

Final Report

**State Support of
Youth SBIRT and SBIRT-Like Prevention Programs:
Report of Case Studies**

January, 2015

For the
Conrad N. Hilton Foundation

Prepared by:
The National Association of State Alcohol and Drug Abuse Directors

NASADAD Board of Directors

President.....Mark Stringer (Missouri)
First Vice President.....Theodora Binion (Illinois)
Vice President for Internal Affairs.....Barbara Cimaglio (Vermont)
Vice President for Treatment.....Dave Felt (Utah)
Vice President for Prevention.....Kim Fornero (Illinois)
Immediate Past President.....Flo Stein (North Carolina)
Secretary.....JoAnne Hoesel (North Dakota)
Treasurer.....Kathy Skippen (Idaho)

Regional Directors

Joseph Harding (New Hampshire), Arlene Gonzalez-Sanchez (New York),
Gary Tennis (Pennsylvania), Cassandra Price (Georgia), Kevin Moore (Indiana),
Rochelle Head-Dunham (Louisiana), Kathy Stone (Iowa), JoAnne Hoesel (North Dakota),
Cory Nelson (Arizona), Kathy Skippen (Idaho)

Executive Director

Robert I.L. Morrison

Acknowledgements

Numerous people contributed to the development of this document. This report was produced by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) under a grant from the Conrad N. Hilton Foundation. Dr. Tracy Tlumac and Ms. Shalini Wickramatilake served as the principal authors of this document, with overall guidance and direction from Henrick Harwood (NASADAD).

We would like to thank the staff of the State Substance Abuse Agencies in Massachusetts, Michigan, New York, Oregon, and Wisconsin for their assistance and support on this project. The Project also benefited greatly from the advice and support of Ms. Alexa Eggleston of the Hilton Foundation. This document could not have been accomplished without the assistance of those mentioned above. Nonetheless, NASADAD is responsible for the accuracy and completeness of this document and any omissions, inaccuracies or errors are the responsibility of NASADAD.

The views, opinions, and content are those of NASADAD's technical staff and do not necessarily reflect the views, opinions, or policies of the NASADAD Board of Directors. NASADAD is solely responsible for the content herein.

Table of Contents

EXECUTIVE SUMMARY AND INTRODUCTION.....	1
SUMMARY OF FINDINGS FROM INQUIRY	4
METHODOLOGY FOR CASE STUDIES.....	6
STATE CASE STUDIES	7
Massachusetts	7
Michigan	10
New York	11
Oregon.....	14
Wisconsin	17
CONCLUSION	21
APPENDICES	23
Appendix A: Inquiry of State Youth Coordinators	23
Appendix B: Inquiry of State Prevention Coordinators	30
Appendix C: Case Study Discussion Guide	37

**State Support of
Youth SBIRT and SBIRT-Like Prevention Programs:
Report of Case Studies**

Executive Summary and Introduction

This document reports the findings from case studies of five State initiatives directed at identifying and providing interventions to youth that exhibit “elevated” or “high” risk for substance use disorders. To a certain extent this is a population that has gotten less attention and arguably less support than those that need treatment services due to substance use disorders, and youth that are addressed through primary prevention (they have not yet initiated or are in the very earliest stages of substance use initiation). States have very high profile “primary prevention” initiatives, and have also funded treatment services for youth for many years.

The focus of this project is to highlight State efforts that support services for “high risk” youth intended to prevent their escalation of use, particularly “screening, brief intervention and referral to treatment” (or SBIRT) services. Traditionally, these services are offered in venues where individuals present for health services, such as doctor’s offices, community health clinics and emergency rooms. The theory behind use of such locations is to encourage healthcare providers to address substance use as part of health and efficiently reach persons at elevated risk for substance use, misuse, and disorders that could benefit from interventions at a time when they are more likely to be receptive to advice, in an environment that is perceived as supportive and nonthreatening.

The general approach of SBIRT has also been employed by prevention professionals within the substance abuse field, although it has been referred to and promoted with a completely differently rubric. “Primary” prevention is the major focus of the field due to a provision in the Substance Abuse Prevention and Treatment Block Grant legislation. The understanding of the field was broadened by the 1994 IOM report on prevention research, which differentiated between “universal,” “selective” and “indicated” approaches. “Selective”

and to some degree “indicated” approaches to substance use disorder (SUD) prevention have a great deal in common with SBIRT. Selective and indicated prevention strategies frequently are located where there is access to persons at elevated risk of substance use, misuse, and disorder (such as school health clinics, after school programs, youth centers, prenatal clinics, etc.). They perform quick and efficient screenings to identify individuals that are engaging in potentially harmful use of substances, provide brief interventions that give the individual accurate information about the potential harms of substance use, misuse, and disorder, and attempt to provide motivation to change risky behaviors.

For the purposes of this report we are labeling selective and indicated prevention approaches “SBIRT-like” because these are very similar in their constitution to SBIRT—systematic screening, followed by brief interventions. Still, they often take place in community and educational rather than primary health settings. In this inquiry of State substance abuse agencies we have examined to what degree States are supporting either SBIRT, or “SBIRT-like” SUD prevention efforts, and the extent to which these are similar to the youth SBIRT efforts that they fund.

The primary findings of the inquiry phase of the study were:

- A minority of States support youth SBIRT initiatives in their treatment branches,
- A majority of States support “SBIRT-like” selective/indicated youth prevention services,
- The SBIRT-like prevention services are similar in design to existing SBIRT efforts, and
- A large majority of State SUD agencies support one or the other of these initiatives.

These findings have been documented in the presentation report of the inquiry, which is a companion document to this report on the 5 State case studies.

The 5 brief case studies looked at SBIRT and SBIRT-like initiatives in Massachusetts, Michigan, New York, Oregon, and Wisconsin. Information is reported on the development, organization and operation of their services directed at youth that have initiated substance use. From the inquiry and case studies it can be seen that the “SBIRT” and “SBIRT-like” services are similar in terms of their target populations (youth) and services (screenings, with brief interventions for those screening positive).

Based on these findings we recommend that efforts to learn more about and promote implementation of SBIRT services for youth should include outreach to both the SUD treatment and prevention sides of SUD State agencies. Often the respective activities of these two areas are not well enough understood to gain an accurate understanding of whether and what sort of services are being provided by the State to individuals that have initiated substance use/abuse, but have not yet reached the severity/acute to require or benefit from “treatment initiatives.

Adolescents and young adults comprise more than 25% of admissions to the public substance abuse treatment system. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a quick, effective method for identifying those at risk for alcohol and substance abuse problems, providing a brief intervention, and referring an individual to treatment if necessary. The focus of this inquiry was State agencies responsible for substance abuse services because they often play an instrumental role in disseminating new and improved methods through their providers. The Conrad N. Hilton Foundation sought to learn more about whether States have implemented innovative and effective Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiatives specifically for youth as part of their Substance Use Prevention and Early Intervention Strategic Initiative.

The National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), as a membership organization comprised of the 50 states, the District of Columbia, and the U.S. territories, is uniquely qualified to undertake this project. NASADAD’s mission is to promote the efficient delivery of effective substance abuse prevention, treatment, and recovery services. The organization functions as a “learning community” through which States collaborate and provide support, advice, and information about effective strategies. NASADAD proposed developing and administering an inquiry to learn more about State youth SBIRT efforts to members of one of its component groups—the State Youth Substance Abuse Coordinators Committee (Youth Coordinators)—comprised of State staff members who oversee youth substance abuse services in their States. NASADAD would subsequently produce a report of the findings along with 5 State case studies on youth SBIRT programs.

Summary of Findings from Inquiry

A total of 19 Youth Coordinators responded (29 did not respond): AL, GA, IL, KY, MI, MN, MS, NC, NJ, OH, OK, PA, RI, SC, SD, TN, UT, WA, and WY. A total of 19 Prevention Coordinators responded (38 non-responders): AL, IL, KS, LA, MI, MO, MT, NC, NE, NH, Northern Mariana Islands, NY, OR, PA, RI, SD, TX, UT, and VA.

Due to the low response rate, a supplemental inquiry was sent via email on October 22, 2014 to all the Youth and Prevention Coordinators who did not respond to the initial inquiry, followed by five email reminders. Twenty-one Youth Coordinators responded to the short form inquiry: CA, CO, Guam, IA, IL, KS, LA, MA, MA, MD, MS, MT, NJ, OH, OR, SC, SC, TX, VT, WI, WV; as did 17 Prevention Coordinators: AR, GA, HI, IA, IL, KS, LA, MT, NJ, OH, OR, PA, SD, TX, UT, VA, and TN. A total of 33 Youth Coordinators and 27 NPNs responded to the two inquiries, from 39 unique states and 2 territories, with 17 Youth Coordinators and 23 NPNs indicating that their State has either a youth SBIRT and/or selective/indicated prevention program for youth. However, NASADAD only received substantive information about 23 programs total—17 from NPNs and 6 from the Youth Coordinators. The youth SBIRT and SBIRT-like prevention programs received funding from either the State Substance Abuse (SSA) agency or another source. While 33.3% of Youth Coordinators indicated that their respective State SSA funds and SBIRT services for youth, 81.5% of Prevention Coordinators indicated that their SSA funds selective and/or indicated prevention strategies for youth (see Figures 1 and 2).

Figure 1

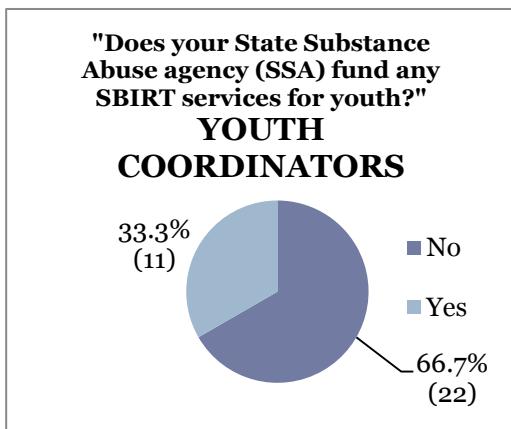
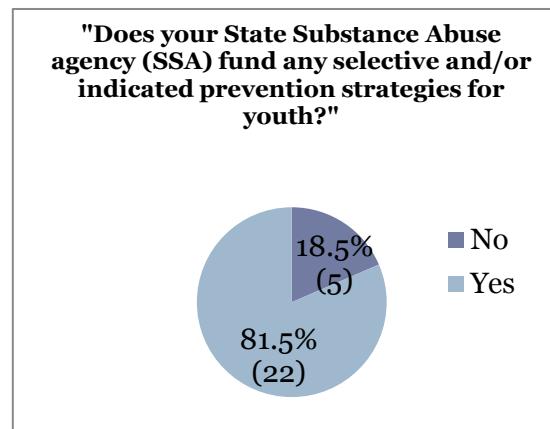


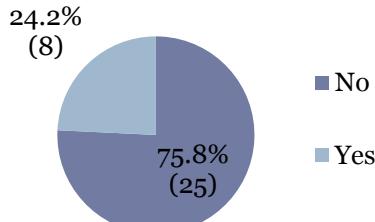
Figure 2



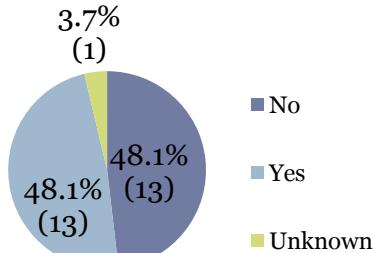
Only 24.2% of Youth Coordinators and 48.1% of Prevention Coordinators were aware of Youth SBIRT/SBIRT-like initiatives in their State that are funded by another State agency (see Figures 3 and 4).

Figure 3

**"Are you aware of Youth SBIRT initiatives in your State that are funded by another State agency?"
YOUTH COORDINATORS**

**Figure 4**

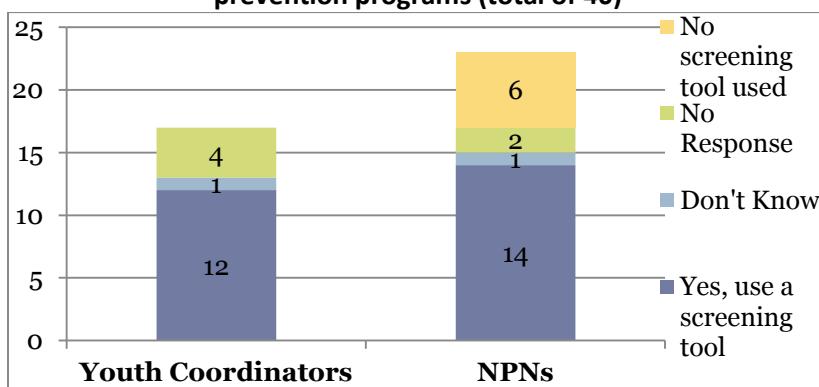
"Are you aware of selective and/or indicated prevention strategies for youth in your State that are funded by another State agency?"



Those States that do fund these SBIRT and SBIRT-like programs have been doing so ranging from 1 to 29 years, with an overwhelming majority of program participants served being 12-17 years old. Many of the programs had a web site and used training manuals and other materials for their professional prevention staff. Some of the programs targeted selective population (i.e., all middle or high school students), whereas, others screened youth into the programs (see Figure 5).

Figure 5

Use of Screening Tools in identified youth SBIRT and/or SBIRT-like selective/ indicated prevention programs (total of 40)



A variety of screening tools were used, such as CRAFFT, GAIN SS, AUDIT, CAGE, POSIT, MAST, and Screening to Brief Intervention (S2BI). The interventions were delivered primarily by the screening tool questions being filled out by the youth, followed by an individual intervention. Programs were implemented in school classrooms, after-school programs, mentoring programs, school-based health centers, and community centers. Most of the program staff were required to receive some type of training in order to administer the intervention, and included credentialed substance abuse prevention staff; trained prevention specialists; classroom teachers; student assistance counselors; nurses; social workers; and physician's assistants. About one-half of the programs are regularly evaluated and listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), but only a handful have had their evaluation data written up in a report or paper.

Methodology for Case Studies

In March 2014, NASADAD staff developed a series of questions (**Appendix A**) regarding State support for youth SBIRT programs, including how they are delivered; who delivers the programs and any required training; screening tools used; location where programs are administered; and any evidence of effectiveness. The questions were pilot tested with a Youth Coordinator member and National Prevention Network (NPN) member to provide feedback for question content and clarity. NASADAD staff included an NPN member, the State staff person who oversees and distributes funding for State youth prevention programs. The NPN member suggested replacing the "SBIRT" language with the phrase "selective and/or indicated prevention strategies or programs" since the Substance Abuse Prevention and Treatment (SAPT) Block Grant "20 percent prevention set-aside" funds may not be used to fund SBIRT programs (but may otherwise be funded by the Block Grant). Therefore, a similar set of questions was developed replacing the term "SBIRT" with "selective and/or indicated prevention strategies or programs" (**Appendix B**). NASADAD also received feedback from the Hilton Foundation to incorporate a question about Medicaid billing codes.

After the questions were finalized, NASADAD staff formatted the inquiries into the online survey tool, Survey Monkey. The first email was sent on May 19, 2014 with a link to the Survey Monkey inquiry to the 48 State Youth Coordinators and the 57 Prevention Coordinators. NASADAD staff sent out one email reminder every week for four weeks and two reminders during the final week. The Youth Coordinators and Prevention Coordinators were given four weeks to respond to the inquiry.

State Case Studies

NASADAD identified 5 States that have novel and effective youth SBIRT or selective and/or indicated prevention initiatives. After compiling the information obtained through the inquiries, initial contact was made with the individual who answered the inquiry questions. Additional follow-up questions were drafted and sent to the individuals as a discussion guide for the telephone conversations (**Appendix C**). Coordinating schedules was sometimes challenging, however, discussions were arranged and more detailed information gathered from five states: Massachusetts, Michigan, New York, Oregon, and Wisconsin.

Massachusetts

Program Description: SBIRT in School-based Health Centers (SBHC)

After Massachusetts completed a SAMHSA SBIRT grant that ended in 2012, the Bureau decided that they wanted to build capacity for SBIRT practice throughout the State. In July of 2012, the Massachusetts Department of Public Health School-Based Health Center Program procured services for the operation of 32 SBHCs that they fund. As part of the contract, each SBHC medical provider is required to incorporate SBIRT into routine adolescent visits. Providers must meet specific performance measure targets. The program's first target is to have 75% of SBHC clients aged 12 to 18 years be seen by a nurse practitioner and assessed at least once during the school year for substance use using the CRAFFT tool. The second target is for 100% of screened students to receive a brief intervention and, if appropriate, referral to treatment.

Program Delivery

Several years ago, a pilot program was developed to train nurse practitioners in SBHCs on delivering youth SBIRT interventions. The trainings were held regionally, followed by on-site training for individual providers. The nurse practitioners collected data on the first 100 students they screened. Following the pilot program, an RFP was sent out to the 32 SBHCs that are contracted with the Bureau. The RFP explicitly stated that nurse practitioners would be re-trained and that they would be required to collect and report data on all students who were screened. For this program, the brief intervention is unique compared to its counterpart adult SBIRT program within the State. It is not just high-risk individuals who receive an intervention; youth who are screened and have no substance use, misuse, disorder behaviors still receive a brief intervention in the form of positive reinforcement.

Massachusetts Screening, Brief Intervention, and Referral to Treatment Training and Technical Assistance program (MASBIRT) is the State vendor that acts as the training arm of the youth SBIRT program. The trainings for providers focus on the importance of SBIRT for the overall long-term health of adolescents and how to administer the CRAFFT. The CRAFFT is comprised of two parts; part A asks the respondent whether over the past 12 months they have drank any alcohol, smoked marijuana or hashish, and/or used anything else to get high. If the answer is "no" to all three questions, the respondent is only asked the first question of part B. If the answer is "yes" to any of the questions, the respondent is asked all six questions in part B. The questions in part B ask whether the respondent has ever ridden in a car driven by someone who was high or had been using alcohol or other drugs; used alcohol or other drugs to relax, feel better, or fit in; use alcohol or other drugs while alone; forget things they did while using alcohol or other drugs; or have family/friends tell them to cut down on substance use; and, gotten into trouble while using alcohol or other drugs.

Due to concerns about the length of the CRAFFT, Boston Children's Hospital—the developer of the CRAFFT—is creating the Screening to Brief Intervention (S2BI), which is more refined than its predecessor. The S2BI will screen youth with only two questions, saving time for both the provider and client. The tool asks questions on the frequency of using eight types of drugs in the past year. S2BI utilizes an electronic device, such as a tablet, on which youth are

asked how many times in the past year they have used tobacco, alcohol, or marijuana. If the respondent answers “yes” to any of the questions, they are then asked, how many times in the past year they have used prescription drugs that were not prescribed for them; illegal drugs; inhalants; or herbs or synthetic drugs. The timeline for incorporating the S2BI into the SBIRT program is unknown at this time.

The Bureau of Substance Abuse Services sponsored regional SBIRT follow-up trainings with an Institute for Health and Recovery Trainer for the SBHC medical providers. The goal was to increase provider self-efficacy and strengthen Motivational Interviewing skills. These trainings are conducted at each site, and are open to all school staff members, from the principal to custodial staff, so they have an understanding of the CRAFFT and Motivational Interviewing.

Evaluation

The SBHCs collect health data on their students, and one of the data points now included is information from the SBIRT session. Based on data from 2013 when the program was first implemented, more than 7,000 CRAFFT screenings were administered, resulting in 64.3 % of all SBHC clients being screened. Of those students, 78.0% received a brief intervention. Of all the screenings administered, 6.6% resulted in a positive score that warranted an intervention and for some, a referral to treatment.

Challenges, Lessons Learned, and Next Steps

The major lesson learned is related to staff turnover and training. When a nurse practitioner leaves a site, the program would not be sustained because the replacement has not been trained. In the future, the State would like to offer ongoing training to assure that program staff have the capacity to continue even if a staff member leaves. Another challenge is that the CRAFFT screening tool has been considered relatively time-consuming. Within the next several months, the program hopes to replace the CRAFFT with the S2BI, which would significantly reduce the amount of time needed to screen students.

Contact Information

Carol Girard

SBIRT Program Coordinator, State of Massachusetts Bureau of Substance Abuse Services

Email: carol.d.girard@state.ma.us

Michigan**Program Description: Prevention Targeting Vulnerable Youth and Families**

In Michigan, the State Substance Abuse Prevention and Treatment (SAPT) block grant supports an overwhelming majority of youth selective and/or indicated prevention programs. In addition to SAPT funds, counties also allocate a portion of the TA2 liquor tax for evidence-based substance abuse prevention and treatment programs. The 15 substance abuse prevention coordinators throughout the State oversee the youth programs, which include: *Project SUCCESS, Early Risers, Teen Intervene, and Creating Lasting Family Connections (CLFC)*.

Delivery of the Programs:

The programs are delivered by trained, certified prevention providers in a variety of locations such as school classrooms, after-school programs, mentoring programs, public housing complexes, recreation centers, and churches. *Project SUCCESS* (Students Using Coordinated Community Efforts to Strengthen Students) targets 12-17 year olds who are at high-risk for substance use, misuse, or disorder due to discipline problems, poor academic performance, and parental substance misuse or disorder. *Early Risers* targets 6-12 year old elementary school students who are at a high-risk for development, conduct, and substance use problems. This early, comprehensive program integrates child-, school-, and family-focused interventions to target both risk and protective factors. *Teen Intervene* is a brief, early intervention program for 12-17 year olds who are displaying early stages of alcohol or drug use. Finally, *Creating Lasting Family Connections* is a family-focused intervention that builds resiliency among youth aged 9 to 17 years old to reduce alcohol and drug use. The program is administered to youth and their parents/guardians in community-based locations such as churches, recreational centers, and schools.

Evaluation

The programs are regularly evaluated and have demonstrated success. Both the *Project SUCCESS* and *Teen Intervene* program participants indicated gaining more knowledge about substance use, misuse, and disorder risk and protective factors. The *Creating Lasting Family Connections* participants also increased their knowledge about substance use, misuse, and disorder, and program participants experienced a 10% reduction in substance abuse-related school detentions. Other positive outcomes include: increased participation in tutoring and school attendance, improvement in academic achievement, positive self-concept, increased enrollment in the *Early Risers* program, more parental engagement, and better communication between parents and teachers.

Challenges, Lessons Learned, and Next Steps

The programs all experienced challenges and lessons learned that led to some programmatic changes. These included recognizing the necessity to have well-trained staff and build relationships; updating staff training; starting program enrollment during the summer; and elaborating more on parental information and support based on participant feedback. Depending on funding, there are plans to sustain and expand all programs in the future either in additional counties and/or school districts.

Contact Information

Larry Scott

Manager, Substance Abuse Prevention Section, Bureau of Substance Abuse & Addiction Services, Michigan Department of Community Health

Email: scottl11@michigan.gov

New York**Program Description: Advancing Teen Intervene and SBIRT**

The state of New York employs approximately 180 prevention providers making up a \$100 million system. Prevention providers are located throughout the state's counties, with 35 substantial programs in New York City (NYC) alone. New York implements two separate

screening, brief intervention and referral to treatment (SBIRT) programs among youth: *Teen Intervene* and a school-based health center screening program. It is also important to note that New York is working with Treatment Research Institute (TRI) on a Hilton Foundation grant to implement an electronic screening tool in school-based health centers in NYC beginning in January 2015.

Delivery of the Program

Teen Intervene is a brief intervention program aimed at reducing substance use, misuse, and disorder among adolescents, aged 12-17. It is administered at schools, community centers, and after school programs. Youth who meet the criteria are then enrolled in six 40-minute individual sessions with a trained counselor. Parental involvement is optional at either session 5 or 6. The goal of the program is to provide brief intervention with at-risk teens, examine the effects of substance use, misuse, and disorder in their lives, and teach them to make healthier choices. The intervention was also used last year to screen for gambling with state dollars. Prevention dollars are provided to school districts and the providers determine the need in various schools.

Teen Intervene “train the trainer” sessions are being conducted with school personnel throughout the state who implement the program. The trainers are Certified Prevention Technician (CPT) staff and individuals who deliver the intervention are recognized by Hazelden for three years. There are plans to train an additional 40 more school staff, and training is being extended to other groups that work with youth, such as Boys & Girls Clubs, in order to have a bigger reach with kids. Regular meetings are held with providers to assist with fidelity issues and adjustments are made, if necessary.

New York also implements a *SBIRT intervention* for youth that is a billable service outside of the system. The SBIRT program is overseen by a staff person, and to date, the interventions have been conducted in 3-4 pilot sites. The intervention targets both high- and low-risk high school students by screening for simple high-risk behaviors then making a referral, if necessary. New York is working with Treatment Research Institute (TRI) on a Hilton Foundation grant to implement an electronic screening tool in school-based health centers in NYC beginning in January 2015. The goal is that every high school student who visits a school-

based health center will be screened with the CRAFFT¹ tool by either a nurse or mental health worker who is trained in using the tool along with motivational interviewing techniques. It is estimated that the tool will eventually be used in 227 school-based health centers and serve approximately 200,000 kids throughout the state.

Evaluation

As part of the *Teen Intervene* program, process data and 30-day use data was collected, as well as before and after assessments with program participants. However, the State data system is going through changes and evaluation data was not available.

The youth SBIRT program has been in place for 2-3 years and has had some limited data collected. During the second round, 3 school-based health clinics indicated that they would collect all of the CRAFFT forms. However, the state staff found flaws in how the data was collected. Therefore, during the upcoming third round, the state will ask provider to sign a memorandum of understanding (MOU) of what they're committing to and what's required.

Challenges, Lessons Learned, and Next Steps

Both programs in New York have experienced challenges and lessons learned. Challenges for *Teen Intervene* have mostly dealt with the settings in which the intervention is implemented and keeping people trained to administer the intervention. There is fewer trained staff in the field now than there was five years ago. That could be attributed to funding issues and competition with other requirements that are mandated for schools. On the positive side, the state has worked with the *Teen Intervene* program developer to modify the length of the program to accommodate school staff and students.

¹ CRAFFT is an acronym of first letters of key words in the six 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/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?

One challenge with the SBIRT program was a lack of funds to support the necessary staff. One staff person in the state office managed the program. However, the Hilton Foundation grant beginning in January 2015 will provide more support. A lesson learned was to maintain continuous communication with providers to ensure fidelity and provide opportunities for improvement, if needed.

Contact Information

Scott Brady

Director, Bureau of Prevention Services with the New York State Office of Alcoholism and Substance Abuse Services

Email: Scott.Brady@oasas.ny.gov

Oregon**Program Description: Adolescent Health Project**

One of Oregon's priorities is to reduce alcohol use among the State's youth. The Oregon Adolescent Health Project aims to increase screening for substance use and depression among youth during annual well visits. The Oregon Pediatric Society (OPS) and the Oregon Pediatric Improvement Partnership (OPIP) worked together in order to implement this project. Reducing alcohol exposure for youth is a State-specific performance measure included in Oregon's Title V Maternal and Child Health Block Grant. The objectives of the Adolescent Health Project, which is funded by the Public Health and Addictions & Mental Health Divisions, include: increased provider and staff awareness of lifetime alcohol dependence risk among early alcohol initiators; increased standardized, universal screening with evidence-based screening tools; and increased provider and staff skills and efficacy in providing brief intervention and referral to treatment.

In order for more youth to be screened for alcohol use, the Adolescent Health Screening Project was implemented. Many providers do not screen for alcohol use due to unclear standards and insufficient time, so the Screening Project aims to engage primary care and community health staff. The program also serves as an incentive measure for coordinated care organizations in the State.

Delivery of the Program

The first cohort, participating during the 2013-2015 biennium, is comprised of nine sites that include pediatric primary care practices, school-based health centers (SBHC), federally qualified health centers, and hospitals. These sites are distributed throughout the State, with two pediatric private practice sites on the Oregon coast, three SBHCs in central Oregon, and one private practice and one SBHC in eastern Oregon.

Screening Tools and Referral Training (START) is a collaborative effort by the Partners in Addictions and Mental Health, whose work focuses on adolescent depression, and the Oregon Pediatrics Improvement Partnership, who facilitate practice change and assist with evaluation. Before implementation, staff from each site participated in a training facilitated by OPS-START Program and OPIP trainers. The day-long trainings begin with general discussions about the well visit and delivering care to the general adolescent population. The training focuses on best practices in delivering adolescent well visits, use and scoring of screening tools, brief intervention techniques, billing, and implementation strategies. The program aims to train as many professionals on the practice team as possible. This includes, but is not limited to doctors, allied health professionals, and billing staff. Training is also opened to community providers who are interested in attending, at no cost. The majority of trainees are providers.

The adolescent well visit is an appropriate setting for delivering critical preventive services because adolescent primary care providers are in the ideal position to help prevent, identify, and aid in treatment of substance use, misuse, and disorder. The target population for this program is ages 12-17. Currently, there is no specific focus on including the Native American population, although some organizations are interested in it targeting Native American youth. Extra steps must be taken in order to reach both the rural and urban Native American population.

Evaluation

Providers who conduct the well visits are educated on the survey before administration. Pre- and post-tests are administered to test for changes in staff members' SBIRT knowledge level. The Office Report Tool, developed by OPIP, measures changes in policy, procedures, and

practices. The purpose of the Adolescent Health Project Office Report Tool is to identify processes used by practices and track the implementation of processes that are related to screening for depression and substance use, misuse, and disorder, brief interventions, referral to treatment, and referral tracking.

Challenges, Lessons Learned, and Next Steps

While most participating clinics were aware of screening tools and had implemented them for some adolescent patients, very few had standardized, universal screening procedures. Consistent with research, the most often cited reasons for not screening included time limitations, lack of training, lack of knowledge of community behavioral health services for referrals, and concerns about confidentiality.

Confidentiality issues pose a major challenge. Many sites, with the exception of SBHCs, did not have standardized policies or practices ensuring the provider and adolescent had private time together. Many sites were hesitant to bill for sensitive screenings or services (including substance use, misuse, and disorder and mental health) for fear of confidentiality being breached via a bill, explanation of benefits, or communication through an online patient portal. Instead, sites absorbed the cost of services, limiting the use of claims data for evaluation and performance monitoring. Robust policies and protections of confidentiality are necessary to engage and empower youth as they transition to independent consumers of health services and ensure they receive the care they need.

Oregon has strict minor consent laws; youth must be age 15 or older to receive general medical care without the consent of a parent or guardian, and 14 years or older to consent for behavioral health services. There is currently no law protecting minors from providers disclosing information to parents or guardians. Inadvertent information disclosure is possible in the case of an insurance company sending a billing summary to parents with description of services rendered to the minor. The Health Screening Project has seen that youth are much less likely to seek available services if there is a possibility of compromised confidentiality. Regarding Health Information Exchange and e-Health Recording, current policies are not aligned with emerging technology used to share information.

A majority of participating providers did not have standardized processes for tracking referrals and reported that they rarely or never received a report back from the substance use provider after a referral was made. Many cultural, technical, and legal issues hinder communications between addiction and mental health and primary care providers. Solutions to these issues will be necessary as efforts to integrate physical and behavioral health services continue.

The program plans to recruit youth in the Portland Metro area for the second cohort. Age of program participation will drop to 12 years old, and increased interest in program participation is expected. Discussions about sustainability have begun at the State level, as funding ends in 2016. The program also seeks to implement facilitated learning communities as a component of post-training and check-in efforts. Beginning with the second cohort, the program will work to measure SBIRT through e-Health Records, in order to track implementation and measure evidence-based elements, such as specific brief intervention, referrals, warm handoffs if applicable, and scores given, if any.

Contact Information

Elizabeth Thorne

Adolescent Health Policy & Assessment Specialist, Oregon Health Authority

Email: Elizabeth.k.thorne@dhsoha.state.or.us

Wisconsin

Program Description: A Targeted Approach to Using SBIRT in Schools

Wisconsin's universal SBIRT program began in 2006 when they received a five-year SBIRT grant from SAMHSA to incorporate SBIRT into many health care settings throughout the State. During this period, Wisconsin conducted a small feasibility study on adolescents. The results of that study showed that SBIRT in health care settings with youth was very successful, youth responded well, and 6-month follow-up results indicated positive outcomes. While there was no subsequent statewide implementation of youth SBIRT in health care settings, there is

currently a youth SBIRT program in school settings. The program aims to incorporate SBIRT into high schools in southeastern Wisconsin by hiring health educators to administer SBIRT in health classes.

The second program in Wisconsin, called the School SBIRT Program, is not considered a pure SBIRT program because it does not include universal screening. The Department of Public Instruction (DPI) and the Department of Health Services (DHS) collaborated to develop a targeted SBIRT program in school districts across the State. DPI is willing to sacrifice universality of the program for the sake of sustainability.

Delivery of the Program

The universal SBIRT program, Alliance for Wisconsin Youth-Southeast (AWY-SE), received a \$50,000 Development Grant from the Wisconsin Partnership Program of the University of Wisconsin School of Medicine and Public Health from April 2012 to March 2013. The purpose of the grant was to allow the members of the Alliance to plan for implementation of SBIRT with high school students. The long-term goal of the project was to prevent youth from experiencing the adverse consequences of substance use, misuse, and disorder. Within the one-year scope of the project, the short-term goals were to educate members of AWY-SE about SBIRT and lay the groundwork for future implementation of SBIRT in community-based settings throughout the region.

Over the course of the grant period, there was one half-day SBIRT training, eleven SBIRT phone conferences and four SBIRT-focused AWY-SE meetings. About thirty-five individuals attended an initial half-day SBIRT training in May 2012, including twelve AWY-SE coalition members. Topics presented and discussed in the training included: goals of the project and an overview of youth SUD trends within the State; data supporting the use of SBIRT in clinics and hospitals; review of previous SBIRT implementation in schools across the States; and the CRAFFT questionnaire and effectiveness of motivational interviewing. The screening is delivered electronically on a tablet or laptop, and the brief intervention is administered by a health educator.

The targeted SBIRT program is administered by existing pupil services staff, who are social workers, psychologists, counselors, and nurses. These staff members are trained in the

delivery of SBIRT and the Global Appraisal of Individual Needs- Short Screen (GAIN SS). The GAIN SS is conducted on paper, and students receive in-person brief intervention.

The targeted approach is used in schools for this SBIRT program because staff do not have the resources to screen all students, and it is assumed that school staff have an understanding of which students are high-risk. Those students who have experienced an SUD event, mental health issues, truancy, and those who are on the school's list of failing students, are considered high-risk and are targeted for SBIRT.

Training for the School SBIRT program is available through a collaborative effort between the Wisconsin Safe and Healthy Schools (WISH) Center, the Wisconsin Department of Public Instruction, and the Wisconsin Department of Health Services (DHS). The first day of training is experiential and skills-focused, during which staff learn the basics of motivational interviewing as applied to the delivery of SBIRT. The goal of training is to prepare staff to begin delivering services.

After the one-day training, staff can deliver SBIRT services immediately for approximately one month, and also begin a simple data collection process. During the second training session, staff share experiences and data from the prior month and continue skill-building and practicing the protocol. Sessions from the prior month are recorded so that a trainer can code the session for fidelity and provide the trainee individualized feedback.

Technical assistance is available to participating staff and districts following training to help identify and strategize implementation barriers and to promote fidelity of service delivery. Total cost of training is \$100 per person. Over the past year, DPI has started a train-the-trainer program, and there are now five trainers for the targeted SBIRT program.

Evaluation

Evaluation of the universal program found that AWY-SE was successful in meeting its objectives. Pre- and post-tests of members of AWY-SE members and community partners show substantial increases in understanding of the SBIRT process both generally and its application in community settings. In general, community members started out knowing less about SBIRT than did AWY-SE coalitions, but both groups evidenced large knowledge gains between pre-

and post-tests. Not only were all participants much more knowledgeable about SBIRT at the end of the grant period, but the project was also successful in obtaining commitments from seven community partners to go forward with SBIRT pilot projects in the future.

For the targeted SBIRT program, students who participate in the initial SBIRT program receive a 30-day follow up of the same screening, and results have shown significant behavioral progress made by most students.

Challenges, Lessons Learned, and Next Steps

The primary challenges encountered during implementation of the universal program were lack of staff time to implement a universal screening tool, lack of school finances to pay for implementation of a universal screening tool, and concerns about bringing outside staff into the schools to do the screening.

The first two barriers can be mitigated by the ability of AWY-SE to bring the staff and resources of the local coalitions into the schools. By pursuing additional funding from outside the school system the local coalitions can support the SBIRT process without requiring schools to pay anything.

Grant funds can pay for staff training in SBIRT and Motivational Interviewing. Since the screening is a short-term project, most schools approached so far do not seem to mind allowing non-school staff to administer the CRAFFT, however, schools that are unwilling to allow outside staff to do the screening can opt to have their own staff trained.

The sixty-hour Motivational Interviewing training was seen by several coalitions and schools as a barrier to SBIRT implementation. Most community partners felt the time commitment was too burdensome and made it difficult to attend the training. School staff didn't think that the length of time required was feasible, and said they could never afford to have a school guidance counselor attend such a long training, particularly if no continuing education units were offered. Despite these challenges, the staff, as well as students, considered the program to be successful and helpful.

One of the challenges of implementing targeted SBIRT in schools is that a degree of harm reduction is allowed within the SBIRT approach. Harm reduction approaches do not align

with school districts' zero tolerance policies. Another challenge is that delivering SBIRT with fidelity requires that school leadership prioritize its implementation, and staff take the necessary time and focus to integrate SBIRT into practice. While leadership and staff have students' best interests in mind, incorporating yet another program into existing procedures can be difficult.

The biggest theme with regard to lessons learned in the targeted program is related to training. Most of the work happens after the training has been completed. While training workshops are effective, DPI and DHS would like to offer continued learning and professional development opportunities. They hope to create an SBIRT Professional Learning Community (PLC), starting in a handful of districts initially and becoming a statewide network of school staff who are delivering SBIRT. The Community would provide monthly meetings or teleconferences to review skills, troubleshoot, and share stories. The Milwaukee school district has already committed to creating a PLC as a pilot.

Contact Information

Scott Caldwell

SBIRT Program Coordinator, State of Wisconsin Bureau of Prevention, Treatment, and Recovery

Email: Scott.Caldwell@dhs.wisconsin.gov

Conclusion

The goals of this report were to learn more about State youth SBIRT programs and highlight five innovative and effective (or promising) State programs as case studies. Despite the initial challenges of encouraging Youth Coordinators and NPNs to respond to the inquiry, NASADAD staff persistence resulted in a respectable response and valuable information was gathered. Of particular interest, is that these intervention programs are with youth who are not in treatment, but in the early stages of potentially developing substance use, misuse, or disorder. Despite a widespread belief that youth SBIRT programs are treatment-related, there is less actually being done on the treatment side of the house in most States. But on the prevention side, there are a lot more of these "selective and/or indicated" prevention programs that utilize a screening tool; however, they are not specifically referred to as "SBIRT" programs.

These are very similar programs in their constitution—systematic screening, followed by brief interventions—however, there was some initial confusion based on how the programs were labeled. Once the discrepancy was realized, it became clear that complementary substance use, misuse, and disorder screening and brief intervention efforts were occurring in both the treatment and prevention areas.

Appendix A

Inquiry: Screening Brief Intervention and Referral to Treatment (SBIRT) for Youth

*This inquiry is being distributed to all State **Youth Coordinators**. The goal is to identify Screening Brief Intervention and Referral to Treatment (SBIRT) initiatives and approaches for youth that are novel and effective (or at least promising) in identifying youth at risk for substance abuse.*

1. Does your State Substance Abuse agency (SSA) fund any Screening Brief Intervention and Referral to Treatment (SBIRT) services with youth? **Yes or No**
 - a. If yes, how many different Youth SBIRT initiatives does your agency fund?
2. Are you aware of any other Youth SBIRT initiatives in your State that are NOT funded through the SSA? **Yes or No**
3. Is your State planning any expansion of screening and brief intervention or Youth SBIRT services as part of implementation of Affordable Care Act (ACA)? **Yes, No, Unsure**
 - a. If yes, please describe.
4. To your knowledge, have the Medicaid codes been activated? **Yes, No, Unsure**
 - a. If yes, what are they?
5. Is SBIRT is being reimbursed by insurance companies? **Yes, No, Unsure**

Questions 6-52 aim to gather more details of **up to three (3) Youth SBIRT programs** in your State that are considered novel and effective (or at least promising) in identifying youth at risk for substance abuse.

Program 1

6. What is the name of the Youth SBIRT program?
7. Does the program have any resources, such as a web site? **Yes or No**
 - a. If yes, please list.
8. If funding is provided by the State, how long has the State been funding this Youth SBIRT initiative?
9. Indicate (or provide your best estimate) the age range of youth served.
Age Range (indicate percentage next to each category)

____% 12-17
____% 18-24

10. Race/Ethnicity (indicate percentage next to each category)
____% White/Caucasian
____% Black/African American
____% Asian

- % Hispanic or Latino
- % American Indian/Alaska Native
- % Native Hawaiian/Other Pacific Islander
- % More than one race reported
- % Unknown

11. Does the program include any manuals? **Yes or No**
a. If yes, please describe.

12. Which screening tool is used for the Youth SBIRT intervention?

- AUDIT (Alcohol Use Disorders Identification Test)
- ASSIST (Alcohol, Smoking, Substance Involvement, Screening Test)
- DAST (Drug Abuse Screening Test)
- CAGE (Cut Down, Annoyed, Guilty, Eye-Opener)
- CRAFFT
- Other (What? _____)
- Don't know

13. How is the SBIRT intervention delivered?

- Web-based screening tool only
- Web-based screening tool, followed by individual intervention
- Questions filled out by youth, followed by individual intervention
- Questions asked face-to-face by an individual, followed by intervention
- Other? Please explain: _____
- Don't know

14. In what setting is the Youth SBIRT intervention administered?

- Primary care center
- Emergency room
- Trauma center
- Community Health Center
- Community Center
- School

- Afterschool program
- Mentoring program
- Other? (Where? _____)
- Don't know

15. What type of staff delivers the SBIRT services and intervention?

- Primary care physician
- Emergency room physician
- Community health center physician
- Nurse (primary care or ER)
- Substance abuse counselor
- Other? (Who? _____)

Don't know

16. Are staff required to receive any training in order to administer the SBIRT intervention? **Yes or No**
 - a. If yes, what does the training consist of?
17. Is certification or some sort of credentialing required for sites (as well as staff) that deliver the intervention? **Yes or No**
 - a. If yes, please describe.
18. Is the program listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), or other lists of evidence-based interventions/practices? **Yes or No**
19. Is the SBIRT program regularly evaluated? **Yes or No**
 - a. If yes, please describe what information is collected and any findings.
20. Have any reports, papers, or presentations been drafted or published about the program evaluation? **Yes or No**
 - a. If yes, please list.
21. Program 2? **Yes or No**
22. What is the name of the Youth SBIRT program?
23. Does the program have any resources, such as a web site? **Yes or No**
 - a. If yes, please list.
24. If funding is provided by the State, how long has the State been funding this Youth SBIRT initiative?
25. Indicate (or provide your best estimate) the age range of youth served.
Age Range (indicate percentage next to each category)

% 12-17
 % 18-24
26. Race/Ethnicity (indicate percentage next to each category)

% White/Caucasian
 % Black/African American
 % Asian
 % Hispanic or Latino
 % American Indian/Alaska Native
 % Native Hawaiian/Other Pacific Islander
 % More than one race reported
 % Unknown
27. Does the program include any manuals? **Yes or No**

- b. If yes, please describe.
28. Which screening tool is used for the Youth SBIRT intervention?
- AUDIT (Alcohol Use Disorders Identification Test)
 ASSIST (Alcohol, Smoking, Substance Involvement, Screening Test)
 DAST (Drug Abuse Screening Test)
 CAGE (Cut Down, Annoyed, Guilty, Eye-Opener)
 CRAFFT
 Other (What? _____)
 Don't know
29. How is the SBIRT intervention delivered?
- Web-based screening tool only
 Web-based screening tool, followed by individual intervention
 Questions filled out by youth, followed by individual intervention
 Questions asked face-to-face by an individual, followed by intervention
 Other? Please explain: _____
 Don't know
30. In what setting is the Youth SBIRT intervention administered?
- Primary care center
 Emergency room
 Trauma center
 Community Health Center
 Community Center
 School
 Afterschool program
 Mentoring program
 Other? (Where? _____)
 Don't know
31. What type of staff delivers the SBIRT services and intervention?
- Primary care physician
 Emergency room physician
 Community health center physician
 Nurse (primary care or ER)
 Substance abuse counselor
 Other? (Who? _____)
 Don't know
32. Are staff required to receive any training in order to administer the SBIRT intervention? **Yes or No**
- c. If yes, what does the training consist of?
33. Is certification or some sort of credentialing required for sites (as well as staff) that deliver the intervention? **Yes or No**

- d. If yes, please describe.
34. Is the program listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), or other lists of evidence-based interventions/practices? **Yes or No**
35. Is the SBIRT program regularly evaluated? **Yes or No**
- e. If yes, please describe what information is collected and any findings.
36. Have any reports, papers, or presentations been drafted or published about the program evaluation? **Yes or No**
- f. If yes, please list.
37. Program 3? **Yes or No**
38. What is the name of the Youth SBIRT program?
39. Does the program have any resources, such as a web site? **Yes or No**
- a. If yes, please list.
40. If funding is provided by the State, how long has the State been funding this Youth SBIRT initiative?
41. Indicate (or provide your best estimate) the age range of youth served.
Age Range (indicate percentage next to each category)
- % 12-17
% 18-24
42. Race/Ethnicity (indicate percentage next to each category)
- % White/Caucasian
% Black/African American
% Asian
% Hispanic or Latino
% American Indian/Alaska Native
% Native Hawaiian/Other Pacific Islander
% More than one race reported
% Unknown
43. Does the program include any manuals? **Yes or No**
- b. If yes, please describe.
44. Which screening tool is used for the Youth SBIRT intervention?
- AUDIT (Alcohol Use Disorders Identification Test)
 ASSIST (Alcohol, Smoking, Substance Involvement, Screening Test)
 DAST (Drug Abuse Screening Test)
 CAGE (Cut Down, Annoyed, Guilty, Eye-Opener)

- CRAFFT
 Other (What? _____)
 Don't know

45. How is the SBIRT intervention delivered?

- Web-based screening tool only
 Web-based screening tool, followed by individual intervention
 Questions filled out by youth, followed by individual intervention
 Questions asked face-to-face by an individual, followed by intervention
 Other? Please explain: _____
 Don't know

46. In what setting is the Youth SBIRT intervention administered?

- Primary care center
 Emergency room
 Trauma center
 Community Health Center
 Community Center
 School
 Afterschool program
 Mentoring program
 Other? (Where? _____)
 Don't know

47. What type of staff delivers the SBIRT services and intervention?

- Primary care physician
 Emergency room physician
 Community health center physician
 Nurse (primary care or ER)
 Substance abuse counselor
 Other? (Who? _____)
 Don't know

48. Are staff required to receive any training in order to administer the SBIRT intervention? **Yes or No**

c. If yes, what does the training consist of?

49. Is certification or some sort of credentialing required for sites (as well as staff) that deliver the intervention? **Yes or No**

d. If yes, please describe.

50. Is the program listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), or other lists of evidence-based interventions/practices? **Yes or No**

51. Is the SBIRT program regularly evaluated? **Yes or No**

e. If yes, please describe what information is collected and any findings.

52. Have any reports, papers, or presentations been drafted or published about the program evaluation?

Yes or No

f. If yes, please list.

53. May we contact you for more information for a case study about any Youth SBIRT initiatives in your State that might be instructive to other states/communities? **Yes or No**

54. Name

55. Email

56. State

Appendix B

Inquiry: Selective and/or Indicated Substance Abuse Interventions for Youth

This inquiry is being distributed to all State NPNs. The goal is to identify selective prevention strategies and/or indicated prevention interventions for youth that are novel and effective (or at least promising) in identifying youth at risk for substance abuse.

1. Does your State Substance Abuse agency (SSA) fund any selective and/or indicated prevention services with youth? **Yes or No**
 - a. If yes, how many different selective and/or indicated prevention initiatives does your agency fund?
2. Are you aware of any other Youth selective and/or indicated prevention initiatives in your State that are NOT funded through the SSA? **Yes or No**
3. Is your State planning any expansion of screening and brief intervention or Youth selective and/or indicated prevention services as part of implementation of Affordable Care Act (ACA)? **Yes, No, Unsure**
 - a. If yes, please describe.
4. To your knowledge, have the Medicaid codes been activated? **Yes, No, Unsure**
 - a. If yes, what are they?
5. Is SBIRT is being reimbursed by insurance companies? **Yes, No, Unsure**

Questions 6-52 aim to gather more details of **up to three (3) Youth selective and/or indicated prevention programs** in your State that are considered novel and effective (or at least promising) in identifying youth at risk for substance abuse.

Program 1

6. What is the name of the Youth selective and/or indicated prevention program?
7. Does the program have any resources, such as a web site? **Yes or No**
 - a. If yes, please list.
8. If funding is provided by the State, how long has the State been funding this Youth selective and/or indicated prevention initiative?
9. Indicate (or provide your best estimate) the age range of youth served.
Age Range (indicate percentage next to each category)

% 12-17
% 18-24

10. Race/Ethnicity (indicate percentage next to each category)

- % White/Caucasian
- % Black/African American
- % Asian
- % Hispanic or Latino
- % American Indian/Alaska Native
- % Native Hawaiian/Other Pacific Islander
- % More than one race reported
- % Unknown

11. Does the program include any manuals? **Yes or No**

- a. If yes, please describe.

12. Which screening tool is used for the Youth selective and/or indicated prevention intervention?

- AUDIT (Alcohol Use Disorders Identification Test)
- ASSIST (Alcohol, Smoking, Substance Involvement, Screening Test)
- DAST (Drug Abuse Screening Test)
- CAGE (Cut Down, Annoyed, Guilty, Eye-Opener)
- CRAFFT
- Other (What? _____)
- Don't know

13. How is the selective and/or indicated prevention intervention delivered?

- Web-based screening tool only
- Web-based screening tool, followed by individual intervention
- Questions filled out by youth, followed by individual intervention
- Questions asked face-to-face by an individual, followed by intervention
- Other? Please explain: _____
- Don't know

14. In what setting is the Youth selective and/or indicated prevention intervention administered?

- Primary care center
- Emergency room
- Trauma center
- Community Health Center
- Community Center
- School
- Afterschool program
- Mentoring program
- Other? (Where? _____)
- Don't know

15. What type of staff delivers the selective and/or indicated prevention services?

- Primary care physician
- Emergency room physician
- Community health center physician

- Nurse (primary care or ER)
- Substance abuse counselor
- Other? (Who? _____)
- Don't know

16. Are staff required to receive any training in order to administer the selective and/or indicated prevention intervention? **Yes or No**
 - a. If yes, what does the training consist of?
17. Is certification or some sort of credentialing required for sites (as well as staff) that deliver the intervention? **Yes or No**
 - a. If yes, please describe.
18. Is the program listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), or other lists of evidence-based interventions/practices? **Yes or No**
19. Is the selective and/or indicated prevention program regularly evaluated? **Yes or No**
 - a. If yes, please describe what information is collected and any findings.
20. Have any reports, papers, or presentations been drafted or published about the program evaluation? **Yes or No**
 - a. If yes, please list.
21. Program 2? **Yes or No**
22. What is the name of the Youth selective and/or indicated prevention program?
23. Does the program have any resources, such as a web site? **Yes or No**
 - g. If yes, please list.
24. If funding is provided by the State, how long has the State been funding this Youth selective and/or indicated prevention initiative?
25. Indicate (or provide your best estimate) the age range of youth served.
Age Range (indicate percentage next to each category)

% 12-17
 % 18-24

26. Race/Ethnicity (indicate percentage next to each category)
 - % White/Caucasian
 - % Black/African American
 - % Asian
 - % Hispanic or Latino
 - % American Indian/Alaska Native

% Native Hawaiian/Other Pacific Islander
 % More than one race reported
 % Unknown

27. Does the program include any manuals? **Yes or No**
h. If yes, please describe.
28. Which screening tool is used for the Youth selective and/or indicated prevention intervention?
- AUDIT (Alcohol Use Disorders Identification Test)
 ASSIST (Alcohol, Smoking, Substance Involvement, Screening Test)
 DAST (Drug Abuse Screening Test)
 CAGE (Cut Down, Annoyed, Guilty, Eye-Opener)
 CRAFFT
 Other (What? _____)
 Don't know
29. How is the selective and/or indicated prevention intervention delivered?
- Web-based screening tool only
 Web-based screening tool, followed by individual intervention
 Questions filled out by youth, followed by individual intervention
 Questions asked face-to-face by an individual, followed by intervention
 Other? Please explain: _____
 Don't know
30. In what setting is the Youth selective and/or indicated prevention intervention administered?
- Primary care center
 Emergency room
 Trauma center
 Community Health Center
 Community Center
 School
 Afterschool program
 Mentoring program
 Other? (Where? _____)
 Don't know
31. What type of staff delivers the selective and/or indicated prevention intervention?
- Primary care physician
 Emergency room physician
 Community health center physician
 Nurse (primary care or ER)
 Substance abuse counselor
 Other? (Who? _____)
 Don't know

32. Are staff required to receive any training in order to administer the selective and/or indicated prevention intervention? **Yes or No**
i. If yes, what does the training consist of?
33. Is certification or some sort of credentialing required for sites (as well as staff) that deliver the intervention? **Yes or No**
j. If yes, please describe.
34. Is the program listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), or other lists of evidence-based interventions/practices? **Yes or No**
35. Is the selective and/or indicated prevention program regularly evaluated? **Yes or No**
k. If yes, please describe what information is collected and any findings.
36. Have any reports, papers, or presentations been drafted or published about the program evaluation? **Yes or No**
l. If yes, please list.
37. Program 3? **Yes or No**
38. What is the name of the Youth selective and/or indicated prevention program?
39. Does the program have any resources, such as a web site? **Yes or No**
g. If yes, please list.
40. If funding is provided by the State, how long has the State been funding this Youth selective and/or indicated prevention initiative?
41. Indicate (or provide your best estimate) the age range of youth served.
Age Range (indicate percentage next to each category)
- ____% 12-17
____% 18-24
42. Race/Ethnicity (indicate percentage next to each category)
____% White/Caucasian
____% Black/African American
____% Asian
____% Hispanic or Latino
____% American Indian/Alaska Native
____% Native Hawaiian/Other Pacific Islander
____% More than one race reported
____% Unknown

43. Does the program include any manuals? **Yes or No**
h. If yes, please describe.
44. Which screening tool is used for the Youth selective and/or indicated prevention intervention?
- AUDIT (Alcohol Use Disorders Identification Test)
 - ASSIST (Alcohol, Smoking, Substance Involvement, Screening Test)
 - DAST (Drug Abuse Screening Test)
 - CAGE (Cut Down, Annoyed, Guilty, Eye-Opener)
 - CRAFFT
 - Other (What? _____)
 - Don't know
45. How is the selective and/or indicated prevention intervention delivered?
- Web-based screening tool only
 - Web-based screening tool, followed by individual intervention
 - Questions filled out by youth, followed by individual intervention
 - Questions asked face-to-face by an individual, followed by intervention
 - Other? Please explain: _____
 - Don't know
46. In what setting is the Youth selective and/or indicated prevention intervention administered?
- Primary care center
 - Emergency room
 - Trauma center
 - Community Health Center
 - Community Center
 - School
 - Afterschool program
 - Mentoring program
 - Other? (Where? _____)
 - Don't know
47. What type of staff delivers the selective and/or indicated prevention intervention?
- Primary care physician
 - Emergency room physician
 - Community health center physician
 - Nurse (primary care or ER)
 - Substance abuse counselor
 - Other? (Who? _____)
 - Don't know
48. Are staff required to receive any training in order to administer the selective and/or indicated prevention intervention? **Yes or No**
i. If yes, what does the training consist of?
49. Is certification or some sort of credentialing required for sites (as well as staff) that deliver the intervention? **Yes or No**

- j. If yes, please describe.
50. Is the program listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), or other lists of evidence-based interventions/practices? **Yes or No**
51. Is the selective and/or indicated prevention program regularly evaluated? **Yes or No**
- k. If yes, please describe what information is collected and any findings.
52. Have any reports, papers, or presentations been drafted or published about the program evaluation? **Yes or No**
- l. If yes, please list.
53. May we contact you for more information for a case study about any Youth SBIRT initiatives in your State that might be instructive to other states/communities? **Yes or No**
54. Name
55. Email
56. State

Appendix C: Case Study Discussion Guide

Youth SBIRT/Selective and/or Indicated Prevention Programs Discussion Questions

- I. Program Description
 - a. Please describe your State's youth SBIRT or selective and/or indicated prevention program(s).
 - b. Is there a website or other materials for the program?
 - c. Describe the funding sources for the program
- II. Delivery of Youth Programs
 - a. In what setting(s) is the program implemented?
 - b. Who is the target population for the program? (age, race, SES)
 - c. Does your agency collaborate with any other organizations to implement this program?
 - d. Who delivers the screening and/or intervention?
 - e. Are those who deliver the intervention required to attend training? If so, please describe.
 - f. What (if any) screening tool is used? How is it followed up? Individual, group, etc.?
- III. Evidence of Effectiveness
 - a. What evaluation has been done to date?
 - b. What kind of data or tracking system do you use?
 - c. Do you have any outcome or anecdotal data? If so, please describe.
 - d. Are there any reports, papers, or presentations on this program?
- IV. Conclusion
 - a. What lessons have been learned about program implementation, training, etc.?
 - b. What challenges has your agency encountered in developing and implementing this program?
 - c. How will this program be sustained if funding were to be eliminated or decrease?
 - d. Are there plans to expand the program to other geographical locations, populations, or settings?
 - e. Are there any final comments you'd like to make about the program?