



TESTIMONY

UNIVERSAL HEALTH CARE ACTION NETWORK OF OHIO (UHCAN OHIO)

Ohio Department of Education Plan for Every Student Succeeds Act

Joint Education Oversight Committee

March 9, 2017

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Chairman Cupp, Ranking Member Sykes, thank you for this opportunity for UHCAN Ohio to testify on the Ohio Department of Education's plan to implement the Every Student Succeeds Act

Overview

The Universal Health Care Action Network of Ohio (UHCAN Ohio) appreciates the opportunity to testify on Ohio's proposed plan to implement the *Every Student Succeeds Act* (ESSA). UHCAN Ohio is a statewide health care advocacy organization whose mission is to achieve high quality, accessible, affordable health care for all Ohioans. We ask that the Ohio ESSA plan be modified to add substance misuse as a named concern, and SBIRT as a specific strategy that can be used in schools to address substance misuse.

In 2014 we started a new campaign called *Somebody Finally Asked Me!* (SFAM). This campaign advocates for universal screening (not testing) of young people for risky substance use. It is called Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT has the support of the American Academy of Pediatrics, who urge their physicians to apply SBIRT in medical settings to adolescents. Through simple questions asked privately by trained professionals, adolescents who acknowledge even minimal drug or alcohol experimentation can be assisted to examine this use and develop strategies to avoid substance use. UHCAN Ohio's focus has been encouraging schools to adopt SBIRT; eight school districts are implementing SBIRT.¹

We commend the Ohio Department of Education ("Department") for reaching out to interested parties throughout the state. We note, however, that while the ESSA plan is clear about providing support for social and emotional learning and for mental health awareness, the plan could be clearer in acknowledging that risky substance use disrupts the well-being and academic success of students across Ohio and should be addressed.

In addition, the Department's ESSA plan identifies specific funded strategies/programs being carried out in Ohio schools that support student well-being. We urge the Department to include SBIRT as a specific strategy cited to address the concern of substance misuse.

We note that SBIRT for adolescents has received support from the U.S. Surgeon General in his 2016 report: *FACING ADDICTION IN AMERICA: The Surgeon General's Report on Alcohol, Drugs and Health*, calling "results of preliminary studies promising."

On February 10, 2017 the Ohio Joint Committee on Drug Use Prevention and Education convened by the Ohio Attorney General, the Speaker of the Ohio House and the Ohio Senate

¹ During the 2016-17 school year SBIRT is either being done or is in a planning stage in Allen, Butler Cuyahoga, Franklin, Hamilton and Scioto counties.

President released its recommendations for protecting and educating youth, particularly in schools, about the risks of substance misuse. The Committee recommends the use of proper screening techniques such as the Screening, Brief Intervention and Referral to Treatment (SBIRT) to detect substance abuse needs...”

A number of Ohio school districts are implementing or planning to implement SBIRT in their schools or school-based health centers. These include schools in Cleveland Heights/University Heights, Dublin, Lima, New Richmond, Norwood, Oxford and Portsmouth. Other states are supporting SBIRT for youth in different capacities. Wisconsin has implemented SBIRT for youth in the southeastern region. In New York approximately 200,000 students will receive SBIRT at the 227 SBHCs annually. Massachusetts requires all medical providers who are employed in the 32 SBHCs to implement SBIRT. A New Hampshire youth SBIRT Initiative targets primary care settings, hospitals and community health centers to implement SBIRT. (Harris, Ramos & Condon, 2015).

I. Adolescent substance misuse should be incorporated into the ESSA plan as a concern.

The plan incorporates the Department’s intention to use the Positive Behavioral Interventions and Supports (PBIS) framework to provide a well-rounded education.

In Section 6.1, the Department notes its intent to actively support the social-emotional well-being of students and identifies measurable items to be tracked in this endeavor, including incidents of bullying, harassment, and intimidation; reductions in the use of discipline practices that remove students from classrooms; and reducing the use of aversive behavioral interventions that compromise the health and safety of children will serve as benchmarks along with measures of student learning and measures of school climate.”

After “climate.” We would recommend that the following sentence be added:

Activity outside of the school campus can reduce social-emotional well-being and learning outcomes, including substance misuse, and schools need to address such misuse to improve learning outcomes of all students. Reduced substance use can be measured through OH YES and local survey data.

II. SBIRT should be identified as an in-school strategy to be considered in averting substance misuse by students.

The health and safety recommendations of the Department are contained in *Section 6: Supporting All Students* starting at page 86. Under the heading “Implementation of the PBIS Framework” (on page 90) the Department identifies particular areas of focus, including

behavioral and mental health and a particular approach to address the behavioral and mental health needs. This includes policies for teaching staff mental health awareness, trauma sensitive school approaches, and other policies. We suggest adding the language:

One such approach to behavioral health is Screening, Brief Intervention and Referral to Treatment (SBIRT). Schools may apply SBIRT to identify and intervene with students who are misusing substances and to make appropriate referrals, thus fostering a more positive school climate.

III. Support Within the ESSA Statute for Including SBIRT

Title IV (21st Century Schools), Part A (Student Support and Academic Enrichment Grants) is the ESSA section that provides funding for strategies that contribute to the well-being of the whole student. Section 4104 provides for activities that **foster safe, healthy, supportive and drug-free environments**. (Section 4104(b)(3)(B)—emphasis added)

Section 4108 identifies, **Activities to Support Safe and Healthy Students**, including drug and violence prevention activities and programs that are evidence-based, programs to educate students against the use of alcohol, tobacco, marijuana, smokeless tobacco products, and electronic cigarettes; and professional development and training for school personnel in prevention, education, early identification, intervention mentoring, recovery support services and, where appropriate, rehabilitation referral, as related to drug and violence prevention

Conclusion

The *Every Student Succeeds Act*, particularly at Title IV Part A, provides legislative support for a strong effort by schools to identify and address the issues that can impede a strong academic performance. The Ohio ESSA plan references specific strategies that the Department does and will employ to address mental health issues and well-being. UHCAN Ohio believes that it is also important to name substance misuse as a related problem, and that it is critical to identify strategies to address substance misuse by students. The recent report from the Ohio Joint Committee on Drug Use Prevention Education has specifically named SBIRT as a recommended approach for intervention. Schools across the country, as is noted in Appendix, are introducing SBIRT and the Surgeon General has called it a promising approach to adolescent substance misuse. We strongly recommend that the Ohio ESSA plan be modified to add substance misuse as a named concern, and SBIRT as a specific strategy that can be used in schools to address substance misuse.

Thank you for this opportunity to testify. The attached appendix provides documentation on the evidence basis for SBIRT use with adolescents.

**APPENDIX A – COMMENTS OF UHCAN OHIO ON THE
OHIO DEPARTMENT OF EDUCATION (ODE) *EVERY STUDENT SUCCEEDS ACT* (ESSA) PLAN**

Summary of the Research that Shows the Evidential Basis for SBIRT's Effectiveness with Youth

Prepared for UHCAN Ohio

by Shauna P. Acquavita, PhD, MSW & Kayleigh Fiser, BA January 2017

Executive Summary

Adolescent substance misuse and dependence is the origin of the most costly and largest preventable public health problem in America (CASA Columbia, 2011). Ohio is home to one of the highest rates of underage binge alcohol use in the U.S. (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Endorsed by the American Academy of Pediatrics (2011), Screening, Brief Intervention, Referral to Treatment (SBIRT) is an evidence-based practice to identify, reduce and prevent tobacco, alcohol and drug use and abuse (SAMHSA, 2016). SBIRT for youth can be performed in primary care centers, schools and school health centers (SBHC), after-school programs, youth centers and prenatal clinics (National Association of State Alcohol and Drug Abuse Directors [NASADAD], 2015).

While SAMHSA has funded grants to train and implement SBIRT since 2003, the main focus has been on adults. Systematic reviews of the literature conducted in 2012 and 2013 have found limited support of SBIRT with youth due to lack of research studies (Yuma-Guerrero et al., 2012; Mitchell et al., 2013). However, other states are implementing SBIRT in various settings for youth due to promising results from studies published since then. SBIRT for youth is being administered in high school health classes in some areas in Wisconsin; New York, Massachusetts and New Mexico are implementing SBIRT in SBHC's (Harris, Ramos & Condon, 2015; NASADAD, 2015). New Hampshire is implementing SBIRT in primary care, hospitals and community health centers (SBIRT-NH, 2016).

SBIRT in SBHC's and primary care offices has shown the most promising success. In a study with 12 high school SBHC's in New Mexico implementing SBIRT with adolescents ages 14 to 17, follow-up after six months indicated students had significant reductions in drug use and days of drinking to intoxication (Mitchell et al., 2012). In a quasi-experimental study of SBIRT in primary care offices with adolescents (12 to 18) with nine medical offices in New England and 10 in Prague, Czech Republic, results at three and six months indicated less alcohol use in participants from New England, less cannabis use in Prague, and an overall reduction in initiation to drinking with follow-up after 12 months (Harris et al., 2012). Other studies have shown that SBHC's that bill for SBIRT services will make SBIRT feasible and sustainable, and a variety of health care providers can implement SBIRT (Curtis, McLellan & Gabellini, 2014; Sterling et al., 2015). There are several valid and reliable screening tools available to administer SBIRT for youth, allowing it to be tailored to different settings. Moreover, within the next few years, ongoing studies funded by NIH and the Conrad Hilton Foundation will publish results that will provide more information on best practices for youth and SBIRT for approach, sustainability and settings. One of the studies overseen by the Centers for Disease Control examines how to implement SBIRT with youth as part of a comprehensive regional substance use disorder prevention and sexual risk behavior reduction program in Indiana, Kentucky and Ohio (Conrad Hilton Foundation, 2017).

With underage drinking costing the U.S. an estimated \$68 billion annually (CASA Columbia, 2011), prevention and intervention efforts are needed to address substance

use among youth. The effectiveness of SBIRT with youth is still being studied; however, results are promising. Being able to implement SBIRT in a wide variety of settings will allow for a greater reach to prevent and address substance use disorders in youth.

Introduction

Adolescent substance use and dependence is the origin of the most costly and largest preventable public health problem in America (CASA Columbia, 2011). Ohio is home to one of the highest rates of underage binge alcohol use in the U.S. (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The most common illicit drugs used among Ohio's high school-aged youth include synthetic cannabis, hallucinogens, prescription opioids and prescription stimulants (Ohio Substance Abuse Monitoring Network [OSAMN], 2016). OSAMN also reports Ohio youth are not using over the counter cough and cold medicine for medical purposes. Eighty percent of youth involved in the juvenile court system in Ohio report cannabis use (OSAMN, 2016). With 90% of adults who are diagnosed with a substance use disorder first using substances before age 18 (CASA Columbia, 2011), a prevention and intervention method is needed for substance misuse and dependence among youth.

Screening, Brief Intervention, Referral to Treatment (SBIRT) is an evidence-based practice to identify, reduce and prevent tobacco, alcohol and drug use and abuse (SAMHSA, 2016). Endorsed by the American Academy of Pediatrics (2011), SBIRT is based on a public health model and, in relation to youth, looks to eliminate substance use and dependence. While most commonly found in primary care centers, SBIRT for youth can be performed in a variety of community and educational settings such as schools and school health centers (SBHC), after-school programs, youth centers and prenatal clinics (National Association of State Alcohol and Drug Abuse Directors [NASADAD], 2015).

According to NASADAD (2015), other states are supporting SBIRT for youth in different capacities. Wisconsin has implemented SBIRT for youth in the southeastern region by hiring health educators to administer SBIRT in high school health classes. New York received a foundation grant to implement an electronic screening tool in SBHCs so that approximately 200,000 students will receive SBIRT at the 227 SBHCs annually. Massachusetts requires all medical providers who are employed in the 32 SBHCs to implement SBIRT. In 2013, 7,000 students were screened; 64% reported use of alcohol or drugs. New Hampshire Youth SBIRT Initiative targets primary care settings, hospitals and community health centers to implement SBIRT in order to screen a minimum of 10,000 youths and young adults (ages 12–22) by 2017 (SBIRT-NH, 2016). New Mexico implements SBIRT in their SBHCs and found from 2012–2013 38% of students who sought care screened positive for alcohol and/or drugs (Harris, Ramos & Condon, 2015).

Studies Conducted on Youth SBIRT

SAMHSA has funded grants to train and implement SBIRT since 2003; however, their main focus for SBIRT has been with adults. Yuma-Guerrero and colleagues' (2012) systematic review of randomized control trials for SBIRT with adolescents prior to January 2011 only found seven articles; two included participants who were 18 and older. Mitchell and colleagues (2013) conducted a review of the literature on randomized control trials for SBIRT with adolescents age 14 to 17 and found 13 studies (years 2005 to 2010). Due to the dearth of literature, results for both reviews were limited, and further research was recommended. Since then, other studies have been implemented to test the feasibility of SBIRT with adolescents.

Youth SBIRT

Cunningham and colleagues (2012) implemented a randomized control study with 726 adolescents using a Brief Intervention (BI) to address violence and alcohol misuse called SafERteens. Adolescents age 14 to 18 who were admitted to the Emergency Department at Hurley Medical Center in Flint, Michigan, between September 2006 and September 2009 were recruited. Youth completed a computerized assessment (including AUDIT-C), then were randomly assigned to a control group or BI delivered by a computer or therapist assisted by a computer. A total of 84% of participants completed a follow-up after 12 months. Compared to the control group, the therapist assisted by a computer group showed significant reductions in peer aggression and peer victimization after 12 months. BI and control groups did not differ on alcohol-related variables for the same period. Limitations included: a low level of alcohol use that allowed participants into the study; illicit drug use was not addressed; the study is specific to the location and has limited generalizability; self-report was used by participants; and findings may be biased to those who did participate in the 12-month follow-up.

A multi-site, repeated measures study examining SBIRT in SBHCs was conducted by Mitchell and colleagues (2012). Adolescents ages 14 to 17 from 13 high schools in New Mexico were administered SBIRT with the CRAFFT screening by behavioral health counselors from May 2005 to May 2008. A BI was administered depending on the score of the CRAFFT. Six-month, follow-up data was available on 553 participants. Results indicated students who received SBIRT had significant reductions in drug use and days of drinking to intoxication. Days of alcohol use did not show a significant result. Limitations to this study include: its high Hispanic population, limiting generalizability; lack of randomization; the use of self-report; and findings may be biased to those who participated in the six-month follow-up.

A quasi-experimental study of SBIRT in primary care offices with adolescents ages 12 to 18 years by Harris and colleagues (2012) was implemented at nine medical offices in New England (n = 2,096) and 10 in Prague, Czech Republic (n = 589). The study took place from 2005 to 2008. Participants completed measures, including the CRAFFT, during the initial treatment as usual study phase (TAU). The computer screening and brief advice (cSBA) group completed a computerized screen and viewed results, scientific information and true-life stories of the harms of substance use. Providers received talking points to prompt two to three minutes of brief advice. Results indicated the cSBA resulted in less alcohol use in New England (16% vs.

23% at 3 months; 29% vs. 38% 12 months) and less cannabis use in Prague (6% vs. 10% at 3 months; 17% vs. 29% at 12 months). A significant effect on initiation was found whereby 44% of fewer cSBA adolescents reported starting drinking during the 12-month period. There were similar findings for cannabis initiation in Prague. Limitations included: nonrandomized, asynchronous study design; two groups in New England were not equivalent in baseline substance use; results are unable to be generalized to other locations; and the effects of the intervention on other drug use was not able to be assessed.

Curtis, McLellan and Gabellini (2014) conducted a pilot study of how feasible and economical it was to implement SBIRT in two urban New York schools from February to June 2012. During that time, 248 students (four to five students per day) from grades 6–12 were randomly recruited. Students were screened using the CRAFFT tool, and BI was used when appropriate. Forty-two percent of students reported using alcohol and/or drugs within the past year. Results indicated that if billing of SBIRT had occurred, this could be economically feasible. Limitations included: a disproportionately high number of Hispanic students recruited, limiting generalizability; and no statistical analyses were performed examining outcomes for substance use, as this was a feasibility study.

A cluster-randomized, hybrid implementation and effectiveness trial with 1,871 patients of a large pediatric clinic at Kaiser Permanente in Oakland, California, was implemented between November 1, 2011, through October 31, 2013, by Sterling and colleagues (2015). Participants age 12 to 18 were randomized to either (1) pediatricians trained to provide SBIRT (Ped) or (2) Behavioral Health Care Practitioner trained to provide SBIRT (BHCP), or (3) Usual Care (UC). Ped and BHCP administered the CRAFFT. Results indicated Ped and BHCP had better screening, assessment and brief intervention rates than the UC arm. Patients in the Ped and UC arms were more likely to be referred to specialty treatment than those in the BHCP arm. BHCPs implemented SBIRT efficiently and effectively. Limitations included: study administered with adolescents who had insurance; the possibility that overlap in interventions between Ped and UC occurred; the use of self-report by participants; and no follow-up on outcomes for substance use among participants.

Screening Measure Studies for Youth SBIRT

It is important to have valid and reliable measures when assessing adolescents for alcohol, tobacco and other drugs. There are several screening tools available to implement SBIRT with youth. The most popular one is the Car, Relax, Alone, Friends/Family, Forget, Trouble (CRAFFT) (see Knight et al., 1999). However, limitations with the CRAFFT include: length of measures; lack of questions about tobacco use; and no individual risk scores for substances, only an overall score (Borus, Parhami & Levy, 2016). Therefore, screening tools that are efficient, accurate and include a wide variety of substances are being developed and/or tested for validity and reliability among the adolescent population for SBIRT.

Validation of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) for alcohol, tobacco and cannabis and ASSIST-Lite, an abbreviated version for cannabis, was conducted by Gryczynski and colleagues (2014). It was a cross-sectional study with 525 adolescents ages 12 to 17 at a federally qualified health center in Baltimore, Maryland. Results indicated good overall internal consistency and validity for the ASSIST. It was also able to measure problem severity for cannabis use, and identify tobacco, alcohol and cannabis use disorders. The ASSIST-Lite also was able to identify cannabis use disorders. Limitations included: lack of information on date and length of recruitment; the evaluation of the standard adult version of the ASSIST (3.0), and not a draft version for youth that is currently being developed; factor analysis suggested the measure could be improved; the use of self-report; and that the study was primarily with African-American youth, thus limiting generalizability to other populations.

Kelly and colleagues (2016) examined the validity of the Brief Screener for Tobacco, Alcohol and other drugs (BSAD) for adolescents by conducting a cross-sectional study with 525 adolescents ages 12 to 17. Participants were recruited when waiting for primary care appointments in three sites of a federally qualified health center in Baltimore, Md., from June 2012 through February 2013. Thirty percent of adolescents reported using more than one substance within the last year, nearly 22% reporting using alcohol, 16% cannabis, and nearly 10% tobacco use, and 3% reported using other illicit drugs besides cannabis. The measure was found to be valid. Limitations included: the inability to measure the severity of use; the study relied upon self-report; the participants were mainly African-American; and optimal cut points were not examined to see if they differed by gender or age group.

Levy and colleagues (2016) implemented SBIRT targeting medically fragile youth at Boston's Children's Hospital to validate the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Youth Alcohol Screening Tool. It was a cross-sectional study of 388 youth ages 9–18 years being treated for Type 1 diabetes, asthma, cystic fibrosis, inflammatory bowel disease or juvenile idiopathic arthritis. Results indicated 30% had reported alcohol use in the past year, and nearly 7% of drinkers met criteria for an alcohol use disorder. The NIAAA Youth Alcohol Screening tool was found to be valid and able to be used among medically fragile youth. The same was heterogeneous in race, gender and socioeconomic status. Limitations included: lack of information on date and length of recruitment; the use of self-report; a small percentage of youth met the criteria for alcohol use disorder; and results were limited to this particular medical center.

The psychometric performance of four screeners for adolescents was examined in a cross-sectional study by D'Amico and colleagues (2016). The NIAAA Screening Guide (SG), the Alcohol Use Disorders Identification test, the CRAFFT, and the Personal Experience Screening Questionnaire Problem Severity Scale (PESQ-PS) were tested for alcohol and cannabis use outcomes with 1,573 adolescents age 12 to 18 recruited in four primary care clinics in Los Angeles, Calif., and Pittsburgh, Pa., between April 2013 and November 2015. Results indicated

the CRAFFT and PESQ-PS were the best at identifying alcohol use disorder (AUD) and cannabis use disorder (CUD) among youth. The NIAAA-SG was second and better for AUD than CUD. The AUDIT was the least successful at identifying AUD and CUD as compared to the rest of the measures. Limitations included self-report and the order in which the screenings were administered, as it may have impacted results.

Current Research Projects

Mitchell and colleagues (2016) are currently overseeing a cluster-randomized trial of adolescent (ages 12–17) SBIRT in seven federally qualified health center clinics in Baltimore, Md. The CRAFFT screening tool will be utilized for this study and administered by the Medical Assistant. Depending on the score, brief advice will be provided by a primary care doctor. The participant will then either be referred out for services or a behavioral health counselor will then implement the Brief Intervention. The study will also implement an HIV risk screening within the SBIRT model. Specific implementation outcomes will be examined such as sustainability, cost-effectiveness, and adoption of practice.

The Conrad Hilton Foundation has funded many currently ongoing SBIRT youth projects (Conrad Hilton Foundation, 2017). The School-Based Health Alliance was awarded a two-year \$1,000,000 grant in November 2016 to implement youth SBIRT in SBHCs. In March 2016, the California Community Foundation was awarded \$300,000 for a two-year project to support a partnership with Children’s Hospital Los Angeles and the L.A. Trust for Children’s Health to implement SBIRT at four L.A. County SBHCs. Also in March 2016, the National Council for Behavioral Health was awarded a four-year \$2,000,000 grant to implement SBIRT for youth in federally qualified health centers. The National Foundation for the Centers for Disease Control and Prevention received \$1,500,000 in November 2015 to fund a three-year program to implement SBIRT as part of a comprehensive regional substance use disorder prevention and sexual risk behavior reduction program in Indiana, Kentucky and Ohio. The Center for Health Care Strategies, Inc. received a three-year \$900,000 grant in November 2015 to partner with Association for Community Affiliated Plans to support SBIRT adoption by health plans that serve low-income and vulnerable youth. In November 2014, Children’s Hospital Corporation received a four-year grant to validate outcome measures of SBIRT for youth in primary care settings. Also in November 2014, Behavioral Health System Baltimore, Inc. received a three-year grant to integrate SBIRT for youth in high schools and pediatric primary care settings across Maryland. At that time, the University of New Mexico Center on Alcoholism, Substance Abuse and Addictions also received a three-year grant of \$1,700,00 to expand an SBIRT pilot project to SBHCs throughout New Mexico. Sheedy and Hunt (2015) are in the process of evaluating SBIRT to youth in diverse settings funded by the Conrad Hilton Foundation, including two dozen health, school and community-based settings, some of which are listed above.

Conclusion

It is estimated that underage drinking costs the U.S. \$68 billion annually (CASA Columbia, 2011). While rates of illicit drug use appear to be declining among adolescents, perceived risk of harmful effects of illicit drugs is also decreasing (NIDA, 2016). Youth still need prevention and intervention efforts to address substance use. The effectiveness of SBIRT for youth and screening measures to use for this intervention are still being studied. However, results are promising. Some states have already taken the necessary measures to implement SBIRT for youth. The most popular route is through SBHCs. Administering SBIRT in SBHCs has the potential to address substance use in adolescents (Harris, 2016), as it can help to provide a medical home to youth and trained health professionals administering SBIRT (Beaton, Sbuskin & Chapman, 2016). Further, sustainability is possible if SBHCs bill for SBIRT services. Over the next several years, results from current SBIRT youth research projects will be published and more information on the effectiveness of various screening tools, providers and settings will become available.

References

- American Academy of Pediatrics (2011). Policy Statement: Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatrics. *Pediatrics*, 128, e1130-e1340.
- Beaton, A., Subkin, C. D., Chapman, S. (2016). Addressing substance misuse in adolescents: A review of the literature on the screening, brief intervention, and referral model. *Current Opinion in Pediatrics*, 28, 2, 258-265.
- Borus, J., Parhami, I., & Levy, S. (2016). Screening, Brief Intervention, and Referral to Treatment. *Child and Adolescent Psychiatric Clinics of North America*, 25(4), 579-601.
- Conrad Hilton Foundation (2017). Available at <https://www.hiltonfoundation.org/>
- Cunningham, R. M., Chermack, S. T., Zimmerman, M. A., Shope, J. T., Bingham, C. R., Blow, F. C., & Walton, M. A. (2012). Brief motivational interviewing intervention for peer violence and alcohol use in teens: One-year follow-up. *Pediatrics*, 129(6), 1083-1090. doi:10.1542/peds.2011-3419.
- Curtis, B. L., McLellan, A. T., & Gabellini, B. N. (2014). Translating SBIRT to public school settings: An initial test of feasibility. *Journal of Substance Abuse Treatment*, 46(1), 15.
- D'Amico, E. J., Parast, L., Meredith, L. S., Ewing, B. A., Shadel, W. G., & Stein, B. D. (2016). Screening in primary care: what is the best way to identify at-risk youth for substance use?. *Pediatrics*, 138(6), e20161717.
- Gryczynski, J., Kelly, S. M., Mitchell, S. G., Kirk, A., O'Grady, K. E., & Schwartz, R. P. (2015). Validation and performance of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) among adolescent primary care patients. *Addiction*, 110(2), 240-247.
- Harris, S. K., Csemy, L., Sherrit, L., Starostova, O., Van Hook, S., Johnson, J., . . . Knight, J. R. (2012). Computer-facilitated substance use screening and brief advice for teens in primary care: An international trial. *Pediatrics*, 129(6), 1072-1082. Doi:10.1542/peds.2011-1624
- Harris, B., Ramos, M. M., Condon, T. P. (2015, March 10). SBIRT in New Mexico School Based Health Centers. Webinar by ATTC. Retrieved at <http://my.ireta.org/sites/ireta.org/files/NM%20SBIRT%20in%20SBHCs%20FINAL.pdf>
- Harris, B. R. (2016). Communicating about screening, brief intervention, and referral to treatment: Messaging strategies to raise awareness and promote voluntary adoption and implementation among New York school-based health center providers. *Substance Abuse*, 37(4), 511-515. doi:10.1080/08897077.2016.1175400.

- Kelly, S. M., Gryczynski, J., Mitchell, S. G., Kirk, A., O'Grady, K. E., & Schwartz, R. P. (2014). Validity of brief screening instrument for adolescent tobacco, alcohol, and drug use. *Pediatrics*, *133*(5), 819-826.
- Knight J. R., Shrier, L. A., & Bravender, T. D., et al. (1999) A new brief screen for adolescent substance abuse. *Archives of Pediatric Adolescent Medicine*, *153*, 591-596.
- Levy, S., Dedeoglu, F., Gaffin, J. M., Garvey, K. C., Harstad, E., MacGinnitie, A., . . . Weitzman, E. R. (2016). A screening tool for assessing alcohol use risk among medically vulnerable youth. *PLoS One*, *11*(5), e0156240. doi:10.1371/journal.pone.0156240
- Mitchell, S. G., Gryczynski, J., Gonzales, A., Moseley, A., Peterson, T., O'Grady, K. E., & Schwartz, R. P. (2012). Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Substance Use in a School-Based Program: Services and Outcomes. *The American Journal on Addictions*, *21*(s1), S5-S13.
- Mitchell, S. G., Gryczynski, J., O'Grady, K. E., & Schwartz, R. P. (2013). SBIRT for adolescent drug and alcohol use: Current status and future directions. *Journal of Substance Abuse Treatment*, *44*(5), 463-472. doi:10.1016/j.jsat.2012.11.005
- Mitchell, S. G., Schwartz, R. P., Kirk, A. S., Dusek, K., Oros, M., Hosler, C., ... & O'Grady, K. E. (2016). SBIRT implementation for adolescents in urban federally qualified health centers. *Journal of substance abuse treatment*, *60*, 81-90.
- The National Association of State Alcohol and Drug Abuse Directors. (2015, January). State support of Youth SBIRT and SBIRT-Like Prevention Programs: Report of Case Studies. Conrad N. Hilton Foundation. Retrieved at <http://nasadad.org/wp-content/uploads/2015/04/State-Youth-SBIRT-and-SBIRT-Like-Case-Study-Report-Final.pdf>
- The National Center on Addiction and Substance Abuse at Columbia University (June 2011). Adolescent Substance Use America's #1 Public Health Problem. Retrieved at <http://www.centeronaddiction.org/addiction-research/reports/adolescent-substance-use>
- National Institute of Drug Abuse (2016, December). Monitoring the future survey: High School and Youth Trends. Retrieved at <https://www.drugabuse.gov/publications/drugfacts/monitoring-future-survey-high-school-youth-trends>
- Ohio Substance Abuse Monitoring Network. Surveillance of Drug Trends in the State of Ohio June 2015-January 2016. Executive Summary. Retrieved at <http://mha.ohio.gov/Portals/0/assets/Research/OSAM-TRI/Jan2016-Executive-Summary.pdf>
- SAMHSA (2016, January 7). SBIRT. Retrieved at <http://www.samhsa.gov/sbirt>

SBIRT-NH. (2016). Screen & Intervene: NH Youth SBIRT Initiative. Retrieved at <http://sbirtnh.org/>

Sheedy, C., & Hunt, D. (2015). Preventing, screening, and intervening in youth substance use: examining implementation of SBIRT in diverse settings. *Addiction Science & Clinical Practice*, 10(Suppl 2):O28.doi:10.1186/1940-0640-10-S2-O28.

Sterling, S., Kline-Simon, A. H., Satre, D. D., Jones, A., Mertens, J., Wong, A., & Weisner, C. (2015). Implementation of screening, brief intervention, and referral to treatment for adolescents in pediatric primary care: A cluster randomized trial. *JAMA Pediatrics*, 169(11), e153145. Doi:10.1001/jamapediatrics.2015.3145

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (August 7, 2014). The NSDUH Report: Underage Binge Alcohol Use Varies within and across States. Rockville, MD.

Yuma-Guerrero, P. J., Lawson, K. A., Velasquez, M. M., Von Sternberg, K., Maxson, T., & Garcia, N. (2012). Screening, brief intervention, and referral for alcohol use in adolescents: A systematic review. *Pediatrics*, 130(1), 115-122. doi:10.1542/peds.2011-1589

Resources

This article provides detailed information on why SBIRT should be implemented with adolescents, different measures available, and steps involved for SBIRT with youth for health professionals:

Borus, J., Parhami, I., & Levy, S. (2016). Screening, Brief Intervention, and Referral to Treatment. *Child and Adolescent Psychiatric Clinics of North America*, 25(4), 579-601.

This article is policy statement from the American Association of Pediatrics supporting SBIRT:

Committee on Substance Abuse, Levy S. J., and Kokotailo, P. K. (2011) Substance use screening, brief intervention, and referral to treatment for pediatricians. *Pediatrics*, 128, e1330-e1340.

This is an editorial from a psychiatric nursing publication on the importance of implementing adolescent SBIRT:

Delaney, K. R. (2016). Adolescent substance use: Moving screening into the practice mainstream: Editorial. *Journal of Child and Adolescent Psychiatric Nursing*, 29(1), 4-5. doi:10.1111/jcap.12135.

This article emphasized the importance of SBIRT in schools for school psychologists:

Fisher, S. D., Malone, C., & Sheehan, C. (2016). Integrated mental health and substance use interventions in secondary schools. *Communique (0164775X)*, 45(2), 24-26.

This site provides information about SAMHSA's SBIRT initiative:

<https://www.samhsa.gov/sbirt>

This article provides information on why SBIRT should be implemented with adolescents and how to implement it in a clinical setting:

Levy, S. J., & Williams, J. F. (2016). Substance use screening, brief intervention, and referral to treatment. *Pediatrics*, 138(1), e20161211.

This is a practitioner's guide for SBIRT for youth by NIAAA:

National Institute on Alcohol Abuse and Alcoholism. (2011) Alcohol screening and brief intervention for youth: a practitioner's guide; excerpt for MedScape CME course.

Available at

<http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuideAlgorithm.pdf>

This article discusses SBIRT for Adolescents (SBIRT-A), a set of recommended adaptations to the SBIRT model to better serve the developmental needs of adolescents:

Ozechowski, T. J., Becker, S. J., & Hogue, A. (2016). SBIRT-A: Adapting SBIRT to maximize developmental fit for adolescents in primary care. *Journal of Substance Abuse Treatment*, 62, 28-37. doi:10.1016/j.jsat.2015.10.006.

This article identifies three diverse populations (including adolescents) that could benefit from SBIRT and provides resources and support for implementation across a broad range of settings:

Russett, J. L. (2016). Best practices start with screening: A closer look at screening, brief intervention, and referral to treatment in adolescent, military, and LGBTQ populations. *Journal of Addictions & Offender Counseling*, 37(2), 116-126. doi:10.1002/jaoc.12020.

This is a Fact Sheet about SBIRT by SAMHSA

SAMHSA. (2012, July). Fact Sheet. Screening, Brief Intervention and Referral to Treatment.

Available at:

https://www.whitehouse.gov/sites/default/files/page/files/sbirt_fact_sheet_ondcp-samhsa_7-25-111.pdf

This is a white paper on SBIRT.

SAMHSA. Evidence Supporting the Effectiveness of SBIRT. (2011, April 1). Available at:

https://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf

This is the most recent Surgeon General's Report:

U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing *Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.