Screening, Brief Intervention, and Referral to Treatment for Adolescents: Lessons Learned and Considerations for California

California Institute for Behavioral Health Solutions
Adolescent Early Intervention and SUD Treatment Summit
November 8, 2017
Background and Acknowledgments

• Since 2013, the Conrad N. Hilton Foundation has invested over $54 million nationwide in prevention and early intervention for youth age 15-22
  • Promote service delivery in FQHCs, schools, mental health centers, justice settings
  • Empowering peers and community coalitions to lead early intervention advocacy and policy development
  • Developed adolescent SBIRT resource hub for communities and providers nationwide: https://www.adolescentsubstanceuse.org/

• Generated significant knowledge and experience about adolescent early intervention services and their implementation
Panel Overview

Background and Context
Howard Padwa, Ph.D., UCLA Integrated Substance Abuse Programs

Research on Adolescent SBIRT
Shannon Gwin-Mitchell, Ph.D., Friends Research Institute

Implementing Adolescent SBIRT in Primary Care
Stacy Sterling, Dr.P.H., M.S.W., M.P.H. Kaiser Permanente of Northern California

Implementing Adolescent SBIRT in Schools
Timothy Condon, Ph.D., University of New Mexico

Lessons Learned in the Hilton Initiative and Adolescent SBIRT in the Age of Cannabis Legalization
Leigh Fischer, M.P.H., Abt Associates
We Can’t Treat Our Way Out of This Public Health Crisis

• 7.8% of Californians with alcohol use disorders receive treatment

• 11.7% of Californians with drug use disorders receive treatment

Prevention will be critical to closing the SUD treatment gap

SAMHSA 2015
Most Substance Use Starts in the Teen/Young Adult Years

- Child: 1.5%
- Teen: 67%
- Adult: 26%
- >25: 5.5%

First Marijuana Use, (Percent of Initiates)
Adolescent Brain Development: Age 5-20

Red indicates more gray matter, blue less gray matter. Neural connections are pruned back-to-front. The prefrontal cortex ("executive" functions), is last to mature.
The Interaction between the Developing Nervous System and Substances of Abuse Leads to:

- Difficulty in decision making
- Difficulty understanding the consequences of behavior
- Increased vulnerability to memory and attention problems

This can lead to:

- Increased experimentation
- Substance use disorders

Fiellin 2008.
The Time to Prevent SUD is Adolescence

- Early onset substance use predicts development of SUD
  - Alcohol before age 15: Four times more likely to have AUD in future
  - Cannabis before 17: Two-five times more likely to develop SUD

- The later adolescents start using, the less likely they are to develop SUD
  - Alcohol: During adolescence, odds of dependence decrease 14% for every year of delayed first use
  - Drugs: Odds of dependence decrease 4-5% for every year of delayed first use

NIDA 2014; Lynskey 2003; Grant 1997, 1998
SBIRT: A Population Approach to Prevention and Early Intervention

• **Screening** a population to identify individuals who are using substances in a risky or unhealthy way

• **Brief Intervention** to change behaviors and attitudes of individuals who are putting their health at risk with substance use.
  • Sometimes this is one conversation, sometimes a few sessions

• **Referral to Treatment** for individuals who require specialty care
SBIRT: A Population Approach to Prevention/Early Intervention

- **Severe**: Identify individuals with SUD; link them with specialty care or other services as needed
- **Substantial**: Educate individuals who are using substances; motivate behavior change
- **Moderate**: Prevention and education
- **Mild**: None
Potential Public Health Impact:
SBIRT for Adolescents

• Could potentially play a role in:

  • Reducing prevalence of SUD among adolescents and young adults

  • Addressing adverse substance-related problems (teen pregnancy, truancy, dropout, justice involvement)

  • Preventing the development of future health problems that can stem from substance use during adolescence
The Current Opportunities

• DMC-ODS Waiver
  • SBIRT Services
  • Capacity to provide services outside specialty settings
  • Encourage development of youth system of care for “RT”

• Proposition 64
  • Funding for treatment and prevention services
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State of the Research on Adolescent SBIRT

Shannon Gwin Mitchell, Ph.D.
Senior Research Scientist
Friends Research Institute, Inc.
Baltimore, Maryland, USA

November 8, 2017
AAP Policy Statement:
Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians

*Pediatrics, 2011*¹

- “As a component of comprehensive pediatric care, adolescents should receive appropriate guidance regarding substance use during routine clinical care.”
What Was the Evidence Supporting the Recommendations?

- At the time, very little
  - SAMHSA “What is SBIRT” paper, 2009
  - Evidence of effective adolescent screenings recently developed (CRAFFT)
  - Limited research on BI with any population other than college students and alcohol
  - Even less on RT processes or adolescent SBIRT as a comprehensive service delivery approach
AAP Adolescent SBIRT Recommendations Updated in 2016: What Changed?

- Included newer validated screening instruments

- Added the Jonas et al (2012) systematic review and meta-analysis
  - Included 38 articles reporting on 23 randomized, controlled trials; Sample sizes ranged from 72 to 1559, and study durations ranged from 6 to 48 months;
  - Eleven studies were done solely in US, 2 focused on older adults, 5 focused on young adults or college students, 1 enrolled pregnant women, no studies of adolescents

- Concluded:
  “…the low cost of SBIRT, minimal potential for harm, and emerging study results together support the tremendous potential for a population-level benefit from even small reductions in substance use and provide sufficient basis for the incorporation of SBIRT practices into the medial care standards for adolescents.”
What is the Current Research Evidence for Adolescent SBIRT?

- Weak but growing
- Studies of reliable and valid screening instrument
- Studies of brief intervention techniques
- Studies of SBIRT
  - Quasi-experimental studies
  - Randomized effectiveness trials
  - Implementation studies
Reliable and Valid Screening Instruments: Alcohol Only

- **NIAAA screener**
  - Alcohol
    - Not tobacco or drugs
    - Tailors question order according to age

- **AUDIT**
  - Alcohol Use Disorders Identification Test
  - Modified to be used with ages 13-19
Reliable and Valid Screening Instruments: Multiple Substances

- CRAFFT \(^3,4\)
  - Car, Relax, Alone, Friends/Family, Forget, Trouble
  - Alcohol, marijuana, other drugs
    - Not tobacco
  - High test-retest reliability; good criterion validity
  - Validated against DSM-IV and 5

- ASSIST \(^10\)
  - Alcohol, Smoking, and Substance Involvement Screening Test
Reliable and Valid Screening Instruments: Multiple Substances

- **S2BI** \(^{11,12}\)
  - Screening to Brief Intervention
  - Alcohol, tobacco, and marijuana
    - Plus other drug use
  - Identified possible DSM-5 SUD

- **BSTAD** \(^{13,14}\)
  - Brief Screener for Tobacco, Alcohol & Other drugs
  - Also hits the big 3
    - Plus other drug use
  - Expanded NIAAA screener format
  - Validated against DSM-5 and CRAFFT
SBIRT for Adolescent Drug and Alcohol Use: Current Status and Future Directions

- Literature review focused on:
  - RCTs examining 1 or more SBIRT component (S, BI, S+BI)
  - Include at least some 14-17 year old participants,
  - English language publications

- 15 studies demonstrated heterogeneity in:
  - Settings - primary care, ED, school
  - Screener used - none, CRAFFT, AUDIT, GAIN-I, diagnostic interview, self-reported recent use
  - Substances - alcohol, cannabis, stimulants, tobacco, other drugs
  - BI content and practitioner - # sessions, length of sessions, computer, peer, researcher, SW, case worker, etc.
  - Follow-up period - 1, 3, 6, and 12 months
Paper’s Conclusions

- Most studies focused on alcohol use among adolescents seeking care in ED
  - More research in other settings with other substances needed

- Screening is indispensable ingredient in SBIRT model, serving as gateway for further intervention
  - Optimal Screening tools should be reliable, valid, and brief

- Interventions should be developmentally appropriate

- RT elements largely missing from SBIRT research
Effectiveness of Brief Interventions as Part of the SBIRT Model for Reducing the Non-Medical Use of Psychoactive Substances: A Systematic Review

Young, et al, 2014 31

- Only included RCTs where participants were screened opportunistically and then received 1:1 verbal BI
- Focus on psychoactive substance use, not alcohol, nicotine, and caffeine
- BIs w/ 4 or fewer sessions compared with no/delayed intervention or info only
- Adolescents and adults in some study samples
Continued
Young et al, 2014 (continued)

- Search of electronic databases and gray literature = 8,836 records found but only 5 RCTs

- Sample age ranges included: 13-18; 14-21; 16-62; and 2 studies with adults only

- BI length also varied: single session + handout; single session + handout + follow-up call; 4 sessions; 4 sessions + letter
Paper’s Conclusions
Young et al, 2014

- Insufficient evidence exists as to whether BIs, as part of SBIRT, are effective for reducing the use of, or harms associated with nonmedical use of, psychoactive substances when these interventions are administered to nontreatment-seeking, screen-detected populations.
Screening and brief intervention for alcohol and other abuse
Harris et al, 2014

- Small but growing body of research on the effectiveness of opportunistic BIs following screening in clinical settings
- The strongest BI effects related to harm reduction
  - Effects on substance use have been more modest
    - Tend to be stronger at shorter (< or = 6 months) rather than longer follow-up (> or = 12 months)
    - Problems related to active control conditions
- A few studies have shown initial support for a prevention effect of BI among abstinent adolescents
- Little is known about the effects of BI for adolescents with dependence and needing RT because of a lack of studies
Implementation Studies

- Two recently completed adolescent SBIRT implementation cluster randomized trials in primary care settings examining BI delivery strategies
  - Dr. Sterling’s Kaiser study 38
  - Our adolescent SBIRT study in federally qualified health centers 39
- The level of behavioral health integration already existing can impact implementation fidelity and reach
Referral to Treatment

- Little research done on linkage to care as part of SBIRT
- Easier to do for adults than kids
- Easier to do for some substances, like alcohol, than others
- What kind of treatment do kids need
Things to Consider...

- More research needed on RT
  - Interested in participating in research?
- Pediatricians are hesitant to conduct adolescent SBIRT if they don’t know that treatment options are available
  - Go to them – don’t wait for them to find you!
Thank you

Shannon Gwin Mitchell, Ph.D.
Senior Research Scientist
Friends Research Institute, Inc.
Baltimore, Maryland, USA
smitcall@friendsresearch.org
Specialty addiction and psychiatry treatment initiation and engagement: Results from an SBIRT randomized trial in pediatrics

Stacy Sterling, DrPH, MSW

California Institute for Behavioral Health Solutions Adolescent Early Intervention and Treatment Summit
Sacramento, CA – November 8-9, 2017
KP Northern California

- 4 million members, 46% of commercial market share in region
- 500,000+ adolescent (11-18) members
- Diverse membership: race/ethnicity, cultural/linguistic, geographic, SES
- 21 hospitals, 233 medical office buildings
  - 67,975 employees, 7,447 active physicians, 700 pediatricians
    - Mature EHR
    - Integrated system (medical, psychiatry, alcohol and drug treatment services)
      - Capitated payment system
      - Embedded research
Adolescent SBIRT – Specialty Treatment Initiation and Engagement

Referral to Treatment has been the least well-studied component of SBIRT:

Among adolescents presenting to the emergency department for alcohol-related problems – those who received a brief intervention which included facilitated referral (help navigating specialty treatment system, making appointments, reminder calls) were more likely to have attended specialty treatment, at 4 and 12 month follow-up (Tait, 2004, 2005).

Adolescents who received SBIRT from an embedded-behavioral health clinician, including facilitated referral, had higher rates of specialty behavioral health treatment initiation. African-American teens were less likely to initiate specialty treatment, compared to whites. (Sterling, 2017)
Adolescent SBIRT Trial in Pediatric Primary Care (NIAAA)

Pragmatic, cluster-randomized, hybrid effectiveness and implementation trial

Population base of adolescents – EHR data, 9,032 Total Adolescent Well-Visits

Oakland Pediatrics Clinic
52 Providers

1/3 of PCPs randomized to PCP Arm

1/3 of PCPs randomized to ‘BC’ arm

1/3 of PCPs randomized to control condition

PCPs trained to deliver SBIRT (Both AOD and MH)
3 – 1-Hour Trainings + boosters and feedback

BC trained to conduct SBIRT
PCPs refer to BC (Both AOD and MH)
1 – 1-Hour training + boosters and feedback

Treatment as usual
Informed about assessment tools in EHR
NIAAA Adolescent SBIRT Pragmatic Trial
Research Questions

1. Effectiveness

   Provider Outcomes:
   Which SBIRT model produces better implementation outcomes - screening, assessment, brief intervention and referral rates?
   - EHR & Automated Utilization Data

   Patient Outcomes:
   Which model produces better patient outcomes (AOD use, mood symptoms, related-school, legal & family problems) at 1 and 2 years?
   - EHR Data

   Which model results in better specialty treatment (AOD or Psychiatry) initiation and engagement rates?
   - EHR & Automated Utilization Data

2. Cost

   Which model of care is most cost-effective?
   - Automated Utilization & Cost Data

3. Implementation Process

   What are the barriers to, or facilitators of, implementation?
   - Qualitative key informant interviews
20. During the past year did you drink any alcohol?

21a. During the past year did you use marijuana?

21b. During the past year have you used any other drug to get high (such as prescription drugs, meth, ecstasy, glue or cocaine)?

22. During the past few weeks, have you OFTEN felt sad, down or hopeless?

23. Have you seriously thought about killing yourself, made a plan, or tried to kill yourself?

24a. Have you ever had sex (including oral, vaginal, or anal sex)?

24b. If yes, do you or your partner always use a condom when you have sex?

25. Are you attracted to guys, girls, or both?
Workflow

AT RISK = Eligible for Further Assessment with CRAFFT +
Endorsed an AOD or Mood Screening Question from the Teen Well Check Questionnaire
or
Pediatrician’s clinical judgment that teen is at risk

No

Affirm good choices

Yes

Ped Arm

BC Arm

Usual Care

Ped Delivers SBIRT

Ped Refers to BC for SBIRT

Usual Care

November 7, 2017
11/1/2011-10/31/2013  9,032 Total Adolescent Well-Visits

73% of adolescents screened; Intervention arms had slightly but significantly higher screening rates than Usual Care (p<.05)

Females had slightly higher screening rates compared to males (53% vs. 48%, p<.05) across all risk behaviors

Eligible patients included those who:

- 1) screened positive on at least one of the TWCQ pre-screening questions,
- and/or
- 2) were determined to need further screening based on the pediatrician’s clinical judgement.

Analytical sample: 1871 adolescents; (n=584 pediatrician-only, n=671 embedded-BC, n=616 UC)
Alesia

A 17 year-old 12th grader, lives in the family home with her mother, father, older brother, adopted sister, aunt, two cousins, and grandmother.

Referred by her pediatrician due to mood symptoms and endorsing alcohol and marijuana use – CRAFFT scores = 4; CAR, RELAX, ALONE, and FRIENDS, smokes cigarettes.

Mood Symptoms/Anxiety/Anger throughout her life.

During the brief intervention, she disclosed her experiences of stress and feelings of depression. Discussed family conflict. Her methods of coping include listening to music, watching Netflix, and "partying," drinking alcohol and smoking marijuana to relax.

She declined referral to Child and Family Psychiatry.

The interventionist remained in contact with her in the weeks the brief intervention, however, and ultimately accepted a referral to the Psychiatry department after several weeks, “so I can work on how I feel and why I need to smoke.”
Patient Outcomes – Specialty Treatment Initiation and Engagement

**Treatment Initiation** (1+ visit to either substance use or mental health treatment within 6 months of referral)

- 18% of patients were referred to specialty treatment; 26.7% initiated
- Patients in the Behavioral Clinician arm were more likely to start treatment than those in the Pediatrician-only (AOR=3.99, 95% CI=1.99-8.00) and Usual Care arms (AOR=1.83, 95% CI=0.99-3.38)
- Pediatrician-only arm patients were less likely to start treatment than Usual Care (AOR=0.53, 95% CI=0.28-0.99)
- African American teens were less likely to start treatment compared with Whites; no gender or age differences

**Treatment Engagement** (2+ visits within 30 days of Tx initiation)

- 92% of those who were referred and initiated engaged in treatment
- No differences were found in treatment engagement across the arms.

SBIRT can improve identification and treatment of teen substance use problems and risk

An embedded Behavioral Clinician model may be a more feasible and effective approach to facilitating specialty treatment initiation than Usual Care or Pediatrician-delivered

In primary care – we need to look beyond pediatricians, to take advantage of care teams, integration
Dilemma of KP Medi-Cal Managed Care Teens and Carve-Out

**Fragmentation of care** resulting from the carve-out = barrier for patients and families and a dilemma for providers, who want easily accessible resources to which they can refer their patients.

Many county treatment systems **lack capacity** to adequately meet the needs of adolescents, especially those with linguistic, culturally-specific treatment needs, or with co-occurring conditions requiring specialized treatment, such as Eating Disorders.

**Exacerbating disparities**

**Kaiser Substance Use Treatment Clinician:** “Families would call me from the waiting room, the reception told them they couldn’t be seen because they were Medi-Cal, that they had to go to the County. But the County doesn’t have any Spanish-speaking services, and the parents were mono-lingual. I told reception to just send them up because I couldn’t just do nothing. I feel bad just giving these families the number at the County – there’s nothing there for them.”

**Kaiser Pediatrician:** “It’s awful, Medi-Cal kids just disappear into a black hole when you refer them to the County. There is nothing worse than having to give people the 800 number (County #).”
Thank you

stacy.a.sterling@kp.org
New Mexico SBIRT School-Based Health Centers Implementation Project

Timothy P Condon, PhD, Daisy Rosero, and Mary Ramos, MD, MPH

California Institute for Behavioral Health Solutions Adolescent Early Intervention and Treatment Summit

November 8, 2017
Sacramento, California

Partners

• NM Department of Health (NMDOH), Office of School and Adolescent Medicine (OSAH)
• The University of New Mexico (UNM) Center on Alcoholism, Substance Abuse and Addiction (CASAA)
• UNM Pediatrics, Envision New Mexico
• Conrad N. Hilton Foundation
Presenter Disclosures

Science Advisory Board for Recovery Centers of America (consultant)
Chief Science Advisory, Center for Health and Justice at TASC-IL (Trainer)
Background

- Adolescent substance use is serious health concern in New Mexico and United States
- Rates of adolescent substance use in New Mexico are higher than national rates of use
Substance Use Rates among NM and US High School Students - 2015

Project Objectives: NMDOH SBIRT

• Refine and validate a clinical guidance instrument to aid providers in appropriate brief interventions for substance use concerns.

• Integrate this clinical guidance instrument into an electronic platform (eSHQ).

• Train PC and BH providers on SBIRT screening instruments and Motivational Interviewing (MI).
  – Includes coaching and on-going technical assistance.
New Mexico School-Based Health Centers

- Well positioned to help address adolescence substance/alcohol use
- Include Primary Care (PC) and Behavioral Health (BH) providers
- Provide confidential services
- Universally administer a screening health questionnaire that includes the CRAFFT* = evidence-based screen for adolescent substance use

* [http://www.ceasar-boston.org/clinicians/crafft.php](http://www.ceasar-boston.org/clinicians/crafft.php)
Primary Care Provider (Physician, Nurse Practitioner, Physician’s Assistant)

Masters level Behavioral Health Providers

Referral to Treatment

New Mexico Department of Health SBHCs

SBHCs

Coordinator
Current Practice in NM SBHCs

- Integrated care model
  - PCP (typically a Nurse Practitioner)
  - BH (Master’s level counselor or therapist)
- Screening with Student Health Questionnaire (SHQ)
  - Global health screen adapted from AAP* Bright Futures recommendations used in NM Department of Health (NMDOH) SBHCs, once annually
- Includes CRAFFT, a validated tool to screen for adolescent substance abuse

*American Academy of Pediatrics
CRAFFT

• Most extensively researched adolescent substance abuse screening instrument for use in primary care settings

• Especially useful for providers because CRAFFT screens for student problems associated with both alcohol and other drug problems

• 6 questions: positive responses on 2+ defined as positive screen

http://www.ceasar-boston.org/clinicians/crafft.php
New CHISPA Instrument Designed: Clinical tool to follow CRAFFT Screens

- Structures initial assessment following positive CRAFFT score of 2+

- CHISPA is more specific than CRAFFT:
  Uses 3 month time frame to assess:
  - substances used
  - frequency of use
  - adverse events associated with use
  - readiness to quit or reduce use

- CHISPA can also be used for monitoring change in use
CHISPA Design

- Provides specificity
- Ask students to report on:
  - substances used
  - frequency of use
  - adverse events
  - readiness to quit/reduce use
  - past quit attempts
- 3 month time frame
- Can be used for monitoring change in use over time

1. Which of the substances listed below have you used anytime during the past 3 months? (Check all that apply to you)

- Alcohol (beer, wine, liquors, distilled spirits, etc.)
- Marijuana (weed, bud, cush, hash, hashish)
- Synthetic marijuana (Spice, K2)
- Drugs causing hallucinations: Acid (LSD), mushrooms (shrooms)
- Club Drugs (erecty, X, GHB, Molly, Rohypnol)
- Special P, Salvia, PCP
- Huffing or snorting (glue, aerosol sprays, paint, varnish, thinners, etc.)
- Other substances (describe):
  - I have NOT used any alcohol or drugs or substances of any type during the past 3 months (if no use, stop here)

2. On how many days during the past 3 months did you usually use alcohol or drugs or other substances to get high?

- No days
- 1-5 days per month
- 1-2 days per week
- 3-6 days per week
- 5-6 days per week
- 7 days/week

3. During the past 3 months, when you used alcohol or drugs, did you . . .

- Black out or pass out (or forget to do important things)
- Use alcohol with any downer drugs
- Drive while intoxicated on alcohol or high on drugs (or ride with others who were)
- Have 4 or more drinks of alcohol on any day (1 drink = 1 beer, 1 glass of wine, or 1 ounce liquor)
- Intake any drugs or substances
- Use so much alcohol or drugs that you had to go or be taken to the emergency room
- Have sex without using a condom
- Get into physical fights
- Get injured due to fights or accidents
- Have serious conflicts or arguments with family members or teachers or close friends

4. On your most recent report card for school, please write down how many courses for which you made each grade.

- Please make your best estimates if you are not sure. A: ________ B: ________ C: ________ D: ________ F: ________

5. How much do you want to try to stop or reduce your use of alcohol or drugs?  
- Not at all
- A little
- Some
- A lot

6. Have you ever tried to stop or reduce your use of alcohol or drugs?  
- Never
- Yes, once
- Yes, more than once
- Yes, all the time
Implementation Plans In NMDOH SBHCs

- Training on Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Motivational Interviewing Training (MI)
- Training on use of iPad with eSHQ, CRAFFT and CHISPA App
- Technical Assistance with all aspects of program
- Data collection and feedback to SBHCs
Training

This training was conducted using traditional face to face methods and via telehealth. It was designed to develop skills needed to perform a 10-15 minute brief intervention after an adolescent has a positive substance use screen. Providers also receive three private, individualized coaching sessions to reinforce training and further improve their skills.

Technical Assistance

Site Visits

At least two site visits are conducted once at the beginning of the year and again at the end of the year. Additional site visits as needed.

Monthly Check In

Each site receives a monthly check in call to discuss technology, health screens and respond to provider or staff questions. Additional communications as needed.
CRAFFT and CHISPA

Negative CRAFFT ➔ Positive reinforcement
Positive CRAFFT ➔ CHISPA (seamlessly, electronic)

CHISPA
- Structures information gathering to guide brief intervention
- Helps make judicious use of limited behavioral health resources in our state
- Informs interventions at follow up visits
• 14 counties

• 32 SBHCs enrolled and trained (76%)

• 104 PC and BH Providers trained

• 67 Ancillary Staff trained

* March 2015 – June 2017
**CHISPA Preliminary Data**

**High school students > 14 years old**

March 2015 – June 2017 - SBHCs

<table>
<thead>
<tr>
<th>eSHQs administered</th>
<th># of CRAFFT positive (CHISPA administered)</th>
<th>Positive CRAFFT</th>
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</thead>
<tbody>
<tr>
<td>4522</td>
<td>768</td>
<td>17%</td>
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Successes to Date

• NMDOH adds SBIRT to the “Standards and Benchmarks” for all DOH supported SBHCs
• CHISPA clinical guidance instrument validated
• CHISPA integrated into an electronic platform
• Increase understanding of SBIRT principles by SBHCs
• Moving more SBHCs to adopt eSHQ + CHISPA
• 32 SBHCs enrolled

Challenges

• EHR interface
• Connectivity
• Workforce turnover
• Rigorous MI training/provider time
• Provider time
Thank you for your attention!
The Conrad N. Hilton Foundation’s

Evaluating the Impact

Youth Substance Use Prevention and Early Intervention Strategic Initiative
Objectives

1. Discuss the Youth Substance Use Prevention and Early Intervention initiative
2. Share recommendations
3. Highlight key takeaways
4. Describe lessons learned from the Colorado experience with cannabis
Youth Substance Use Prevention and Early Intervention Strategic Initiative

3 OVERARCHING GOALS

1. Ensure health professionals and other youth-serving providers have the knowledge and skills to provide screening and early intervention services.

2. Improve funding for, access to, and implementation of screening and early intervention services.

3. Conduct research and advance learning to improve screening and early intervention practices.

Evaluating the Impact
Monitoring, Evaluation, and Learning Project

• Measure progress toward meeting goals

• Identify key areas of learning and provide recommendations

• Collect data and use that data to advise on improvements

• Identify systems change needed to sustain implementation and support scalability of SBIRT
Progress Made

Evaluating the Impact
The Initiative’s Reach

Evaluating the Impact
Improving Knowledge and Skills

N = 685,933

N = 27,864
Increasing Access to SBIRT

- SBIRT services implemented in 623 sites
Services Delivered

- Screenings: 61,321
- Brief Interventions: 8,426
- Referrals to Treatment: 1,180
## Services Delivered

<table>
<thead>
<tr>
<th>Setting</th>
<th>Total Screened</th>
<th>Volume of BI</th>
<th>Volume of RT</th>
<th>BIs per Total Screened</th>
<th>RT per Total Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Settings</td>
<td>31,684</td>
<td>1,399</td>
<td>235</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Schools and School-Based Health Centers</td>
<td>21,632</td>
<td>2,432</td>
<td>122</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>2,876</td>
<td>2,611</td>
<td>390</td>
<td>91%</td>
<td>14%</td>
</tr>
<tr>
<td>Juvenile Justice Programs</td>
<td>142</td>
<td>140</td>
<td>48</td>
<td>99%</td>
<td>34%</td>
</tr>
<tr>
<td>Community Behavioral Health Organizations</td>
<td>4,987</td>
<td>1,844</td>
<td>385</td>
<td>37%</td>
<td>8%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>61,321</td>
<td>8,426</td>
<td>1,180</td>
<td>14%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Note: Due to data reporting limitations, these data may include duplicate records, e.g., youth who are screened twice might be counted twice.
Recommendations
Assess Quality and Impact of Training and Technical Assistance
Use More Standardized Approaches for Implementation and Data Collection
Identify Strategies for Reaching Most Vulnerable Youth
Strengthen Financing Mechanisms for Prevention and Early Intervention
Key Takeaways

1. Ongoing training and education is needed
2. Multiple sessions of BI may increase impact
3. Need to screen earlier and address multiple risk factors
4. Involving parents offers potential for better results
5. Most youth need linkage to pro-social activities, not treatment
6. Need to expand evidence-based services for youth
Population level impact
Thank you!