SBIRT FOR ADOLESCENTS: ADDRESSING RISK FOR DEVELOPING A SUBSTANCE USE DISORDER

Adolescence spans the ages of 12-17. It has been identified as a critical developmental period marked by significant physical, social, emotional and neurobiological changes. Key regions in the adolescent brain, including the prefrontal cortex (controls decision making), the amygdala (controls emotion), and the orbitofrontal cortex (establishes priorities) are not fully developed until early adulthood, making adolescents highly susceptible to risky behaviors, especially experimentation with alcohol and drugs. Research has established that substance use disorders are adolescent onset disorders, and misuse and abuse patterns during the adolescent period, can have detrimental effects on the developing brain (Volkow & Li, 2005; NIDA’s ABCD Study). Furthermore, early initiation (use of alcohol and/or drugs at early ages) and poly-substance use (use of more than one substance at a time) doubles an adolescent’s risk of developing a substance use disorder (NIDA, 2014).

SBIRT (Screening, Brief Intervention, Referral to Treatment) is an evidence based approach designed to help health professionals understand an adolescent’s “level of risk” for developing a substance use disorder and making an informed decision on the next steps to triage such risk. Two tools that have been validated for identifying substance use disorder risk among adolescent populations include the CRAFFT and the S2BI. It is important to distinguish screening from clinical assessments. Assessments are lengthy evaluations of patient medical/mental health histories to diagnose disorders/diseases and develop treatment plans. Screenings are a brief procedure used to flag risk symptoms associated with a given disorder or medical condition and engage in a brief [early] intervention (with or without a referral to treatment) to change risk behaviors. Motivational Interviewing (MI) strategies underlie brief interventions, to help facilitate risk reduction behavior change. Key MI techniques that are effective with adolescent populations include expressing empathy, rolling with resistance, exploring discrepancy, and supporting self-efficacy. Another way to help leverage behavior change among adolescents is integrating faith & spirituality into the discussion, and exploring how it may or may not play a role in decision-making. Click HERE to watch a video of SBIRT being done with an adolescent. Watch how faith and spirituality can be leveraged in an encounter with an adolescent HERE.
Beginning in January 2017, SBIRT training has been implemented in undergraduate and graduate programs for Psychology, Social Work, and Nursing programs at APU, along with faith-based university partners, including Fresno Pacific, Cal Baptist, Concordia Irvine, La Sierra, and Biola across respective disciplines. The training is delivered using an interactive, web-based learning management system (visit www.sbirtfaithandspirituality.org for the training). To date, well over 200 students have been trained. Results from satisfaction surveys show that the training has been well received, with the following areas reported as “very useful”: gaining knowledge about substance use disorders and SBIRT practice, the web-based, online training format, the integration of faith and spirituality, and the training video resources that show SBIRT practice in respective disciplines. Additionally, monthly Learning Community Webinars have been implemented for faculty and staff to provide technical assistance and education/information related to specific aspects of SBIRT practice. The goal of these webinars is to support the needs and concerns of our partners during the implementation of the SBIRT student training.

Several SBIRT trainings have also been implemented in the community, targeting practice settings, including the L.A. County Department of Mental Health Clergy Academy, the L.A. County Department of Public Health substance use and mental health disorder specialty clinics/agencies, and APU Counseling and Student Health Centers. These trainings are conducted in-person, face-to-face by Project Trainers, Drs. Sherry Larkins and Rachel Castaneda. Preceptors and supervisors are offered a Certificate of Completion (satisfying the State SBIRT 4-hour training requirement) and 4 contact hours towards Continuing Education Credit. Training Preceptors and Supervisors is critical to ensure that students have support to practice SBIRT at their clinical and practicum sites. Over the next few months, SBIRT training will be provided for community field sites that partner with APU clinical programs (MSW, MFT, PsyD, undergraduate internships and nurse practitioner community / hospital settings) to provide students with practice opportunities. For additional information about community trainings, visit the EVENTS page on our website.
This article proposes a set of recommendations for tailoring SBIRT practice to adolescent populations, called SBIRT-A (Screening, Brief Intervention, and Referral to Treatment for Adolescents) to more specifically meet their developmental needs and risks. The authors put forth the following recommendations related to “Screening”: (a) alcohol and drug brief screeners should be conducted as part of routine care, performed during every clinical encounter, using validated tools for adolescents; (b) screening results should be integrated into electronic systems to ensure results are discussed with adolescents; and (c) the administration of the screening should be sensitive to self-report biases of youth. The authors developed a risk algorithm to consider when conducting brief interventions with adolescents, which includes three dimensions: 1. SUD risk severity, 2. SUD protection, and 3. readiness to change using a contemplation ladder, with higher rungs representing greater levels of readiness to change. The authors also recommended using a computerized platform to calculate risk (based on algorithm) and monitoring the adolescent’s risk profiles. For the referral to treatment aspect of SBIRT, the authors suggest providers use a youth-centered, strength-based, structured hand-off to a community agency geographically local, and include a caregiver to support the youth and increase the likelihood of follow-through.