# Screening, Brief Intervention, and Referral to Treatment

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**KEYWORDS**

• Screening, Brief Intervention, and Referral to Treatment • Substance use • Adolescents • Screening • Alcohol • Substance abuse • Motivational interviewing

**KEY POINTS**

- Screening, Brief Intervention, and Referral to Treatment is a quick, effective technique with which to manage substance use in adolescents and young adults.
- Use of a validated measure for detecting substance use and abuse is significantly more effective than unvalidated tools or provider intuition. There are a variety of validated tools available to use in the adolescent/young adult population.
- There are opportunities to increase the efficiency and scalability of screening by using computerized questionnaires. This area continues to evolve rapidly.

## INTRODUCTION

Substance use is a major driver of morbidity and mortality in adolescents and young adults and a cause of numerous public health problems including elements of mortality (eg, unintentional injury, suicide, motor vehicle accidents) and morbidity (eg, sexual transmitted infections, involvement in violence as either perpetrator or victim,

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unprotected intercourse leading to teen pregnancy) for this population. Age of onset of both alcohol and marijuana use is inversely associated with risk of substance use disorder (SUD) development.[1,2] Marijuana use during adolescence has increased in recent years and is associated with an increased risk of mental illness, cognitive decline, and increased risk of opioid addiction.[3–6]

Substance use is most commonly initiated during adolescence. According to a nationally representative survey, 4,336,000 adolescents (or 17.4% of persons age 12–17 in the United States) are estimated to have used illicit drugs including marijuana, cocaine, heroin, hallucinogens, and inhalants or misused prescription medications (ie, medications that were not prescribed to them, or at a higher dose or different route than was prescribed) in 2014.[7] Specifically, 292,000 adolescents smoke cigarettes daily; 257,000 adolescents drink alcohol heavily (drinking 5 or more drinks on the same occasion in the past month); and 1,251,000 (or 5% of all adolescents) meet diagnostic criteria for a substance use related disorder for any illicit drug or alcohol. Substance use may be the most important modifiable health risk behavior of adolescence; consequently, substance use should be identified and addressed.

Both the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry recommend inquiring about substance use during initial psychiatric evaluations.[8,9] Specifically, the American Academy of Child and Adolescent Psychiatry practice parameter encourages brief interventions or referrals for more intensive services for substance use when warranted, in addition to treatment for the co-occurring psychopathology.[9] Given these recommendations and the availability of effective, brief SUD interventions in pediatric mental health settings, it is compelling for mental health and primary care clinicians to screen and provide brief treatments for SUD.[10–14]

There is a movement to screen and provide brief interventions for adolescent substance use. In 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched an initiative to increase rates of identifying and addressing substance use in routine medical care for both adults and children and developed a framework called *Screening, Brief Intervention, Referral to Treatment* (SBIRT).[15] In accordance with the broad goal of expanding the medical home to incorporate mental and behavioral health treatment as set forth by the Affordable Care Act, several professional organizations and government agencies recommend incorporating SBIRT into routine health care for adolescents.[15–20] This movement presents both an opportunity and a challenge, as clinicians feel squeezed for time because they are encouraged to cover more material and document more thoroughly at each clinical encounter, a trend seen throughout medicine. For example, a review of American Academy of Pediatrics (AAP) guidelines in 2006 identified 162 recommended verbal health directives for children and families throughout childhood routine health visits.[21] Similarly, family practice doctors estimated they would need to spend 7.4 hours per working day on preventive advice if they were to follow all of their professional recommendations.[22] In this landscape, SBIRT must be quick, inexpensive, and easy to implement.

In 2012, the United States Preventative Services Task Force released guidelines recommending SBIRT to address tobacco and alcohol use as part of routine health care of adults. The United States Preventative Services Task Force has determined that there are insufficient data to support a similar recommendation for the adolescent population, suggesting the need for more research to determine how to best address substance use with adolescents.[23,24] Nonetheless, based on promising data and the low cost and low risk of SBIRT, the AAP released a policy statement in 2011 recommending universal SBIRT for tobacco, alcohol, and other substance use be