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Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians

COMMITTEE ON SUBSTANCE ABUSE

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Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians

abstract

FREE

As a component of comprehensive pediatric care, adolescents should receive appropriate guidance regarding substance use during routine clinical care. This statement addresses practitioner challenges posed by the spectrum of pediatric substance use and presents an algorithm-based approach to augment the pediatrician's confidence and abilities related to substance use screening, brief intervention, and referral to treatment in the primary care setting. Adolescents with addictions should be managed collaboratively (or comanaged) with child and adolescent mental health or addiction specialists. This statement reviews recommended referral guidelines that are based on established patient-treatment–matching criteria and the risk level for substance abuse. *Pediatrics* 2011;128:e1330–e1340

COMMITTEE ON SUBSTANCE ABUSE

KEY WORDS
alcohol, screening, SBIRT, substance abuse

ABBREVIATIONS
SBIRT—screening, brief intervention, and referral to treatment
AAP—American Academy of Pediatrics
BNI—brief negotiated interview

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INTRODUCTION

Although it is common for adolescents and young adults to try mood-altering chemicals, including nicotine, it is important that this experimentation not be condoned, facilitated, or trivialized by adults including parents, teachers, and health care providers. Use of alcohol and other drugs remains a leading cause of morbidity and mortality for young people in the United States.[1,2] Even the first use of alcohol or another drug can result in tragic consequences such as unintentional injury or death. All substance use involves health risks that can occur long before there is drug addiction, and teenagers seem to be particularly susceptible to health risk–taking behaviors and injuries related to alcohol, tobacco, and other drug use.[3,4] In addition, research has established that adolescence is a period of neurodevelopmental vulnerability for developing addictions; age at first use is inversely correlated with lifetime incidence of developing a substance use disorder.[4–6]

The pediatrician has a well-recognized and important professional and societal role in the prevention, detection, and management of all pediatric health risks and disorders, including tobacco, alcohol, and other drug use among children and adolescents. Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*,[7] primary care practitioners are ideally suited for preventing problem behaviors and consistently screening for them, including the development of mental health disorders and psychosocial problems, among which are substance use and addiction. The nonuse message should be reinforced by pediatricians through clear and consistent information presented to patients, parents, and other family members

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TABLE 1 Substance Use Spectrum and Goals for Office Intervention

Stage	Description	Office Intervention Goals
Abstinence	The time before an individual has ever used drugs or alcohol (more than a few sips)	Prevent or delay initiation of substance use through positive reinforcement and patient/parent education
Experimentation	The first 1–2 times that a substance is used and the adolescent wants to know how intoxication from using a certain drug(s) feels	Promote patient strengths; encourage abstinence and cessation through brief, clear medical advice and educational counseling
Limited use	Use together with ≥1 friends in relatively low-risk situations and without related problems; typically, use occurs at predictable times such as on weekends	Promote patient strengths; further encourage cessation through brief, clear medical advice and educational counseling
Problematic use	Use in a high-risk situation, such as when driving or babysitting; use associated with a problem such as a fight, arrest, or school suspension; or use for emotional regulation such as to relieve stress or depression	As stated above, plus initiate office visits or referral for brief intervention to enhance motivation to make behavioral changes; provide close patient follow-up; consider breaking confidentiality
Abuse	Drug use associated with recurrent problems or that interferes with functioning, as defined in the *DSM-IV-TR*	Continue as stated above, plus enhance motivation to make behavioral changes by exploring ambivalence and triggering preparation for action; monitor closely for progression to alcohol and other drug addiction; refer for comprehensive assessment and treatment; consider breaking confidentiality
Addiction (dependence)	Loss of control or compulsive drug use, as defined in the *DSM-IV-TR* as "dependence"	As stated above, plus enhance motivation to accept referral to subspecialty treatment if necessary; consider breaking confidentiality; encourage parental involvement whenever possible

DSM-IV-TR indicates *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.*

while developing and maintaining a trusting patient care relationship.[8] To decrease the health burden associated with substance use and substance use disorders, the Substance Abuse and Mental Health Services Administration recommends that universal screening for substance use, brief intervention, and/or referral to treatment (SBIRT) become a part of routine health care.[9] As a group, adolescents are at the highest risk of experiencing substance use–related acute and chronic health consequences, so they are also the age group likely to derive the most benefit from universal SBIRT. Specific SBIRT tools and strategies have well-documented efficacy for adult alcohol and drug use.[10,11] More recently, developmentally appropriate tools and strategies have been designed specifically for use with adolescents.[12–15]

Experience with substances can be considered a spectrum that varies from primary abstinence to addiction. The goal of applying universal SBIRT with adolescents is to identify an individual's experience along this spectrum and institute the appropriate intervention for each adolescent at every health care visit. Table 1 outlines a conceptual framework for the adolescent substance use spectrum and provides stage-correlated goals for optimal primary care office intervention.

Incorporating SBIRT practices into the primary care routine interfaces well with structured psychosocial interview schemes in common use, such as HEADSS or SSHADESS.[16,17] Following the HEADSS acronym guides the adolescent interview through questions about home, education, activities, drug and alcohol use, sexuality, and suicide. The SSHADESS interview framework covers the same life areas and underscores resiliency by identifying the patient's perceived and realized strengths before exploring environmental context and risks. Structured tools can be easily incorporated into the written or electronic health record to remind the practitioner to conduct screening and document the results. Recent research has established that adolescents who present for either urgent or follow-up care appointments are more likely to report alcohol and drug use and other high-risk behaviors when compared with those who present for well care, so substance use screening is recommended whenever an adolescent presents for outpatient care.[18] In recognition of the challenges posed by conducting health-risk screening amid the time constraints and competing medical needs found in nearly every practice context, the National Institute on Alcohol Abuse and Alcoholism is developing an empirically based 2-question alcohol use screen as part of a guide for interdisciplinary health care personnel for assessing adolescent alcohol use and then responding to the screening results. Because alcohol use is often the first risk behavior in which adolescents engage, alcohol-only screening may be a reasonable approach when time does not permit a full psychosocial interview.[19] The expectation remains that soon thereafter a full psychosocial interview, including strengths promotion and risk screening, will be conducted during a scheduled follow-up appointment. Whenever a child or adolescent has a positive alcohol-only screening result, a full psychosocial evaluation should be conducted as soon as possible, because underage drinking is associated

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with a greater likelihood of other risk behaviors.[20]

This policy statement builds on the American Academy of Pediatrics (AAP) statements on tobacco, alcohol, and other drug use by providing pediatricians with additional guidance and tools for boosting their confidence and competence in preventing, detecting, and influencing the course of adolescent substance use.[8] The SBIRT framework presented here is similar in structure to the "ask, advise, refer" recommendation for tobacco use. For detailed information about providing care for adolescents who use tobacco, see the AAP technical report "Tobacco as a Substance of Abuse."[21]

SCREENING

Screening is a procedure applied to populations and is intended to identify people with a disease, condition, or symptom. Screening does not yield a formal diagnosis but, rather, guides further decision-making. Screening an adolescent for substance use is designed to determine if the adolescent has used alcohol or other drugs in the previous 12 months and, if so, to delineate the associated level of risk.

Succinct screens for adolescent substance abuse are available and outlined in the AAP statements "Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Substance Abuse"[8] and "Alcohol Use by Youth and Adolescents: A Pediatric Concern."[22] The CRAFFT screen is a validated, developmentally appropriate, brief, easy-to-use screen with good discriminative properties for determining high risk of substance use disorders in the adolescent age group treated in primary care.[12] Use of this screening tool has been researched more extensively than any other substance use screening method in the adolescent age group. As a measure of risk, each "yes" answer to the 6 CRAFFT questions is scored as 1 point, so as the score increases, there is a corresponding greater likelihood of having a substance use disorder (ie, meets the diagnostic criteria for having substance abuse or substance dependence [addiction] delineated in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*[23] [DSM-IV-TR]). Recently, the CRAFFT tool was effectively integrated into an adolescent SBIRT algorithm and toolkit produced for Massachusetts practitioners by a collaborative led by the Massachusetts Department of Public Health Bureau of Substance Abuse Services.[14] This statement will lead the practitioner through this time-efficient, research-informed adolescent SBIRT algorithm (Fig 1).

The SBIRT algorithm starts with a 2-step method of using the CRAFFT screening tool. First, the clinician asks 3 specific opening questions to determine if the adolescent has used alcohol or other drugs in the previous 12 months, and the answers to these questions determine what portion of the CRAFFT screen is indicated (Fig 1 [start at the top center]). Adolescents who answer "no" to all 3 opening questions (Fig 1, upper left) are still asked the "C" (or "car") question to determine if they have placed themselves at risk by riding with an alcohol- or drug-"influenced" or intoxicated driver. Those who answer "yes" to any of the opening questions are asked all 6 CRAFFT questions (Fig 1, upper right). This 2-step screening may be accomplished by interview with the physician or office staff or by self-administered written or electronic survey. As with all psychosocial interviews, screening for substance use is most informative when conducted confidentially without a parent or guardian present. Before screening, both patients and parents should be well informed about the confidentiality policy followed in that practice setting, including the safety-related limits that justify whether to continue or break confidentiality.[24]

BRIEF INTERVENTION

Brief intervention describes a screening outcome-responsive conversation that focuses on encouraging a patient to make healthy choices and personal behavior changes regarding risky activity such as substance use. In primary care pediatrics, the term "brief intervention" encompasses a spectrum of responses that includes providing patients who report no substance use with brief positive feedback about their ability to make healthy choices. When the screening process reveals alcohol or other drug use, the indicated brief intervention ranges from providing brief advice to using a brief negotiated interview based on motivational techniques to encourage the desired behavior change or acceptance of a referral for treatment.

Low Risk: Abstinence

Screening should be conducted whenever possible, regardless of visit type, and should always be included as part of the annual well-adolescent visit. Adolescents who report no use of tobacco, alcohol, or other drugs *and* answer "no" to the "car" question of the CRAFFT screen are at low risk of having a substance use disorder. It is important that these patients receive praise and encouragement for making smart decisions and healthy choices (Fig 1, upper left ["no to all opening questions"]).[17] Experience is showing that even a few positive words from a physician can delay initiation of alcohol use by adolescents.[25] Anticipatory guidance to avoid riding with a driver who has been drinking or using drugs is always appropriate.

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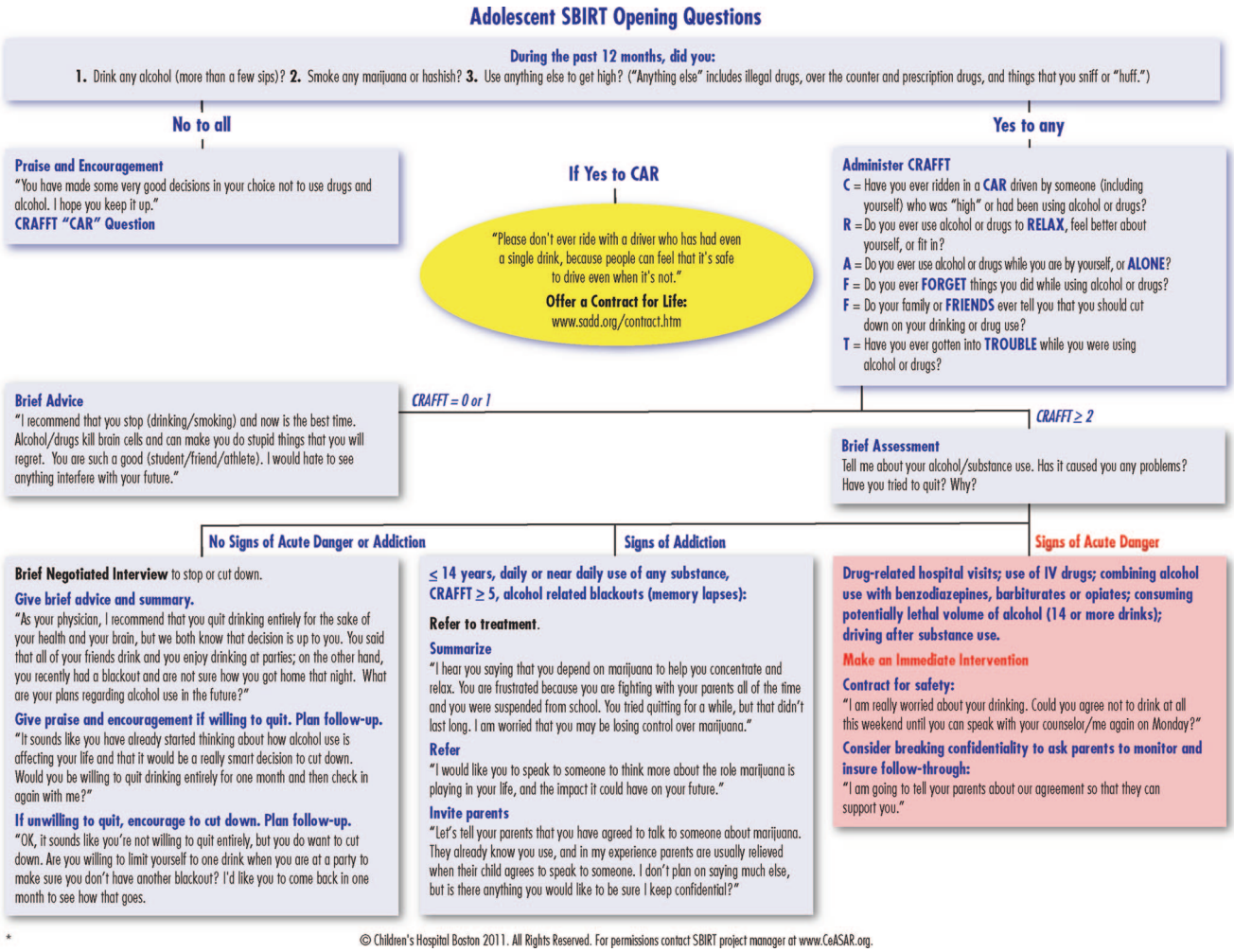

FIGURE 1
Adolescent SBIRT algorithm. (Reprinted with permission from the Adolescent Substance Abuse Program, Children's Hospital Boston.)

Driving Risk

All adolescents who report driving after alcohol or drug use or riding with a driver who has been using alcohol or drugs (ie, answer "yes" to the "car" question) should receive educational counseling regarding the associated danger (Fig 1, top-center oval). Ask adolescents to make a safety plan and commit to avoiding future driving/riding risks. The Contract for Life developed by Students Against Destructive Decisions (SADD) is a short, thought-provoking statement that can be used to facilitate development of a safety plan between an adolescent and a parent or other responsible adult.[26] This contract can be downloaded from the SADD Web site (www.saddonline.com/contract.htm). Pediatricians should consider breaking confidentiality if the adolescent cannot or will not commit to avoiding riding with a driver who has been using alcohol and/or drugs or avoiding their own alcohol or other drug use and driving—the basis for their positive response to the "car" question.

Moderate Risk: CRAFFT-Negative

Adolescents who have begun using alcohol or drugs and score 0 or 1 on the CRAFFT screen are considered at moderate risk of having substance use–associated problems (Fig 1, middle-left side). These adolescents may benefit from brief intervention consisting of both clear advice to stop alcohol and other drug use and educational counseling about the health effects of drug use (eg, "Recent research has confirmed that brain growth continues into at least the 20s, and alcohol poisons developing brain cells"). Brief intervention for adolescents in this category should also include recognition of strengths and positive personal and family attributes (eg, "You are such a good student, it would be a shame to let alcohol interfere with your education").

High Risk: CRAFFT-Positive

Adolescents who test positive on the CRAFFT screen, defined as having a

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CRAFFT score of 2 or greater, are at high risk of having a substance use disorder. The middle right side of the SBIRT algorithm shows that the adolescent with a positive CRAFFT-screen result should undergo further assessment to detect whether the alcohol and/or other drug use indicates acute danger or "red flags" for addiction and to reveal the level of conviction the adolescent has for engaging in behavior change. To look for a pattern of increasing alcohol or other drug use, ask adolescents about their drug use history, their experience with any alcohol- or other drug-associated problems or troubles, and whether they have made quit attempts and why. A well-conducted assessment that encourages an adolescent to discuss problems associated with drug use and reasons for quit attempts is consistent with motivational-interviewing or motivational-enhancement techniques for supporting positive behavior change and can be the first step of brief intervention for this level of substance use.

Signs of Acute Danger

An adolescent who reports experience with certain risk behaviors, such as having a drug-related hospital visit, using intravenous drugs, combining sedatives (including alcohol, benzodiazepines, barbiturates, or opioids), consuming a potentially lethal volume of alcohol (≥14 drinks), or driving or engaging in other potentially dangerous activity after alcohol or drug use, shows clear signs of acute danger that warrant immediate intervention (Fig 1, lower-right rectangle). If any sign of addiction is also present, the corresponding lower-middle portion of the Fig 1 algorithm will guide the medically indicated action, which is treatment referral. The next step when addiction is not yet a concern is to ask the adolescent to commit to avoiding the behavior(s) and consider using a simple written contract to document this commitment. If the adolescent is unwilling or unable to commit or seems to underestimate the significance of alcohol or other drug use, consider breaking confidentiality to protect patient safety. Adolescents who choose to disclose such high-risk behaviors to a clinician might be asking for help. If breaking confidentiality is required to protect safety, discuss with the adolescent exactly what you will disclose and what you can keep confidential. Often, teens are most concerned about protecting small details (ie, which friends are involved, where they obtained substances, etc) that would have minimal impact on their immediate safety plan and can be kept confidential. Design a plan that involves the parent(s) or another responsible adult, professional counselors, and other substance abuse–related services. Schedule close follow-up to ensure patient compliance and safety.

Red Flags for Addiction

Probable substance addiction is indicated by red-flag findings, including a CRAFFT score of 2 or more in an adolescent aged 14 years or younger, daily or near-daily use of any substance, a CRAFFT score of 5 or higher, and alcohol-related blackouts (memory lapses) (Fig 1, lower-middle rectangle). Breaking confidentiality to protect patient safety is, again, a key consideration. Parents should be involved in this process whenever possible, because most adolescents will not follow through with a referral on their own. In most cases, parents will already be highly suspicious or aware of their adolescent's drug use, although they might underestimate the extent or severity. Adolescents might be willing to include their parent(s) in a discussion of recommendations, particularly if the clinician can present any concerns and recommendations in the context of positive patient and family attributes, such as mentioning the adolescent's honesty when screened or willingness to undergo further assessment. An adolescent with an addiction red flag should be referred for detailed evaluation and subspecialty treatment that is as specific to adolescents with substance use disorders as possible (see "Referral to Treatment").

No Signs of Acute Danger or Addiction

Adolescents who have had relatively minor consequences associated with their substance use should be engaged in a brief negotiated interview (BNI) based on motivational principles to encourage abstinence or risk reduction (Fig 1, lower-left rectangle). In contrast to brief advice, a BNI involves a negotiation that attempts to reduce substance use and related risk behaviors by using the negative aspects of substance use as reported by the adolescent. The BNI is based on the principles of motivational interviewing, which is a counseling approach in which a clinician encourages a patient to explore the effects of his or her current behavior on personal interests or goals. These principles align well with established pediatric medical home practices of providing confidential care and building a trust relationship and rapport. Motivational-interviewing or BNI techniques are particularly useful for adolescents who have experienced problems associated with alcohol or drug use but remain ambivalent about continued use or have not yet considered the possibility of changing their behavior. A full review of motivational interviewing is beyond the scope of this statement; interested readers are referred to the seminal work by Miller and Rollnick.[27]

Brief negotiated interviews have been used successfully to reduce both alcohol[28–30] and marijuana[31] use by adoles-

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I,_____ , agree to not drink alcohol, use drugs, or take anyone else's medication for the next _____ days. I also will not provide drugs, alcohol, or prescription medications for anyone else during this time. In addition, I agree to not drive a motor vehicle while under the influence of drugs or alcohol, nor will I ride with a driver who has been drinking or using drugs.
I will come to my follow-up appointment with _____on _____.
Signed, _____

Date: _____

FIGURE 2
Abstinence challenge. (Reprinted with permission from the Adolescent Substance Abuse Program, Children's Hospital Boston.)

cents in emergency care settings. These studies all used multicomponent interventions delivered by peer health educators. To date, no study has examined the effectiveness of this type of intervention when conducted by clinicians working with adolescents in the primary care setting, although these techniques have been used and studied extensively with adult patients. We recommend that clinicians performing a BNI in primary care (1) summarize information from the assessment (see above), (2) repeat for emphasis any problems associated with substance use identified by the adolescent, and (3) ask the adolescent whether he or she would like to make changes in the future (eg, "I understand that you really enjoy smoking marijuana with your friends. On the other hand, you were suspended from the basketball team after the coach caught you with marijuana, and you are worried that having a 'record' of marijuana use might be bad for your college applications. What are your plans regarding marijuana use in the future?"). Telling adolescents who are invested in their substance use to stop using substances can trigger resistance, whereas asking about their own plans might present an opportunity for positive feedback (eg, "It sounds as if you have already thought this through. I fully support your decision to quit using for now"). When an adolescent professes interest in making a behavior change, consider asking for a signed commitment not to use alcohol or other drugs for a defined time period (Fig 2). Patients who are not willing to try complete abstinence might agree to risk reduction. In these cases, discuss concrete parameters for tracking progress.

All patients who have had a brief negotiated interview need follow-up to ensure patient compliance and safety. Adolescents who have met their goals can benefit from both a discussion of the pros and cons of their decreased substance use and reinforced motivation toward sustained behavior change. Those who were unable to meet their own goals might benefit from more extensive and individual counseling targeted specifically at substance use provided by an allied mental health professional such as a social worker or psychologist. Referral to interdisciplinary mental health professionals within the same practice setting often optimizes patient compliance. Research on the effectiveness of individual substance abuse counseling with motivational interviewing in particular has shown decreased harmful behaviors in adolescents, including decreased frequency of alcohol use and episodes of drinking and driving, alcohol-related injuries, and other problems.[29,32–36] In addition, an arm of the Cannabis Youth Treatment Study[37] revealed that motivational enhancement therapy using motivational-interviewing techniques plus cognitive behavioral therapy had greater cost-effectiveness and efficacy when compared with family therapy and psychoeducational support.

REFERRAL TO TREATMENT

Referral to treatment describes the facilitative process that provides patients identified as needing more extensive evaluation and treatment with access to appropriate services. In accordance with the SBIRT algorithm (Fig 1), signs of acute danger or red flags for addiction usually indicate the need for referral to adolescent-specific specialty care.

Addiction is a neurologically based, chronic, relapsing disorder that requires long-term management and monitoring. Any adolescent who meets the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* criteria for substance dependence should be assessed by a professional experienced with adolescent addiction.[23] Because resistance and denial (ie, lack of insight) are intrinsic to substance use disorders and are expected at this stage of the disease, the patient and/or family might be unwilling to pursue an evaluation that is clearly indicated. Despite this potential challenge, it is important for the pediatrician to remain engaged with the patient and family and supportive during discussions and decision-making about the patient's care options. Motivational-interviewing strategies can often be helpful in encouraging an adolescent and/or the family to accept a referral.

It is essential that pediatricians establish effective working relationships with alcohol and other drug treatment professionals and facilities in their communities to ensure that adolescent patients have access to treatment that is appropriate for their developmental, psychosocial, medical, and mental health needs. Adolescent patients with alcohol or other drug use disorders should be

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managed collaboratively (or comanaged) with child and adolescent mental health or addiction specialists whenever possible and scheduled for medical home office visits throughout the recovery process.

Deciding where to refer an adolescent in need of treatment is often complicated by limited treatment availability and insurance-coverage complexities. In most cases, pediatricians refer adolescent patients to a mental health or addiction specialist to conduct a comprehensive biopsychosocial assessment and determine the appropriate level of care from the treatment spectrum, which ranges from outpatient substance abuse counseling to long-term residential treatment programs. In 2001, the American Society of Addiction Medicine revised its comprehensive national guidelines for placement, continued stay, and discharge for patients with alcohol and other drug problems, devised separate guidelines for adults and adolescents, and detailed 5 broad levels of care that range from early intervention to medically managed intensive inpatient treatment and correspond to addiction severity, related problems, and potential for behavior change and recovery[38] (Table 2).

An essential part of assisting the substance-using adolescent is becoming familiar with available community options, such as education and prevention services for those identified early in their substance use, or treatment modalities such as treatment-locator mechanisms and patient-treatment–matching criteria. The Center for Substance Abuse Treatment has published evidence-based treatment and assessment protocols, manuals, and facility-contact information (available at www.chestnut.org/li/apss/CSAT/protocols/index.html). To help identify treatment options throughout the country, the Substance Abuse and Mental Health Services Administration maintains a comprehensive and easy-to-use substance abuse treatment facility locator on its Web site (www.samhsa.gov/treatment/index.aspx). This site also includes both a buprenorphine physician and treatment program locator and an opioid treatment program directory. Opioid addiction and alcohol abuse are the primary indications for medication-assisted treatment in adult populations, and buprenorphine is effective for managing withdrawal of opioid-dependent adolescents and facilitating treatment completion.[39,40]

Successful addiction treatment usually involves more than 1 level of care during a long recovery process. Most patients in addiction treatment consider themselves "recovering" rather than "recovered" in recognition of their lifelong potential for relapse. Whether treatment begins in outpatient or inpatient care, it should continue at a level appropriate for the patient's recovery process, often through sequential or overlapping therapeutic levels that usually include participation in a formal structured program, 12-step self-help groups (eg, Alcoholics Anonymous, Alateen, Narcotics Anonymous), continued after-care programs, and self-help recovery work.

Medical home follow-up plays a key role for all patients in recovery. Relapse can be prevented, but because it often occurs, it should be anticipated as a potential part of the recovery process. Relapse should be viewed not as failure but as a learning opportunity important to the recovery process. Pediatricians have an important supportive role when a patient relapses and once again should initiate referral to treatment. By collaborating with addiction medicine specialists and other mental health professionals and working with the school, the family, and third-party payers, the pediatrician plays a central and essential role in the substance abuse treatment and recovery process for children and adolescents.

CRITERIA FOR THE SELECTION OF A SUBSTANCE ABUSE TREATMENT PROGRAM

The following criteria were based on Substance Abuse and Mental Health Services Administration and Center for Substance Abuse Treatment standards as optimal goals for inpatient or outpatient substance abuse treatment programs that serve the pediatric population.[41] The program will:

1. View drug and alcohol abuse as a primary disease rather than a symptom.
2. Include a comprehensive patient evaluation and developmentally appropriate management and treatment referral plan for associated medical, emotional, and behavioral problems identified.
3. Maintain rapport with the patient's pediatrician to facilitate seamless after-care and primary care follow-up.
4. Adhere to an abstinence philosophy. Drug use is a chronic disease, and a drug-free environment is essential. Tobacco use should be prohibited, and nicotine-cessation treatment should be provided as part of the overall treatment plan. Continued tobacco, alcohol, or other drug use should be viewed as a need for more treatment rather than discharge or refusal to treat.
5. Maintain a low patient-to-staff ratio.
6. Employ treatment professionals who are knowledgeable in both addiction treatment and child and adolescent behavior and development.
7. Ensure that professionally led support groups and self-help groups are integral parts of the program.

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TABLE 2 Substance Use Treatment

Outpatient	
Group therapy	Group therapy is a mainstay of substance abuse treatment for adolescents with substance use disorders. It is a particularly attractive option, because it is cost-effective and takes advantage of the developmental preference for congregating with peers. However, group therapy has not been extensively evaluated as a therapeutic modality in this age group, and existing research has produced mixed results.[46,48]
Family therapy	Family-directed therapies are the best validated approach for treating adolescent substance abuse. A number of modalities have been demonstrated effective. Family counseling typically targets domains that figure prominently in the etiology of substance use disorders in adolescents: family conflict, communication, parental monitoring, discipline, child abuse/neglect, and parental substance use disorders.[46]
Intensive outpatient program	IOPs serve as an intermediate level of care for patients who have needs that are too complex for outpatient treatment but do not require inpatient services. These programs allow people to continue with their daily routine and practice newly acquired recovery skills both at home and at work.
	IOPs generally comprise a combination of supportive group therapy, educational groups, family therapy, individual therapy, relapse prevention and life skills, 12-step recovery, case management, and aftercare planning. The programs range from 2 to 3 h/d, 2–5 d/wk, and last 1–3 months. These programs are appealing, because they provide a plethora of services in a relatively short period of time.[49,a]
Partial hospital program	Partial hospitalization is a short-term, comprehensive outpatient program in affiliation with a hospital that is designed to provide support and treatment for patients with substance use disorders. The services offered at these programs are more concentrated and intensive than regular outpatient treatment; they are structured throughout the entire day and offer medical monitoring in addition to individual and group therapy. Participants typically attend sessions for 7 or 8 h/d, at least 5 d/wk, for 1–3 weeks. As with IOPs, patients return home in the evenings and have a chance to practice newly acquired recovery skills.[50,b]
Inpatient/residential	
Detoxification	Detoxification refers to the medical management of symptoms of withdrawal. Medically supervised detoxification is indicated for any adolescent who is at risk of withdrawing from alcohol or benzodiazepines and might also be helpful for adolescents withdrawing from opioids, cocaine, or other substances. Detoxification may be an important first step but is not considered definitive treatment. Patients who are discharged from a detoxification program should then begin either an outpatient or residential substance abuse treatment program.[47,48]
Acute residential treatment	ART is a short-term (days to weeks) residential placement designed to stabilize patients in crisis, often before entering a longer-term residential treatment program.[47] ART programs typically target adolescents with co-occurring mental health disorders.
Residential treatment	Residential treatment programs are highly structured live-in environments that provide therapy for those with severe substance abuse, mental illness, or behavioral problems that require 24-hour care. The goal of residential treatment is to promote the achievement and subsequent maintenance of long-term abstinence and equip each patient with both the social and coping skills necessary for a successful transition back into society. Residential programs are classified as short-term (<30 d) or long-term (≥30 d).
	Residential programs generally comprise individual and group-therapy sessions plus medical, psychological, clinical, nutritional, and educational components. Residential facilities aim to simulate real living environments with added structure and routine to prepare patients with the framework necessary for their lives to continue drug- and alcohol-free after completion of the program.[51,c]
Therapeutic boarding school	Therapeutic boarding schools are educational institutions that provide constant supervision for their students by a professional staff. These schools offer a highly structured environment with set times for all activities; smaller, more specialized classes; and social and emotional support. In addition to the regular services offered at traditional boarding schools, therapeutic schools also provide individual and group therapy for adolescents with mental health or substance use disorders.[52,d]

IOP indicates intensive outpatient program; ART, acute residential treatment.

[a] See www.ncbi.nlm.nih.gov/books/NBK25875.

[b] See www.cignabehavioral.com/web/basicsite/provider/pdf/levelOfCareGuidelines.pdf.

[c] See www.ncbi.nlm.nih.gov/books/NBK25881.

[d] See www.ncbi.nlm.nih.gov/books/NBK24159.

8. Maintain separate treatment groups for patients at varying developmental levels (adolescents versus young adults versus older adults).
9. Involve the entire family in the treatment, and relate to the patients and their families with compassion and concern. Strive to reunify the family whenever possible.
10. Ensure that follow-up and continuing care are integral parts of the program.
11. Offer patients an opportunity to continue academic and vocational education and assistance with restructuring family, school, and social life. Consider formal academic and cognitive skills assessment, because unidentified weaknesses might contribute to emotional factors that contribute to the substance use.
12. Keep the family apprised of costs and financial arrangements for inpatient and outpatient care and facilitate communication with managed care organizations.

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13. Be located as close to home as possible to facilitate family involvement, although separation of the adolescent from the family might be indicated initially.

DUAL DIAGNOSIS

The fact that other psychiatric disorders occur with increased frequency in adolescents who use tobacco, alcohol, or other drugs raises additional diagnostic and therapeutic considerations.[42–44] This potential for dual diagnosis makes it essential for the pediatrician to be knowledgeable about the prevalence of co-occurring psychiatric diagnoses and how they manifest so that comprehensive assessment of a substance-using adolescent can include screening for any coexisting disorders and timely referral to the most suitable and effective treatment available.

BILLING AND PAYMENT ISSUES FOR PEDIATRICIANS

Time-based *Current Procedural Terminology* (CPT) codes are available specifically for tobacco use–cessation counseling and for structured alcohol/substance abuse screening and brief intervention (SBI) counseling. Medicare uses time-based G-codes for structured SBI services. Medicaid has established H-codes, which individual states must "turn on" (ie, approve) for reimbursement, although many states have not yet completed this activation process. G-codes and H-codes are located in the Healthcare Common Procedural Coding System (HCPCS) level II code set. A comprehensive fact sheet on coding substance use screening and SBIRT is available at the AAP Practice Management Online site (http://practice.aap.org/content.aspx?aid=2914), and further clarification can be addressed through the AAP coding hotline (AAPCodinghotline@aap.org) and the annually updated AAP publication *Coding for Pediatrics*.[45] Insurers differ markedly in their coding interpretation and reimbursement rates. Certain substance use diagnoses might be considered mental health disorders that require "carve-out" contract services provided by mental health specialists and are not allowable as reimbursable primary care provider services. Furthermore, physicians should be aware that when an adolescent is covered by a parent's insurance policy and the insurance company sends the policyholder an explanation of benefits that includes defined diagnostic codes, the adolescent patient's confidentiality is at risk of compromise.

RECOMMENDATIONS FOR PEDIATRICIANS

The AAP recommends that pediatricians:

1. Become knowledgeable about all aspects of SBIRT through training program curricula or continuing medical education that provide current best-practices training.
2. Become knowledgeable about the spectrum of substance use and the patterns of nicotine, alcohol, and other drug use, particularly by the pediatric population in their practice area.
3. Ensure appropriate confidentiality in care by becoming familiar and complying with state and federal regulations that govern health information privacy, including the confidential exchange of substance use and treatment information.
4. Screen all adolescent patients for tobacco, alcohol, and other drug use with a formal, validated screening tool, such as the CRAFFT screen, at every health supervision visit and appropriate acute care visits, and respond to screening results with the appropriate brief intervention.
5. Augment interpersonal communication and patient care skills by becoming familiar with motivational-interviewing techniques.
6. Develop close working relationships with qualified and licensed professionals and programs that provide the range of substance use prevention and treatment services, including tobacco cessation, that are necessary for comprehensive patient care.
7. Facilitate patient referrals through familiarity with the levels of treatment available in the area and application of the multidimensional assessment criteria to determine the intensity of services needed.
8. Make referrals to adolescent-appropriate treatment for youth with problematic use or a substance use disorder.
9. Consider throughout the SBIRT process that psychiatric disorders can co-occur in adolescents who use psychoactive substances.
10. Stay abreast of coding regulations, strategies, and updates to bill for tobacco, alcohol, and other drug use SBIRT services.
11. Advocate that heath care institutions and payment organizations provide mental health and substance use services across the pediatric/adolescent ages and developmental stages while ensuring parity, quality, and integration with primary care and other health services.

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REFERENCES

1. Centers for Disease Control and Prevention. Alcohol-attributable deaths and years of potential life lost: United States, 2001. *MMWR Morb Mortal Wkly Rep*. 2004;53(37):866–870
2. Substance Abuse and Mental Health Services Administration. *The Relationship Between Mental Health and Substance Abuse Among Adolescents*. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration; 1999
3. DuRant RH, Smith JA, Kreiter SR, Krowchuk DP. The relationship between early age of onset of initial substance use and engaging in multiple health risk behaviors among young adolescents. *Arch Pediatr Adolesc Med*. 1999;153(3):286–291
4. Hingson RW, Zha W. Age of drinking onset, alcohol use disorders, frequent heavy drinking, and unintentionally injuring oneself and others after drinking. *Pediatrics*. 2009;123(6):1477–1484
5. Chambers RA, Taylor JR, Potenza MN. Developmental neurocircuitry of motivation in adolescence: a critical period of addiction vulnerability. *Am J Psychiatry*. 2003;160(6):1041–1052
6. Substance Abuse and Mental Health Services Administration. *Results From the 2008 National Survey on Drug Use and Health: National Findings*. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration; 2009.NSDUH series H-36, DHHS publication SMA 09-4434
7. Hagan J, Shaw J, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
8. Kulig JW; American Academy of Pediatrics, Committee on Substance Abuse. Tobacco, alcohol, and other drugs: the role of the pediatrician in prevention, identification, and management of substance abuse. *Pediatrics*. 2005;115(3):816–821
9. Substance Abuse and Mental Health Services Administration. *Screening, Brief Intervention, and Referral to Treatment: What Is SBIRT?* Rockville, MD: Center for Substance Abuse Treatment; 2009
10. Babor TF, McRee BG, Kassebaum PA, Grimaldi PL, Ahmed K, Bray J. Screening, brief intervention, and referral to treatment (SBIRT): toward a public health approach to the management of substance abuse. *Subst Abus*. 2007;28(3):7–30
11. Madras BK, Compton WM, Avula D, Stegbauer T, Stein JB, Clark HW. Screening, Brief Interventions, Referral to Treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: comparison at intake and 6 months later. *Drug Alcohol Depend*. 2009;99(1–3):280–295
12. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med*. 2002;156(6):607–614
13. Levy S, Knight J. Screening, brief intervention, and referral to treatment for adolescents. *J Addict Med*. 2008;2(4):215–221
14. Massachusetts Department of Public Health, Bureau of Substance Abuse Services. *Provider Guide: Adolescent Screening, Brief Intervention, and Referral to Treatment—Using the CRAFFT Screening Tool*. Boston, MA: Massachusetts Department of Public Health; 2009
15. Clark DB, Gordon AJ, Ettaro LR, Owens JM, Moss HB. Screening and brief intervention for underage drinkers. *Mayo Clin Proc*. 2010;85(4):380–391
16. Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr*. 2004;21:64–92
17. Ginsburg K. Viewing our adolescent patients through a positive lens. *Contemp Pediatr*. 2007;24:65–76
18. Knight JR, Harris SK, Sherritt L, et al. Prevalence of positive substance abuse screen results among adolescent primary care patients. *Arch Pediatr Adolesc Med*. 2007;161(11):1035–1041
19. Masten AS, Faden VB, Zucker RA, Spear LP. Underage drinking: a developmental framework. *Pediatrics*. 2008;121(suppl 4):S235–S251
20. Moritsugu KP, Li TK. Underage drinking: understanding and reducing risk in the context of human development. Foreword. *Pediatrics*. 2008;121(suppl 4):S231–S232
21. Sims TH; American Academy of Pediatrics, Committee on Substance A. Technical report: tobacco as a substance of abuse. *Pediatrics*. 2009;124(5). Available at: www.pediatrics.org/cgi/content/full/124/5/e1045
22. Kokotailo P; American Academy of Pediatrics, Committee on Substance Abuse. Alcohol use by youth and adolescents: a pediatric concern. *Pediatrics*. 2010;125(5):1078–1087
23. American Psychiatric Association. *Diagnostic Criteria From DSM-IV-TR*. Washington, DC: American Psychiatric Association; 2000
24. Weddle M, Kokotailo P. Adolescent substance abuse: confidentiality and consent. *Pediatr Clin North Am*. 2002;49(2):301–315
25. Harris S, Csemy L, Sherritt L, et al. Computer-facilitated screening and physician brief advice to reduce substance use among adolescent primary care patients: a multi-site international trial. Poster presented at: 2011 Pediatric Academic Societies annual meeting; April 30–May 3, 2011; Denver, CO
26. Students Against Destructive Decisions. Contract for life. Available at: www.sadd.org/contract.htm. Accessed October 4, 2011
27. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People for Change*. 2nd ed. New York, NY: Guilford Press; 2002
28. Monti PM, Colby SM, Barnett NP, et al. Brief intervention for harm reduction with alcohol-positive older adolescents in a hospital emergency department. *J Consult Clin Psychol*. 1999;67(6):989–994
29. Spirito A, Monti PM, Barnett NP, et al. A randomized clinical trial of a brief motivational intervention for alcohol-positive adolescents treated in an emergency department. *J Pediatr*. 2004;145(3):396–402
30. Monti PM, Barnett NP, Colby SM, et al. Motivational interviewing versus feedback only in emergency care for young adult problem drinking. *Addiction*. 2007;102(8):1234–1243
31. Bernstein E, Edwards E, Dorfman D, Heeren T, Bliss C, Bernstein J. Screening and brief intervention to reduce marijuana use among youth and young adults in a pediatric emergency department. *Acad Emerg Med*. 2009;16(11):1174–1185
32. Baer JS, Kivlahan DR, Blume AW, McKnight P, Marlatt GA. Brief intervention for heavy-drinking college students: 4-year follow-up and natural history. *Am J Public Health*. 2001;91(8):1310–1316
33. Borsari B, Carey KB. Effects of a brief motivational intervention with college student drinkers. *J Consult Clin Psychol*. 2000;68(4):728–733
34. Kokotailo P, Gold M. Motivational interviewing with adolescents. *Adolesc Med State Art Rev*. 2008;19(1):54–68
35. Marlatt GA, Baer JS, Kivlahan DR, et al. Screening and brief intervention for high-risk college student drinkers: results from a 2-year follow-up assessment. *J Consult Clin Psychol*. 1998;66(4):604–615
36. Monti P, Barnett N, O'Leary T. Motivational enhancement for alcohol-involved adolescents. In: Monti P, Colby S, O'Leary T, eds. *Adolescents, Alcohol, and Substance Abuse: Reaching Teens*

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Through Brief Interventions. New York, NY: Guilford Press; 2001:145–182

37. Dennis M, Godley SH, Diamond G, et al. The Cannabis Youth Treatment (CYT) Study: main findings from two randomized trials. *J Subst Abuse Treat*. 2004;27(3):197–213
38. Fishman M; American Society of Addiction Medicine. *ASAM Patient Placement Criteria: Supplement on Pharmacotherapies for Alcohol Use Disorders*. Philadelphia, PA: Wolters Kluwer Health/Lippincott, Williams & Wilkins; 2010
39. Gowing L, Ali R, White J. Buprenorphine for the management of opioid withdrawal. *Cochrane Database Syst Rev*. 2006;(2):CD002025
40. Woody GE, Poole SA, Subramaniam G, et al. Extended vs short-term buprenorphine-naloxone for treatment of opioid-addicted youth: a randomized trial. *JAMA*. 2008;300(17):2003–2011
41. Center for Substance Abuse Treatment. *Treatment of Adolescents With Substance Abuse Disorders*. Rockville, MD: Department of Health and Human Services; 1999. CSAT Treatment Improvement Protocol Series, No. 32
42. Clark DB, Pollock N, Bukstein OG, Mezzich AC, Bromberger JT, Donovan JE. Gender and comorbid psychopathology in adolescents with alcohol dependence. *J Am Acad Child Adolesc Psychiatry*. 1997;36(9):1195–1203
43. Gee RL, Espiritu RC, Huang LN. Adolescents with co-occurring mental health and substance use disorders in primary care. *Adolesc Med Clin*. 2006;17(2):427–452
44. Grilo CM, Becker DF, Walker ML, Levy KN, Edell WS, McGlashan TH. Psychiatric comorbidity in adolescent inpatients with substance use disorders. *J Am Acad Child Adolesc Psychiatry*. 1995;34(8):1085–1091
45. American Academy of Pediatrics. *Coding for Pediatrics, 2011*. 16th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2011
46. Bukstein OG, Bernet W, Arnold V, et al. Practice parameter for the assessment and treatment of children and adolescents with substance use disorders. *J Am Acad Child Adolesc Psychiatry*. 2005;44(6):609–621
47. Fournier ME, Levy S. Recent trends in adolescent substance use, primary care screening, and updates in treatment options. *Curr Opin Pediatr*. 2006;18(4):352–358
48. Vaughan BL, Knight JR. Intensive drug treatment. In: Neinstein LS, Gordon C, Katzman D, et al, eds. *Adolescent Healthcare: A Practical Guide*. 5th ed. Philadelphia, PA: Lippincott, Williams & Wilkins; 2009:671–675
49. Center for Substance Abuse Treatment. Services in intensive outpatient treatment programs. In: *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*. Treatment Improvement Protocol (TIP) Series 47. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006. Chapter 4. Available online at: http://www.ncbi.nlm.nih.gov/books/NBK25875/
50. CIGNA. Level of care guidelines for behavioral health and substance abuse. Available at: www.cignabehavioral.com/web/basicsite/provider/pdf/levelOfCareGuidelines.pdf. Accessed September 23, 2011
51. Center for Substance Abuse Treatment. Triage and placement in treatment services. In: *Substance Abuse Treatment for Adults in the Criminal Justice System*. Treatment Improvement Protocol (TIP) Series 44. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2005. Chapter 3. Available online at: http://www.ncbi.nlm.nih.gov/books/NBK14168/
52. Center for Substance Abuse Treatment. Therapeutic communities. In: *Treatment of Adolescents with Substance Use Disorders*. Treatment Improvement Protocol (TIP) Series 32. Rockville, MD: Substance Abuse and Mental Health Services Administration; 1999. Chapter 5. Available online at: http://www.ncbi.nlm.nih.gov/books/NBK14221/

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