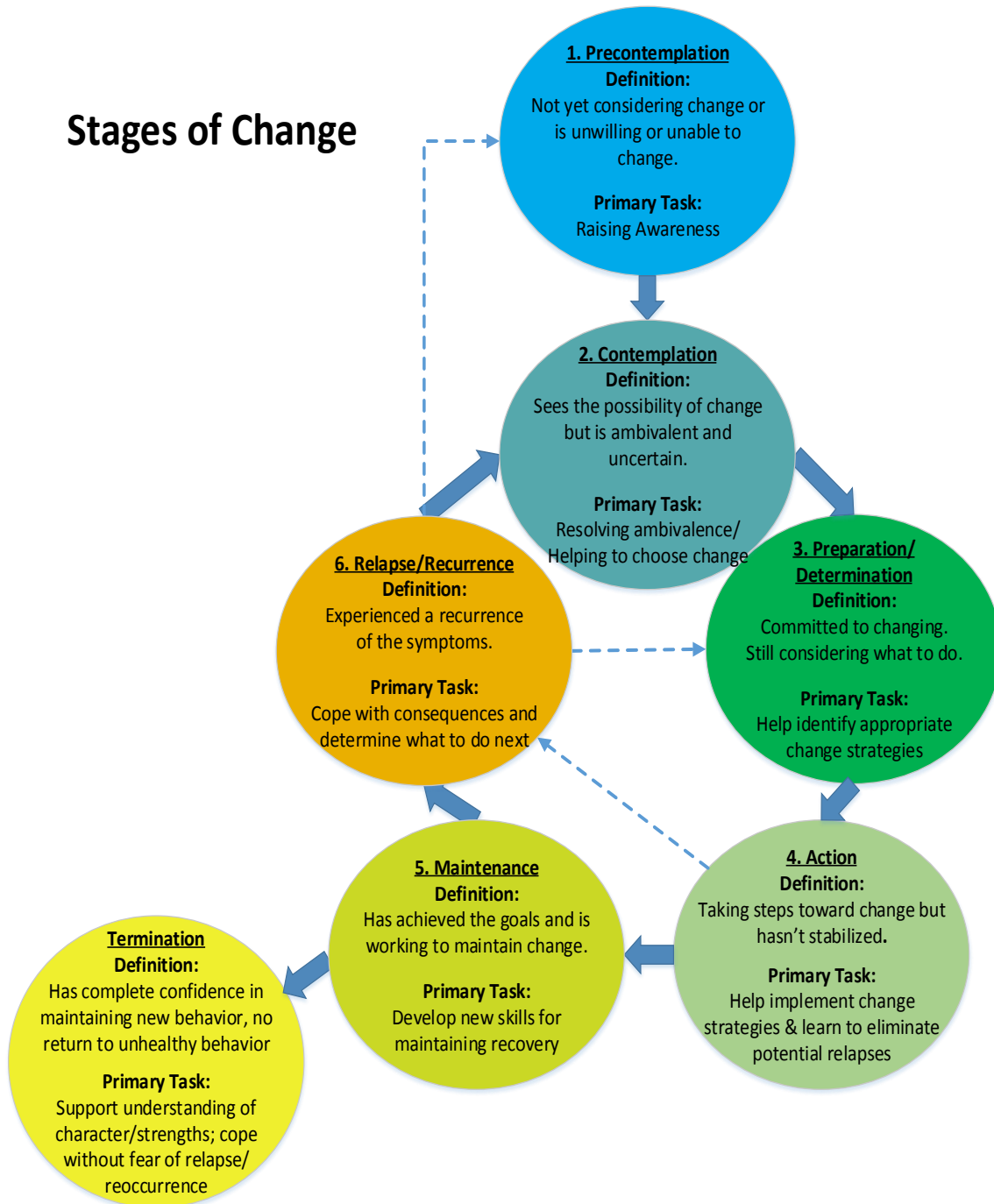
Prochaska and DiClemente found common stages of change over hundreds of behavior change studies:

- **Precontemplation** – The adolescent is unaware/under aware that their substance use is unhealthy, does not see a need to change, may feel hopeless, may wish others would change so they do not have to and has little or no interest in changing their behavior in the foreseeable future.
- **Contemplation** – The adolescent is aware of their unhealthy substance use behavior, is considering possible changes in behavior and is ambivalent about changing. Adolescents may feel hopeless about making a decision to change and sticking with it.

- Preparation – The adolescent makes a commitment to act and develops a plan to change (but has not made changes yet). They may test some initial steps and may feel hesitant or uncertain about success.
- Action – The adolescent takes the plunge and has started to change behaviors and thoughts to break patterns of unhealthy substance use and begins creating new behavior patterns.
- Maintenance – The adolescent is able to sustain changed behaviors and thoughts over an extended period of time, continues to make positive changes in other areas of their life and develops new coping skills to respond to stressors and changing environments.¹⁴⁸ These maintenance of changed behaviors also works to prevent relapse.
- Termination – The adolescent has complete confidence (self-efficacy) they can maintain new behavior (e.g., abstinence), not return to unhealthy behavior, or able to cope with the fear of relapse.

The practical skills of Motivational Interviewing (MI) are used to help adolescents to progress through the Stages more rapidly than they would on their own. With your assistance, adolescents can move more quickly through the Stages. Some may regress to an earlier Stage even after progress has been made. Others may get stuck. The following figure below illustrates the dynamic nature of the Stages of Change model:^{148,149}

Figure K: Stages of Change Model¹⁵⁰



As a practitioner, you have opportunities at whatever stage an adolescent is in to assist in enhancing motivation, skills and commitment to change.

- **Precontemplation** – Cultivate ambivalence by raising awareness of and recognition of potential risks and negatives associated with alcohol and other substance use. The *Decisional Balance Worksheet* is located in Appendix K to help adolescents assess the reasons for wanting or not wanting to change.

- **Contemplation** – Tip the balance in the adolescent’s ambivalence by generating reasons for changing and risks of not changing, supporting their confidence in the ability to change alcohol and other substance use patterns.
- **Preparation/determination** – Increase the adolescent’s commitment to decrease or discontinue alcohol and other substance use, develop options, choose among them and assist them in committing to a viable and acceptable plan.
- **Action** – Help the adolescent implement their plan, revise it as needed and sustain commitment to change even when faced with difficulties and setbacks.
- **Maintenance** – Turn changes in thinking and behaviors into healthy habits, resolve problems as they arise, sustain changes that make it difficult to go back to old, unhealthy, substance use patterns and thus prevent relapse.¹⁴⁸
- **Relapse/recurrence**—Help the adolescent understand the importance of returning to maintenance. For some, the clinical task associated with precontemplation may be needed.

Figure L: Stages of Change: Intervention Matching Guide¹⁵⁰

Stages of Change: Intervention Matching Guide		
<p>1. Pre-contemplation</p> <ul style="list-style-type: none"> • Offer factual information • Explore the meaning of events that brought the person to treatment • Explore results of previous efforts • Explore pros and cons of targeted behaviors 	<p>2. Contemplation</p> <ul style="list-style-type: none"> • Explore the person’s sense of self-efficacy • Explore expectations regarding what the change will entail • Summarize self-motivational statements • Continue exploration of pros and cons 	<p>3. Preparation/Determination</p> <ul style="list-style-type: none"> • Offer a menu of options for change • Help identify pros and cons of various change options • Identify and lower barriers to change • Help person enlist social support • Encourage person to publicly announce plans to change
<p>4. Action</p> <ul style="list-style-type: none"> • Support a realistic view of change through small steps • Help identify high-risk situations and develop coping strategies • Assist in finding new reinforcers of positive change • Help access family and social support 	<p>5. Maintenance</p> <ul style="list-style-type: none"> • Help identify and try alternative behaviors (drug-free sources of pleasure) • Maintain supportive contact • Help develop escape plan • Work to set new short and long term goals 	<p>6. Relapse/Recurrence</p> <ul style="list-style-type: none"> • Frame recurrence as a learning opportunity • Explore possible behavioral, psychological, and social antecedents • Help to develop alternative coping strategies • Explain Stages of Change & encourage person to stay in the process • Maintain supportive contact

Motivational Interviewing Skills Used in Brief Interventions^{143,144}

When practitioners use Motivational Interviewing (MI) techniques, many people with substance use-related problems decrease their alcohol, tobacco, and other drug use; reduce their risks of injury, driving under the influence (DUI), home and social dysfunction; and engage in and complete substance use treatment.^{151,152} Many practitioners feel that they already use MI techniques in their clinical practice. Research studying actual clinical sessions shows big gaps between theory and practice, even in highly trained MI clinicians.

Great emphasis is placed on understanding the spirit of MI. It's the combination of MI techniques and conveying the spirit of MI that makes MI effective. How you think about and understand the intervention process is vitally important in shaping it. MI holds a belief that each person possesses a powerful potential for change and understand that ambivalence to change is "normal." There are three fundamental aspects that summarize the **spirit of MI**:

- *Collaboration* - partnerships.
- *Evocation* - listening and eliciting from the adolescent.
- *Autonomy* - respecting the adolescent's ability to choose.

Collaboration
the process by which people and/or organizations work together to accomplish a common mission

Remember, you cannot make an adolescent change. Change belongs to the adolescent.

The following eight MI skills can be used when counseling adolescents to reduce their risks of alcohol and other substance-related problems:

- 1) Asking open-ended questions
- 2) Affirming the adolescent
- 3) Utilizing reflective listening
- 4) Summarizing the adolescent's thoughts and feelings
- 5) Eliciting change talk
- 6) Asking permission and giving advice
- 7) Generating a menu of options
- 8) Managing pushback

Change talk
expression of adolescent's desires, abilities, reasons and needs to change unhealthy behavior

Each of these MI skills is important to use right from the beginning of a brief intervention and can be used in every interaction you have with adolescents.

These eight motivational counseling skills will help adolescents with unhealthy and dependent alcohol and other substance use to move through the Stages of Change to reduce their risk and make behavior change. Your primary focus of brief interventions with moderate risk adolescents is motivating them to reduce risk by changing their drinking and other substance use patterns. Your primary focus for high risk adolescents also is to motivate them to reduce their risk of alcohol and other substance-related problems. Often, this will involve motivating them to engage in treatment specifically addressing alcohol dependence, other substance use and mental health problems.

Each skill is described in this module, with examples provided. To help with learning these skills, we suggest a role playing exercise as described below.

Motivational Interviewing Skills Role Play



Role Play Exercise: Students/practitioners form dyads to practice some of the techniques that you are learning. For this situation, one person will act as the practitioner who has administered the CRAFFT or AUDIT and determined the adolescent to be at high risk of experiencing alcohol-related problems. The other person will act as the adolescent having difficulty in school. These role plays can be conducted with a third person who acts as the observer. If performing the role play with an observer, refer to Appendix G and use one of the Brief intervention Observation Sheets. The practitioner will practice providing a motivational brief intervention to this adolescent. This is an opportunity for you to practice using the eight MI skills included in this module:

- Asking open-ended questions
- Affirming adolescents
- Utilizing reflective listening
- Summarizing adolescents' thoughts and feelings
- Eliciting change talk
- Asking permission and giving advice
- Generating options
- Managing pushback

Adolescent: You are a 17-year-old who has been referred by your teacher to the school-based health clinic or counseling center because your grades have dropped and you've been missing classes. You agreed to go talk to someone about what's going on in your life. If asked about your alcohol use, you might push back a little by say something like: *"We normally have 5 or 6 Jack and Cokes and a couple of beers maybe 3 to 4 nights a week while hanging with my friends. It's a lot of fun. I'm not sure why you're asking about my drinking because I'm really here because I told my teacher I would come talk with you about all the stuff I'm going through. I'm failing some classes. My parents are probably divorcing. They fight constantly. Drinking with my friends makes me forget about all that stuff and I don't have to listen to it. Drinking really isn't an issue for me. It actually makes me feel better but if I keep failing tests I'm not going to pass this year."*

Motivational Skill #1: Asking Open-Ended Questions^{143,144}

The way you ask questions can powerfully affect your ability to motivate adolescents to change. An efficient way to gather factual information is to ask close-ended questions.

Close-ended questions - questions that are phrased in a way to elicit a very brief or “yes” or “no” response.

Examples:

“Did someone tell you to call me?”

“Do you think you have a problem with alcohol?”

“Are you in school?”

The adolescent could easily answer with a brief, factual answer or with a “yes” or “no” to each of these questions. You will have to ask more questions to understand why the adolescent answered as she did. This could start a series of longer questions from you and short answers from the adolescent. Although this may be an efficient way to gather intake information, it is not an effective way to engage the adolescent in a productive working relationship. Open-ended questions are more helpful in developing rapport and creating the opportunity to support and encourage the adolescent’s existing motivation to change.

Open-ended questions – questions that are phrased in a way that encourage the adolescent to explore and share her feelings, experiences and perspectives.

Examples:

“What brings you to the clinic today?”

“How would you describe how alcohol is affecting your life?”

Both methods of asking questions can gain important information. The goal of asking a question in a clinical interaction is to elicit a thoughtful answer that will give you an understanding of the adolescent’s perspective and enable her to explore her problems and efforts at solutions. Open-ended questions invite the adolescent to discuss an issue for as long as she deems necessary and allows her to identify what information she regards as most important. They also provide you with the opportunity to listen.

Open-ended questions encourage the adolescent to include information not specifically mentioned in the question. These questions support *collaboration* because they put the adolescent in control of the direction, pace and tone of the interaction and place you in a listening role. Compare the following interactions and judge for yourself which method of questioning seems more productive.

Conversation #1 (Close-ended Questions):

- Practitioner: *“Did your friend ask you to call me for help?”*
- Adolescent: *“Yes.”*
- Practitioner: *“Are you having problems at home?”*
- Adolescent: *“Yeah, sorta.”*
- Practitioner: *“Has your friend suggested you call for help before today?”*
- Adolescent: *“Yes, but I didn’t want to.”*
- Practitioner: *“When was that?”*
- Adolescent: *“Last year.”*

Conversation #2 (Open-ended Questions):

- Practitioner: *“What prompted you to meet with me today?”*
- Adolescent: *“My teacher suggested it. He knows my parents are going through a divorce, and I’m starting to have trouble at school.”*
- Practitioner: *“Tell me more about what you mean when you say, I’m starting to have trouble at school.”*
- Adolescent: *“Well, I’m failing some classes and sometimes I don’t go to school. I feel so stressed out from listening to my parents fight all the time. At first, I thought they’d work it out but I don’t think so anymore. They started arguing about custody over me and my younger sister. When things started getting nasty, it got harder and harder for me to deal with. I was so anxious I didn’t want to go to school so I’d just skip it and go hang with my brother’s friends who graduated last year. I’m worried that we’ll get split up and have to live with different parents that I’m having trouble concentrating at school, and I’m starting to forget my homework. My grades are getting bad and I’m scared I’ll jeopardize my chances to get into college.”*

Although not every adolescent will respond with as much information, the differences between these two interactions are clear. When open-ended questions were asked:

- the adolescent is able to divulge a great deal of information that you would not have otherwise known;
- the adolescent reveals important information about their experiences and critical incidents;
- the adolescent talks more and you listen more, with you prompting and guiding the conversation;

- the adolescent is more actively involved, focused on what they think is most relevant for you to know and has more control over the direction of conversation;
- the adolescent shares more than just facts and reveals emotions about the situation;
- you foster a conversation rather than an interrogation;
- the adolescent feels supported, heard and understood; and
- you and the adolescent have a better chance of developing a strong, therapeutic collaboration.

Comparing Close-Ended and Open-Ended Questions ¹⁴³	
Close-Ended Questions	Open-Ended Questions
<i>So, you are here because your parents are concerned about your use of alcohol, correct?</i>	<i>Tell me, what is it that brings you here today?</i>
<i>Is everything okay at school?</i>	<i>How are things going for you at school?</i>
<i>Do you agree that it would be a good idea for you to get treatment for your alcohol use?</i>	<i>What do you think about the possibility of getting treatment for your alcohol use?</i>
<i>First, I'd like you to tell me about your alcohol intake. On a typical day, how much do you drink?</i>	<i>Tell me about your alcohol intake during a typical day.</i>
<i>Do you like to drink?</i>	<i>What are some of the things you like about drinking?</i>
<i>How has your alcohol intake been this week, compared to last: more, less or about the same?</i>	<i>What has your alcohol intake been like during the past week?</i>
<i>Do you think you drink alcohol too often?</i>	<i>In what ways are you concerned about your drinking?</i>
<i>How long ago did you have your last drink?</i>	<i>Tell me about the last time you had a drink.</i>
<i>When do you plan to quit drinking?</i>	<i>So what do you think you want to do about your drinking?</i>

In addition to the positives of asking open-ended questions, there is also potential for serious negative effects of asking close-ended questions. **Because you have to generate a list of questions from assumptions and incomplete information about the adolescent, close-ended questions may be presumptive, invasive or leading.** You can end up with partial or inaccurate information and generate defensiveness. For example, if you were to ask, “*Do you binge drink often?*” the adolescent is forced to answer a question that she may not be ready to explore or may not have a clear answer. Furthermore, this question introduces the idea of abuse into the adolescent’s consciousness and could indicate to her that you think or believe that she may have been abused. Even though you may believe that you are simply asking a standard question, your intentions may not be clear to the adolescent. This method of questioning can damage the relationship, making adolescents more passive and turning sessions into

question and answer interactions. In general, open-ended questions are exploratory, not as threatening and are less leading than close-ended questions.

With close-ended questions, there is a potential to incorrectly assume facts or circumstances based on the adolescent's responses. For example, the question, "*Did either of your parents abuse you as a child?*" includes several assumptions. If the adolescent responds "*no*," you might presume that she had not been abused by her parents. However, if she does not feel comfortable using the word "*abused*" and might interpret her experience with her father as "*strict discipline*," important information is lost. Additionally, the adolescent may have been abused by someone other than a parent. Not only is this example a directive question, but it is also a narrow one. An adolescent's understanding of what went/goes on in her family is revealing, and open-ended questions better allow her to express it.

Open-ended questions typically begin with words such as "*what*" and "*how*" or phrases such as "*tell me about...*" Often, open-ended questions are not technically questions but are statements that implicitly ask for a response. Open-ended questioning can be time-consuming and could elicit unnecessary information. It can be a common mistake to lapse into asking close-ended questions. If that happens, follow the "no" or "yes" with a "Tell me more about why you said no/yes..." It is your responsibility to keep the session focused, while still allowing the adolescent to explore her emotions and thoughts. Some ways to keep the session focused include prefacing questions with guiding statements such as "I really want to understand how you see the situation or how you view your alcohol use." Or "Help me understand how other things happening in your life may be related to your drinking or drug use."

Motivational Skill #2: Affirming Adolescents^{143,144}

Affirming – recognizing the adolescent’s strengths and accomplishments, complementing or making statements of appreciation and understanding

Adolescents and young adults with substance use problems may feel overwhelmed by feelings of shame and inadequacy. Affirming is a strength-based approach to support adolescent *self-efficacy*, which is their self-confidence that change is achievable. Affirming makes it more likely that adolescents will recognize their own capacity to discuss difficult topics and appreciate their ability to alter them. This is done by the practitioner demonstrating appreciation and understanding through the use of compliments and reflective listening statements that recognize the adolescent’s strengths and capacity to change. Affirming statements do not have to be complex or lengthy; they must simply be sincere, timely and positive. Affirmations must be genuine or they will sound phony, which most adolescents will pick up on. Seek to affirm the following:

Self-efficacy

an impression that one is capable of performing in a certain manner or attaining certain goals

- Goals
- Values
- Intentions
- Efforts
- Strengths
- Willingness to engage in conversation and explore issues
- Intrinsic values as a person (especially important for a very discouraged or overwhelmed person)

Examples:

“Thank you for showing up to this appointment and being willing to talk with me.”

“I appreciate your willingness to discuss these things with me. I can tell that you really care about other people in your life.”

“I can see that you care about your future.”

“Your family and friends and not letting them down really matter to you.”

“Getting through school is one of the most important things in your life right now.”

Affirming is a skill that is intuitive to most practitioners. When affirming an adolescent:

- **Focus on strengths**

“I have noticed that you are really good at identifying strategies which help you reduce stress.”

- **Encourage the adolescent’s persistence in spite of past problems**

“You did a great job dealing with pressure from your friends to drink when you made a commitment to cut back.”

- **Make encouraging statements and elicit positive responses**

“You’re making great progress. Tell me how you feel in comparison to 2 weeks ago.”

- **Acknowledge the positives**

“It seems to me that school is going better for you. You’re getting to school on time and are no longer getting into trouble for being late. That must feel really good.”

- **Point out and celebrate steps taken so far**

“You have worked very hard. You have come so far in 3 weeks.”

- **Remind the adolescent of past successes**

“I know this appears very difficult to overcome. You have been able to do it before.”

- **Compliment willingness to talk about difficult issues**

“Thank you for taking a few minutes to talk with me about your alcohol/marijuana use. I appreciate your openness and sharing your experiences and thoughts with me today.”

- **Celebrate the adolescent as a person**

“You are a kind and warm person. I can see how this problem affects you.”

Motivational Skill #3: Utilizing Reflective Listening^{143,144}

Ideally, most of your time in a session should be spent listening. By carefully listening to the adolescent and responding with reflective listening statements, you encourage and support the adolescent's ability to explore and problem-solve her problems. Reflective listening is a powerful and underutilized force for change.^{153,154} Skilled reflective listening can prompt a person to begin to *talk themselves into change*. Additionally, people are generally more impressed by and tend to believe in what they hear themselves saying compared to what practitioners tell them. In that way, open questions and skilled reflections help the adolescent *hear themselves talking out loud*.

Reflective listening – also known as parallel talk or paraphrasing, occurs when you carefully listen to an adolescent's thoughts, perceptions and feelings then restate them for the purpose of clarification and further exploration.

The primary goals of reflective listening are to:

- 1) help you accurately understand not only what the adolescent is *saying* but also what she is *meaning* by her words;
- 2) help the adolescent clarify her thoughts; and
- 3) reassure the adolescent that you are listening and understand her point of view.

One of your main tasks is to help adolescents accurately identify their feelings, thoughts and perceptions. Adolescents often have difficulty accurately describing how they feel about a particular situation and often have conflicted perceptions and emotions. Reflective listening statements can help the adolescent clarify her thoughts and emotions and help you better understand her. For example, an adolescent may say, "*I hate my coach. I should just quit the team.*" You might assume that **they do** not like being on the soccer team. However, by making reflective listening statements, you can encourage them to explore their feelings further, as well as clarify your understanding of their feelings about their athletic performance.

Example:

Adolescent: *“I hate my coach. I should just quit the soccer team.”*

Practitioner: *“You hate your coach and think it would be better for you to quit playing soccer.”*

Adolescent: *“Yeah! My coach is always hassling me to work faster, work harder. But it is hard to commit all those hours after school when I have so much homework to do. I’m under so much pressure. So I go over to my buddy’s house after practice and his brother gets us some beer. We just hang out and play video games. Then, the next day, I’m so tired at school. My head is pounding and I feel like I’m going to get sick. Still, I know I have to keep up with practice and everything my coach is asking of me.”*

Practitioner: *“What I hear you saying is that because your body is hung-over from the previous night’s drinking, you are finding it difficult to perform at your best in soccer practice.”*

Adolescent: *“Yeah, I guess so.”*

The example above illustrates how an adolescent may say one thing and mean something entirely different. Taken at face value, the adolescent hates soccer because the coach puts on the pressure to work hard. Actually, the adolescent is not performing at practice as expected due to the physical effects related to drinking. Reflective listening statements help the adolescent feel they are being heard and allows the discussion to stay focused and truthful.

Reflective listening statements help you avoid “roadblocks,” that prevent clinical progress. Examples of roadblocks include: ¹⁰⁶

- *Commanding*: imposing a view on the adolescent that they need to act in a certain way
- *Threatening*: warning or cautioning the adolescent about what might happen if they do not change
- *Prematurely giving advice*: offering unsolicited solutions or making suggestions
- *Moralizing*: telling people what they should do
- *Criticizing*: disagreement between practitioner and adolescent which implies judgment or blaming
- *Shaming*: labeling or ridiculing the adolescent can make them feel humiliated¹³⁴

Roadblocks tend to break-up or change the direction of the adolescent’s thought-processes and make it more difficult for the adolescent to explore thoughts and feelings. Even some responses that might seem helpful or therapeutic (e.g. approving, reassuring and agreeing) can be roadblocks. These kinds of comments insert a judgment or a perspective that can shut down or redirect the conversation and the adolescent’s free expression.

Here are several reflective listening phrases you can use to clarify and reflect back your understanding of what the adolescent is trying to convey:

- *I understand the problem is...*
- *I'm sensing...*
- *I wonder if...*
- *I get the impression that...*
- *As I hear it, you...*
- *From your point of view...*
- *In your experience...*
- *I'm picking up that you...*
- *Where you're coming from...*
- *You mean...*
- *Could it be that...?*
- *Let me see if I understand. You...*
- *You feel...*
- *From where you stand...*
- *You think...*
- *What I think I hear you saying...*

You are not simply restating the adolescent's thoughts verbatim (although sometimes using the adolescent's own words can be very powerful). Rather, you are strategically restating the adolescent's words to encourage more thought and discussion.

Adolescent: *"I don't have a drinking problem. I just drink 4 or 5 times per week with my friends."*

Practitioner: *"You drink almost every day of the week and you do not feel that you have a drinking problem."*

Reflective listening may also include your inferences based on previous statements of the adolescent, affect that mismatches content or other clinical cues. This is called "continuing the paragraph." However, you need to be careful not to overreach and go too far beyond what the adolescent is trying to convey.

Adolescent: *"I don't want to grow up to be like my parents. They never cared for me like they should because they were always drunk."*

Practitioner: *"You want a better life for yourself than your parents' lives. So you are here to ensure that alcohol does not interfere with that."*

You can also pull out a few of the adolescent's words and repeat those to form a reflective listening statement.

Adolescent: *"I got way too drunk last night and really feel it this morning."*

Practitioner: *"So, getting drunk last night did not feel good."*

Most of your responses in a session should be reflective listening statements. It may feel much easier and more comfortable for you to ask the adolescent a series of questions. But, question and answer, with you asking the questions and the adolescent answering, puts the responsibility for fixing the adolescent's problems on you. Your task is to help the adolescent make their own solutions using their own resources and motivation. There may be a tendency to think that a heavy dose of reflective statements is not

effective in moving the adolescent to the action stage. This is not the case. Reflection encourages the adolescent self-efficacy and intentions to change.

When the practitioner amplifies statements and themes it can help clarify what the adolescent really means. If the practitioner incorrectly interprets the adolescent's comments, the adolescent will correct them, which can further help the patient to clarify what they really think and feel.

Reflective listening statements work well with open-ended questions. As a general rule, you should try not to ask more than 2 open-ended questions in a row and make at least 2 reflective listening statements after each open-ended question. For example:

- Practitioner: *“How would you feel about us bringing in your parents into this conversation to help them understand more about what’s going on with you and to talk with them about additional services so that you could get the care that you need?” (Open-ended question)*
- Adolescent: *“I’m not sure about that. I know that my parents would be really mad if they knew that I was drinking at parties.”*
- Practitioner: *“You’re concerned about bringing your parents into this conversation because you feel that they will be upset and mad at you because of your drinking.”(Reflective listening statement)*
- Adolescent: *“Well, they don’t know that I drink at parties. I know I probably do need to talk to somebody and get some help but I don’t know if I want to start with telling my parents.”*
- Practitioner: *“I could understand that you’re uncomfortable talking to your parents about something you think they would be upset about. It also sounds like you are interested in getting additional care and talking to someone about cutting back on or stopping your drinking. (Reflective listening statement – exposing ambivalence) What is the way you would like to proceed here?”*
- Adolescent: *“Hmm, I don’t know. May I could talk to someone here first before I get my parents involved.”*

Motivational Skill #4: Summarizing Adolescents' Thoughts and Feelings^{143,144}

In a single session, an adolescent may present a lot of overlapping bits of information about themselves and the challenges they face. Often, adolescents are not able to see how these bits fit together, or the similarities among the thoughts, feelings or situations that they present. Summarizing allows you to help the adolescent see patterns, highlight similarities or inconsistencies and emphasize the adolescent's choices and strengths.

Summarizing – linking together statements or themes and presenting a condensed version.

Summarizing helps the adolescent to change because it:

- Demonstrates you are actively listening and remembering the current and previous conversations;
- Reinforces information and brings into focus themes and strengths presented by the adolescent;
- Provides an opportunity for you to highlight aspects of the adolescent's thoughts and feelings that support change;
- Draws from the exact words spoken by the adolescent that contain their own motivations for change;
- Provides additional clarity to the adolescent on their views and feelings and offers an opportunity to expand further on previously expressed thoughts and feelings;
- Allows you to bridge from one topic to another; and
- Allows the adolescent to hear in your words what the adolescent has been saying and to correct misperceptions.

Summarizing is done with only a few sentences. Use it sparingly so as to not interrupt the flow of conversation. For example:

Practitioner: *“How do you feel about talking to a counselor to get help with cutting back on or stopping your marijuana use?”*

Adolescent: *“I suppose I don't have a problem talking to someone. Will it go on my school record that I talked to a shrink? I just don't want it to prevent me getting into school or a job someday.”*

Practitioner: *“So you feel you would be okay talking with a counselor to get some help with your marijuana use if it didn't go on your school record. Did I get that right?”*

Adolescent: *“Ok. I plan to go to college and I don't want to blow that.”*

Practitioner: *“Ok, I hear you. You are open to the idea of talking with a counselor about your marijuana use and you want to go to college and get a good job one day. What else?”*

You might conclude a summary statement by asking the adolescent an open-ended question, “*What else?*” rather than a close-ended question, “*Did I miss anything?*” This way, you are inviting her to generate as opposed to simply responding with, “*yes,*” or “*no.*”

Summarizing brings together thoughts and feelings the adolescent may have presented at different points during the current interaction or in previous interactions. It also encourages the adolescent to reflect on thoughts or feelings that she may not have seen as related or interconnected. For example:

Adolescent: *“I don’t understand why everyone seems to think I have a drinking problem. I only drink on weekends at parties after a tough of exams and writing papers. Everyone does that. I enjoy being out, watching a game, drinking and seeing friends. I’m usually the last person at the party. Gives me a chance to hang out with other people.”*

Practitioner: *“So, because you only drink on weekends when you feel stress from a tough week at school, you feel you don’t have a drinking problem anymore than your friends.”*

Adolescent: *“Right! So, I have a few beers to relax! I see the same set of guys up at a friend’s house every weekend, partying and drinking just like I am. You don’t see any of them sitting here right now, do you?”*

Practitioner: *“Ok. I see where you are coming from. But tell me more about how much you drink in comparison to your friends.”*

Adolescent: *“Well they throw back a few beers just like I do. I can probably drink a couple of six packs but most of them can’t hang with me. They’re light weights. They’re drunk after the first 6 then we try to get them home so they don’t make fools out of themselves. I can drink twice what they can. But I can really hold my liquor.”*

Practitioner: *“You seem to have different perspectives on your drinking. On the one hand, you see yourself as just like your friends who are partying with you and, on the other hand, you see yourself as frequently drinking more than your friends and mentioned that they leave before you do.”*

Linking phrases, such as, “*on one hand*” and, “*on the other hand,*” can help the adolescent acknowledge conflicting statements without aggressively confronting the inconsistencies. Linking summaries create an opportunity in the conversation that highlight conflicting ideas or discrepancies that force the adolescent to address the discrepancy or topic without directly confronting them. You can also use summarizing to correct faulty conclusions made by the adolescent or redirect their arguments for not changing.

Summaries are most effective when used in conjunction with open-ended questions and reflective listening. This trio of strategies elicits change statements, gently encourages them to explore these statements further and reinforces the adolescent’s thoughts and feelings by repeating them aloud.

Motivational Skill #5: Eliciting Change Talk^{143,144}

It is rare for an adolescent to walk into a clinical encounter ready to change their lives. Most adolescents are not highly insightful and are likely unmotivated to change behaviors that are not seen as a problem, such as use of alcohol and other drugs. For these adolescents, you are a guide or coach to help them figure out why they want to change and to create a plan based on their personal reasons and motivations to change.

As noted earlier, the primary purpose of motivational counseling is to uncover and stimulate the adolescent's internal motivations to modify unwanted behaviors or initiate new ones. As a practitioner you do not have the power to "make" an adolescent change. You probably do not control the incentives or the punishments to generate the external motivators to change. But, you can help the adolescent verbalize the reasons for and advantages of changing behaviors that are unique to them, utilizing "change talk."

Change talk – statements said by an adolescent that favor changing unhealthy behaviors and describe the reasons for and advantages of changing.

By eliciting change talk, you encourage the adolescent to make their own arguments for changing unhealthy behaviors and to feel motivated to make changes they want. Change talk indicates that the adolescent is moving forward in the process of change. When you hear change talk, this is a big, flashing sign that motivational counseling is headed in the right direction. The more change talk from the adolescent, the more likely they are actually going to change the problem behavior. You can highlight and encourage change talk by recognizing it when it is verbalized and appropriately responding to change talk, you may be able to produce more of it to clarify it and strengthen it to help move the person toward commitment to change.

There are several ways to elicit change talk:

Ask evocative questions – This technique is by far the simplest and most direct. These are open-ended questions geared towards 1 of the 5 categories of change talk - desire of change, ability to change, reasons to change, need to change, and commitment to change (also known as DARN-C). Examples:¹⁴³

- **Desire to change**

- ▶ "Why might you want to make a change [quit, cut back] in how much you drink?"
- ▶ "What, if anything, worries you about your current drinking pattern?"
- ▶ "What would be some benefits if you cut back on how much you drank?"
- ▶ "If you reduced or stopped drinking, what would be better? What would be worse?"
- ▶ "In what ways has your marijuana use been a problem for you?"
- ▶ "I can see that you are feeling stuck, frustrated and discouraged at the moment. What is going to have to change?"

- ▶ *“To what extent would you like to make changes in your drinking/use of marijuana?”*
- ▶ *“How difficult would it be for you to cut back or stop drinking?”*
- ▶ *“What do you wish were different about your life/situation right now? How does drinking [marijuana] fit into the picture?”*
- **Ability to change**
 - ▶ *“How might you go about making this change [if you decided to]?”*
 - ▶ *“What is the first step you would take to make a change in your use of alcohol [or marijuana]?”*
 - ▶ *“What plan do you have to make the change happen? What methods can you use?”*
 - ▶ *“What encourages you that you can change if you want to?”*
 - ▶ *“What personal strengths do you have that will help you succeed?”*
 - ▶ *“What gives you confidence that you can stop drinking/stop smoking marijuana?”*
 - ▶ *“When else in your life have you made a significant change like this? How did you do it?”*
 - ▶ *“Who could offer you helpful support in making this change? In what ways?”*
 - ▶ *“What methods would you be willing to try that may work for you to change your drinking?”*
- **Reasons to change**
 - ▶ *“What are some disadvantages if your drinking habits stayed the same?”*
 - ▶ *“What are some of the best reasons you can think of to change a change [quit smoking marijuana]?”*
 - ▶ *“How has your drinking affected your school performance or other important things in your life?”*
 - ▶ *“What are some advantages of changing your drinking habits?”*
 - ▶ *“How would things be better with your parents if you cut back or stopped drinking?”*
- **Need to change**
 - ▶ *“How will your life be better if you make these changes?”*
 - ▶ *“How is drinking [using marijuana] getting in the way of what matters most to you in your life?”*
 - ▶ *“If you cut back or stopped drinking, how would your life in a year from now be different?”*
 - ▶ *“What makes you think you need to do something about your drinking?”*
 - ▶ *“In what ways do you think you or other people have been harmed by your drinking?”*
 - ▶ *“If you stayed the same with your drinking pattern, what negatives might happen? What positives might happen?”*
- **Commitment to change**
 - ▶ *“What is the next step you will take to change your drinking [marijuana use]?”*
 - ▶ *“When will you take the next step to make this change?”*
 - ▶ *“What approaches [steps] will you use to help keep yourself on track with making this change?”*
 - ▶ *“Who will you ask to support you [help you] as you are making this change?”*
 - ▶ *“How will you know that your plan for change is working?”*

For adolescents who do not think that change is necessary, you may want to try asking some of the following questions:

- ▶ *“Why might someone who care a lot about you [your mother or father, teacher or pastor...] be concerned about your drinking?”*
- ▶ *“What advice would you give someone in your situation—for example, another 15 year old girl who smokes weed every day and got in trouble but also hopes to stay involved in the theatre club?”*

Use readiness rulers – Readiness rulers, such as the importance and confidence rulers defined below, can assist adolescents in determining how central or important changing is to them at present and how able or confident they feel about making the change.

The rulers give you and the adolescent graphic feedback about progress and can stimulate reflection about the adolescent’s motivation to change. Adolescent responses can be used to continue a conversation that hopefully elicits more change talk.

Readiness to Change – How ready are they to make a change? *“I’m ready to cut back on my drinking. I can see that it’s affecting my life.”* The adolescent is expressing they are ready and willing to take steps to reduce their substance use or make a behavior change that reduces their risk.

Importance – How important, or what is the current value, of the change to the individual? *“I want to stop drinking because it’s getting harder to get up and get to school on time, and I could lose my chance at college admission because of it.”* This adolescent is expressing their desire and reasons to change and is placing importance on changing.

Confidence – How confident are they in their ability to change? *“I’d like to quit, but I’m not sure I can. Drinking with my friends is kind of fun and when I’ve tried to stop before my friends just hassle me. I’m not sure I could stop even if I wanted to.”* This adolescent is expressing a desire to change but is unsure of their ability to change. Confidence is an important barrier to address because people hate to fail and many adolescents may have already secretly tried to change and been unable to. Normalizing how hard it is to change, how many times a person may need to try and the importance of getting help can help move the adolescent through the sense of being a failure.

To use the **importance ruler**, ask the adolescent:

- ▶ *“On a scale of 0 to 10, how important would you say it is for you to reduce or stop drinking, with 0 being not at all important and 10 being extremely important?”*
- ▶ *“On a scale of 0 to 10, how important would you say it is for you to stop smoking marijuana, with 0 being not at all important and 10 being extremely important?”*
- ▶ *“On a scale of 0 to 10, how important would you say it is for you to not be hung over and ready to perform your best during your game on Saturday, with 0 being not at all important and 10 being extremely important?”*

To use the **confidence ruler**, ask the adolescent:

- ▶ *“On a scale of 0 to 10, how confident would you say you are about being able to stop drinking, with 0 being not at all confident and 10 being extremely confident?”*
- ▶ *“On a scale of 0 to 10, how confident would you say you are about being able to stop smoking marijuana, with 0 being not at all confident and 10 being extremely confident?”*
- ▶ *“On a scale of 0 to 10, how confident would you say you are about being able to not drink the night before your big game, with 0 being not at all confident and 10 being extremely confident?”*

Once the adolescent has answered either of these questions, support high scores and explore ratings by discussing their choice of numbers.

You could ask a question to elicit desire, ability, reasons, and/or need to change:

- ▶ *“What led you to pick a [6] and not a lower number like a [2]?”*
- ▶ *“What led you to choose a [2] and not a [0]?”*

You could ask this question to help generate options for a change plan.

- ▶ *“What would it take for you to go from a [6] to a [7]?”*
- ▶ *“What would it take for you to move from a [2] to a [4]?”*

It is useful to also ask why ratings were not lower. This gives the adolescent an opportunity to explore their positive motivations to change and negative consequences of staying stuck. Asking why a low score was not higher invites the adolescent to generate reasons not to change. Clearly, the goal is to help the adolescent to express reasons that motivate them to change and give the adolescent confidence that they can be successful.

When an adolescent chooses ‘0’:

- Acknowledge it.
- Affirm autonomy.
 - ▶ *“It is totally your decision what to do/whether to change your use of marijuana or not; I only want what is best for you.”*
- Follow-up with a friendly, inquisitive question.
 - ▶ *“What would tell you that smoking weed was becoming a problem for you?”*
 - ▶ *“How would you know if the time was right or making a change was a good idea to help you achieve the goals that you have for yourself?”*

Explore the status quo – Asking the adolescent to express the advantages and disadvantages of continuing to use alcohol or other drugs, as well as the advantages and disadvantages of changing their substance use patterns can help clarify their thinking. It allows them to verbalize the two sides of the ambivalence that keep them stuck in unhealthy behaviors or thoughts. The adolescent may have never verbalized the positive benefits they get from not changing their behavior. There are advantages and disadvantages to the adolescent’s current behavior; you can help the adolescent to generate their own values or beliefs that can support positive change and the values or beliefs that sustain the status quo.

Ask for elaboration – When an adolescent makes a change statement, you can reinforce the change talk by asking them to explore the thought in more detail. If they express that they drink or use other substances too much, you could ask them to say more about how much they are drinking or using drugs, how often and what they consider is “too much.” You might ask them to describe a specific example such as when they drank or used marijuana too much. By describing this event, they are likely to describe negative consequences resulting from their substance use and reasons they want to change. By asking the adolescent to elaborate on change talk, you can help them to more fully explore motivations to change and reasons to tilt the decisional balance toward positive action.

Ask about extremes – Another way of eliciting change talk is by asking the adolescent to describe the most extreme consequences that might occur if they do not change.

- ▶ *“What are the worst things you could imagine happening to you if you do not stop drinking?”*
- ▶ *“What worries you the most about continuing to drink/using drugs?”*

On the other hand, asking the adolescent about the most extreme positive consequences of changing their behavior can be beneficial as well.

- ▶ *“What is the best thing that could happen if you stop drinking?”*
- ▶ *“What are the great things you hope will happen by not smoking marijuana?”*
- ▶ *“Describe to me the most significant things that you would like to do with your life if alcohol was not a part of it.”*

You might also find it useful to ask the adolescent to consider how likely they consider the extreme negatives or extreme positives to be. For example, how likely do they feel it would be, if they keep drinking and driving, that they will get a DUI, lose their license, get kicked off the team, fail some classes, jeopardize their future, not get into college, injure themselves or someone else? How likely is it that, if she cut down on drinking, she would lose weight, improve her grades or feel healthy and positive about life? How likely is it that, if he stopped smoking marijuana with his friends after school, he would get his homework done and be more prepared for his exams?

Look backwards – Asking the adolescent to describe and compare a time before they were drinking (or engaging in other substance use) and the present can highlight how much alcohol has negatively affected their life.

- ▶ *“Do you remember a time in your life when your life was going well? Tell me about that time period.”*
- ▶ *“Describe to me a memory you have from a time when you were not drinking heavily.”*
- ▶ *“Tell me about a time when your relationship with your parents was going well.”*
- ▶ *“Suppose you were someone else describing you before you started smoking marijuana. Tell me what they would say about you.”*

Look forward – Just as with looking backwards, asking the adolescent to look into their future can elicit in their own words the likely outcome if they do not change drinking and drug use behaviors.

- ▶ *“Where do you think you will be 1 year from now if you continue to drink alcohol at this level?”*
- ▶ *“What effects do you think your continuing to drink at these levels will have on your brain in 5 years from now?”*
- ▶ *“Where do you think you’ll be in 2 years if you continue daily use of marijuana?”*

On the other hand, asking the adolescent to evaluate their future life without drinking alcohol or using substances can plant the seeds of change by inviting them to envision leading a healthy life.

- ▶ *“What do you think your life could look like 10 years from now if you stop drinking the way you do now?”*
- ▶ *“What do you think your relationship with your parents could look like 3 months from now if you stop smoking marijuana?”*
- ▶ *“What do you think your performance in school (or at practice) could look like if you weren’t feeling sick and hung over when you came to school?”*

Finally, ask the adolescent to consider the perspective that others may have about using substances.

- ▶ *“What would your friends say if you increased your use?”*
- ▶ *“What about your parents—what would they think if they knew you drank or use marijuana?”*

Explore goals and values – Asking the adolescent to identify which goals and values they hold most important helps to highlight the gap between what they want and what they have now. You are helping to sharpen the positives and negatives of the current behavior from their own values and goals. Exploring the adolescent’s values and goals gets them to reconsider the ambivalence about change from their perspective and motivation. Perhaps the adolescent wishes to improve their school performance, be a better teammate, improve their relationship with parents/guardian/friends, graduate from high school, continue their education, get their driver’s license, get into the military, or get a job. All of these could be threatened by their use of alcohol and other substances. If the adolescent places a high value on having friends and all of their friends drink (or use other substances), then your efforts are focused on eliciting change talk involving non-drinking (non-substance using) friends.

- ▶ *“What matters most to you in your life right now?”*
- ▶ *“What kind of person do you hope to become as you grow into adulthood?”*

Motivational Skill #6: Asking Permission and Giving Advice¹⁴³

Generally, the adolescent should be the source of ideas for changing unhealthy and problematic behaviors. Yet there are times when adolescents are unable to explore their problems more fully or to develop an appropriate course of action. You may have advice or insight that can move them forward toward change, but it is preferred to seek a plan from the adolescent. When an adolescent has “ownership” of solutions to problems, behavior change is enhanced. Ask permission first before offering direct advice and be clear that the adolescent is in charge and is welcome to take the advice or leave it. The responsibility and strength to make healthy choices ultimately belong to the adolescent’s, not you. Your role is to provide assistance, support and alternative perspectives.

Advice is a reasonable strategy in three situations:

- 1) **The adolescent specifically asks for your expertise** – Adolescents will often ask you for your opinion or recommendation. Some adolescents may want your technical advice, e.g., choice of a behavioral health counselor or other health care provider, type of treatment, medications, or peer/recovery support group. Take care to evaluate the possible benefits and drawbacks before jumping in. Advice at this point is most beneficial when the adolescent has explored their opinions on the topic first. At times, a request for advice is a way to divert from the hard, painful work that the adolescent has to do to own the problem and the solution. If you feel that the timing is appropriate and the adolescent has sufficiently engaged in exploring options, you could offer advice. In some settings and circumstances, health care professionals may feel compelled to offer advice even when the adolescent has not specifically asked for it. Providing unsolicited, non-judgmental advice to adolescents is unlikely to be harmful; however, it is respectful to ask permission prior to doing so.
- 2) **The adolescent has granted you permission to give advice** – Many practitioners are very eager to offer their opinions, even when the adolescent has not asked for it. Consider holding back on unsolicited advice, unless three criteria are met:
 - You have elicited the adolescent’s own ideas and knowledge on the subject.
 - Your advice is important to the adolescent’s safety or will increase motivation to change.
 - The adolescent has granted permission.

Asking permission reinforces that the strength and responsibility for change is the adolescent’s, not yours. Permission can be requested directly or indirectly:

- ▶ *“I have a couple of thoughts about your plan of action. Would you mind if I shared them with you?”*
- ▶ *“I don’t know if this will work for you or not, but I could give you some ideas of what other people have done in your situation.”*
- ▶ *“As a health care professional I would like to offer some advice. Would that be okay?”*

- ▶ *“I’d like to share a few ideas on how you might deal with that situation in the future. Would you be interested in hearing them?”*

An adolescent could deny your request to provide advice. The adolescent “owns” the change process. A person who is uninterested in advice is probably not very ready to change. If they are unwilling or unable to receive your advice, that is their choice.

- 3) The adolescent is obviously headed in a direction that could be harmful** – Sometimes adolescents explore their ideas about how to change and decide on plans that are not helpful or that directly undermine their goals. In this instance, it is entirely appropriate for you to intervene and offer a different perspective. However, even at this point, the adolescent does not have to listen or adhere to your advice. You must respect their autonomy. Regardless of the path chosen by the adolescent, you must maintain a safe environment for them to come back and discuss the choices and the consequences resulting from them.

Adolescent: *“I think I can still go to a party at a friend’s house without drinking too much.”*

Practitioner: *“It sounds like that might be a difficult thing to do. It is clearly your choice. Can you think of some other activities to socialize with your friends that don’t put you at risk for drinking too much?”*

OR

Practitioner: *“That seems like a risky thing to do. Tell me how that’s worked in the past for you.”*

OR

Practitioner: *“Tell me how this will work for you. Let’s explore some strategies so you can be successful doing this.”*

Motivational Skill #7: Generating Options¹⁴³

Generating options – assisting the adolescent in developing alternative solutions to the current behavior, evaluating and choosing between options, testing that choice in practice and making necessary changes to achieve the adolescent’s goal.

The adolescent holds the responsibility of making changes in their life, or choosing the status quo. However, you can help them generate options and choose between them to solve problems. By using the motivational skills of affirming, reflecting, summarizing and open-ended questioning, you can assist adolescents toward changed behavior and thoughts.

Help the adolescent explore goals and create an action plan that contains achievable goals. To help explore goals, use open-ended questions to initiate dialogue.

Examples:

- ▶ *“What changes are you thinking about making?”*
- ▶ *“What do you think you will do? What can you do tomorrow? Or today?”*
- ▶ *“What do you see as your options?”*

Developing a change plan has some similarities to developing goals in other areas of one’s life, e.g., in school or at work. The adolescent may find it helpful to use SMART goal setting guidelines. SMART stands for **S**pecific, **M**eaningful, **A**ttainable, **R**ealistic and **T**ime-bound. The following questions could be useful prompts for creating an adolescent’s change plan that is based on their strengths and capacities:

Examples:

- ▶ *“What will be your first (next) step?”*
- ▶ *“What will you do in the next 1 or 2 days?”*
- ▶ *“What will you do differently at the next party?”*
- ▶ *“What goal have you set to achieve by our appointment next week?”*
- ▶ *“What might get in the way?”*
- ▶ *“How will you deal with those challenges?”*

For adolescents who are heavily involved with alcohol or other drugs or have mental illness or experience teen dating violence, short-term goals might best focus on engaging parents/guardians in the conversation in order to get an appointment with another behavioral health care provider, or initiating substance use treatment. The *Setting Goals for Change Exercise*, which is located in Appendix D, and the *Change Plan Worksheet*, which is located in Appendix E can help you and the adolescent develop SMART goals. Discussing options for more intensive treatment for substance use or other problems is no different from discussing options for other issues. The choice and responsibility is the adolescent’s and may include the parents/guardians. You are collaborator and coach.

- **Develop a range of options.** Not all options for changing a problem behavior will be equally desirable or feasible. By developing several options and exploring the pros and cons of each, the adolescent can choose which methods might work best for them. Compare the following two conversations with an adolescent at high risk for alcohol dependence that further illustrates this concept:

Example #1 (Single Option):

Adolescent: *“One of my goals is to stop drinking so much, but I honestly don’t know how to do that. I get the shakes when I don’t drink and all of my friends drink. They’ll just heckle me if I don’t drink. What am I supposed to do? Do you have any suggestions?”*

Practitioner: *“Well, we could try to get you in today to talk with the doctor or other health professional who specializes in working with adolescents. We could start by inviting your parents/guardian to join us in this discussion to talk about some of the options available to you such as intensive inpatient treatment.”*

Adolescent: *“I don’t know about that. I live with my grandma and this will kill her. She has no idea about any of this. Could I just talk to someone here first before we get my grandma involved? Would I have to go away to some rehab place? I don’t think I could do that. I help my grandma take care of my younger brothers.”*

Example #2 (Multiple Options):

Young adult: *“I want to stop drinking all together, but I honestly do not know how to do that. What do you suggest I do?”*

Practitioner: *“Well, there are several different options available to you. You could enter into an inpatient treatment program or perhaps an outpatient program would work better for you. Some people benefit greatly from twelve-step and other peer/mutual support groups. I can review each of these options with you then you can decide which of these options seems the best to you, keeping in mind that you do not have to select just one option?”*

Young adult: *“I would like some help. When I’m not drinking, it’s like I crave it. I know that isn’t good but drinking with my friends at parties helps me talk to people. I’m less nervous and I have fun. What scares me the most about stopping drinking is how anxious I’ll feel and how I won’t have any friends to hang out with. You mentioned peer support groups. Can you tell me more about that? And, what is outpatient treatment? Could I do that and still go to school? I don’t want to do something that makes me miss school. People will know something’s up.”*

By offering several options, the adolescent (and parents/guardians) can evaluate choices that are not appealing and ones that could work. Talking through the positive and negative aspects of options is

another way to stimulate change talk and commitment to change. For example, if the adolescent has previously tried peer/mutual support groups, such as AA or Smart Recovery, and found they helped with heavy drinking for a while, but the feelings of craving got them back to drinking, you might explore other options including periodic in-person or telephone counseling check-ups, and return to the peer/mutual support meetings.

Motivational Skill #8: Managing Pushback¹⁴³

Changing behavior is never easy. Even though some adolescents may express some readiness to change, it is likely that adolescents will exhibit some pushback to changing their problem behavior at some points in counseling. Acknowledge and normalize ambivalence. This strategy helps the person become more receptive to the possibility of change in the future.

Pushback – responses that express opposition to an idea, observation or plan. It may be relational or in defense of continuing a behavior.

The intensity of the pushback to change the adolescent exhibits may be related to several factors, including the fact that the adolescent did not initiate the appointment for services and previous counseling was not a favorable experience^{143,151} Research indicates that your response to adolescent pushback can either increase or decrease future pushback from the adolescent.^{143,155} Practitioners should not be surprised if the adolescent shows pushback. It can be a common response by any individual in therapy and it may even be more of an issue when an adolescent is engaged in a conversation about behavior change.¹⁵⁶ Use the pushback as an opportunity to discuss the adolescent's fears, concerns and ambivalence about changing.

The first step in managing pushback is to recognize it. According to Miller and Rollnick, these are four general types of resistant behaviors:^{143,157}

- **Arguing** – The adolescent contests your accuracy, expertise or integrity.
- **Interrupting** – The adolescent breaks in and interrupts you in a defensive manner.
- **Negating** – The adolescent expresses an unwillingness to recognize problems, cooperate, accept responsibility or take advice.
- **Ignoring** – The adolescent shows evidence of ignoring or not following you.

Once you recognize pushback, you then can respond, taking care not to encourage more pushback. Dig through the noise of pushback and tune into what the adolescent is actually trying to convey. An appropriate response to pushback validates the adolescent's emotions, while decreasing the intensity of the pushback. This can be accomplished in several ways:

- **Simple reflection** – Acknowledge the adolescent's disagreement without causing defensiveness. Practitioner: *“I hear what you are saying and can understand why you would feel that way.”*

- **Amplified reflection** – Reflect back what the adolescent has said in an exaggerated way. If done successfully, this encourages the adolescent to back off a bit and will elicit the other side of their ambivalence. The tone of your voice is critical to this approach.

Adolescent: *“My parents and friends think I have a problem with drinking. I am doing just fine.”*

Practitioner: *“So, you seem to believe you have complete control over your drinking.”*

- **Double-sided reflection** – Acknowledge both sides of the adolescent’s ambivalence. This requires pulling together information the adolescent has offered throughout the clinical encounter. Utilizing “and” instead of “but” can help maintain a balanced emphasis on each statement.

Adolescent: *“I don’t drink any more than any of my girlfriends.”*

Practitioner: *“I can see your point. You view your drinking as normal when compared to your friends. But earlier you mentioned that your drinking may be negatively impacting your relationship with your parents and younger sister. What do you think about this?”*

- **Shifting focus** – Shift the adolescent’s attention away from the roadblock that is impeding their progress. Taking a “detour” can diffuse pushback, especially in difficult situations.

Adolescent: *“I wouldn’t be here if I hadn’t blown positive on that breathalyzer. I guess you are going to tell me to quit drinking or lose my shot at college.”*

Practitioner: *“Hey, I just met you. Why don’t we first begin by talking about what was going on that led up to the positive alcohol test?”*

- **Reframing** – Acknowledge the validity of the adolescent’s perspective and observations and offer a new meaning or interpretation.

Adolescent: *“I have always been able to handle my liquor. I could drink a 12-pack of beer in one night and most people would not know that I was drunk. No matter how much I drink, I can still handle my business.”*

Practitioner: *“That is an interesting perspective, and I can see how you would view that as a benefit. Being able to drink that much without others noticing indicates a high level of tolerance and may mean you have a very great risk for developing a serious alcohol problem.”*

- **Emphasizing personal control** – Communicate to the adolescent that it is their decision whether or not to make a behavior change. This frees you of control and puts them in charge.

Practitioner: *“It is not my place to tell you what you can or cannot do. I am simply here to help you understand your options and to assist with any elements of this process that you find troubling. How you live your life, including whether or not you choose to follow the recommendations made by the doctor, is ultimately up to you.”*

- **Siding with the negative** – Agree with the adolescent that they may not need to change. Often when you take the negative side, adolescents will respond by presenting positive reasons to change.

Adolescent: *“I don’t know if stopping drinking will really make that much difference in my life.”*

Practitioner: *“Well, perhaps it won’t. You could keep drinking, or you could try stopping for a while and then see whether the problems in school and with your friends improve. Then you can decide whether or not you stay alcohol free. The recommended guidelines for anyone under the age of 21 is no alcohol use.”*

You can also create or intensify pushback when you behave in a way that shifts the power balance between you and the adolescent. The following table presents examples of four types of responses to an adolescent’s pushback that you should avoid:¹⁴³

Responses to Avoid	Example
Arguing for change – You directly take up the pro-change side of ambivalence on a particular issue and try to persuade the adolescent to make a change.	<i>“You have no idea how wonderful your life can be if you were to just give up drinking. You could spend more time with your family; you would not be hung over in the morning at school; you would lose weight; and think of all the money you would be saving each month!”</i>
Assuming the expert role – You structure the conversation in a way that communicates that you “have all the answers.”	<i>“I have been doing this for a long time. I can tell you for certain that you are not going to be able to stop smoking marijuana while you are still hanging out with that group of friends.”</i>
Labeling – You propose acceptance of a specific label or diagnosis to characterize or explain the adolescent’s behavior.	<i>“I think it is important for you to acknowledge that you are a pot head before we can get anywhere in making you better.”</i>
Claiming preeminence – Your goals and perspectives override those of the adolescent.	<i>“I’ve been in recovery a long time. You really need to listen to me. I’ve been where you are, and you need help.”</i>

Sample Interaction: Brief Intervention with Moderate Risk, Non-Resistant, Contemplative Young Adult, Age 20

Brief motivational clinical encounter with a non-resistant or contemplative young adult, age 20, going to community college, working part-time, and has a girlfriend who expressed concern about his drinking.

This is an example of a brief intervention with a young adult who is ambivalent about his drinking. He is open to discussing behavior change. The practitioner focuses on amplifying his ambivalence in order to help him prepare to change his drinking behavior.

- Practitioner:** *Alright, Steve, thank you for answering those questions for me. I appreciate your openness. (Affirmation) Would it be alright if I provided some feedback? (Asking permission to provide feedback or advice)*
- Young Adult:** *Yeah, I guess that'd be OK.*
- Practitioner:** *OK, great. Based on your answers to the questions I asked about your alcohol use, it appears that you are at moderate risk of experiencing health, social, and other problems due to the amount of alcohol you drink. (Providing feedback with permission) What are your thoughts about this? (Open-ended question)*
- Young Adult:** *Well, that surprises me. I don't think I have a problem with my drinking. I don't know why I scored so high.*
- Practitioner:** *So, this comes as a surprise and you're unclear about how alcohol could put you at risk for any problems. (Reflection) Would it be alright with you if I explained more about why I'm concerned? (Asking permission to provide feedback or advice)*
- Young Adult:** *Yeah, I guess that'd be alright.*
- Practitioner:** *You mentioned before that you enjoy drinking on the weekends to relax and that you generally have about five or six drinks. You also mentioned that drinking has interfered with your school performance on a couple of occasions, that you missed work due to hangover, and that your girlfriend has expressed concern about your drinking. (Summary) According to the lower-risk drinking guidelines, the recommendation is that young adults should totally avoid alcohol since any drinking puts you at risk for health and other problems associated with alcohol. Young adults are particularly at risk for experiencing problems due to alcohol. (Advice with permission) What do you think about this information?*

- Young Adult:** *Well, I know that it's illegal to drink under the age of 21 but in other countries you can drink much younger so it can't be all that bad for you. I'll be 21 in a couple of months and I've been drinking since I was 16 so I can handle my liquor. I don't even feel that drunk when I have six drinks.*
- Practitioner:** *So, you know the legal age to drink is 21. And you don't feel that intoxicated after six drinks even though you are still drinking more than the amount that is considered safe for men of any age. (**Reflection**) Would it be alright if I shared some thoughts on that? (**Asking permission to provide feedback**)*
- Young Adult:** *Yeah, that's OK.*
- Practitioner:** *You mentioned that you aren't feeling the effects of the alcohol even when you have six drinks. (**Reflection**) This is likely an indication that your tolerance has increased over time, meaning that it takes more alcohol to have the same effect. This is a concern because it greatly increases the likelihood that you will or maybe are already experiencing some problems. For example, problems such as hangovers, poor performance in school or sports, relationship problems, and problems at work. (**Feedback with permission**) Given this information, I'm curious to know how ready you feel you are to cut back or quit drinking. On a scale of zero to ten – zero being not ready at all and ten being extremely ready, how ready would you say you are? (**Open-ended question using readiness ruler**)*
- Young Adult:** *Hmm, that's hard to say. I mean, I don't want to mess up my relationship with my girlfriend. And I can't afford to lose my job due to my drinking. I'm supposed to get a bonus at work and I'm planning to buy my girlfriend an engagement ring. I'm going to propose to her on her birthday. She gets so mad at me after a night of drinking. Sometimes she won't talk to me for a week. If cutting back or not drinking meant I wouldn't have these problems, then I'd say I'm probably a seven in terms of being ready.*
- Practitioner:** *A seven is pretty high. It sounds like cutting back or not drinking is pretty important to you and that you are quite ready. (**Affirmation**) What do you think makes you a seven and not a lower number, such as a four or five? (**Eliciting change talk**)*
- Young Adult:** *I guess it's because I don't want some of those things to happen.*
- Practitioner:** *Like what things?*
- Young Adult:** *Like putting my job in jeopardy or upsetting my girlfriend. (**Change talk**) Plus, my health is important to me. I work out regularly and try to take care of myself. (**Change talk**)*

Practitioner: *Those all sound like very important reasons to make a change in how much you drink. (**Affirmation**) Now, using that same zero to ten scale, what would it take to move you from a seven, feeling quite ready, to a ten, feeling extremely ready, to change? (**Open-ended question using readiness ruler**)*

Young Adult: *Well, I guess there are some reasons why I don't want to change. Like I said before, I enjoy going out with the guys. I can't see myself totally not drinking... We like to watch the game and throw a few back. It's how I relax. They might wonder why I'm not letting loose as much. I don't want things to change with my buddies.*

Practitioner: *Your friendships sound like a great source of relaxation for you. (**Reflection**) How would it be if you explained to your friends that you are cutting back on your drinking for health reasons and because you care about important things like school, your job and your relationship? (**Open-ended question**)*

Young Adult: *Well, I guess if I made a point of it when I first started, explaining that it was due to my health and those other things, then that would be easier than explaining the other reasons. (**Change talk**) They would probably understand that better... They might even hold me to it!*

Practitioner: *So, you see your friends as people in your life that could help you stick to your goal. And maybe if you told them why this change is importance to you, then it would help you feel even more ready to make a change and cut down on your drinking. (**Reflection**)*

Young Adult: *Yeah, if they see that it's something important to me, not just being pressured by my girlfriend or judging them, but that I can still go out and have a good time but just not drink so much, then yeah, they might give me a hard time if they see me slipping up. Plus, they already know how my girlfriend feels. They might even give me grief if they know I'm upsetting her.*

Practitioner: *It seems that your friends would recognize your goal as reasonable and that it would be a good idea for several reasons. (**Reflection**)*

Young Adult: *Yes, definitely.*

Practitioner: *So what would this change actually look like in terms of how much you will drink when you're out with friends?*

Young Adult: *I'm not sure... what were those limits?*

Practitioner: *Well, first of all, I do need to emphasize that no alcohol until you're 21 is best. And then, for men 21 and older, up to a total of 14 drinks in a week and never more than 4 in one day is considered the lower risk limit.*

Young Adult: *Hmmm... I'm going to have to think about this... But I guess it wouldn't be such a big deal to try to stay within the 4 drink daily limit.*

Practitioner: *How comfortable are you with staying in the 14 drinks in a week limit?*

Young Adult: *(laughs) That would be pretty easy, as I usually only go out and drink on the weekends.*

Practitioner: *That sounds like a good plan to never have more than 4 drinks when you go out with your friends, and never exceeding 14 drinks in one week. How confident do you feel about sticking to this plan – say again on a scale from 0 -10?*

Young Adult: *Oh, I'd say like an eight at least—pretty confident. My relationship and school really are my priorities right now.*

Practitioner: *So, it sounds like you're pretty sure you can make this change—especially when you consider what matters most to you right now.*

Young Adult: *Yeah, that's right.*

Practitioner: *Alright, Steve, I'd like to summarize our conversation to make sure I'm not missing anything. I really appreciate you being so open to discussing this with me. (Affirmation)*

Young Adult: *No problem.*

Practitioner: *Today, we've assessed your current alcohol use pattern and discussed cutting back on your drinking. Currently, you're drinking well above the lower risk drinking limits and have expressed that it is important to you to cut back on the number of drinks you consume. This is something that you are very ready to attempt and you believe that once you have your friends' support, you will be even more ready to commit to. (Summary) Do I have that right?*

Young Adult: *Yeah, I think that pretty much covers it.*

Practitioner: *Great. In what ways can I support you in achieving this goal? (Open-ended question)*

Young Adult: *I think just checking in about it next time would be helpful.*

Practitioner: *OK, then that's what we'll do. I'll be sure to check in with you about progress toward this goal when you come back for your follow-up appointment. Now, let's discuss some of your other concerns.*

Sample Interaction: Brief Intervention with Moderate Risk, Resistant or Pre-Contemplative Adolescent, Age 16, Sports Physical/Re-injury

Brief motivational clinical encounter with a resistant or pre-contemplative adolescent age 16, scored at risk on the CRAFFT during sports physical and follow-up for previous re- injury.

This is an example of a brief intervention with an adolescent who does not yet recognize the potential negative consequences of her substance use. She is not open to discussing behavior change because she does not recognize that she has a problem. The practitioner focuses on developing discrepancy between the adolescent's values and her current drinking or using behavior in order to help her begin contemplating the pros and cons of her drinking.

Practitioner: *Alright Mary, thank you for answering those question about alcohol and drugs. I appreciate your openness. (Affirmation)*

Adolescent: *Are you going to tell my parents? I'm really just here to talk about my ankle and get my sheet saying I'm good to play field hockey. I'm going to be a starter this year.*

Practitioner: *Congratulations. It sounds like hockey is really important to you and it says a lot about your skills and hard work that you will be a starter. (Reflection) You mentioned that you re-injured your ankle. Tell me more about what happened.*

Adolescent: *Well, I was walking home from a friend's house late at night and I fell off the sidewalk. I was tired and must have twisted it when I fell.*

Practitioner: *That must have been really painful. You reported that you drink alcohol and sometimes smoke marijuana. Thank you for being honest about that. (Affirmation) What role, if any, do you think alcohol or marijuana may have played in the fall that led to re-injuring your ankle?*

Adolescent: *Well, we weren't doing hard drugs or anything. My girlfriend's parents were out of town and we were hanging out watching movies. We did a few shots of out of her parent's liquor cabinet but wasn't a big deal. We had a couple of shots and smoked a little weed but it didn't get out of control. I was fine by the time I walked home.*

Practitioner: *So, you fell off the sidewalk walking home from a friend's house after drinking and smoking marijuana. (Reflection)*

Adolescent: *Yeah, but like I said, I was fine. I'm sure it had nothing to do with it.*

Practitioner: *Would it be alright if I provided some feedback? (Asking permission to provide feedback or advice)*

Adolescent: *OK....here we go...if you have to....*

Practitioner: *Well, based on your answers to the questions about alcohol and marijuana, you are at increased risk of experiencing problems including accidents and injuries. What are your thoughts about this? (**Open-ended question to elicit adolescent input**)*

Adolescent: *Well, it's like this. I don't want my parent to be upset with me. They wouldn't be happy if they found out what I was doing before I came home that night. I obviously want to be cleared to stay on the field hockey team, and yeah, every time I re-injure my ankle it totally hurts, it's so painful. I know if it doesn't heal soon I'm not going to be able to be a starter. (**Change talk**) But I also don't think I'm doing anything that's all that different from my friends. At it's not meth or something. Marijuana is all natural. I mean, it's pretty normal. Pretty much everyone does it.*

Practitioner: *I understand you've worked so hard to be a starter on the field hockey team. (**Affirmation**) It seems reasonable that you would want to unwind in your free time. You see drinking and smoking marijuana with your friends as just a way to hang out and relax (**Reflection**). Am I getting that right? (**Reflection**) What are some of the other ways you might be able to relax and have fun that but don't increase your risk of re-injuring your ankle so you can avoid losing your starter position? (**Eliciting adolescent input on alternatives to substance use**)*

Adolescent: *Hmm...I don't know. It's not like I'm going to take up basket weaving or crocheting like my grandmother.*

Practitioner: *I understand. Basket weaving does not interest me either. But there are lots of ways to relax, to unwind. What did you do before you started using substances?*

Adolescent: *I did listen to music. Sometimes I watched TV.*

Practitioner: *These seem reasonable. Anything else?*

Adolescent: *Sometimes I would call my friends.*

Practitioner: *Do you see any advantages of these strategies compared to using substances?*

Adolescent: *Not really.*

Practitioner: *I can think of at least one. Can I offer my idea? (**Asking permission**)*

Adolescent: *Ok, I suppose.*

Practitioner: *These other options would not get you into trouble with others, like your parents or your field hockey coach.*

Adolescent: *Assuming they would know about this!*

Practitioner: *Correct. But things could go the other direction too – where your drinking or using could get discovered.*

Adolescent: *It could happen but I am careful.*

Practitioner: *Yes, I see where you are coming from. So where does this leave us? What about these other non-drinking and non-using strategies to relax? (**Eliciting adolescent input**)*

Adolescent: *I could think about using some of them. Perhaps. (**Change talk**)*

Practitioner: *Okay, so tell me more about what you might consider trying in the near future, say, the next week? (**Open-ended question to elicit a goal/action plan**)*

Adolescent: *Hmmm. Ok, let's put "listening to music" at the top of the list.*

Practitioner: *Great. How can I help with this goal? (**Open-ended question**)*

Adolescent: *Maybe we can re-connect in a couple of weeks.*

Sample Interaction: Brief Intervention with Moderate Risk, Resistant or Pre-Contemplative Adolescent, Age 15, Physical Injury

Brief motivational clinical encounter with a resistant or pre-contemplative adolescent age 15, scored at risk on the CRAFFT during office visit about a knee injury.

This is an example of a brief intervention with an adolescent who does not yet recognize the potential negative consequences of his drinking. He is not open to discussing behavior change because he does not recognize how alcohol and marijuana may be contributing to current and possible future problems. The practitioner focuses on developing discrepancy between the adolescent's values and his current use of alcohol and drugs in order to help him begin contemplating the pros and cons of his drinking.

Practitioner: *Alright Jeremy, thank you for answering those questions about alcohol and drugs. I appreciate your openness. (Affirmation)*

Adolescent: *Are you going to tell my parents? Is my coach going to find out? I'm really just here to talk about my knee and get my sheet saying I'm good to play. This is my first year on the basketball team and if I can't play someone else will take my spot and I worked hard to get on the team.*

Practitioner: *Congratulations. It sounds like basketball is really important to you and it says a lot about your skills and hard work that you made the team. (Reflection) You mentioned that you fell and injured your knee. Tell me more about what happened.*

Adolescent: *Well, I was riding my bike with some friends and got thrown off when I hit a pot hole. We were in a hurry. I guess I just wasn't paying attention.*

Practitioner: *That must have been really painful. You reported that you drink alcohol and sometimes smoke marijuana. Thank you for being honest about that. (Affirmation) What role, if any, do you think alcohol or marijuana may have played in the fall off your bike that led to injuring your knee?*

Adolescent: *I don't know, probably nothing. If they would just fix the pot holes people wouldn't get hurt. It's not like I was drunk. I only had a few beers at that point. I can easily drink a 6 and it doesn't affect me. The night was just getting started...we were headed to a party. I could hardly feel anything when I got on my bike. Alcohol had nothing to do with my fall.*

Practitioner: *So, you fell off your bike after hitting a pot hole on your way to party after drinking a few beers with your friends. (Reflection)*

Adolescent: *Yeah, but like I said, I couldn't feel a thing. I'm sure it had nothing to do with it.*

Practitioner: *Would it be alright if I provided some feedback? (Asking permission to provide feedback or advice)*

Adolescent: *OK....here we go...if you have to....*

Practitioner: *Well, based on your answers to the questions about alcohol and marijuana, any drinking or use of marijuana puts you at increased risk of experiencing problems including such as accidents and injuries. What are your thoughts about this? (Open-ended question to elicit adolescent input)*

Adolescent: *Well, I just can't believe this knee thing is happening to me right now. I don't want my coach to be upset with me. He wouldn't be happy if he found out what I was doing. I obviously want to get my knee fixed so I can play in the game next week. I know if it's not better soon coach isn't gonna play me. I've worked so hard to make this team. (Change talk) I don't do anything different than my friends...they all drink a little especially if we're going to party. At least it's not meth or something. And marijuana is all natural. I mean, it's normal. Pretty much everyone does it.*

Practitioner: *I understand you've worked so hard to make the basketball team. (Affirmation) It seems reasonable that you would want to unwind in your free time. You see drinking and smoking marijuana with your friends as just a way to hang out and have fun. (Reflection). Am I getting that right?*

Adolescent: *Yeah, that's right. Plus it's just not that big of a deal really!*

Practitioner: *I also need to let you know that drinking or smoking marijuana during your teenage years can be especially harmful because your brain is still developing. Over time it can lead to problems with learning, affect your grades and interfere with your goals. That's why I strongly recommend that you entirely avoid alcohol and drugs at this stage of your life. What are your thoughts about this? (Open-ended question to elicit adolescent input)*

Adolescent: *I don't know... My brain seems fine. And my grades are OK.*

Practitioner: *What are some other ways you might be able to have fun that don't involve alcohol or marijuana? (Eliciting adolescent input on alternatives to substance use)*

Adolescent: *Hmm...I don't know. This town is so boring!*

Practitioner: *I only want what's best you so that you have the greatest chance of accomplishing your goals in the future. (Affirmation) I'm curious, on a scale from 0-10, where 0 is not at all important and 10 is very important, how important is to you to quit or cut back on your use of alcohol and marijuana? (0-10 Importance Ruler to Enhance Motivation)*

Adolescent: *Oh, I don't know...maybe like a 3.*

Practitioner: *So, what makes you a 3 and not a lower number like a 1 or a 2? (Open-ended Question)*

Adolescent: *Oh, I guess because I don't want to have anything happen that could hurt my chances on the basketball team or get me in trouble with my coach.*

Practitioner: *So, basketball is very important to you and you also care a lot about not disappointing your coach. (Reflection)*

Adolescent: *Yeah, I guess...*

Practitioner: *What you decide to do really is up to you. (Affirmation. Acknowledge autonomy) I wonder if we could discuss some steps you could take to keep yourself as safe as possible if and when you do drink alcohol or smoke marijuana? (Asking permission)*

Adolescent: *Like what do you mean?*

Practitioner: *Well, for example, you could decrease how often you drink alcohol and smoke marijuana, you could cut way back on how much alcohol you consume so that it will be less likely that you would have another injury. You could decide to never ride a bike or drive a car after drinking or using marijuana. You could decide never to ride in a car with someone else who has been drinking or smoking marijuana. What do you think? What might work for you?*

Adolescent: *I suppose I could maybe drink and smoke weed a little less often or have a little less.*

Practitioner: *So, tell me more...*

Adolescent: *Like maybe only having one drink. And cut back a little on the weed when it gets passed around. I never ride with a person who's been drinking or smoking weed and I don't have my license yet. That's why I ride my bike.*

Practitioner: *I'm really glad to hear that you have made the decision to never ride in a car with someone who has been drinking or using marijuana. (Affirmation) How do you think it would work for you to drink less alcohol and smoke less marijuana when you're with your friends? (Open-ended question)*

Adolescent: *It would probably go fine...*

Practitioner: *What might be difficult?*

Adolescent: *Well, if they pressure me or I just forget.*

Practitioner: *What would you say if someone was pressuring you?*

Adolescent: *Maybe that I'm focused on having a really good basketball season and too much alcohol or weed could mess it up.*

Practitioner: *That sounds like a good response. And what could help you remember?*

Adolescent: *I'm not sure...I can probably remember...*

Practitioner: *How do you think it would work for you to walk instead of ride your bike after drinking or smoking marijuana?*

Adolescent: *Well, if everyone else is taking their bike and I'm the only one walking, that probably won't work. Maybe I can convince them to walk too but it will definitely take much longer to get anywhere. That's why we take our bikes.*

Practitioner: *What would you say if someone was pressuring you to ride your bike after drinking or smoking marijuana?*

Adolescent: *Maybe the same kind of thing...that I'm focused on having a really good basketball season and if I'm drinking and fall off my bike again and get hurt it could ruin my season.*

Practitioner: *That sounds like a good response. And what could help you remember?*

Adolescent: *I can remember, this knee will be a constant reminder!*

Practitioner: *So, Jeremy, it sounds like at this point you're not ready to completely quit drinking or smoking marijuana but you can see that maybe there are a few good reasons to cut back - especially because basketball is so important to you and because you don't want to have problems with your coach. You feel pretty confident that you will be able to remember what you would say if someone pressures you and be able to stick with this decision. Did I summarize where you're at pretty accurately? (**Summarizing the conversation**)*

Adolescent: *Yeah, that sounds about right.*

Practitioner: *Again, I appreciate your willingness to have this discussion with me. (**Affirmation**) I do need to remind you that the very best thing for your health and future would be to totally avoid alcohol and marijuana until you are at least 21. And I would like to check in with you about this the next time I see you. Is that OK?*

Adolescent: *Yeah, That's fine but I need a note for my coach. Are you going to give me something that says I'm okay to play next week?*

Additional Videos with Sample Interactions

University of Florida Institute for Child Health Policy & Cherokee National Behavioral Health produced a video entitled “The Effective School Counselor With a High Risk Teen: Motivational Interviewing Demonstration.” The video is located at: https://www.youtube.com/watch?v=_TwVa4utplI

HealthTeamWorks, a nonprofit produced a video entitled “Motivational Interviewing: Adolescent Follow Up on Positive Alcohol Screen.” The video is located at: <https://www.youtube.com/watch?v=JZrYk86EDIQ>

Boston University School of Public Health BNI ART Institute produced the following videos to breakdown SBIRT with adolescents:

- 1) Rapport: SBIRT for alcohol/drugs with adolescents
https://www.youtube.com/watch?v=v3_uxCpZ7wg
- 2) Pros & Cons: SBIRT for alcohol/drugs with adolescents
<https://www.youtube.com/watch?v=dLGYfADKYJo>
- 3) Feedback: SBIRT for alcohol/drugs with adolescents
<https://www.youtube.com/watch?v=h5bpAvmjrCs>
- 4) Readiness Rules: SBIRT for alcohol/drugs with adolescents
<https://www.youtube.com/watch?v=oVVociJ0P8o>
- 5) Action Plan: SBIRT for alcohol/drugs with adolescents
<https://www.youtube.com/watch?v=dqOs5N4QPNw>
- 6) Thanks: SBIRT for alcohol/drugs with adolescents
<https://www.youtube.com/watch?v=WKVPZUtWXME>

University of Maryland Baltimore School of Social Work produced a video entitled “SBIRT for Social Work Juvenile Justice Program.” The video is located at: <https://www.youtube.com/watch?v=8Nc49gzFxT8&feature=youtu.be>

Motivational Interviewing Skills Role Play



Role Play Exercise: Partner with two other participants to practice conducting a brief intervention using some of the motivational interviewing skills that you are learning. For this situation, one person will act as the practitioner who has administered the CRAFFT or S2BI and determined, based on the score that the adolescent is at risk of experiencing alcohol-related problems. One person will act as an adolescent who is seeking help for some bothersome problems. Another will be the practitioner who practices providing a motivational brief intervention. The third person will act as an observer and rate the practitioner on the MI skills used.

The practitioner should consider using the BNI Adolescent Algorithm (Figure I.), and screening tools and pocket cards located in the Appendix to help facilitate the brief motivational intervention conversation. The observer should use the Brief Intervention Observation Sheet (BIOS) below to assess use of MI skills.

Adolescent: You are a 16-year-old adolescent whose mother was diagnosed with cancer 3 months ago. You have been feeling “unhappy” inside. If asked to talk about your life, you might say, *“I don’t really feel like talking about it. Things are rough at home. I’ve had to fight for everything, but things keep being taken away from me.”* You are reluctant and do not think you drink a lot since you only drink to excess on the weekends.

If Asked About Pros & Cons:

PROS: It helps you escape and numbs the pain that you have to keep inside all week. Then when you get home after school on Friday, *“I open up my parents’ cabinet and take a few shots. When I’m buzzed I feel less angry and sad.”*

CONS: *“I cannot risk failing out of school. I won’t be able to get a good job.”* Lately, you have been staying home from school sick on Mondays because of your alcohol intake on Sunday. **If pressed for more cons:** You know that alcohol has caused you some problems in the past, and you don’t want them repeated.

When Asked About Your Readiness: You think that your readiness is about 3 out of 10. It’s not a 1 or a 2 because you don’t want to disappoint your mother while she is sick, but you feel unmotivated to change a problem that only occasionally gets out of control.

If the Practitioner Suggests a Plan/Next Steps: You feel like you can cut back whenever you want. However, you feel stressed and sad at the moment, and you’re not sure stopping drinking at this point will help. **If pressed:** You agree that you are drinking to not feel as sad on the weekends, but it does start to “turn super sad at a certain point after drinking a pint... once I’m drunk I actually feel more sad.”

Brief Intervention Observation Sheets

Brief Intervention Observation Sheets (BIOS) can be used by the observer to assess use of brief intervention using key motivational interviewing skills throughout a role play. The observer listens for examples of each skill and places a hash mark (/) in the appropriate row. The observer also makes note of good examples of each type to provide helpful feedback following the role play. Alternative BIOSs are offered in the Appendix G, including the “SBIRT Oregon Intervention Observation Sheet” adapted from the BI Adherence/Competence Scale, created by D’Onofrio et al. for Project ED Health.

Listener Response	Count (Hash Mark)	Good Examples
Open Questions		
Closed Questions		
Affirmations		
Reflective Listening		
Summaries		
Advice with Permission		
Eliciting Change Talk (includes rulers)		



Role Play Exercise: Partner with two other participants to practice some of the techniques that you are learning. For this situation, one person will act as the practitioner who has administered either the CRAFFT, S2BI, or AUDIT and determined based on the screening score that the young adult is at moderate risk of experiencing alcohol-related problems. One person will act as the young adult who is seeking help for some bothersome problems. The practitioner will practice providing a motivational brief intervention to this young adult. The third person will act as an observer and rate the practitioner on the MI skills used.

The practitioner should consider using the BNI Adolescent Algorithm (Figure I.), and screening tools and pocket cards located in the Appendix to help facilitate the brief motivational intervention conversation. The observer should use the Brief Intervention Observation Sheet (BIOS) below to assess use of MI skills.

Young Adult: You are an 18-year-old who is concerned because you recently injured your wrist in a fight, have been missing class at community college and arguing more with your family. You were living with your significant other, but caught them cheating on you. So, you moved in with your parents, who are not too happy about you being there while you have little income from a part-time job. You were blowing off some steam with friends a few nights ago when a fight broke out. When you returned home, your parents insisted you go to the hospital to get your wrist checked out. You drink 1 to 2 beers during the week and 4 to 6 drinks on most weekend nights. You also sometimes smoke pot on the weekends but only if a friend has some. You think this kind of drinking is the “norm” for most people your age.

If Provider Asks About Pros & Cons:

PROS: Everyone you know drinks like you do; it is a part of your social life. You enjoy the slight buzz you get when you drink, and it especially feels good after a long week of juggling school and work. It helps you to have fun and forget about all your stress.

CONS: At first, nothing you can think of. **If the provider prompts you about regrets:** You admit that you blacked out when you injured your arm and are not quite sure what happened. You are lucky you did not hit your head. Although your wrist still hurts, the bruising is gone and it is not swollen anymore. You concede that it was probably the alcohol that made you black out.

When Asked About Your Readiness: You identify yourself as a 2 on the Readiness Scale and feel that there is not really a need to change your behavior. **If the provider asks “why not a 1 or 0?”** You do not want to black out again. You are pretty confident that if you want to change in the future, you will be able to do it on your own.

If the Practitioner Suggests a Plan/Next Steps: You do not really feel that drinking is a problem, but you agree that maybe drinking so much that you black out is not a good thing. So you agree to try to drink less, drink slower and make sure there is a friend to watch out for you.

References

References

1. Substance Abuse and Mental Health Services Administration. About Screening, Brief Intervention, and Referral to Treatment (SBIRT). 2015; <http://www.samhsa.gov/sbirt/about>. Accessed September 16, 2015.
2. Carney T, Myers BJ, Louw J, Okwundu CI. Brief school-based interventions and behavioural outcomes for substance-using adolescents. *Cochrane Database of Systematic Reviews* 2016. 2016(Issue 1).
3. National Institute on Drug Abuse. *Principles of Adolescent Substance Use Disorder Treatment: A Research-based Guide*. NIDA;2014. NIH Publication Number 14-7953.
4. Substance Abuse and Mental Health Services Administration. Talk. They Hear You. 2015; <http://www.samhsa.gov/underage-drinking>. Accessed November 18, 2015, 2015.
5. Siqueira L, Smith V. Binge Drinking. *American Academic of Pediatrics*. 2015;136(3).
6. Turrisi R, Mallett KA, Cleveland MJ, et al. Evaluation of Timing and Dosage of a Parent-Based Intervention to Minimize College Students' Alcohol Consumption. *Journal of Studies on Alcohol and Drugs*. 2013;74(1):30-40.
7. Guide to Community Preventive Services. Preventing Excessive Alcohol Consumption. 2015; www.thecommunityguide.org/alcohol/index.html.
8. Guide to Community Preventive Services. Improving adolescent health. 2013; www.thecommunityguide.org/adolescenthealth/index.html.
9. Whitlock EP, Polen MR, Green CA, Orleans T, Klein J. Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the US Preventive Services Task Force. *Annals of Internal Medicine*. 2004;140(7):557-568.
10. Solberg LI, Maciosek MV, Edwards NM. Primary care intervention to reduce alcohol misuse: ranking its health impact and cost effectiveness. *Am J Prev Med*. 2008;34(2):143-152. e143.
11. Maciosek MV, Coffield AB, Edwards NM, Flottemesch TJ, Goodman MJ, Solberg LI. Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis. *Am J Prev Med*. 2006;31(1):52-61.
12. U.S. Preventive Services Task Force. Recommendation Statement: Screening And Behavioral Counseling Interventions In Primary Care To Reduce Alcohol Misuse. Washington, DC: US Preventive Services Task Force; 2013.
13. National Quality Forum. *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: Robert Wood Johnson Foundation;2007.
14. Madras BK, Compton WM, Avula D, Stegbauer T, Stein JB, Clark HW. Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: comparison at intake and 6 months later. *Drug Alcohol Depend*. 2009;99(1-3):280-295.
15. Bernstein J, Bernstein E, Tassiopoulos K, Heeren T, Levenson S, Hingson R. Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug Alcohol Dependence*. 2005;77(1):49-59.

16. Copeland J, Swift W, Roffman R, Stephens R. A randomized controlled trial of brief cognitive-behavioral interventions for cannabis use disorder. *Journal of Substance Abuse Treatment*. 2001;21(2):55-64.
17. World Health Organization. *The effectiveness of a brief intervention for illicit drugs linked to the alcohol, smoking, and substance involvement screening test (ASSIST) in 30 primary health care settings: a technical report of phase III findings of the WHO ASSIST Randomized control trial*. Retrieved June 16, 2010 2008.
18. Ozechowski T, Becker SJ, Hogue, A. . SBIRT-A: Adapting SBIRT to maximize developmental fit for adolescents in primary care. *Journal of substance abuse treatment*. 2016;62(2016):28-37.
19. Barnett E, Sussman S, Smith C, Rohrbach LA, Spruijt-Metz D. Motivational Interviewing for adolescent substance use: A review of the literature. *Addictive Behaviors*. 2012;37(12):1325-1334.
20. Winters KC, Leitten W. Brief intervention for drug-abusing adolescents in a school setting. *Psychology of Addictive Behaviors*. 2007;21(2):249-254.
21. Winters KC, Fahnhorst T, Botzet A, Lee S, Lalone B. Brief intervention for drug-abusing adolescents in a school setting: Outcomes and mediating factors. *Journal of Substance Abuse Treatment*. 2012;42(3):279-288.
22. Erickson SJ, Gerstle M, Feldstein SW. Brief interventions and motivational interviewing with children, adolescents, and their parents in pediatric health care settings - A review. *Archives of Pediatrics & Adolescent Medicine*. 2005;159(12):1173-1180.
23. Grenard JL, Ames SL, Pentz MA, Sussman S. Motivational interviewing with adolescents and young adults for drug-related problems. *International Journal of Adolescent Medicine and Health*. 2006;18(1):53-67.
24. Tait RJ, Hulse GK. A systematic review of the effectiveness of brief interventions with substance using adolescents by type of drug. *Drug and alcohol review*. 2003;22(3):337-346.
25. Jensen CD, Cushing CC, Aylward BS, Craig JT, Sorell DM, Steele RG. Effectiveness of Motivational Interviewing Interventions for Adolescent Substance Use Behavior Change: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*. 2011;79(4):433-440.
26. Winters KC, Leitten W, Wagner E, O'Leary Tevyaw T. Use of brief interventions for drug abusing teenagers within a middle and high school setting. *Journal of School Health*. 2007;77(4):196-206.
27. Carney T, Myers B. Effectiveness of early interventions for substance-using adolescents: findings from a systematic review and meta-analysis. *Subst Abuse Treat Prev Policy*. 2012;7(1):1-15.
28. Toumbourou JW, Stockwell T, Neighbors C, Marlatt GA, Sturge J, Rehm J. Interventions to reduce harm associated with adolescent substance use. *The Lancet*. 2007;369(9570):1391-1401.
29. Clark DB, Moss HB. Providing Alcohol-Related Screening and Brief Interventions to Adolescents through Health Care Systems: Obstacles and Solutions. *PLoS medicine*. 2010;7(3):e1000214.

30. Bender K, Tripodi SJ, Sarteschi C, Vaughn MG. A Meta-Analysis of Interventions to Reduce Adolescent Cannabis Use. *Research on Social Work Practice*. 2011;21(2):153-164.
31. Tanner-Smith EE, Lipsey MW. Brief alcohol interventions for adolescents and young adults: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment*. 2015;21:1-18.
32. D'Amico EJ, Miles JNV, Stern SA, Meredith LS. Brief motivational interviewing for teens at risk of substance use consequences: A randomized pilot study in a primary care clinic. *Journal of Substance Abuse Treatment*. 2008;35(1):53-61.
33. Tripodi SJ, Bender K, Litschge C, Vaughn MG. Interventions for reducing adolescent alcohol abuse: A meta-analytic review. *Archives of Pediatrics & Adolescent Medicine*. 2010;164(1):85-91.
34. Baer JS, Garrett SB, Beadnell B, Wells EA, Peterson PL. Brief motivational intervention with homeless adolescents: Evaluating effects on substance use and service utilization. *Psychology of Addictive Behaviors*. 2007;21(4):582-586.
35. Martin G, Copeland J. The adolescent cannabis check-up: Randomized trial of a brief intervention for young cannabis users. *Journal of Substance Abuse Treatment*. 2008;34(4):407-414.
36. Elster A, Kuznets N. *Guidelines for adolescent preventive services*. Baltimore, MD: American Medical Association;1994.
37. Levy SJ, Williams JF, AAP Committee on Substance Use and Prevention. Substance Use Screening, Brief Intervention, and Referral to Treatment. *Pediatrics* 2016;138(1).
38. Committee on Substance Abuse. Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians. *American Academy of Pediatrics*. 2011;128(5):e1330-e1340.
39. American Academy of Pediatrics Committee on Substance Abuse. Policy Statement - Alcohol Use by Youth and Adolescents: A Pediatric Concern. *Pediatrics*. 2010;125(5):1078-1087.
40. U.S. DHHS. The Surgeon General's call to action to prevent and reduce underage drinking. In: Office of the Surgeon General, ed. Washington, DC: US Department of Health and Human Services; 2007.
41. Babor TF, McRee BG, Kassebaum PA, Grimaldi PL, Ahmed K, Bray J. Screening, Brief Intervention, and Referral to Treatment (SBIRT) toward a public health approach to the management of substance abuse. *Substance abuse*. 2007;28(3):7-30.
42. National Institute on Alcohol Abuse and Alcoholism. *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide*. Bethesda, MD: US Dept of Health and Human Services; 2011.
43. Croft B, Parish SL. Care Integration in the Patient Protection and Affordable Care Act: Implications for Behavioral Health. *Administration and Policy in Mental Health and Mental Health Services Research*. 2013;40(4):258-263.
44. Centers for Medicare and Medicaid Service Informational Bulletin. Prevention and Early Identification of Mental Health and Substance Use. March 2, 2013.
45. Center for Medicare and Medicaid Services. Early and Periodic Screening, Diagnostic, and Treatment. <http://www.medicare.gov/Medicare-CHIP-Program-Information/By->

[Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html](#). Accessed January 27, 2014.

46. Fornili K, Alemi F. Medicaid reimbursement for screening and brief intervention: amending the Medicaid state plan and approving state appropriations for the Medicaid state match. *Journal of Addictions Nursing*. 2007;18(4):225-232.
47. Centers for Disease Control and Prevention. Fact Sheets - Underage Drinking. 2014; <http://www.cdc.gov/alcohol/fact-sheets/underage-drinking.htm>. Accessed October 5, 2015.
48. National Institute on Alcohol Abuse and Alcoholism. *Why do adolescents drink, what are the risks, and how can underage drinking be prevented?* Bethesda, MD: NIAAA;2006. 67.
49. Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE, Miech RA. *Monitoring the Future national survey results on drug use, 1975-2015: Volume II, college students and adults ages 19-55*. 2016.
50. Johnston LD, O'Malley PM, Bachman JG, Schulenburg JE. *Monitoring the Future national results on drug use: 2012 Overview, Key Findings on Adolescent Drug Use*. Ann Arbor: Institute for Social Research, The University of Michigan;2013.
51. Squeglia LM, Jacobus J, Tapert SF. The influence of substance use on adolescent brain development. *Clinical EEG and neuroscience*. 2009;40(1):31-38.
52. Fields J, Teitelbaum S. The Physician's Approach to Substance Use in Adolescents. *Northeast Florida Medicine*. 2012;63(1).
53. Miller JW, Naimi TS, Brewer RD, Jones SE. Binge drinking and associated health risk behaviors among high school students. *Pediatrics*. 2007;119(1):76-85.
54. Eggleston A. Substance Use Prevention & Early Intervention Strategic Initiative. Paper presented at: SBIRT webinar series;2015.
55. Lipari RN, Park-Lee E, Van Horn S. America's need for and receipt of substance use treatment in 2015. *Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration*. 2016.
56. Substance Abuse and Mental Health Services Administration. Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-45, HHS Publication No.(SMA) 12-4725. Rockville, MD. *Substance Abuse and Mental Health Services Administration*; 2012.
57. Dennis ML, Clark HW, Huang LN. The need and opportunity to expand substance use disorder treatment in school-based settings. *Advances in School Mental Health Promotion*. 2014;7(2):75-87.
58. National Institute for Alcohol Abuse and Alcoholism. *Helping Patients Who Drink Too Much: A Clinician's Guide*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism;2015.
59. National Institute on Alcohol Abuse and Alcoholism. *Rethinking Drinking: Alcohol and Your Health*. Rockville, MD;2009.
60. Hanes M. Effects and Consequences of Underage Drinking. *Juvenile Justice Bulletin*. 2012.

61. SAMHSA pushes SBI to address baby-boomer drug use. *Alcoholism & Drug Abuse Weekly*. 2010;22(3):1-3.
62. Substance Abuse and Mental Health Services Administration. *Results from the 2006 National Survey on Drug Use and Health: National Findings*. Rockville, MD;2007.
63. Substance Abuse and Mental Health Services Administration. *Issue Brief #5 for Employers: Save Your Company Money By Assuring Access to Substance Abuse Treatment*. Rockville, MD;2008.
64. Knight JR, Sherritt L, Harris SK, Gates EC, Chang G. Validity of brief alcohol screening tests among adolescents: a comparison of the AUDIT, POSIT, CAGE, and CRAFFT. *Alcoholism: Clinical and experimental research*. 2003;27(1):67-73.
65. Crocker K. Adolescent Substance Abuse: How to Interview and Assess in the Primary Care Setting. *The Journal for Nurse Practitioners*. 2015;11(4):471-472.
66. Harris SK, Knight JR, Van Hook S, et al. Adolescent substance use screening in primary care: validity of computer self-administered vs. clinician-administered screening. *Substance Abuse*. 2016;37(1):197-203. .
67. Kroenke K, Spitzer RL, Williams JBW. The PHQ-9: Validity of a Brief Depression Severity Measure. *Journal of General Internal Medicine*. 2001;16(9):606-613.
68. Miller WR, Hedrick KE, Orlofsky DR. The Helpful Responses Questionnaire: A procedure for measuring therapeutic empathy. *Journal of Clinical Psychology*. 1991.
69. Van De Looij-Jansen PM, De Wilde EJ. Comparison of Web-Based versus Paper-and-Pencil Self-Administered Questionnaire: Effects on Health Indicators in Dutch Adolescents. *Health Serv Res*. 2008;43(5p1):1708-1721.
70. Winters KC, Kaminer Y. Screening and assessing adolescent substance use disorders in clinical populations. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2008;47(7):740-744.
71. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent Medicine*. 2002;156(6):607-614.
72. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. *Archives of Pediatrics & Adolescent Medicine*. 1999;153(6):591-596.
73. Kelly TM, Donovan JE, Chung T, Cook RL, Delbridge TR. Alcohol Use Disorders Among Emergency Department–Treated Older Adolescents: A New Brief Screen (RUFT-Cut) Using the AUDIT, CAGE, CRAFFT, and RAPS-QF. *Alcoholism: Clinical and Experimental Research*. 2004;28(5):746-753.
74. Subramaniam M, Cheok C, Verma S, Wong J, Chong SA. Validity of a brief screening instrument—CRAFFT in a multiethnic Asian population. *Addictive Behaviors*. 2010;35(12):1102-1104.
75. Levy SJ, Kokotailo PK. Substance use screening, brief intervention, and referral to treatment for pediatricians. *Pediatrics*. 2011;128(5):e1330-e1340.
76. Harris SK SL, Copelas S, Knight John Rogers. *Reliability and validity of past-12-month use frequency items as opening questions for the updated CRAFFT adolescent substance use screening system*. Lausanne, Switzerland: 2016.

77. Couper MP, Tourangeau R, Conrad FG, Zhang C. The Design of Grids in Web Surveys. *Social Science Computer Review*. 2013;31(3):322-345.
78. Chung T, Colby SM, Barnett NP, Rohsenow DJ, Spirito A, Monti PM. Screening adolescents for problem drinking: performance of brief screens against DSM-IV alcohol diagnoses. *J*. 2000;61(4):579-587.
79. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. *The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care*. World Health Organization;2001.
80. Lincoln P. Low-risk drinking guidelines: Where do the numbers come from? *Institute for Research, Education, and Training in Addictions Blog*;2013.
81. Fairlie AM, Sindelar HA, Eaton CA, Spirito A. Utility of the AUDIT for screening adolescents for problematic alcohol use in the emergency department. *International Journal of Adolescent Medicine and Health*. 2006;18(1):115-122.
82. Dennis ML, Chan Y-F, Funk RR. Development and Validation of the GAIN Short Screener (GSS) for Internalizing, Externalizing and Substance Use Disorders and Crime/Violence Problems Among Adolescents and Adults. *The American Journal on Addictions*. 2006;15 Suppl 1:s80-s91.
83. 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.
84. Levy S, Shrier L. *Adolescent SBIRT Toolkit for Providers*. Boston, MA: Boston Children's Hospital;2014.
85. Skinner HA. The drug abuse screening test. *Addictive behaviors*. 1982;7(4):363-371.
86. Substance Abuse and Mental Health Services Administration. Screening Tools. 2016; <http://www.integration.samhsa.gov/clinical-practice/screening-tools>. Accessed August 2, 2016.
87. 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.
88. National Institute on Drug Abuse. American Psychiatric Association Adapted NIDA Modified ASSIST Tools; <https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/american-psychiatric-association-adapted-nida>. Accessed August 2, 2016.
89. National Institute on Drug Abuse. *Screening for drug use in general medical settings: Resource Guide*. US DHHS NIH;2012.
90. National Institute for Alcohol Abuse and Alcoholism. *Assessing Alcohol Problems: A Guide for Clinicians and Researchers*. Bethesda, MD: U.S. Department of Health and Human Services;2003.
91. Harris SK, Csemy L, Sherritt L, et al. Computer-facilitated substance use screening and brief advice for teens in primary care: an international trial. *Pediatrics*. 2012;129(6):1072-1082.
92. Babor TF, Higgins-Biddle JC. *Brief intervention for hazardous and harmful drinking: a manual for use in primary care*;2001.

93. Hennessy EA, Tanner-Smith EE. Effectiveness of brief school-based interventions for adolescents: A meta-analysis of alcohol use prevention programs. *Prev Sci*. 2015;16(3):463-474.
94. Mitchell SG, Gryczynski J, O'Grady KE, Schwartz RP. SBIRT for adolescent drug and alcohol use: current status and future directions. *J Subst Abuse Treat*. 2013;44(5):463-472.
95. Yuma-Guerrero PJ, Lawson KA, Velasquez MM, von Sternberg K, Maxson T, Garcia N. Screening, brief intervention, and referral for alcohol use in adolescents: a systematic review. *Pediatrics*. 2012;130(1):115-122.
96. Bernstein E, Edwards E, Dorfman D, Heeren T, Bliss C, Bernstein J. Screening and Brief Intervention to Reduce Marijuana Use Among Youth and Young Adults in a Pediatric Emergency Department. *Acad Emerg Med*. 2009;16(11):1174-1185.
97. Schermer CR, Moyers TB, Miller WR, Bloomfield LA. Trauma center brief interventions for alcohol disorders decrease subsequent driving under the influence arrests. *Journal of Trauma and Acute Care Surgery*. 2006;60(1):29-34.
98. Burke BL, Arkowitz H, Menchola M. The efficacy of Motivational Interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology*. 2003;71(5):843-861.
99. Bertholet N, Daepfen JB, Wietlisbach V, Fleming M, Burnand B. Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis. *Archives of Internal Medicine*. 2005;165(9):986-995.
100. Samson JE, Tanner-Smith EE. Single-session alcohol interventions for heavy drinking college students: a systematic review and meta-analysis. *Journal of studies on alcohol and drugs*. 2015;76(4):530-543.
101. Jonas DE, Garbutt JC, Amick HR, et al. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the US Preventive Services Task Force. *Annals of internal medicine*. 2012;157(9):645-654.
102. Goldstein MG, Whitlock EP, DePue J. Multiple behavioral risk factor interventions in primary care: summary of research evidence. *Am J Prev Med*. 2004;27(2):61-79.
103. Moyer A, Finney JW. Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction*. 2002;97(3):p279-292.
104. Gentilello LM, Rivara FP, Donovan DM, et al. Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery*. 1999;230(4):473.
105. Boston University School of Public Health TBAI. A leader in using SBIRT for health care settings. <http://www.bu.edu/bniart/>. Accessed November 23, 2015.
106. Miller WR, Rollnick S. *Motivational interviewing: Helping people change*. Guilford press; 2012.
107. D'Onofrio G, Pantalon MV, Degutis LC, et al. Brief Intervention for Hazardous and Harmful Drinkers in the Emergency Department. *Annals of Emergency Medicine*. 2008;51(6):742-750.e742.
108. Pringle J, Seale P, Bray J. *SBIRT Proficiency Checklist Validation Study Pittsburgh, PA: University of Pittsburgh School of Pharmacy;2014.*

109. Pringle JL, Seale JP, Shellenberger S, et al. Development and evaluation of two instruments for assessing screening, brief intervention, and referral to treatment (SBIRT) competency. *Substance abuse*. 2017;38(1):43-47.
110. Vendetti JA, McRee BG, Del Boca FK. Development of the SBIRT checklist for observation in real-time (SCORE). *Addiction*. 2017;112(S2):34-42.
111. Substance Abuse and Mental Health Services Administration CfBHSaQ. *Treatment Episode Data Set (TEDS): 2004-2014. National Admissions to Substance Abuse Treatment Services*. 2016.
112. Hingson RW, Heeren T, MR W. Age at drinking onset and alcohol dependence: age at onset, duration, and severity. *Archives of Pediatrics & Adolescent Medicine*. 2006;160(7):739-746.
113. Sterling S, Valkanoff T, Hinman A, Weisner C. Integrating substance use treatment into adolescent health care. *Current Psychiatry Reports*. 2012;14(5):453-461.
114. Bryant AL, Schulenberg JE, O'Malley PM, Bachman JG, Johnston LD. How Academic Achievement, Attitudes, and Behaviors Relate to the Course of Substance Use During Adolescence: A 6-Year, Multiwave National Longitudinal Study. *Journal of Research on Adolescence*. 2003;13(3):361-397.
115. Gustafson DH, Resar R, Johnson K, Daigle JG. Don't fumble the treatment handoff: Organizations need a systematic approach to ensure clients' smooth transition between levels of care. *Addiction Professional*. Sept/Oct 2008.
116. Office of Applied Studies. *Treatment Episode Data Set (TEDS). Highlights - 2004. National Admissions to Substance Abuse Treatment Services*. Rockville, MD: Substance Abuse and Mental Health Services Administration;2006.
117. American Society of Addiction Medicine. *ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders*. Chevy Chase, MD;2001.
118. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*. Rockville, MD: Substance Abuse and Mental Health Services Administration;2014.
119. Katzenellenbogen R. HEADSS: The "Review of Systems" for Adolescents. *The virtual mentor : VM*. 2005;7(3).
120. Winters KC, Tanner-Smith EE, Bresani E, Meyers K. Current advances in the treatment of adolescent drug use. *Adolescent Health, Medicine and Therapeutics*. 2014;5:199.
121. University of Pittsburgh School of Pharmacy. SBIRT Medical and Residency Training: Referral to Treatment PowerPoint Presentation;2011.
122. Workers NAoS. Code of ethics of the national association of social workers. 2008; <http://www.socialworkers.org/pubs/code/code.asp>. Accessed August 2, 2016.
123. American Nurses Association. Code of Ethics for Nurses. 2015; <http://www.nursingworld.org/codeofethics>. Accessed August 2, 2016.
124. Williams RJ, Chang SY. A Comprehensive and Comparative Review of Adolescent Substance Abuse Treatment Outcome. *Clinical Psychology: Science and Practice*. 2000;7(2):138-166.

125. Tanner-Smith EE, Wilson SJ, Lipsey MW. The comparative effectiveness of outpatient treatment for adolescent substance abuse: A meta-analysis. *Journal of Substance Abuse Treatment*. 2013;44(2):145-158.
126. Stark MM, Campbell BB, Brinkerhoff CC. "Hello, may we help you?" A study of attrition prevention at the time of the first phone contact with substance-abusing clients. *The American Journal of Drug and Alcohol Abuse*. 1990;16(1-2):67-76.
127. Gariti P, Alterman AI, Holub-Beyer E, Volpicelli JR, Prentice N, O'Brien CP. Effects of an appointment reminder call on patient show rates. *Journal of Substance Abuse Treatment*. 1995;12(3):207-212.
128. Festinger DS, Lamb R, Kountz MR, Kirby KC, Marlowe D. Pretreatment dropout as a function of treatment delay and client variables. *Addictive Behaviors*. 1995;20(1):111-115.
129. Leigh G, Ogborne AC, Cleland P. Factors associated with patient dropout from an outpatient alcoholism treatment service. *J*. 1984;45(4):359-362.
130. Rees DW, Beech HR, Hore BD. Some factors associated with compliance in the treatment of alcoholism. *Alcohol and Alcoholism*. 1984;19(4):303-307.
131. Woody G, O'Hare K, Mintz J, O'Brien C. Rapid intake: A method for increasing retention rate of heroin addicts seeking methadone treatment. *Comprehensive Psychiatry*. 1975;16(2):165-169.
132. RTI International, America USo, SAMHSA OoAS, America USo. Results From the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings. 2010.
133. Substance Abuse and Mental Health Services Administration. *Incorporating Alcohol Pharmacotherapies into Medical Practice. Treatment Improvement Protocol (TIP) Series 49*. Rockville, MD;2009.
134. The BIG Initiative. *The Employee Assistance Professional's Guide to Screening, Brief Intervention and Treatment*. Washington, DC: The BIG Initiative;2011.
135. Mid-America A. *Psychotherapeutic Medications 2008: What Every Counselor Should Know*. Kansas City, MO: Mid-America Addiction Technology Transfer Center; 2008.
136. Soderstrom CA, DiClemente CC, Dischinger PC, et al. A controlled trial of brief intervention versus brief advice for at-risk drinking trauma center patients. *Journal of Trauma and Acute Care Surgery*. 2007;62(5):1102-1112.
137. Sommers MS, Dyehouse JM, Howe SR, Fleming M, Fargo JD, Schafer JC. Effectiveness of brief interventions after alcohol-related vehicular injury: a randomized controlled trial. *Journal of Trauma and Acute Care Surgery*. 2006;61(3):523-533.
138. Longabaugh R, Woolard R, Nirenberg TD, et al. Evaluating the effects of a brief motivational intervention for injured drinkers in the emergency department. *J*. 2001;62(6):806-816.
139. Scott C, Dennis M. *Recovery Management Checkups: An early re-intervention model*. Chicago, IL;2003.
140. Scott CK, Dennis ML, Foss MA. Utilizing recovery management checkups to shorten the cycle of relapse, treatment reentry, and recovery. *Drug and Alcohol Dependence*. 2005;78(3):325-338.

141. Scott CK, Dennis ML. Results from two randomized clinical trials evaluating the impact of quarterly recovery management checkups with adult chronic substance users. *Addiction*. 2009;104(6):959-971.
142. Scott CK, Dennis ML. Recovery management checkups with adult chronic substance users. In: Kelly JF, White WL, eds. *Addiction Recovery Management*. New York: Springer; 2011:87-101.
143. Miller WR, Rollnick. S. *Motivational Interviewing: Preparing People for Change*. 2 ed. New York: Guilford Press; 2002.
144. Rollnick S, Miller WR, Butler CC. *Motivational Interviewing in Health Care*. New York: Guilford Press; 2008.
145. Miller WR, White W. Confrontation in Addiction Treatment. *Counselor Magazine*. 2007.
146. DiClemente CC. Natural Change and the Troublesome Use of Substances: A Life-Course Perspective. In: Miller WR, Carroll KM, eds. *Rethinking substance abuse: What the science shows, and what we should do about it*. New York: Guilford Press; 2006:81-96.
147. Prochaska JO, Norcross JC, DiClemente CC. *Changing for good*. New York: Avon Books; 1995.
148. DiClemente CC. *Addiction and change: How addictions develop and addicted people recover*. New York: Guilford Press; 2006.
149. DiClemente CC, Schlundt D, Gemmell L. Readiness and stages of change in addiction treatment. *Am J Addict*. 2004;13(2):103-119.
150. ATTC NS. SBIRT Training Slide Deck.
151. Miller WR, Benefield RG, Tonigan JS. Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology*. 1993;61(3):455.
152. Miller WR, Yahne CE, Tonigan JS. Motivational interviewing in drug abuse services: a randomized trial. *Journal of Consulting and Clinical Psychology*. 2003;71(4):754.
153. Rogers CR. *Client-centered therapy: Its current practice, implications and theory*. Boston: Houghton Mifflin; 1951.
154. Rogers CR. Significant Aspects of Client-centered Therapy. *American Psychologist*. 1946;1:415-422.
155. Patterson G, Forgatch M. Therapist behavior as a determinant for client noncompliance: a paradox for the behavior modifier. *Journal of consulting and clinical psychology*. 1985;53(6):846.
156. Winters KC, Botzet A, Fahnhorst T. Adolescent drug abuse treatment: Family and related approaches. In: Scheier LM, Hansen WB, eds. *Parenting and teen drug use*. New York: Oxford; 2014:193-213.
157. Chamberlain P, Patterson G, Reid J, Kavanagh K, Forgatch M. Observation of client resistance. *Behav Therapy*. 1984;15(2):144-155.

Appendices

Appendix A. Screening Tools

CRAFFT

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 <u>alcohol</u> (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Smoke any <u>marijuana or hashish</u> ?	<input type="checkbox"/>	<input type="checkbox"/>
3. Use <u>anything else</u> to get high? (“anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”)	<input type="checkbox"/>	<input type="checkbox"/>

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

No

Yes

↓
Ask CAR question only, then stop

↓
Ask all 6 CRAFFT questions

Part B

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

CONFIDENTIALITY NOTICE:

The information recorded on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

© CHILDREN’S HOSPITAL BOSTON, 2009. ALL RIGHTS RESERVED.

Reproduced with permission from the Center for Adolescent Substance Abuse Research, CeASAR, Children’s Hospital Boston. (www.ceasar.org)

Las Preguntas CARLOS (CRAFFT)

Por favor responda a todas las preguntas con la mayor sinceridad posible; sus respuestas serán tratadas de forma confidencial

Parte A

Durante los últimos doce meses:

- | | No | | Sí |
|--|--------------------------|--|--------------------------|
| 1. ¿Ha consumido <u>bebidas alcohólicas</u> (más de unos pocos sorbos)? | <input type="checkbox"/> | } Si respondió con un NO las tres primeras preguntas (A1, A2, A3), pase ahora a la pregunta B1 | <input type="checkbox"/> |
| 2. ¿Ha fumado <u>marijuana</u> o probado <u>hachís</u> ? | <input type="checkbox"/> | | <input type="checkbox"/> |
| 3. ¿Ha usado <u>algún otro tipo</u> de sustancias que alteren su estado de ánimo o de conciencia?
El término "algún otro tipo" se refiere a drogas ilícitas, medicamentos de venta libre o de venta con receta médica, así como a sustancias inhalables que alteren su estado mental. | <input type="checkbox"/> | | <input type="checkbox"/> |

Si respondió con un SÍ a CUALQUIERA de las tres primeras preguntas (A1, A2, A3), pase ahora a las preguntas B1 a B6

Parte B (CARLOS)

- | | No | Sí |
|--|--------------------------|--------------------------|
| 1. ¿Ha viajado, alguna vez, en un <u>CARRO</u> o vehículo conducido por una persona (incluyéndolo a usted) que haya consumido alcohol, drogas o sustancias psicoactivas? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ¿Le han sugerido, alguna vez, sus <u>AMIGOS</u> o su familia que disminuya el consumo de alcohol, drogas o sustancias psicoactivas? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. ¿Ha usado, alguna vez, bebidas alcohólicas, drogas o sustancias psicoactivas para <u>RELAJARSE</u> , para sentirse mejor consigo mismo o para integrarse a un grupo? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. ¿Se ha metido, alguna vez, en <u>LIOS</u> o problemas al tomar alcohol, drogas o sustancias psicoactivas? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. ¿Ha <u>OLVIDADO</u> , alguna vez, lo que hizo al tomar alcohol, drogas o sustancias psicoactivas? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. ¿Ha consumido, alguna vez, alcohol, drogas o alguna sustancia psicoactiva, encontrándose <u>SOLO</u> y sin compañía? | <input type="checkbox"/> | <input type="checkbox"/> |

NOTA SOBRE EL CARÁCTER CONFIDENCIAL DE LA INFORMACIÓN

La información incluida en esta página puede estar protegida por normas federales sobre confidencialidad (42 CFR Parte 2) que prohíben su divulgación, a no ser que medie una autorización escrita para el caso específico. NO basta con que se cuente con una autorización generalizada en materia de divulgación de la información médica.

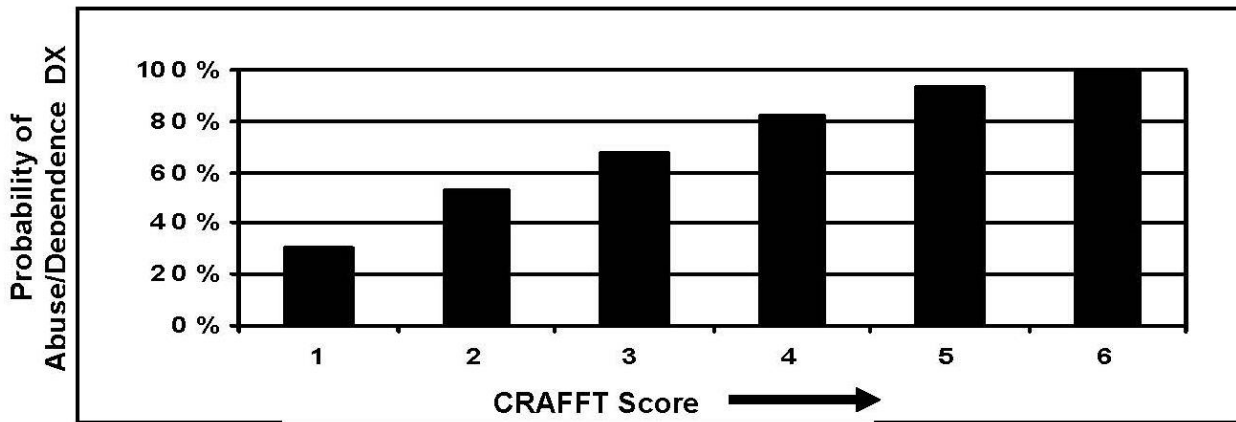
© Children's Hospital Boston, 2009.

Reproducción autorizada por el Center for Adolescent Substance Abuse Research, CeASAR, Children's Hospital Boston. La reproducción CRAFFT fue posible, gracias al apoyo de la Massachusetts Behavioral Health Partnership.

SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each “yes” response in **Part B** scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score^{1,2}



DSM-IV Diagnostic Criteria³ (Abbreviated)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

© Children’s Hospital Boston, 2009. This form may be reproduced in its exact form for use in clinical settings, courtesy of the Center for Adolescent Substance Abuse Research, Children’s Hospital Boston, 300 Longwood Ave, Boston, MA 02115, U.S.A., (617) 355-5433, www.ceasar.org.

References:

1. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-6.
2. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Arch Pediatr Adolesc Med 2002;156(6):607-14.
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision. Washington DC, American Psychiatric Association, 2000.

CRAFFT 2.0 – Clinician Interview

The CRAFFT Interview (version 2.0)

To be orally administered by the clinician

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, on how many days did you:

- | | |
|---|-----------|
| 1. Drink more than a few sips of beer, wine, or any drink containing alcohol? Say “0” if none. | # of days |
| 2. Use any marijuana (pot, weed, hash, or in foods) or “ synthetic marijuana ” (like “K2” or “Spice”)? Say “0” if none. | # of days |
| 3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or “huff”)? Say “0” if none. | # of days |

Did the patient answer “0” for all questions in Part A?

Yes



Ask CAR question only, then stop

No



Ask all six CRAFFT* questions below

Part B	No	Yes
C Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
R Do you ever use alcohol or drugs to RELAX , feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
A Do you ever use alcohol or drugs while you are by yourself, or ALONE ?	<input type="checkbox"/>	<input type="checkbox"/>
F Do you ever FORGET things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
F Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
T Have you ever gotten into TROUBLE while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

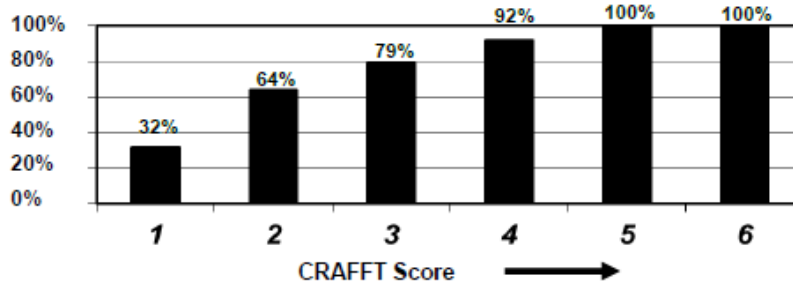
***Two or more YES answers suggest a serious problem and need for further assessment. See back for further instructions →**

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

1. Show your patient his/her score on this graph and discuss level of risk for a substance use disorder.

Percent with a DSM-5 Substance Use Disorder by CRAFFT score*



*Data source: Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: a reevaluation and reexamination. *Substance Abuse*, 35(4), 376–80.

2. Use these talking points for brief counseling.



1. **REVIEW** screening results
For each "yes" response: "Can you tell me more about that?"



2. **RECOMMEND** not to use
"As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, marijuana or other drug because they can: 1) Harm your developing brain; 2) Interfere with learning and memory, and 3) Put you in embarrassing or dangerous situations."



3. **RIDING/DRIVING** risk counseling
"Motor vehicle crashes are the leading cause of death for young people. I give all my patients the Contract for Life. Please take it home and discuss it with your parents/guardians to create a plan for safe rides home."



4. **RESPONSE** elicit self-motivational statements
Non-users: "If someone asked you why you don't drink or use drugs, what would you say?" Users: "What would be some of the benefits of not using?"



5. **REINFORCE** self-efficacy
"I believe you have what it takes to keep alcohol and drugs from getting in the way of achieving your goals."

3. Give patient Contract for Life. Available at www.crafft.org/contract

© John R. Knight, MD, Boston Children's Hospital, 2016.
Reproduced with permission from the Center for Adolescent Substance Abuse Research (CeASAR), Boston Children's Hospital.

(617) 355-5433 www.ceasar.org

For more information and versions in other languages, see www.ceasar.org.

CRAFFT 2.0 – Self-Administered

The CRAFFT Questionnaire (version 2.0)

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the **PAST 12 MONTHS**, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing alcohol ? Put "0" if none.	<input type="text"/> # of days
2. Use any marijuana (pot, weed, hash, or in foods) or " synthetic marijuana " (like "K2" or "Spice")? Put "0" if none.	<input type="text"/> # of days
3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or "huff")? Put "0" if none.	<input type="text"/> # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.
- If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.

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

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

© John R. Knight, MD, Boston Children's Hospital, 2016.

Reproduced with permission from the Center for Adolescent Substance Abuse Research (CeASAR), Boston Children's Hospital.
For more information and versions in other languages, see www.ceasar.org

42 CFR PART 2 CONSENT TO DISCLOSURE OF INFORMATION THAT IS PROTECTED BY FEDERAL LAW

Clinicians involved in the care of patients with substance use issues need to be aware of federal confidentiality laws around the disclosure of information concerning drug and alcohol treatment, specifically 42 CFR Part 2. Substance use history, assessment, laboratory data and treatment plans can only be released if a patient, or a minor patient's parent, signs a specialized 42 CFR Part 2 compliant release form. Importantly, this release only applies to the person or organization named on the signed consent. The patient's information cannot be forwarded or re-released without a new, signed form naming additional care providers or recipients. This also applies when a primary care provider refers a patient for a substance abuse evaluation or treatment. A consultation note cannot be shared without a signed formal 42 CFR Part 2 compliant release of information.

INSTRUCTIONS:

1. Complete this line in the patient's or minor patient's parent's name.
2. Fill in the name, address and phone number of the clinician who is being granted permission by the patient or minor patient's parent to release the specified protected health information.
3. Fill in the name, address and phone number of the individual, clinician or organization who is granted permission by the patient or minor patient's parent to receive the specified protected health information.
4. Please specify the specific protected health information that is covered under this release.
5. Indicate the date upon which this release will expire and after which the clinician named in #2 will no longer have permission to release the specified protected health information.
6. Please sign and date the Release Form.

Rev: 09/21/2017

42 CFR PART 2 CONSENT TO DISCLOSURE OF INFORMATION THAT IS PROTECTED BY FEDERAL LAW

YOU MAY NOT RE-RELEASE THIS INFORMATION TO ANY OTHER PARTY WITHOUT ADDITIONAL SIGNED PERMISSION FROM THE PATIENT OR PARENT WHO AUTHORIZED THE INITIAL DISCLOSURE TO YOU.

1. I, _____
(print or type name)

HEREBY CONSENT TO THE DISCLOSURE HEREINAFTER DESCRIBED AND AUTHORIZE THAT IT BE MADE.

2. DISCLOSURE IS TO BE MADE BY: (name, address and telephone number)

3. DISCLOSURE IS TO BE MADE TO: (name, address and telephone number)

4. THE DISCLOSURE CONSISTS OF THE FOLLOWING INFORMATION CONCERNING THE UNDERSIGNED/THE UNDERSIGNED'S MINOR CHILD:

5. THIS CONSENT WILL TERMINATE UPON THE FOLLOWING DATE, EVENT, OR CONDITION:

6. THIS CONSENT IS SIGNED ON: (Date) _____
SIGNATURE _____
PRINTED/TYPED NAME _____

CRAFTT Pocket Guides

CRAFTT is a mnemonic acronym of first letters of key words in the 6 screening questions. The questions should be asked exactly as written.

- C** Have you ever ridden in a **CAR** driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- R** Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
- A** Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?
- F** Do you ever **FORGET** things you did while using alcohol or drugs?
- F** Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
- T** Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

Screening Adolescents for Alcohol and Drugs

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? (“anything else” includes illegal drugs, synthetic marijuana, over-the-counter and prescription drugs, and things that you sniff or “huff”.)

AVOID Any YES

4. Ask **CAR** question only *CRAFTT Screen (below)

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

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

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

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

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

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

*Two or more **YES** answers on the CRAFTT suggest a serious problem and a need for further assessment.

Referral Information for Comprehensive Assessment:
 SAMHSA’s Toll-Free Referral Helpline: 1-800-462-4357
 Or <http://treatment.samhsa.gov/>
 © Copyright, John R. Knight, MD, Boston Children’s Hospital, 2015.

1. Show your patient his/her score on the graph
 Probability of a Substance Use Disorder

CRAFTT Score →

2. Talking Points for Clinician Counseling

No Use

- Not using drugs and alcohol is a smart decision for your health. You should be proud of yourself. If that ever changes, I hope you feel free enough that we can talk about it.

Any Use

- My recommendation is your doctor is not to use drugs or alcohol at all.
- I am quite concerned about you. Let’s plan a follow-up meeting in about a month.

3. Counseling Points for All

- Alcohol and drugs affect brain development, which continues into your mid-20s.
- Early alcohol and drug use greatly increases your risk for developing addiction, major depression, anxiety disorders, and psychotic thinking.
- Alcohol can hurt and seal your liver; marijuana can hurt your lungs.
- Alcohol and drugs are slower car crashes. Marijuana impairs driving just as much as alcohol does, and its effects last longer.

4. Give each patient the Contract for Life.
<http://www.sadd.org/contract.html>

The Center for Adolescent Substance Abuse Research (CeASAR) at Boston Children’s Hospital
 617-355-5433 www.ceasar.org
 © Copyright, John R. Knight, MD, Boston Children’s Hospital, 2015.

Red laminated 4x5
 CRAFTT Pocket Cards can
 be ordered from Boston
 Children’s Hospital:
<http://craftt.org/>

AUDIT-C and AUDIT

Read questions as written. Record answers carefully. Begin the AUDIT by saying “I am going to ask you some questions about your use of alcoholic beverages during this past year.” Code answers in terms of “standard drinks.” Place the correct answer number in the box at the right.

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	
3. How often do you have 5 (for men age 65 and under) / 4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<i>AUDIT-C Score (add items 1-3):</i>						
<i>Adolescents Positive Screen= 1</i>						
<i>Young adults/Adults age 18+ Positive Screen= 4 for men/3 for women</i>						
<i>If positive, ask the next 7 questions to administer the full AUDIT.</i>						
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
AUDIT Score (add items 1-10)						

GAIN-SS



GAIN Short Screener (GAIN-SS) Version [GVER]: GAIN-SS ver. 3.0

What is your name? a. _____ b. _____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|_| / |__|_| / 20 |__|_|

<p>The following questions are about common psychological, behavioral, and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.</p> <p>After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.</p>	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

- IDScr 1. When was the last time that you had significant problems with...**
- a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?..... 4 3 2 1 0
 - b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?..... 4 3 2 1 0
 - c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?..... 4 3 2 1 0
 - d. becoming very distressed and upset when something reminded you of the past?..... 4 3 2 1 0
 - e. thinking about ending your life or committing suicide?..... 4 3 2 1 0
 - f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?..... 4 3 2 1 0
- EDScr 2. When was the last time that you did the following things two or more times?**
- a. Lied or conned to get things you wanted or to avoid having to do something..... 4 3 2 1 0
 - b. Had a hard time paying attention at school, work, or home..... 4 3 2 1 0
 - c. Had a hard time listening to instructions at school, work, or home..... 4 3 2 1 0
 - d. Had a hard time waiting for your turn..... 4 3 2 1 0
 - e. Were a bully or threatened other people..... 4 3 2 1 0
 - f. Started physical fights with other people..... 4 3 2 1 0
 - g. Tried to win back your gambling losses by going back another day..... 4 3 2 1 0
- SDScr 3. When was the last time that...**
- a. you used alcohol or other drugs weekly or more often?..... 4 3 2 1 0
 - b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?..... 4 3 2 1 0
 - c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?..... 4 3 2 1 0
 - d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?..... 4 3 2 1 0
 - e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?..... 4 3 2 1 0



(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

- CVScr 4. **When was the last time that you...**
- a. had a disagreement in which you pushed, grabbed, or shoved someone?.....4 3 2 1 0
 - b. took something from a store without paying for it?4 3 2 1 0
 - c. sold, distributed, or helped to make illegal drugs?.....4 3 2 1 0
 - d. drove a vehicle while under the influence of alcohol or illegal drugs?.....4 3 2 1 0
 - e. purposely damaged or destroyed property that did not belong to you?.....4 3 2 1 0
5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) Yes No
 1 0
- v1. _____
6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other
 v1. _____
7. How old are you today? Age
- 7a. How many minutes did it take you to complete this survey? Minutes

Staff Use Only						
8. Site ID: _____		Site name v. _____				
9. Staff ID: _____		Staff name v. _____				
10. Client ID: _____		Comment v. _____				
11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered						
13. Referral: MH ___ SA ___ ANG ___ Other ___ 14. Referral codes: _____						
15. Referral comments: v1. _____						
Scoring						
Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)	
IDScr	1a – 1f					
EDScr	2a – 2g					
SDScr	3a – 3e					
CVScr	4a – 4e					
TDSr	1a – 4e					

GAIN-SS copyright © Chestnut Health Systems. For more information on this instrument, please visit <http://www.gaincc.org> or contact the GAIN Project Coordination Team at (309) 451-7900 or GAINInfo@chestnut.org

S2BI: Screening to Brief Intervention In the past year, how many times have you used	
<ul style="list-style-type: none">• Tobacco?• Alcohol?• Marijuana? <p>STOP if all "Never." Otherwise, CONTINUE.</p> <ul style="list-style-type: none">• Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?• Illegal drugs (such as cocaine or Ecstasy)?• Inhalants (such as nitrous oxide)?• Herbs or synthetic drugs (such as salvia, "K2", or bath salts)?	<ul style="list-style-type: none"><input type="radio"/> Never<input type="radio"/> Once or twice<input type="radio"/> Monthly<input type="radio"/> Weekly

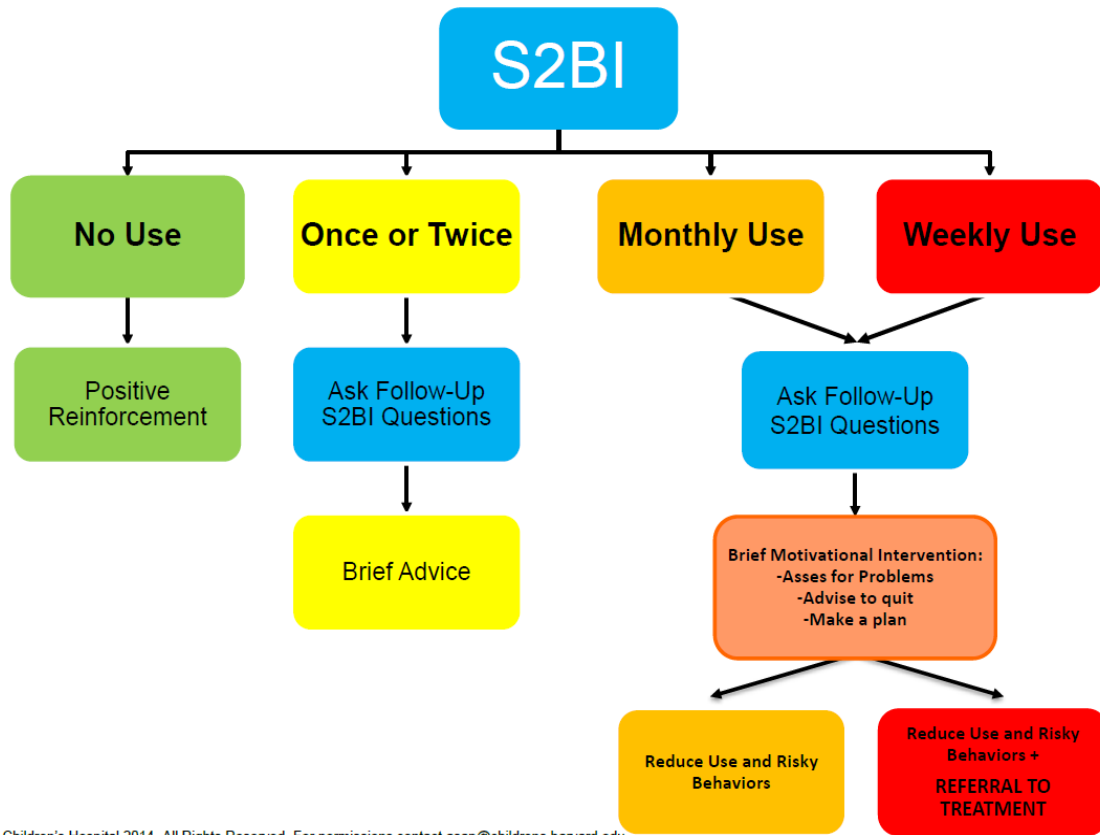
© Boston Children's Hospital 2014. All Rights Reserved. For permissions contact asap@childrens.harvard.edu.



Adolescent Substance Abuse Program



HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL



© Boston Children's Hospital 2014. All Rights Reserved. For permissions contact asap@childrens.harvard.edu.



Adolescent Substance Abuse Program



HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

DAST-10

CLINIC LOGO

Patient Label Here

DRUG USE QUESTIONS (DAST-10)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Drugs include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. Drug use also includes using prescription or over-the-counter medications more than directed.

In the past 12 months...	1	0
1. Have you used drugs other than those required for medical reasons?	<input type="radio"/> Yes	<input type="radio"/> No
2. Do you abuse more than one drug at a time?	<input type="radio"/> Yes	<input type="radio"/> No
3. Are you unable to stop using drugs when you want to?	<input type="radio"/> Yes	<input type="radio"/> No
4. Have you ever had blackouts or flashbacks as a result of drug use?	<input type="radio"/> Yes	<input type="radio"/> No
5. Do you ever feel bad or guilty about your drug use?	<input type="radio"/> Yes	<input type="radio"/> No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	<input type="radio"/> Yes	<input type="radio"/> No
7. Have you neglected your family because of your use of drugs?	<input type="radio"/> Yes	<input type="radio"/> No
8. Have you engaged in illegal activities in order to obtain drugs?	<input type="radio"/> Yes	<input type="radio"/> No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	<input type="radio"/> Yes	<input type="radio"/> No
10. Have you had medical problems as a result of your drug use (such as: memory loss, hepatitis, convulsions, or bleeding)?	<input type="radio"/> Yes	<input type="radio"/> No
TOTAL		

Date _____

SCORING:

Each response from the DAST has a score of either 0 or 1. All “Yes” responses get a score of 1, all “No” responses get a score of 0. After a patient has completed the DAST, add up the number of “Yes” responses for the patient’s score. Below are the scoring guidelines for the DAST.

Scoring Guidelines

Guidelines for Interpretation for DAST-10

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Brief intervention
3-5	Moderate level	Brief intervention plus brief therapy
6-10	Substantial level	Brief intervention plus referral to chemical dependency treatment

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982, 7(4): 363-371. Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007, 32:189-198.

NIDA Modified ASSIST Level 1

Pre-Screen/General Screen, Adolescents, Ages 11-17

The APA is offering a number of “emerging measures” for further research and clinical evaluation. These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. They should be used in research and evaluation as potentially useful tools to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis. Instructions, scoring information, and interpretation guidelines are provided; further background information can be found in DSM-5. The APA requests that clinicians and researchers provide further data on the instruments’ usefulness in characterizing patient status and improving patient care at <http://www.dsm5.org/Pages/Feedback-Form.aspx>.

Measure: DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure— Child Age 11–17

Rights granted: This measure can be reproduced without permission by researchers and by clinicians for use with their patients.

Rights holder: American Psychiatric Association

To request permission for any other use beyond what is stipulated above, contact:
<http://www.appi.org/CustomerService/Pages/Permissions.aspx>

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ Age: _____ Sex: Male Female Date: _____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)					
During the past TWO (2) WEEKS, how much (or how often) have you...												
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?					0	1	2	3	4	
	2.	Worried about your health or about getting sick?					0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?					0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?					0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?					0	1	2	3	4	
	6.	Felt sad or depressed for several hours?					0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?					0	1	2	3	4	
	8.	Felt angry or lost your temper?					0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?					0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?					0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?					0	1	2	3	4	
	12.	Not been able to stop worrying?					0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?					0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?					0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?					0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?					0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?					0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?					0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?					0	1	2	3	4	
In the past TWO (2) WEEKS, have you...												
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?		<input type="checkbox"/> Yes <input type="checkbox"/> No								
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No								
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?		<input type="checkbox"/> Yes <input type="checkbox"/> No								
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?		<input type="checkbox"/> Yes <input type="checkbox"/> No								
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?		<input type="checkbox"/> Yes <input type="checkbox"/> No								
	25.	Have you EVER tried to kill yourself?		<input type="checkbox"/> Yes <input type="checkbox"/> No								

Copyright © 2013 American Psychiatric Association. All Rights Reserved.
This material can be reproduced without permission by researchers and by clinicians for use with their patients.

Instructions to Clinicians

The DSM-5 Level 1 Cross-Cutting Symptom Measure is a self-rated measure that assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the child’s treatment and prognosis. In addition, the measure may be used to track changes in the child’s symptom presentation over time.

This child-rated version of the measure consists of 25 questions that assess 12 psychiatric domains, including depression, anger, irritability, mania, anxiety, somatic symptoms, inattention, suicidal ideation/attempt, psychosis, sleep disturbance, repetitive thoughts and behaviors, and substance use. Each item asks the child, age 11–17, to rate how much (or how often) he or she has been bothered by the specific symptom during the past 2 weeks. The measure was found to be clinically useful and had good test-retest reliability in the DSM-5 Field Trials conducted in pediatric clinical samples across the United States.

Scoring and Interpretation

Nineteen of the 25 items on the measure are each rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The suicidal ideation, suicide attempt, and substance abuse items are each rated on a “Yes or No” scale. The score on each item within a domain should be reviewed. Because additional inquiry is based on the highest score on any item within a domain, the clinician is asked to indicate that score in the “Highest Domain Score” column. Table 1 (below) outlines threshold scores that may be used to guide further inquiry for the domains. With the exception of inattention and psychosis, a rating of mild (i.e., 2) or greater on any item within a domain that is scored on the 5-point scale may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment for that domain is needed. The DSM-5 Level 2 Cross-Cutting Symptom measures listed in Table 1 may be used as a resource to provide more detailed information on the symptoms associated with some of the Level 1 domains.

Frequency of Use

To track change in the child’s symptom presentation over time, it is recommended that the measure be completed at regular intervals as clinically indicated, depending on the stability of the child’s symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic symptoms for the child that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making.

Table 1: DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17: domains, thresholds for further inquiry, and associated Level 2 measures

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Somatic Symptoms	Mild or greater	LEVEL 2—Somatic Symptom—Child Age 11–17 (Patient Health Questionnaire Somatic Symptom Severity [PHQ-15])
II.	Sleep Problems	Mild or greater	LEVEL 2—Sleep Disturbance—Child Age 11-17 (PROMIS—Sleep Disturbance—Short Form) ¹
III.	Inattention	Slight or greater	None
IV.	Depression	Mild or greater	LEVEL 2—Depression—Child Age 11–17 (PROMIS Emotional Distress—Depression—Pediatric Item Bank)
V.	Anger	Mild or greater	LEVEL 2—Anger—Child Age 11–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Pediatric)
VI.	Irritability	Mild or greater	LEVEL 2—Irritability—Child Age 11–17 (Affective Reactivity Index [ARI])
VII.	Mania	Mild or greater	LEVEL 2—Mania—Child Age 11–17 (Altman Self-Rating Mania Scale [ASRM])
VIII.	Anxiety	Mild or greater	LEVEL 2—Anxiety—Child Age 11–17 (PROMIS Emotional Distress—Anxiety—Pediatric Item Bank)
IX.	Psychosis	Slight or greater	None
X.	Repetitive Thoughts & Behaviors	Mild or greater	LEVEL 2—Repetitive Thoughts and Behaviors—Child 11–17 (adapted from the Children’s Florida Obsessive-Compulsive Inventory [C-FOCI] Severity Scale)
XI.	Substance Use	Yes/ Don’t Know	LEVEL 2—Substance Use—Child Age 11–17 (adapted from the NIDA-modified ASSIST)
XII.	Suicidal Ideation/ Suicide Attempts	Yes/ Don’t Know	None

¹Not validated for children by the PROMIS group but found to have acceptable test-retest reliability with child informants in the DSM-5 Field Trial.

Copyright © 2013 American Psychiatric Association. All Rights Reserved.
This material can be reproduced without permission by researchers and by clinicians for use with their patients.

NIDA Modified ASSIST Level 2

Substance Use Screen, Adolescents, Ages 11-17

The APA is offering a number of “emerging measures” for further research and clinical evaluation. These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. They should be used in research and evaluation as potentially useful tools to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis. Instructions, scoring information, and interpretation guidelines are provided; further background information can be found in DSM-5. The APA requests that clinicians and researchers provide further data on the instruments’ usefulness in characterizing patient status and improving patient care at <http://www.dsm5.org/Pages/Feedback-Form.aspx>.

Measure: LEVEL 2—Substance Use—Child Age 11–17 (adapted from the NIDA-Modified ASSIST)

Rights granted: This Instrument may be reproduced without permission by clinicians for use with their own patients.

Rights holder: National Institute on Drug Abuse (NIDA)

To request permission for any other use beyond what is stipulated above, contact:
National Institute on Drug Abuse (NIDA)

LEVEL 2—Substance Use—Child Age 11–17*

*Adapted from the NIDA-Modified ASSIST

Name: _____ Age: _____ Sex: Male Female Date: _____

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you have been bothered by “having an alcoholic beverage”; “smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco”; “using drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)”; and/or “using any medicine ON YOUR OWN, that is, without a doctor’s prescription, to get high or change the way you feel.” The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms **during the past two (2) weeks**. Please respond to each item by marking (✓ or x) one box per row.

						Clinician Use
						Item Score
						Not at All
						Less Than a Day or Two
						Several Days
						More Than Half the Days
						Nearly Every Day
During the past TWO (2) weeks, about how often did you ...						
a.	Have an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b.	Have 4 or more drinks in a single day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c.	Smoke a cigarette, a cigar, or pipe or use snuff or chewing tobacco?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
During the past TWO (2) weeks, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor’s prescription or in greater amounts or longer than prescribed?						
d.	Painkillers (like Vicodin)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e.	Stimulants (like Ritalin, Adderall)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f.	Sedatives or tranquilizers (like sleeping pills or Valium)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<i>Or drugs like:</i>						
g.	Steroids	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
h.	Other medicines	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
i.	Marijuana	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
j.	Cocaine or crack	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
k.	Club drugs (like ecstasy)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
l.	Hallucinogens (like LSD)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
m.	Heroin	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
n.	Inhalants or solvents (like glue)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
o.	Methamphetamine (like speed)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Courtesy of National Institute on Drug Abuse.

This instrument may be reproduced without permission by clinicians for use with their own patients.

Instructions to Clinicians

The DSM-5 Level 2—Substance Use—Child Age 11–17 is an adapted version of the NIDA-Modified ASSIST. ASSIST. The 15-item measure is used to assess the pure domain of alcohol, tobacco/nicotine, prescription medicine, and illicit substance use in children and adolescents. It is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his/her use of various substances **during the past 2 weeks.**

Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (i.e., 0=not at all; 1=less than a day or two; 2=several days; 3=more than half the days; 4=nearly every day). The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score for each item in the section provided for “Clinician Use.” Scores on the individual items should be interpreted independently because each item inquires about the use of a distinct substance. The rating of multiple items at scores greater than 0 indicates greater severity and complexity of substance use.

Frequency of Use

To track change in the severity of the child’s use of alcohol, tobacco/nicotine, prescription or illicit substance over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child’s symptoms and treatment status. Consistently high scores on the measure may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

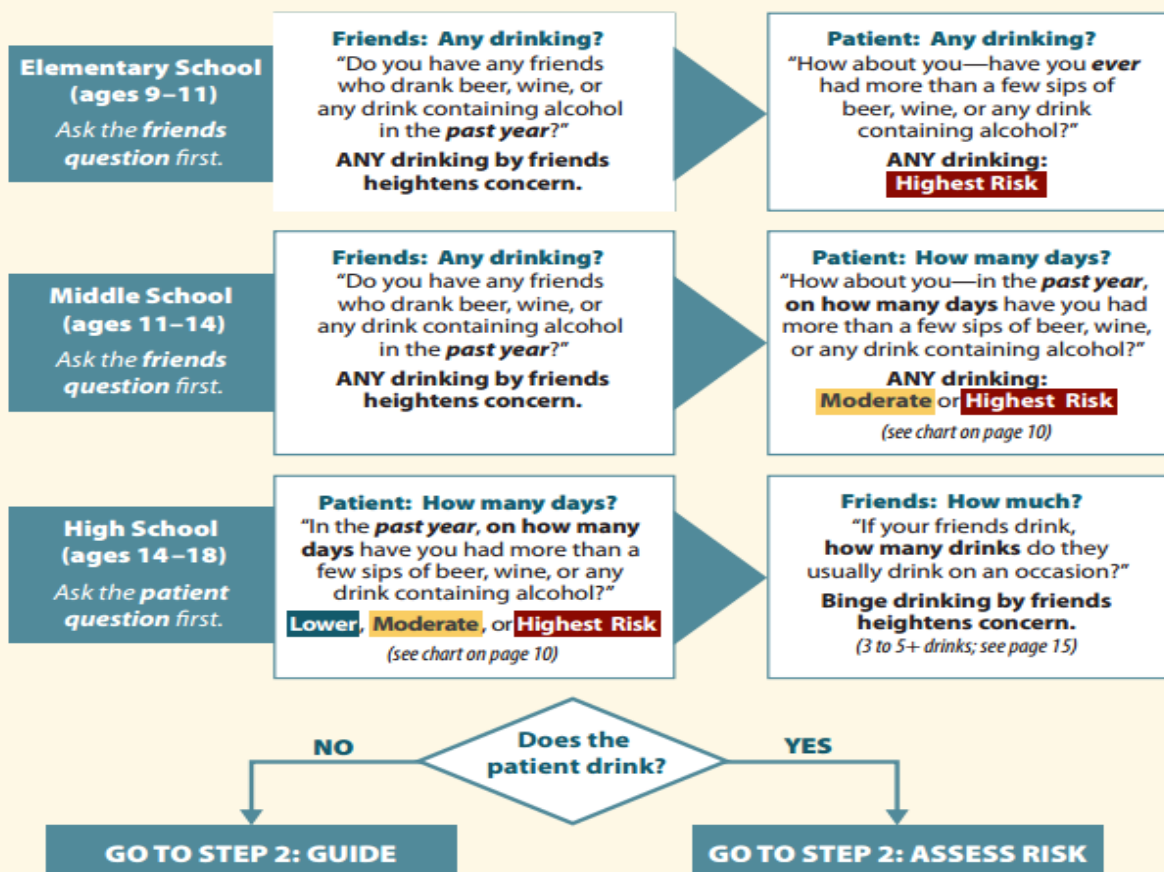
Courtesy of National Institute on Drug Abuse.
This material may be reproduced without permission by clinicians for use with their own patients.

NIAAA Youth Guide Screen

STEP 1: ASK THE TWO SCREENING QUESTIONS








Research indicates that the two age-specific screening questions (about friends' and patient's drinking) are powerful predictors of current and future alcohol problems in youth. Fit them into your office practice in whatever way works best for you, whether by adding them to a pre-visit screening tool or weaving them into your clinical interview. In either case, take steps to protect patient privacy and, if at all possible, conduct an in-person alcohol screen when you are alone with your patient. See page 25 for more information about confidentiality.

Guidelines for asking the screening questions: (1) For elementary and middle school patients, start with the friends question, a less threatening, side-door opener to the topic of drinking. (2) Because transitions to middle or high school increase risk, choose the question set that aligns with a patient's school level, as opposed to age, for patients aged 11 or 14. (3) Exclude alcohol use for religious purposes.



Appendix B. Standard Drink Chart

Standard Drink Chart

12 fl oz of regular beer	8-9 fl oz of malt liquor (shown in a 12-oz glass)	5 fl oz of table wine	3-4 fl oz of fortified wine (such as sherry or port; 3.5 oz shown)	2-3 fl oz of cordial, liqueur, or aperitif (2.5 oz shown)	1.5 fl oz of brandy (a single jigger or shot)	1.5 fl oz shot of 80-proof spirits ("hard liquor")
						
about 5% alcohol	about 7% alcohol	about 12% alcohol	about 17% alcohol	about 24% alcohol	about 40% alcohol	about 40% alcohol

The percent of "pure" alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage.

US Department of Health and Human Services. (2010). Rethinking drinking: Alcohol and your health. *NIH Pub*, (10-3770).

Appendix C. DSM Criteria



Alcohol Use Disorder: A Comparison Between DSM–IV and DSM–5

In May 2013, the American Psychiatric Association issued the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5). Although there is considerable overlap between DSM–5 and DSM–IV, the prior edition, there are several important differences:

Changes Disorder Terminology

- » DSM–IV described two distinct disorders, alcohol abuse and alcohol dependence, with specific criteria for each.
- » DSM–5 integrates the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications.

Changes Diagnostic Thresholds

- » Under DSM–IV, the diagnostic criteria for abuse and dependence were distinct: anyone meeting one or more of the “abuse” criteria (see items 1 through 4) within a 12-month period would receive the “abuse” diagnosis. Anyone with three or more of the “dependence” criteria (see items 5 through 11) during the same 12-month period would receive a “dependence” diagnosis.
- » Under DSM–5, anyone meeting any two of the 11 criteria during the same 12-month period would receive a diagnosis of AUD. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

Removes Criterion

- » DSM–5 eliminates legal problems as a criterion.

Adds Criterion

- » DSM–5 adds craving as a criterion for an AUD diagnosis. It was not included in DSM–IV.

Revises Some Descriptions

- » DSM–5 modifies some of the criteria descriptions with updated language.

DSM History and Background

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) initially developed out of a need to collect statistical information about mental disorders in the United States. The first attempt to collect information on mental health began in the 1840 census. By the 1880 census, the Bureau of Census had developed seven categories of mental illness. In 1917, the Bureau of Census began collecting uniform statistics from mental hospitals across the country.

Not long afterwards, the American Psychiatric Association and the New York Academy of Medicine collaborated to produce a “nationally acceptable psychiatric nomenclature” for diagnosing patients with severe psychiatric and neurological disorders. After World War I, the Army and Veterans Administration broadened the nomenclature to include disorders affecting veterans.

In 1952, the American Psychiatric Association Committee on Nomenclature and Statistics published the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* (DSM–I). The DSM–I included a glossary describing diagnostic categories and included an emphasis on how to use the manual for making clinical diagnoses. The DSM–II, which was very similar to the DSM–I, was published in 1968. The DSM–III, published in 1980, introduced several innovations, including explicit diagnostic criteria for the various disorders, that are now a recognizable feature of the DSM. A 1987 revision to the DSM–III, called the DSM–III–R, clarified some of these criteria and also addressed inconsistencies in the diagnostic system. A comprehensive review of the scientific literature strengthened the empirical basis of the next edition, the DSM–IV, which was published in 1994. The DSM–IV–TR, a revision published in 2000, provided additional information on diagnosis. Since 1952, each subsequent edition of the DSM aimed to improve clinicians’ ability to understand and diagnose a wide range of conditions.



NIH . . . Turning Discovery Into Health®

National Institute on Alcohol Abuse and Alcoholism

www.niaaa.nih.gov • 301.443.3860

A Comparison Between DSM-IV and DSM-5

DSM-IV		DSM-5	
Any 1 = ALCOHOL ABUSE	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household).	1	Alcohol is often taken in larger amounts or over a longer period than was intended. (See DSM-IV, criterion 7.)
	Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol abuse).	2	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. (See DSM-IV, criterion 8.)
	Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct). **This is not included in DSM-5**	3	A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (See DSM-IV, criterion 9.)
	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about the consequences of intoxication, physical fights).	4	Craving, or a strong desire or urge to use alcohol. **This is new to DSM-5**
Any 3 = ALCOHOL DEPENDENCE	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) Markedly diminished effect with continued use of the same amount of alcohol	5	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. (See DSM-IV, criterion 1.)
	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol b) Alcohol is taken to relieve or avoid withdrawal symptoms	6	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. (See DSM-IV, criterion 4.)
	Alcohol is often taken in larger amounts or over a longer period than was intended.	7	Important social, occupational, or recreational activities are given up or reduced because of alcohol use. (See DSM-IV, criterion 10.)
	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.	8	Recurrent alcohol use in situations in which it is physically hazardous. (See DSM-IV, criterion 2.)
	A great deal of time is spent in activities necessary to obtain alcohol (e.g., driving long distances), use alcohol, or recover from its effects.	9	Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol. (See DSM-IV, criterion 11.)
	Important social, occupational, or recreational activities are given up or reduced because of alcohol use.	10	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) A markedly diminished effect with continued use of the same amount of alcohol (See DSM-IV, criterion 5.)
	Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).	11	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal) b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms. (See DSM-IV, criterion 6.)



NIH . . . Turning Discovery Into Health®

National Institute on Alcohol Abuse and Alcoholism

www.niaaa.nih.gov • 301.443.3860

NIH Publication No. 13-7999

November 2013

Appendix D. Goal Setting Exercise

Setting Goals for Change Exercise

The following exercise can be used to help a person set one or more behavior change goals. The goal(s) must be SMART (specific, measurable, attainable, realistic and timely). Although long-term goals may be stated, short-term immediate goals and specific actions and steps to be taken should be clearly stated. Patients only need to set 1 or 2 goals during the session, as setting numerous goals may be overwhelming. At subsequent sessions, previously stated goals and progress made toward them can be revisited and new goals can be stated as goals are achieved. Setting and achieving smaller, fewer goals can build self-efficacy over time.

One goal might be to either cut down or stop drinking. Another goal may have to do with behaviors related to drinking (e.g., *“I won’t drive after I’ve been drinking.”*) The following exercise can be done verbally or written to assist a patient with deciding on what the goals will be.

WILL I CUT DOWN – OR WILL I STOP MY ALCOHOL USE?

Now that you have decided to make a change to your use of substances, your next decision is whether you will use alcohol/drugs less or stop using substances altogether.

To help you make up your mind, think about these questions:

- ▶ Do you have any health or psychological problems that might be made worse by your substance use? - Your provider can advise you.
- ▶ Do you experience withdrawal symptoms when you stop drinking or using drugs? If so, stopping use entirely is probably the best goal for you. - Your provider can help you manage the withdrawal symptoms.
- ▶ Do you have any problems at school as a result of your substance use?
- ▶ Do you have any legal or financial problems as a result of your substance use?
- ▶ Do you have any relationship or family problems because of your substance use?

Have you solved substance use problems before by stopping completely? – Then, this might be your best way now.

Appendix E. Change Plan Worksheet

Change Plan Worksheet

The goal setting exercise below is useful for helping a patient articulate specifically what they want to change and develop a plan for change.

The changes I want to make are:

The most important reasons why I want to make this change are:

My main goals for myself in making this change are:

I plan to do these things in order to accomplish my goals:

Specific action:

When:

Other people could help me with change in these ways:

Person:

Possible ways to help:

These are some possible obstacles to change, and how I could handle them:

Possible obstacle to change:

How to respond:

I will know that my plan is working when I see these results:

You can provide (verbally or written) the following considerations to assist the person in completing the Change Plan Worksheet.

- ▶ *The changes I want to make are...* Be specific. Include goals that are positive (wanting to increase, improve and do more of something) and not just negative goals (stop, avoid or decrease a behavior).
- ▶ *My main goals for myself in making these changes are...* What are the likely consequences of action or inaction? Which motivations for change are most compelling?
- ▶ *The first steps I plan to take in changing are...* How can the desired change be accomplished? What are some specific, concrete first steps? When, where, and how will the steps be taken?

- ▶ *Some things that could interfere with my plan are...* What specific events or problems could undermine the plan? What could go wrong? How will the person stick with the plan despite these particular problems or setbacks?
- ▶ *Other people could help me in changing in these ways...* What specific things can another person do to help them take the steps to change? How will the person arrange for such support?

I will know that my plan is working if... What will happen as a result of taking the different steps in the plan? What benefits can be expected?

Appendix F. Mutual Support Groups

Mutual Support Groups

Alcoholics Anonymous (AA) World Services

P.O. Box 459
New York, NY 10163
Phone: 212.870.3400
Web: www.aa.org

LifeRing

1440 Broadway Suite 312
Oakland, CA 94612-2023
Phone: 510.763.0779
Toll-Free: 800.811.4142
Email: service@lifering.org
Web: www.lifering.org

Moderation Management (MM)

2795 East Bidwell Street
Suite 100-244
Folsom, CA 95630-6480
Phone: 212.871.0974
Email: mm@moderation.org
Web: www.moderation.org

Narcotics Anonymous (NA)

P.O. Box 9999
Van Nuys, CA 91409
Phone: 818.773.9999
Email: fsmail@na.org

Web: www.na.org

Secular Organizations for Sobriety/Save Our Selves (SOS)

4773 Hollywood Blvd.
Hollywood, CA 90027
Phone: 323.666.4295
Email: sos@cfiwest.org
Web: www.sossobriety.org

SMART Recovery

7304 Mentor Avenue, Suite F
Mentor, OH 44060
Phone: 440.951.5357
Fax: 866.951.5357
Email: information@smartrecovery.org
Web: www.smartrecovery.org

Women for Sobriety (WFS)

P.O. Box 618
Quakertown, PA 18951-0618
Phone: 215.536.8026
Email: newlife@nni.com
Web: www.womenforsobriety.org

Appendix G. Brief Intervention Observation Sheets

Brief Intervention Observation Sheet

Did the Resident ...

Raise the subject	1) Respectfully raise the subject of alcohol or drug use (e.g., ask patient for permission to discuss substance use)?	Yes	No
	2) Review patient's substance use patterns and express concern?	Yes	No
Provide feedback	3) Ask patient if he/she sees a connection between substance use and health concerns (if relevant)?	Yes	No
	4) Inform patient of healthy guidelines relevant to his/her sex and age group and tell patient his/her substance use is above guidelines and unsafe?	Yes	No
Enhance motivation	5) Ask patient to select a number on the "Readiness Ruler"?	Yes	No
	6) What was the number?	_____	
	7) Ask patient why he/she did not pick a lower number? Ask patient what would make his/her substance use a problem? OR Ask how important would it be for the patient to prevent that from happening? OR Discuss patient's pros and cons of use?	Yes	No
Negotiate plan	8) Negotiate a goal with the patient based on his/her response to being asked, "What steps would you be willing to take?"	Yes	No
	9) Tell patient that if he/she can stay within healthy limits he/she will be less likely to experience (further) illness or injury related to substance use?	Yes	No
	10) To what degree did the resident use a guiding style?		
	<p style="text-align: center;"><i>Did not use a guiding style</i></p> <p style="text-align: center;">1 2 3 4 5 6 7</p> <p style="text-align: center;"><i>Used a guiding style very effectively</i></p>		

Adapted from the BI Adherence/Competence Scale, created by D'Onofrio et al. for Project ED Health.

BNI-ART Institute
Youth Brief Intervention and Referral: Interview Scoring Sheet

Date Interviewer Initials Evaluator Initials

CRITERIA	Y	N
Engagement <ul style="list-style-type: none"> • ask permission for talk about alcohol/drugs • ask about a day in the person’s life • ask how drinking and marijuana fits in with life • ask about patient’s values, (what’s important to them) 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Decisional Balance: Pros and Cons of alcohol/drug use <ul style="list-style-type: none"> • elicit good things about alcohol/drug use • elicit less good things about alcohol/drug use • draw upon screening answers • sum up and restate in patient’s own words (reflective listening) 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Feedback <ul style="list-style-type: none"> • Ask permission to share information • NIAAA guidelines or salient information • Elicit response from patient 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Readiness Ruler <ul style="list-style-type: none"> • use general readiness to change question (ruler) • ask, why not less? • elicit other reasons for changing 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Negotiate Action Plan <ul style="list-style-type: none"> • elicit specific steps • write steps on the prescription for change form • ask about future goals (discrepancy) & how change fits in • ask about challenges to change • ask about past successes <ul style="list-style-type: none"> ➤ what they did ➤ who/what helped them (social support) ➤ community/resources that helped • explore benefits of change 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Summarize & Thank (Referrals) <ul style="list-style-type: none"> • summarize action plan • offer referrals <ul style="list-style-type: none"> ➤ to primary care ➤ for substance abuse treatment if necessary ➤ to mental health if depression or past psychiatric problems are mentioned • Review/ make additions to prescription for change • Sign/Give prescription for change to patient • Thank patient 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Each “Yes” check = 4 points, Maximum score = 100 points Score _____

General Performance Feedback (20 points—5=2 points; 4=1 point;<4=0)

PART 2 SCORE = _____ TOTAL SCORE (PARTS 1 & 2) = _____

- Language appropriate

Not appropriate	Appropriate
 0	 5
 1	 4
 2	 3
- Open Questions

More Closed	More Open
 0	 5
 1	 4
 2	 3
- Reflective listening

Not reflective	Reflective
 0	 5
 1	 4
 2	 3
- Percent of talking by patient compared to interviewer (Voice)

 0%	 20%	 40%	 60%	 80%
(1)				(5)
- Respect

Disrespectful	Respectful
 0	 5
 1	 4
 2	 3
- Negotiation(Choice)

One-sided Agenda	Shared Agenda
 0	 5
 1	 4
 2	 3
- Affirmations

Not Encouraging	Encouraging self-change
 0	 5
 1	 4
 2	 3
- Knowledge of facts/resources

Low	High
 0	 5
 1	 4
 2	 3
- Allowing for silence and duration of pauses before jumping in

No pause	Uses silence effectively
 0	 5
 1	 4
 2	 3
- Listening for cues

Misses opportunities	Uses opportunities to go deeper
 0	 5
 1	 4
 2	 3

Comments/Examples

Brief Intervention Observation Sheet (BIOS)
for Kognito's *SBI with Adolescents* Online Simulation

Date: _____

Person Conducting the Brief Intervention: _____

Observer: _____

Observer Instructions: Place a ✓ in the Yes/No column corresponding to the components utilized in the role play or standardized patient simulation.

CRITERIA	YES	NO
BUILD RAPPORT		
• Ask about life	<input type="checkbox"/>	<input type="checkbox"/>
• Ask permission to raise subject	<input type="checkbox"/>	<input type="checkbox"/>
• Discuss drinking/drug use	<input type="checkbox"/>	<input type="checkbox"/>
ELICIT PROS AND CONS		
• Elicit pros	<input type="checkbox"/>	<input type="checkbox"/>
• Elicit cons	<input type="checkbox"/>	<input type="checkbox"/>
• Summarize	<input type="checkbox"/>	<input type="checkbox"/>
PROVIDE FEEDBACK		
• Ask permission to share information	<input type="checkbox"/>	<input type="checkbox"/>
• Provide salient info	<input type="checkbox"/>	<input type="checkbox"/>
• Elicit response	<input type="checkbox"/>	<input type="checkbox"/>
ASSESS READINESS		
• Ask about readiness	<input type="checkbox"/>	<input type="checkbox"/>
• Make recommendation for abstinence	<input type="checkbox"/>	<input type="checkbox"/>
• Ask, Why not less? Or What would have to change?	<input type="checkbox"/>	<input type="checkbox"/>
NEGOTIATE AN ACTION PLAN		
• Elicit a specific goal	<input type="checkbox"/>	<input type="checkbox"/>
• Collaborate on specific steps	<input type="checkbox"/>	<input type="checkbox"/>
• Explore challenges to change	<input type="checkbox"/>	<input type="checkbox"/>
SUMMARIZE AND THANK		
• Summarize an action plan	<input type="checkbox"/>	<input type="checkbox"/>
• Offer referrals (as needed)	<input type="checkbox"/>	<input type="checkbox"/>
• Schedule a check-in	<input type="checkbox"/>	<input type="checkbox"/>

© 2016 Kognito. All Rights Reserved.

Developed to accompany Kognito's *SBI with Adolescents* Online Simulation. Adapted from the Brief Negotiated Interview (BNI).

Brief Intervention Observation Sheet

Did the Practitioner ...

				<u>Comments</u>
(1) Raise the subject	1) Explain role and respectfully ask permission to have a discussion about alcohol/drug use	Yes	No	
	2) Review adolescent's alcohol/drug use patterns	Yes	No	
(2) Provide feedback	3) Share the adolescent's screening scores and risk level	Yes	No	
	4) Review drinking guidelines (e.g., NIAAA, American Academy of Pediatrics) relevant to his/her sex and age group	Yes	No	
	5) Explore possible connection to school, work, health, social, family, relationship issues and express concern(s) (if relevant)	Yes	No	
(3) Enhance motivation	6) Ask adolescent to select a number on the "Readiness Ruler" or "Important/Confidence Rulers"	Yes	No	
	7) Ask adolescent "Why didn't you pick a lower number?" or "How would your drinking (drug use) have to impact your life in order for you to start thinking about cutting back?"	Yes	No	
	8) Discuss and summarize adolescent's pros and cons of use	Yes	No	
(4) Negotiate a plan	9) Provide a summary of readiness OR importance/confidence (You said ...)	Yes	No	
	10) Negotiate a goal with the adolescent based on response to asking about next steps (e.g., <i>What steps would you be willing to take?</i>)	Yes	No	
	11) Offer a menu of choices for change, elicit adolescent's ideas/action plan, provide recommendation, secure agreement	Yes	No	
Motivation	12) To what degree did the practitioner use a non-confrontational, motivational style (open-ended questions, affirmations, reflective listening)?			
	<i>Not At All</i> <i>Very Effectively</i> 1 2 3 4 5 6 7			

12. Additional comments about practitioner performance:

Adapted from UMKC's Brief Intervention Observation Sheet (BIOS) developed based on the BI Adherence/Competence Scale and Oregon Brief Observation Sheet.

Appendix H. Brief Intervention Case Studies

BNI-ART Institute Case Study

José Gonzales

PROVIDER

Background: Jose is 19 years old and employed as an auto garage attendant. While at work this morning he dropped a heavy wrench onto his foot from a height of five feet. He arrives to the ED via private transport, limping heavily. He appears very despondent.

Physical Exam: Foot appears swollen. No numbness, no tingling; question of bone tenderness; negative x-ray from triage of foot. He has no past medical history. He has a history of depression, reports drinking alcohol daily, and reports tobacco use. Family history is not contributory in this case. He reports some nausea, and also complains of headache. He believes this might be related to his drinking.

Screening Results: Jose drinks a pint of hard liquor (11 shots) every week day and a pint and a half (15 shots) every weekend. He also reports on the CRAFFT questions, to driving a car after drinking and/or riding with someone who has driven after drinking. He consumes alcohol by himself. His family and friends have cautioned him to cut back, and he also forgets things while he drinks. Joe drinks to feel better about himself, and reports having lost interest in activities that he used to enjoy.

PATIENT

BACKGROUND:

Jose: You are a 19-year-old auto garage attendant who hates his job. After changing oil filters all day, you go to the liquor store and buy a pint of hard liquor (11 shots) on your way to your cousin's house. You get plastered "with all the other winos," stumble home, go to bed and wake up the next morning hung-over and begin the cycle all over again. On the weekends, you consume one and a half pints (15 shots) hard liquor each day. You live with your father who tells you to "lay off the booze." You've tried AA in the past, and have also spoken to your doctor about "medications to control the drinking, stress, and anger."

IF PROVIDER ASKS YOU ABOUT PROS & CONS:

Pros: You like to drink because alcohol numbs the pain, both physical and emotional. It helps you to escape to "a little fantasy land." You also like that alcohol enhances your confidence, making you fearless and granting you "liquid courage."

Cons: You don't like the hangovers every morning. Alcohol gets you into trouble with girls, friends, your family, and also the law. You feel dependent upon alcohol; "like a baby needs his pacifier," you always need your "little bottle."

IF A PROVIDER ASKS YOU ABOUT YOUR READINESS: You identify yourself on the Readiness Ruler as 8 out of 10. You do not choose 5 because you have already tried ways to curb your drinking, although they were unsuccessful. You are tired of the way you live your life.

IF A PROVIDER SUGGESTS PLAN/NEXT STEPS: You admit that quitting all together is the only way you can stop drinking. You are willing to try but do not think it will work. You have so much stress that you can always find a reason to drink. **If prompted by the provider to make an action plan:** You will "lose the losers" you call your friends and seek out people you know who will give you positive support. You agree abstain from alcohol accepts a referral for detox. You also agree to follow-up with your primary care physician.

BNI-ART Institute Case Study

Miguel Rodriguez

PROVIDER

Background: Miguel is a 18 year-old living at home with his mother. He is currently attending some afternoon courses towards a GED. He complains of continued pain following a superficial gunshot wound to the right flank last week. He had been at a party, heard a gunshot, and then felt pain in his back. He was discharged from the ED after a negative CT. He presents today for wound check.

Physical Exam: He complains of back pain. There is no chest pain or shortness of breath. Temperature and vital signs are within the normal ranges. Abdomen is soft. The wound is not infected. It appears to be local.

Screening Results: Miguel reports drinking 2-4 drinks each day, drinking between 14 and 28 drinks per week. The maximum amount of drinks he had on any one day in the past month is 8 drinks.

PATIENT

BACKGROUND:

Miguel: You are 18-years-old, living at home with your mother. You are currently working towards a GED. Your typical day includes getting up early, taking a shower, going outside to chill, attending an afternoon class, and then chilling and drinking with friends. You drink every day, 2 to 4 drinks per day (mostly beer but occasionally hard liquor) -- just enough to get and keep a buzz. You have stopped smoking marijuana as this violates your probation rules and you are "not trying to go to jail." Recently, you were drinking with your friends in the "wrong place at the wrong time," there was a fight, and you were shot and injured.

IF PROVIDER ASKS YOU ABOUT PROS & CONS:

PROS: You like the buzz and alcohol makes you feel good. Drinking is something that you do with your friends when you chill. Although it makes you feel a little bit angry, alcohol really helps to calm you down.

CONS: You don't like the headaches and hangovers the next morning. Sometimes after drinking, you pass out or vomit. Your family has expressed a need for you to cut back on your drinking. Also, alcohol has led to your getting in trouble, fighting, and was a contributing factor toward your gunshot injury. You are also concerned that alcohol will "mess up" your probation.

IF A PROVIDER ASKS YOU ABOUT YOUR READINESS: You identify yourself on the Readiness Ruler as 5 out of 10. You choose a 5 rather than a 3 because you are thinking there are people currently in your life that are trying to bring you down and hold you back, and that this needs to change. You also describe your drinking as "alcohol addiction" since you drink everyday but you don't want to give it up all together

IF A PROVIDER SUGGESTS PLAN/NEXT STEPS: If a provider asks you to make an action plan: You realize this will be hard as all of your friends drink, but make a plan to "chill with positive influence people." You have an aunt who stopped drinking and can be a good support person. You want to cut back on drinking to be more stable and in control of situations, and also in order to focus on getting your GED. You decide to decrease your amount of days drinking; you set a goal of having giving up hard liquor, drinking only on weekends You agree to accept a referral to outpatient counseling.

BNI-ART Institute Case Study

Maria Hernandez

PROVIDER

Background: Maria is a 20 year-old living at home with family. She has recently been committed to a DUI program. She presents to the ED with abrasions and possible wrist fracture after falling.

Physical Exam: The patient is a well-nourished young woman. She reports falling in gravel parking lot, attempted to catch herself with her right hand. Right wrist shows mild edema, mild tenderness upon palpation. Good pulses. You believe you smell alcohol on her breath.

Screening Results: Maria drinks 1/2 pint hard liqueur (6 shots) 6 times per month. She also reports marijuana use.

PATIENT

Background:

Maria: You are a 20-year-old living at home with your mother, father, and brother. You are currently working towards a GED, and recently were committed to a DUI programs and lost her license. You don't like the strict rules at home. When you fight with your mom, you leave the house to go drink or smoke dope with your friends. When you drink, you consume a 1/2 pint of hard liquor; you do this about 6 times per month. You had a fight with your mother earlier today, and went off with a friend to the park. She says her mother, brothers and uncles drink more that she does. A patrolling cop surprised you, and you took off running because you had a stash in your pocket. You got away and ditched the marijuana, but you fell and hurt your wrist and it is all swollen. You present to the ED with a possible fractured wrist.

IF PROVIDER ASKS YOU ABOUT PROS & CONS

PROS: You like the taste of mixed drinks. You are normally a shy person and like how alcohol makes you feel comfortable, confident, and relaxed when talking to other people. Drinking also takes your problems away—or at least makes you stop thinking about them. And it's something to do when you are bored. But even more important, you don't want to stop using marijuana, because that's what all your friends do, and it helps you chill out. **CONS:** You don't like waking up the next morning not feeling well. Your hangovers make you feel “trashy—like a bum.” You don't like the way you look when you are drinking. Coming home late after drinking creates more problems with your mom. Since you are underage, you know that you could get in trouble if the police caught you drinking, and you almost got caught on a possession charge for marijuana today.

IF A PROVIDER ASKS YOU ABOUT YOUR READINESS: You identify yourself on the Readiness Ruler as 6 out of 10. You do not choose 3 because you feel trashy, have gained a lot of weight and are thinking about change—you are “dying to stop drinking.” You realize that sometime you feel like you want to drink—but sometimes you feel like you NEED to drink. And almost getting caught today with enough to put you away for while tipped the balance, and you are worried that you have stepped over a line here.

IF A PROVIDER SUGGESTS PLAN/NEXT STEPS: You agree to decrease the amount of alcohol you drink. Instead of a whole 1/2 pint of tequila, you will just have 2 shots mixed with soda and make it last the whole night. **If prompted by the provider:** You feel confident that you can decrease your alcohol consumption and quit using pot. You know that you are able to control yourself. You don't like the idea of help, because nobody has ever helped you very much before and all my people do is compare to my girl cousins.

BNI-ART Institute Case Study:

Juanita Morales

PROVIDER

Background: Juanita is an 18 year old senior in high school and is planning to graduate this Friday. The patient arrived to the Emergency Department via ambulance after prolonged extrication from a rollover Motor Vehicle Crash in which she was the driver. The Patient was admitted overnight for observation on the closed head injury pathway. The Patient borrowed her boyfriend's car and was out with friends where she had been drinking before driving to pick up her boyfriend. She lost control and the car rolled over multiple times. There was +LOC (loss of consciousness) but the patient is now awake and alert. She remembers waking up and someone asking her *"Are you alive?"*

Physical Exam: The patient complains of neck pain and abdominal pain. MRI of the neck and abdominal CT are negative. No other apparent injuries. The Patient is now A+OX3 (alert and oriented times three).

Screening Results: Juanita reports that she drinks on weekends but has been drinking more during the week lately because she and her friends are partying to celebrate graduation. On the weekends she has up to 8 beers in a night, which usually starts with a couple of shots. +BAC of 0.23.

PATIENT

Background:

Juanita: You are an 18y.o. who lives with a boyfriend and has a 9 month baby. You are a senior in high school and had planned to graduate this Friday. You drink on weekends mainly but have been drinking more during the week lately because you and your friends are partying to celebrate graduation. On the weekends you usually start off with a few shots and then could have up to 8 beers in a night. Last night you borrowed your boyfriend's car and were out with friends for about 2 hours where you had 2 beers and 4 shots before driving to pick him up. You lost control and the car rolled over multiple times. You next remember someone asking you *"Are you alive?"*

If the PROVIDER brings up your BAC and starts giving you feedback say *"No way!"* and *"I was fine, I don't drink any more than my friends do."*

If the PROVIDER asks you about Pros & Cons:

Pros: It is *"what I do"* when you hang out with your friends. You *"Guess it helps me relax"*. And you like to drink to *"celebrate"*.

Cons: You don't like feeling hung over when you *"drink too much"*. *"This"* – (being in the accident) and *"My boyfriend is going to kill me"* Re: his car. Also, you are supposed to start college in the fall and now will *"definitely lose my license"* because of the drunk driving accident/ underage drinking.

If the PROVIDER asks you about your Readiness: You identify yourself as an 8 out of 10 on the readiness ruler. You did not choose a lower number because you *"realize this could have ruined my life and my daughter's"*, *"What if I killed someone?"*

If the PROVIDER asks about a Plan or Next Steps: You want to *"stop drinking, at least for a while."* If the provider asks you about challenges to that plan of stopping drinking completely: You report that you don't want to lose your friends but you could stop hanging out with your friends that drink and look to get a job for the summer. You also report that you could suggest other activities to friends like going to the movies/hikes/shopping. You will definitely plan to stay within the NIAAA guidelines which the provider discussed with you. If prompted to make an action plan: If you are around friends who are drinking you pledge to not drink more than 3 drinks a day. You definitely will not drink and drive or get in a car with someone who has been drinking. You agree to take phone numbers to talk to someone to help you with your plan.

BNI-ART Institute Case Study:

Julia Sanchez

PROVIDER

Background: Julia is a 19 year-old college student, who was drinking in her dorm room with friends. She tripped and hit her head on the bathroom sink. She sustained a superficial laceration over her right eye with an underlying hematoma. Her friends state that there was no loss of consciousness. They insisted she go to the student health center to be checked out. She was subsequently sent to the ER by student health center staff.

Physical Exam: Julia is in good health and takes no medications. The smell of alcohol on her breath is unmistakable. The rest of her exam is normal.

Screening Results: Julia drinks 3-4 drinks during the week and up to 6 beers on weekend nights (Thursday, Friday and Saturday). Her average weekly intake is about 22 drinks per week, but she denies any alcohol-related consequences or concerns.

PATIENT

Background:

Julia: You are a 19 year-old college student. You were drinking in your dorm room with friends. You went to the bathroom, slipped, and hit your head on the sink. You cut your forehead, and although it bled a lot, you want to put a Band-Aid on it and go to bed. You don't know what the big deal is, and what you are doing at the Emergency Department. You are aggravated with having to speak to the doctor about your drinking. You see no association between your alcohol use and tripping in the bathroom. The floor was wet. You drink 3-4 beers during the week and up to 6 beers on most weekend nights. You think this kind of drinking is the "norm" for most people your age.

If Provider Asks About Pros & Cons

PROS: Everyone you know drinks like you do; it is a part of your social life. You enjoy the slight buzz you get when you drink and it especially feels good after a long week of studying. It helps you to have fun and forget about all your work. **CONS:** At first, nothing you can think of. **If provider prompts you about regrets:** you regret having to spend time in the ED but then you also remember that you blacked out last week and aren't quite sure what happened.

If Provider Asks About Readiness: You identify yourself as a 2 on the Readiness Scale and feel that there isn't really a need to change your behavior. **If provider asks "why not 1?":** you don't want to black out again – you missed your period this month and are a little worried about what may have happened the night you blacked out.

If Provider Suggests Plan/Next Steps: You don't really feel that drinking is a problem but you agree that maybe drinking so much that you black out is not a good thing. So you agree to try to drink less, drink slower and make sure there is a friend to watch out for you. **If provider suggests seeing a nurse about the missed period:** you agree to a pregnancy test which is negative. You also agree to cut down on the drinking.

BNI-ART Institute Case Study:

Sara

PROVIDER

Background: Sara is a 19 year-old college student, who at the STD clinic she requested a pregnancy test and checkup for HIV and STD.

Physical Exam: Sara is in good health and takes no medications. The rest of her exam is normal.

Screening Results: Sara drinks 3-4 drinks during the week and up to 6 beers and shots on weekend nights (Thursday, Friday and Saturday). Her average weekly intake is about 22 drinks per week, but she denies any alcohol-related consequences or concerns. Her CAGE score is 0.

PATIENT

Background:

Sara: You are a 19 year-old college student. Last month you went to a bar with friends. The following morning you woke up in a strange room with your clothes scattered on the floor. You quickly got dressed and ran out to the street and caught a cab home. You don't know how you got there. You drink 3-4 beers during the week and up to 6 beers and shots on most weekend nights. You think this kind of drinking is the "norm" for most people your age. You are at the STD clinic because you are concerned since you missed your period and have some burning on urination and did not want to go to student health.

If Provider Asks About Pros & Cons:

PROS: Everyone you know drinks like you do; it is a part of your social life. You enjoy the slight buzz you get when you drink and it especially feels good after a long week of studying. It helps you to have fun and forget about all your work. **CONS:** At first, nothing you can think of. **If provider prompts you about regrets:** you regret that you blacked out last month,

If Provider Asks About Readiness: You identify yourself as a 2 on the Readiness Scale and feel that there isn't really a need to change your behavior. **If provider asks "why not 1?":** you don't want to black out again – you missed your period this month and are a little worried about what may have happened the night you blacked out.

If Provider Suggests Plan/Next Steps: You don't really feel that drinking is a problem but you agree that maybe drinking so much that you black out is not a good thing. So you agree to try to drink less, drink slower and make sure there is a friend to watch out for you. **If provider suggests seeing a nurse about the missed period:** you agree to a pregnancy test which is negative. You also agree to cut down on the drinking.

BNI-ART Institute Case Study

Michael

PROVIDER

Background: Michael is a 17 year-old living at home with his mother. He is currently attending some afternoon courses towards a GED. He complains of continued pain following a superficial gunshot wound to the right flank last week. He had been at a party, heard a gunshot, and then felt pain in his back. He was discharged from the ED after a negative CT. He presents today requesting refills for Percocet and Motrin prescriptions.

Physical Exam: He complains of back pain. There is no chest pain or shortness of breath. Temperature and vital signs are within the normal ranges. Abdomen is soft. The wound is not infected. It appears to be local.

Screening Results: Michael reports drinking 2-4 drinks each day, drinking between 14 and 28 drinks per week. The maximum amount of drinks he had on any one day in the past month is 8 drinks.

PATIENT

BACKGROUND:

Michael: You are 17-years-old, living at home with your mother. You are currently working towards a GED. Your typical day includes getting up early, taking a shower, going outside to chill, attending an afternoon class, and then chilling and drinking with friends. You drink every day, 2 to 4 drinks per day (mostly beer but occasionally hard liquor) -- just enough to get and keep a buzz. You have stopped smoking marijuana as this violates your probation rules and you are "not trying to go to jail." Recently, you were drinking with your friends in the "wrong place at the wrong time," there was a fight, and you were shot and injured.

IF PROVIDER ASKS YOU ABOUT PROS & CONS:

PROS: You like the buzz and alcohol makes you feel good. Drinking is something that you do with your friends when you chill. Although it makes you feel a little bit angry, alcohol really helps to calm you down.

CONS: You don't like the headaches and hangovers the next morning. Sometimes after drinking, you pass out or vomit. Your family has expressed a need for you to cut back on your drinking. Also, alcohol has led to your getting in trouble, fighting, and was a contributing factor toward your gunshot injury. You are also concerned that alcohol will "mess up" your probation.

IF A PROVIDER ASKS YOU ABOUT YOUR READINESS: You identify yourself on the Readiness Ruler as 8 out of 10. You do not choose 5 because you are really ready to change and realize that there are people currently in your life that are trying to bring you down and hold you back, and that this needs to change. You also describe your drinking as "alcohol addiction" since you drink every day.

IF A PROVIDER SUGGESTS PLAN/NEXT STEPS: You decide to decrease your amount of days drinking; you set a goal of having one drink one day a month. **If a provider asks you to make an action plan:** You realize this will be hard as all of your friends drink, but make a plan to "chill with positive influence people." You have an aunt who stopped drinking and can be a good support person. You want to cut back on drinking to be more stable and in control of situations, and also in order to focus on getting your GED. You agree to speak with project ASSERT and accept a referral to outpatient counseling.

BNI-ART Institute Case Study

Michael

PROVIDER

Background: Michael is a 24 year-old living at home with his mother. He is currently attending some afternoon courses towards a GED, and working at night in a 7-11 store. He presents today at the clinic because he is concerned about sores on his penis.

Physical Exam: He has lesions typical of herpes simplex

Screening Results: Michael reports drinking 2-4 drinks each day, drinking between 14 and 28 drinks per week. The maximum amount of drinks he had on any one day in the past month is 8 drinks and drank >4 in 2hrs once in last month when he didn't use a condom. CAGE 1 He feels guilty about not protecting himself.

PATIENT

BACKGROUND:

Michael: You are 24 years-old, living at home with your mother. You are currently working towards a GED, and working the night shift at a 7-11 store. Your typical day includes getting up early, taking a shower, going outside to chill, attending an afternoon class, and then chilling and drinking with friends. You drink every day, 2 to 4 drinks per day (mostly beer but occasionally hard liquor) -- just enough to get and keep a buzz. You have stopped smoking marijuana as this violates your probation rules and you are "not trying to go to jail." One week ago you were drinking with your friends at a bar and met a good looking young man who invited you to his apartment for drinks. You recently developed a burning rash on your penis.

BNI-ART Institute Case Study

Maria

PROVIDER

Background: Maria is a 17 year-old living at home with family. She has recently been committed to DYS custody. She presents to the ED with abrasions and possible wrist fracture after falling.

Physical Exam: The patient is a well-nourished young woman. She reports falling in gravel parking lot, attempted to catch herself with her right hand. Right wrist shows mild edema, mild tenderness upon palpation. Good pulses. You believe you smell alcohol on her breath.

Screening Results: Maria drinks 1 pint hard liqueur (11 shots) 3 times per month. She also reports marijuana abuse in the past.

PATIENT

Background:

Maria: You are a 17-year-old living at home with your mother, father, and brother. You are currently working towards a GED, and recently were committed to DYS and are subsequently drug tested once a week. You don't like the strict rules at home. When you fight with your mom, you leave the house to go drink with your friends. When you drink, you consume a pint of hard liquor; you do this about 3 times per month. You had a fight with your mother earlier today, and went off to drink in a parking lot. You heard police sirens in the distance, took off running, and fell to the ground. You present to the ED with a possible fractured wrist.

IF PROVIDER ASKS YOU ABOUT PROS & CONS

PROS: You like the taste of mixed drinks. You are normally a shy person and like how alcohol makes you feel comfortable, confident, and relaxed when talking to other people. Drinking also takes your problems away—or at least makes you stop thinking about them. And it's something to do when you are bored.

CONS: You don't like waking up the next morning not feeling well. Your hangovers make you feel "trashy—like a bum." You don't like the way you look when you are drinking. Coming home late after drinking creates more problems with your mom. Since you are underage, you know that you could get in trouble if the police caught you drinking.

IF A PROVIDER ASKS YOU ABOUT YOUR READINESS: You identify yourself on the Readiness Ruler as 6 out of 10. You do not choose 3 because you are really ready to change—you are "dying to stop drinking." You realize that sometime you feel like you want to drink—but sometimes you feel like you NEED to drink.

IF A PROVIDER SUGGESTS PLAN/NEXT STEPS: You agree to decrease the amount of alcohol you drink. Instead of a whole pint, you will just have 2 shots mixed with soda and make it last the whole night.

If prompted by the provider: You feel confident that you can decrease your alcohol consumption because you have successfully cut back on smoking pot. You know that you are able to control yourself and can beat your addictions.

IF PROVIDER ASKS YOU ABOUT PROS & CONS:

PROS: You like the buzz and alcohol makes you feel good. Drinking is something that you do with your friends when you chill. Although it makes you feel a little bit angry, alcohol really helps to calm you down.

CONS: You don't like the headaches and hangovers the next morning. Sometimes after drinking, you pass out or vomit. Your family has expressed a need for you to cut back on your drinking. Also, alcohol has led to your getting in trouble, fighting, and was a contributing factor toward your gunshot injury. You

are also concerned that alcohol will “mess up” your probation. But most of all you are upset that you didn’t use a condom and got what looks to you like herpes.

IF A PROVIDER ASKS YOU ABOUT YOUR READINESS: You identify yourself on the Readiness Ruler as 8 out of 10. You do not choose 5 because you are really ready to change and realize that there are people currently in your life that are trying to bring you down and hold you back, and that this needs to change. You also describe your drinking as “alcohol addiction” since you drink every day.

IF A PROVIDER SUGGESTS PLAN/NEXT STEPS: You decide to decrease your amount of days drinking; you set a goal of having one drink one day a month. **If a provider asks you to make an action plan:** You realize this will be hard as all of your friends drink, but make a plan to “chill with positive influence people.” You have an aunt who stopped drinking and can be a good support person. You want to cut back on drinking to be more stable and in control of situations, and also in order to focus on getting your GED. You agree to accept a referral to outpatient counseling and to use condoms.

BNI-ART Institute Case Study:

Ms. Jones

PROVIDER

Background: Ms. Jones is a 19 year-old college student, who was drinking in her dorm room with friends. She tripped and hit her head on the bathroom sink. She sustained a superficial laceration over her right eye with an underlying hematoma. Her friends state that there was no loss of consciousness. They insisted she go to the student health center to be checked out. She was subsequently sent to the ER by student health center staff.

Physical Exam: Ms. Jones is in good health and takes no medications. The smell of alcohol on her breath is unmistakable. The rest of her exam is normal.

Screening Results: Ms. Jones drinks 3-4 drinks during the week and up to 6 beers on weekend nights (Thursday, Friday and Saturday). Her average weekly intake is about 22 drinks per week, but she denies any alcohol-related consequences or concerns.

PATIENT

Background:

Ms. Jones: You are a 19 year-old college student. You were drinking in your dorm room with friends. You went to the bathroom, slipped, and hit your head on the sink. You cut your forehead, and although it bled a lot, you want to put a Band-Aid on it and go to bed. You don't know what the big deal is, and what you are doing at the Emergency Department. You are aggravated with having to speak to the doctor about your drinking. You see no association between your alcohol use and tripping in the bathroom. The floor was wet. You drink 3-4 beers during the week and up to 6 beers on most weekend nights. You think this kind of drinking is the "norm" for most people your age.

If Provider Asks About Pros & Cons:

PROS: Everyone you know drinks like you do; it is a part of your social life. You enjoy the slight buzz you get when you drink and it especially feels good after a long week of studying. It helps you to have fun and forget about all your work.

CONS: At first, nothing you can think of. **If provider prompts you about regrets:** you regret having to spend time in the ED but then you also remember that you blacked out last week and aren't quite sure what happened.

If Provider Asks About Readiness: You identify yourself as a 2 on the Readiness Scale and feel that there isn't really a need to change your behavior. **If provider asks "why not 1?":** you don't want to black out again – you missed your period this month and are a little worried about what may have happened the night you blacked out.

If Provider Suggests Plan/Next Steps: You don't really feel that drinking is a problem but you agree that maybe drinking so much that you black out is not a good thing. So you agree to try to drink less, drink slower and make sure there is a friend to watch out for you. **If provider suggests seeing a nurse about the missed period:** you agree to a pregnancy test which is negative. You also agree to cut down on the drinking.

BNI-ART Institute Case Study:

Ms. Jones

PROVIDER

Background: Ms. Jones is a 19 year-old college student, who at the STD clinic she requested a pregnancy test and checkup for HIV and STD.

Physical Exam: Ms. Jones is in good health and takes no medications. The rest of her exam is normal.

Screening Results: Ms. Jones drinks 3-4 drinks during the week and up to 6 beers and shots on weekend nights (Thursday, Friday and Saturday). Her average weekly intake is about 22 drinks per week, but she denies any alcohol-related consequences or concerns. Her CAGE score is 0.

PATIENT

Background:

Ms. Jones: You are a 19 year-old college student. Last month you went to a bar with friends. The following morning you woke up in a strange room with your clothes scattered on the floor. You quickly got dressed and ran out to the street and caught a cab home. You don't know how you got there. You drink 3-4 beers during the week and up to 6 beers and shots on most weekend nights. You think this kind of drinking is the "norm" for most people your age. You are at the STD clinic because you are concerned since you missed your period and have some burning on urination and did not want to go to student health.

If Provider Asks About Pros & Cons:

PROS: Everyone you know drinks like you do; it is a part of your social life. You enjoy the slight buzz you get when you drink and it especially feels good after a long week of studying. It helps you to have fun and forget about all your work.

CONS: At first, nothing you can think of. **If provider prompts you about regrets:** you regret that you blacked out last month,

If Provider Asks About Readiness: You identify yourself as a 2 on the Readiness Scale and feel that there isn't really a need to change your behavior. **If provider asks "why not 1?":** you don't want to black out again – you missed your period this month and are a little worried about what may have happened the night you blacked out.

If Provider Suggests Plan/Next Steps: You don't really feel that drinking is a problem but you agree that maybe drinking so much that you black out is not a good thing. So you agree to try to drink less, drink slower and make sure there is a friend to watch out for you. **If provider suggests seeing a nurse about the missed period:** you agree to a pregnancy test which is negative. You also agree to cut down on the drinking.

BNI-ART Institute Case Study

Charles

PROVIDER

Background: Charles is an 18 year-old recent high school graduate living at home with his parents. He works the evening shift in a telephone call center. He was referred today by a community health center for rule-out appendicitis.

Physical Exam: He appears uncomfortable. No fevers, nausea, or vomiting. There is tenderness in the right lower abdomen. Lab results show normal white count. Abdominal CT is negative for appendicitis. He will be discharged home to follow-up with primary care physician.

Screening Results: Charles reports drug use; smokes marijuana every weekend, for a total of 8-9 times per month. Smokes alone and with others; often forgets things while smoking. He also rides in cars driven by friends that are high.

PATIENT

BACKGROUND:

Charles: You are 18-years-old, living at home with your parents. You recently graduated from high school and are currently working the evening shift at a telephone call center. After work, you hang out with friends and watch basketball or football games on television. On the weekends, you usually play sports and smoke marijuana. You do smoke by yourself sometimes, often forget things while you were smoking, and have ridden with a driver who was high on several occasions. Three times this year, you have been in fights, but the other person has always started them.

IF PROVIDER ASKS YOU ABOUT PROS & CONS:

PROS: You like the relaxed and happy feeling of being high. You also like how smoking helps to relieve pain.

CONS: You don't like the taste of marijuana, nor how it makes you tired. Once, after smoking at a party, you were "attacked by a couple of guys" and injured. But you don't necessarily think that there was a connection between the fight and your drug use.

IF A PROVIDER ASKS YOU ABOUT YOUR READINESS: You identify yourself on the Readiness Ruler as 5 out of 10. You do not choose 1 or 2 because you have thought about doing drastic things while on marijuana— not like "going off and robbing a bank or anything"—but you see that marijuana can have a strong effect and can make you do negative things. You feel you can be more responsible about your use.

IF A PROVIDER SUGGESTS PLAN/NEXT STEPS: You decide to decrease your amount of smoking; you set a goal of cutting back to two times per month only smoking at parties. **If a provider asks you to make an action plan:** The one bad thing about cutting back will be that it will become harder for you to sleep. However, you know that you can cut down since you have already decreased your smoking. Back in high school, you used to smoke every day after football practice. You agree to follow-up with your primary care doctor.

Case studies are reproduced with permission from BNI-ART Institute.

Appendix I. Sample Release Form

Sample Release of Information

I, _____, authorize _____
(Client Name) (Clinic, Counselor or Doctor's Name)

to disclose to _____
(Name and Location of Person(s)/Organization to Receive Information)

the copies of any and all records and information which you may have in your possession. This includes all the transmission of information and data via verbal and electronic contact.

These records and information include, but may not be limited to:

- Hospital records, including that of attending nurses, physicians, health care personnel and technicians
- Laboratory test results
- Medical examination results
- Medical opinions, diagnosis, progress notes and recommendations
- Treatment plans and progress
- Description of treatment and prescriptions
- Notes of conversations, phone calls, memoranda or any type of communication concerning the overall treatment

I understand that the purpose of this disclosure is: _____

This authorization expires on: _____, or when _____ is no longer providing me with services.

I understand that my records are protected under Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Print Client Name _____ Date _____

Signature of Client _____

Date of Birth _____

Print Witness Name _____ Date _____

Signature of Witness _____

ATTENTION RECIPIENT – Notice Prohibiting Redisclosure

This information has been disclosed to you from the records protected by Federal confidentiality rules 42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug patient.

Appendix J. Sample Client Update Report

Today's Date:	Service Provider's Name:	Service Provider's Address:
---------------	--------------------------	-----------------------------

SECTION 1: CLIENT IDENTIFICATION

Last Name:	First Name:	Middle Name:	Date of Birth:
------------	-------------	--------------	----------------

SECTION 2: CLIENT STATUS

Admission Date: _____ active discharged

SECTION 3: CLIENT COMPLIANCE

Other information: (check all that apply)

- referred to _____
- inpatient
- outpatient program (multiple sessions/wk)
- counseling (weekly or less often)
- withdrew against program advice

- medically compliant
- not medically compliant
- clinically compliant
- not clinically compliant
- no contact/abort
- relapsed
- incarcerated
- deceased

SECTION 4: CLINICAL SUMMARY

Notes:

Service Provider's Signature:

Service Provider's Phone Number:

Appendix K. Decisional Balance Worksheet

Decisional Balance Worksheet

You can use the exercise below to help a patient make a clear decision on whether he/she wants to change. This exercise asks a patient to articulate the pros and cons of changing, as well as continuing their current behavior.

One of the first steps toward successfully changing your substance use is reaching a clear decision that you want to change.

In this exercise, you will think about and record some of the important advantages and disadvantages of changing or continuing your drinking. You will stack up what you have to lose against what you have to gain.

Fill in the table below. When you are finished, review your answers and weigh your reasons for change. Which way does your decisional balance tip?

Changing Your Current Drinking

What's good about it?

What's not so good about it?

Continuing Your Current Drinking

What's good about it?

What's not so good about it?

Appendix L. Pocket Cards

Quick Reference Guide

Funded by SAMHSA • Administered by Colorado Division of Behavioral Health
Managed by Best Business Services, Inc. • Colorado Division of Behavioral Health

YOUR SCREENING RESULT

A STANDARD DRINK

ANY DRINK CONTAINING ABOUT 14 GRAMS OF ALCOHOL*

*NIAAA (www.rethinkingdrinking.niaaa.nih.gov)

12 oz beer 5 oz wine 1.5 oz liquor

LOWER RISK DRINK LIMITS

	DAILY	WEEKLY	OCCASION
WOMEN	1	7	4
MEN	2	14	5
OVER 65	1	7	4

LESS IS BETTER

IT'S SAFEST TO AVOID ALCOHOL IF YOU ARE

- taking medications that interact with alcohol
- have a health condition made worse by drinking
- underage
- planning to drive a vehicle or operate machinery
- pregnant or trying to become pregnant

HOW READY ARE YOU? HOW CONFIDENT ARE YOU? HOW IMPORTANT IS IT TO YOU?

NOT AT ALL 1 2 3 4 5 6 7 8 9 10 EXTREMELY

SOMEWHAT

SBIRT Pocket Card, Adolescents (April 2016)

How many times in the past year have you used tobacco, alcohol or marijuana?
Never, Once or twice, Monthly, Weekly or more

Potential consequences of alcohol and drug use:

Alcohol use is related to the most common causes of injury and death among adolescents.

How much is one drink?

Any Drink Containing About 14 Grams Of Alcohol
*NIAAA (www.RethinkingDrinking.NIAAA.NIH.gov)

Risk Levels

- Never/No use = No risk.
- Once or twice in past year = Low risk.
- Monthly use = Moderate risk.
- Weekly or more = High risk.

What is binge drinking?

	YEARS	DRINKS IN A SITTING
FEMALES	9-17	3
	9-13	3
MALES	14-15	4
	16-17	5

HOW IMPORTANT IS IT TO YOU? | HOW READY ARE YOU? | HOW CONFIDENT ARE YOU?

NOT AT ALL 0 1 2 3 4 5 6 7 8 9 10 EXTREMELY

01 RAISE THE SUBJECT Build rapport: Explore how things are going. Ask permission: "Would it be ok to discuss your answers to the alcohol and drug questions?"

02 PROVIDE FEEDBACK

- Review reported responses. Reinforce positive choices: "It's great that you've chosen not to use alcohol or drugs at this stage of your life. What made you make that decision?"
- Provide feedback: "Alcohol/marijuana use can be especially harmful at this stage of your life when your brain is still developing..."
- Recommend abstinence: "Because I care about your well-being, the best choice is to completely avoid alcohol and drugs at this time in your life."
- Elicit response: "What do you think about this information?"

03 ENHANCE MOTIVATION

- Explore pros and cons: "What do you like about drinking/using marijuana?" "What are some of the not so good things about drinking/using marijuana?" Summarize both sides.
- Explore readiness to change: "On a scale where 0 is not at all ready and 10 is very ready, how ready are you to stop drinking/using marijuana?" Respond: "What made you choose x and not a lower number?"
- Reasons to change: "What are some of the best reasons you can think of to avoid alcohol/marijuana?"

04 NEGOTIATE AND ADVISE

- Reinforce autonomy: "What you choose to do is up to you." Elicit input from adolescent: "What next steps would you like to take?"
- Negotiate a goal.
- Harm reduction: Contract for Life (if 'yes' to car question). Ask: "What steps could you take to reduce harms from alcohol or drug use?"
- Assist with developing a plan. Address co-occurring mental health and other issues.
- Arrange follow-up: depends on level of risk.
- Thank them.

This guide can be used for other risky behaviors, such as tobacco or illicit drug use.

OPTIONS FOR MORE HELP
Referral • www.LinkinCare.org

Funded by SAMHSA • Administered by Colorado Office of Behavioral Health Managed and Implemented by Peer Assistance Services, Inc. • Initiative of Colorado Office of the Governor

SBIRT Colorado | 303.369.0039 ext. 245 | www.ImprovingHealthColorado.org

Please find additional helpful tools listed below from SBIRT Colorado at:

<http://improvinghealthcolorado.org/resources/>

SBIRT Pocket Card, Adults (June 2016)

Lower Risk Drink Limits Poster (September 2015); Spanish version (July 2016)

We Ask Everyone Alcohol Exam Room Poster (February 2016); Spanish version (July 2016)

Alcohol Screening and Brief Counseling Essential Steps (March 2014)

Alcohol and Substance Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) Guideline (September 2011)

Marijuana Guidance Supplement (February 2014)

Appendix M. Acronym List

12-Step	Twelve-Step Facilitation Therapy
AA	Alcoholics Anonymous
AAP	American Academy of Pediatrics
ACC	Assertive Continuing Care
A-CRA	Adolescent Community Reinforcement Approach
AMA	American Medical Association
APA	American Psychiatric Association
ASAM	American Society of Addiction Medicine
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
BSFT	Brief Strategic Family Therapy
CASA	National Center on Addiction and Substance Abuse
CBT	Cognitive-Behavioral Therapy
CDC	Centers for Disease Control and Prevention
CeASAR	Center for Adolescent Substance Abuse Research
CM	Contingency Management
CRAFFT	Car, Relax, Alone, Family, Friends, Trouble
DAST	Drug Abuse Screening Test
EHR	Electronic Health Record
FBT	Family Behavior Therapy
FFT	Functional Family Therapy
GAIN-SS	Global Appraisal of Individual Needs–Short Screener
ICD-10	International Classification of Diseases
MDFT	Multidimensional Family Therapy
MET	Motivational Enhancement Therapy
MI	Motivational Interviewing
MST	Multisystemic Therapy
MTF	Monitoring the Future National Survey
NA	Narcotics Anonymous
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NSDUH	National Survey on Drug Use and Health
PTSD	Post-Traumatic Stress Disorder
S2BI	Screening to Brief Intervention
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment

SMART	Specific, Meaningful, Attainable, Realistic and Time-bound
SSA	Single State Agencies
TFAH	Trust for America's Health
USPSTF	U.S. Preventive Services Task Force
WHO	World Health Organization

Appendix N. Kognito's SBI with Adolescents User Guide

VIRTUAL PATIENT ONLINE SIMULATION


An Integration Guide

SBI with Adolescents is a simulation designed to allow students and professionals to learn and practice how to conduct substance use SBIRT in conversations with realistic virtual patients.

The simulation is designed to complement this Learner's Guide by offering an engaging platform for students to apply and assess their SBIRT skills.

SBI with Adolescents

Assume the role of a health professional and talk with three virtual adolescent patients about their substance use. Try different approaches to see what works best.



Conversation Menu Virtual Coach Virtual Health Professional Virtual Patients

The simulation includes the following modules:

- **Introduction:** General info on adolescent substance use prevalence, consequences, & SBIRT
- **Screening:** Assessing substance use with validated tools
- **Brief Intervention:** Brief Negotiated Interview, Motivational Interviewing
- **2 Practice Conversations (Josh, Emily)**
- **1 Assessment Conversation (Kayla)**

The simulation takes approximately 1-hour to complete, and is accredited for 2.0 ANCC CNE, 2.0 NASW, and 2.0 CME AMA contact hours.



An Integration Guide

There are several ways in which SBI with Adolescents can supplement or augment in-class instruction. Each example below provides a proven integration model that institutions have embraced:

Classical Model

- Teach SBIRT principles and approach in class
- Students take Kognito simulation from the instructional content to interactive conversations at home
- Students take embedded self-assessment conversation within simulation
- Engage in in-class discussion to discuss learning outcomes and feedback

Hybrid Model

- Teach SBIRT principles and approach in class
- Go through one of the simulation scenarios in class within groups or pairs
- Students review instructional content and complete remaining scenarios individually
- Engage in in-class discussion to discuss learning outcomes and feedback

Flipped Model

- Students take all or part of the simulation as a homework assignment
- Students take embedded self-assessment conversation individually
- Class time is devoted to additional difficult cases, exercises, and follow-up questions
- Assessment conversation is then re-taken to show student improvement

Standalone Model

- Students take all of the simulation from the didactic content and interactive conversations at home or in professional settings
- Students take embedded self-assessment conversation individually
- Instructor reviews utilization reports to verify student completion and assessment scores. Within low-scoring sections, instructor can provide individual or in-class remediation
- Compliance and/or successful completion can be linked to assessment score/certification

Performance Monitoring and Improvement

- Usage reports contain vital information in understanding your students' engagement with the simulation, as well as their performance and completion information.
- Score history reports detail each user's progress over time, which can be used to inform where additional training may be needed.
- To access reports for your institution, contact the NORC Learning Collaborative at SBIRTeam@norc.org.

Helpful Hints

- To access the simulation, students need:
- **This link:** www.kognitocampus.com
 - **The Enrollment Key** provided by NORC or Kognito
 - Students can access the virtual patient simulation from any desktop or laptop.
 - Students can start and stop the simulation at any time, or even log out of the system. User progress will be saved.
 - Closed captions are available for those who are hearing-impaired or wish to read dialogue.
 - Kognito technical support is available between 9-6PM ET by contacting support@kognito.com or 646.923.8632.



Appendix O. Resources

Below are a number of resources that may be of interest. Additional resources can be found at <http://sbirt.webs.com/resources>.

1. **Low-risk Drinking Guidelines:** IRETA staff member Piper Lincoln demystifies our national drinking guidelines in this blog. <https://ireta.org/resources/low-risk-drinking-guidelines-where-do-the-numbers-come-from/>
2. **Implementation Barriers to and Facilitators of Screening, Brief Intervention, Referral, and Treatment (SBIRT) in Federally Qualified Health Centers (FQHCs):** This report reviews the research literature on the barriers in FQHCs and primary care and strategies for overcoming those barriers to integrate substance use (SU) care into evolving patient-centered medical/health homes (PCMHs). The literature review is supplemented by extensive interviews with experts and site visits to FQHCs across the country. From these data, several opportunities have been identified that could help FQHCs adopt and sustain SU screening and treatment as a routine part of whole-person care for their patients. <https://aspe.hhs.gov/report/implementation-barriers-and-facilitators-screening-brief-intervention-referral-and-treatment-sbirt-federally-qualified-health-centers-fqhcs>
3. **AAP Substance Use Screening and Intervention Implementation Guide:** Developed by the American Academy of Pediatrics (AAP) in collaboration with the CDC, the [AAP Substance Use Screening and Intervention Implementation Guide](#) is designed to help pediatricians incorporate screening, brief intervention, and referral to treatment (SBIRT) for use of alcohol, tobacco, marijuana, and other drugs among adolescent patients. IRETA also produced a webinar to discuss the rationale for the AAP's policy statement and current efforts to advance adolescent SBIRT primary care settings. Access the webinar at <http://my.ireta.org/node/1394>.
4. **AAP Information on Marijuana:** AAP provides position statements, policies, reports on marijuana use. Access these reports including the AAP's Policy Statement – The Impact of Marijuana Policies on Youth: Clinical, Research, and Legal Update at <https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/substance-use/Pages/marijuana.aspx>
5. **Adolescents and E-Cigarette Use:** Adolescent rates of e-cigarette use are rising rapidly. In response to this growing public health issue, the Surgeon General released a new website with resources for teens and parents. Access the website at <https://e-cigarettes.surgeongeneral.gov/>. Practitioners may also be interested in the 5 A's Intervention.

Developed by the U.S. Public Health Service, the 5 A's is a best-practice guideline supported by the American College of Obstetricians and Gynecologists and the National Cancer Institute. Learn more about the steps at <https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html>

6. **Substance Use Employer Cost Calculator** – <https://www.nsc.org/forms/substance-use-employer-calculator/index.aspx>: This free, online tool is a joint project of the National Safety Council, Shatterproof, and NORC at the University of Chicago. The calculator uses Dr. Eric Goplerud's analysis of the latest economic data and National Survey on Drug Use and Health data to compute the business costs associated with substance use in the workplace. A methodology report describing the data sources and methods underpinning the cost calculator can be found at <https://www.shatterproof.org/resources/substance-use-cost-calculator-employers-methodology>.
7. **Adolescent SBIRT Trainings**: NORC has prepared a suite of materials to support adolescent SBIRT training in a variety of programs. We offer one-hour, half-day, one-day, and two-day versions of power point slide decks for your use in conducting live trainings. More information is available by contacting the SBIRTeam@norc.org.
8. **MEL Project Report on Implementing SBIRT for Youth**: Abt Associates conducts evaluation to gain a better understanding of the various approaches to implementation of youth SBIRT being utilized across the Conrad N. Hilton Foundation's diverse grantees. Abt collects information about how SBIRT services are defined and administered within the Hilton Foundation's funded implementation projects, and to identify similarities and differences between implementation models across sites. Access the reports at <https://www.hiltonfoundation.org/learning/substance-use-prevention-initiative-2016-evaluation-report> and <https://www.hiltonfoundation.org/learning/substance-use-prevention-initiative-2018-evaluation-report>
9. **Confidentiality Resources from Legal Action Center**: The Legal Action Center developed a tool to help organizations determine if federal alcohol and drug confidentiality rules apply to their SBIRT services. The first tool is a Decision Tree that walks you through a series of questions to help you determine if the rules apply to your program. The second tool is a Fact Sheet on confidentiality rule 42 CFR Part 2. For more information, see <https://lac.org/what-we-do/substance-use/prevention-advocacy/>
10. **The Substance Abuse and Mental Health Data Archive (SAMHDA)**: SAMHSA and RTI International provide a wide range of data for analysis. Tools, resources, documentation and data are updated frequently to deliver the most relevant data. Data set files are available for download in SAS, SPSS, STATA, and ASCII formats. For more information, see <http://datafiles.samhsa.gov/>.

11. **UCSF's Drug Abuse Intervention App:** The University of California San Francisco (UCSF) SBIRT group with funding from SAMHSA has released another excellent SBIRT app that is available for free. The medical app walks you through a typical SBIRT interaction from screening to brief intervention and referral to treatment. The app includes an abundant amount of background information on the current epidemiology of alcohol and substance abuse, evidence for SBIRT, step-by-step instructions on how to perform an evaluation, links for referral sites, embedded videos and demos of SBIRT evaluations and social support, and follow-up questionnaires for providers trained in SBIRT. For more information, see the article on MEDPAGE TODAY at <http://www.medpagetoday.com/Blogs/IltifatHusain/59984> and download the app at <https://itunes.apple.com/us/app/ohn-sbirt/id1109510478?mt=8&ign-mpt=uo%3D8>

12. **Treatment Episode Data Set (TEDS):** TEDS is maintained by the Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration (SAMHSA). The TEDS system includes records for some 1.5 million substance abuse treatment admissions annually. While TEDS does not represent the total national demand for substance abuse treatment, it does comprise a significant proportion of all admissions to substance abuse treatment, and includes those admissions that constitute a burden on public funds. For more information, visit <https://www.dasis.samhsa.gov/webt/information.htm>.

13. **Adolescent SBIRT Toolkit for Providers:** The toolkit is a step-by-step health care providers' guide to prevent and address youthful substance use. The Toolkit includes anticipatory guidance ideas and effective screening and intervention tools for providing SBIRT (Screening, Brief Intervention and Referral to Treatment). The toolkit promotes a new screening tool, the S2BI. Listings for accessing a range of treatment services are highlighted. A full print copy with samples of free Massachusetts Department of Public Health prevention or treatment booklets for youth and parents can be ordered at <https://massclearinghouse.ehs.state.ma.us/PROG-BSAS-SBIRT/SA1099.html>.

14. **Clinical SBIRT Proficiency Checklist (CSPC):** Developed by the Proficiency Checklist Workgroup funding by SAMHSA, the CSPC is a validated tool used to assess competency of medical professionals performing SBIRT.^{108,109} See a copy of the tool below.



SBIRT Proficiency Checklist

Trainee Name: _____

Date: _____

Preceptor: _____

Screening (3 items)	Present	Not Present	N/A
Accurately assesses quantity and frequency of alcohol and/or drug use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accurately identifies the patient’s level of risk related to their alcohol or other drug use using an appropriate evidence-based screening instrument.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assesses possible consequences of the patient’s behavior, such as physical, psychosocial, and other consequences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brief Intervention (4 items)	Present	Not Present	N/A
Asks permission to provide feedback about the patient’s substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses reflection and/or open-ended questions to allow patient to react to screening result.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provides feedback about risks associated with the patient’s substance use behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negotiates a goal with the patient based on steps he/she is willing to take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referral to Treatment and Follow-Up (3 items)	Present	Not Present	N/A
Recognizes the patient’s need for substance use treatment based on their screening score and/or medical/behavioral factors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suggests the use of specific community and specialty resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arranges appropriate follow-up (follow-up with provider, referral to treatment, counseling, medication, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motivational Interviewing Spirit (3 items)	Present	Not Present	N/A
Summarizes patient’s stated reasons for change.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negotiates a treatment plan in a collaborative manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affirms the patient’s strengths, ideas, and/or successes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments (may continue on back):

Appendix P. Acknowledgements

Individual Collaborators

Dr. Tracy L. McPherson and Dr. Eric Goplerud: For more than a decade, Drs. McPherson and Goplerud have been among the most visible leaders in the country in substance use training, technical assistance, research and evaluation. Prior to joining NORC at the University of Chicago, Drs. McPherson and Goplerud developed the Center for Integrated Behavioral Health Policy and Ensuring Solutions to Alcohol Problems at George Washington University. As a Senior Fellow and Senior Research Scientist respectively, Drs. Goplerud and McPherson work with professional associations, academic institutions, employers, health insurers, accrediting bodies and government agencies on policy, education, training and quality improvement initiatives that are transforming approaches to detecting and treating alcohol, prescription illicit, and other drug use. Web: www.norc.org

Working in collaboration with Drs. McPherson and Goplerud, **Misti Storie, MS, NCC, MAC**, provides training and technical assistance for the Adolescent SBIRT initiative at NORC. A psychotherapist and consultant in Decatur, Georgia, with a specialization in addiction and trauma, she serves as the Technical Consultant with the BIG SBIRT Initiative, with whom she develops webinars, training materials, and other educational products to expand the use of SBIRT. Web: www.mististorie.com

Additional **members of the NORC staff** that contributed to the production of this Learner’s Guide are listed below in alphabetical order:

Sabrina Bauroth
Hildie Cohen
Hannah Joseph
Danielle Noriega
Anna Schlissel

Consultants (alphabetical order)

Edward Bernstein, M.D.
Professor of Emergency Medicine,
Boston University School of Medicine;
Professor of Community Health Sciences
Boston University School of Public Health

Judith A. Bernstein, RNC, PhD
Professor of Community Health Sciences,
Boston University School of Public Health;
Professor of Emergency Medicine,
Boston University School of Medicine

Michael Brooks, LCSW, BCD (Emeritus)
Organizational Consultant

Brett R. Harris, DrPH
Clinical Assistant Professor
University at Albany School of Public Health

Sharon Levy, MD, MPH
Director, Adolescent Substance Abuse Program
Boston Children's Hospital
Associate Professor of Pediatrics
Harvard Medical School

Ann M. Mitchell, PhD, RN, FAAN
Professor of Nursing and Psychiatry
University of Pittsburgh

J. Paul Seale, MD
Professor and Director of Research
Navicent Health and Mercer University School of Medicine
Macon, GA

David M. Stevens, MD, FAAFP
Research Professor
Milken Institute School of Public Health
George Washington University

Carolyn J. Swenson, MSPH, MSN, RN
Manager of Training and Consultation-SBIRT Colorado
Peer Assistance Services, Inc.

Ken C. Winters, PhD
Addiction Researcher
Winters Consulting Group

Organizational Collaborators (alphabetical order)

The American Association of Colleges of Nursing (AACN) is the national voice for academic nursing representing 810 schools of nursing nationwide. AACN establishes quality standards for nursing education, influences the nursing profession to improve health care, and promotes public support of baccalaureate and graduate nursing education, research, and practice. For information, visit www.aacnnursing.org.

Association for Addiction Professionals (NAADAC) is the largest membership organization that represents the professional interests of more than 85,000 addiction counselors, educators and other addiction-focused health care professionals in the United States, Canada and abroad. NAADAC's 10,500 members are addiction counselors, educators and other addiction-focused health care professionals, who

specialize in addiction prevention, treatment, recovery support and education. An important part of the healthcare continuum, NAADAC's members and its 47 state affiliates work to create healthier individuals, families and communities through prevention, intervention, quality treatment and recovery support. To learn more, please visit www.naadac.org

Center for Clinical Social Work (CCSW) promotes clinical social work as a profession that is highly respected and clearly defined in terms of the rights of its members, the standards to which they adhere and the unique abilities they bring to the challenge of helping others.

Web: www.centercsw.org and acswa.org

Council on Social Work Education (CSWE) is a nonprofit national association representing more than 2,500 individual members, as well as graduate and undergraduate programs of professional social work education, and is recognized as the sole accrediting body for social work education in this country.

Web: www.cswe.org

Institute for Research, Education & Training in Addictions (IRETA) is an independent nonprofit with a mission to help people respond effectively to substance use and related problems. IRETA is a federally-designated training and dissemination center for Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based approach to reducing and preventing at-risk substance use.

Web: www.ireta.org

Kognito

Kognito is a health simulation company that believes in the power of conversation to change lives. We are pioneers in developing research-proven, role-play simulations that prepare individuals to lead real-life conversations that result in measurable changes in social, emotional, and physical health. Our growing portfolio of simulations is used by 300+ leading health, education, government, and nonprofit organizations for professional development and public education. To date, more than 1 million people have engaged in a Kognito simulation. Kognito is the only company with health simulations listed in the National Registry of Evidence-Based Programs and Practices (NREPP). Learn more at www.kognito.com.

NORC at the University of Chicago (NORC) creates unique value for its clients by developing effective, innovative solutions that combine state-of-the-art technology with high quality social science research in the public interest. Web: www.norc.org