# Department of Mental Health & Substance Abuse Services
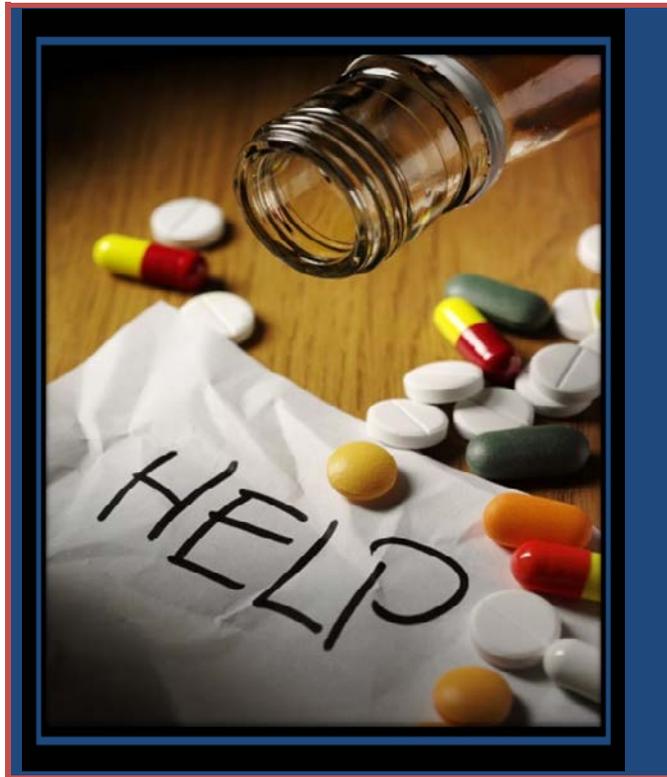


8/15/2016

## Substance Use Best Practice Tool Guide

# PREVENTION/EARLY INTERVENTION

Division of Clinical Leadership in Collaboration with the Division of Substance Abuse Services

# Prevention

Prevention can be defined as any activity designed to avoid substance use and/or abuse and reduce its social and health consequences. Actions may be aimed at reducing demand as shown in health promotions, e.g., and/or reducing supply, for instance, making substances less available (Medina-Mora, 2005).

Preventive factors seek to enhance protective factors and/or reduce risk factors (Kane & Ballue, 2013). Risk factors increase the likelihood of high-risk behaviors, which often result in negative outcomes. Protective factors, on the other hand, lower the probability of high-risk behaviors and promote positive outcomes (Butler Center for Research, 2010).

Prevention is critical in the reduction of negative impact and outcomes associated with substance use and abuse and messages have become one of the most effective prevention interventions. It has been shown that consistent, pervasive messages to young people about substances can prevent substance use and/or abuse. In fact, effective prevention not only routinely repeats the same messages, but it is further delivered by multiple messengers—peers, parents, schools, and the community (Butler Center for Research, 2010).

The primary goal of prevention is to delay or prevent the onset of substance use and/or abuse. Delay alone is important. Research indicates youth that begin using substances prior to age 14 are significantly more likely to become substance dependent at some point in their lives (Butler Center for Research, 2010; CAPT, 2012). Thus, the prevention messages are paramount. Protective factors such as strong family bonds and proactive parenting additionally increase the probability that substance use/abuse will be delayed (Butler Center for Research, 2010).

In practice, there are essentially five models of substance abuse prevention, each based on a different set of underlying assumptions about behaviors of substance abuse and their motivations (Duncan & Gold, 1982).

First, there is the law enforcement model. Prohibition laws played a substantial role along with the threat or infliction of punishment to prevent substance abuse. This model was based on the assumption that substance abuse was moral issue and that people who abused substances must be punished for their own good, not to mention the good of society. Also inherent in this model is the fact that certain substances are inherently evil or at least too potent for people to be allowed to use. Hence, only the threat of punishment could keep people from being tempted to experiment with substances and become hopelessly addicted. This model has not been successful. Actually prohibition of substances resulted in more substance abuse and more crime, along with a growth in a substance-rich black market (Duncan & Gold, 1982).

The medical model is the second model. This model treats substance abuse as if it were an infectious epidemic. It relies on early identification and isolation of people who abuse substances before they can infect others. The model incorporates charts and pamphlets that tell parents and teachers how to identify substance-using/abusing teens. Strategies might consist of having parents search their teen's rooms for substances or to allow strip search of school lockers when there is

adequate suspicion.  Jails are replaced by involuntary treatment.  Like the law enforcement model, neither has the medical model been successful.  It has also been mentioned that users of substances labeled as such through this model might become a self-fulfilling prophecy and live up to the expectations engendered by the label (Duncan & Gold, 1982).

The third model is the educational model.  This model assumes that substance abuse results from poor choices made in ignorance of the hazards and effects of substances.  Thus, it is anticipated that educating people about the dangers of substance abuse will assist them in making the right decisions and avoid substance abuse.  Scare tactics as well as skill-building are applications of this model.  Unfortunately substance education has not been the great success story either, especially not for young people (Duncan & Gold, 1982).

Fourth is the psychosocial model.  Substances are used as a means of coping with day-to-day frustrations and problems.  Prevention then needs to provide opportunities to deal with those issues.  Strategies for preventing substance use might include peer counseling, crisis hotlines, transcendental meditation ™, and the like.  Activities such as adventure and self-expression are also great alternatives to using substances based on this model (Duncan & Gold, 1982).

The fifth and final model is the sociocultural model.  Here the focus is the root of substance abuse in the country, not in the individual person.  The solution then is in changing communities, society, not in changing the individual.  Societies that discriminate against the marginalized (e.g., ethnic minorities) should not expect to escape substance abuse.  Societies that look the other way given gender discrimination, e.g., will not be able to prevent substance use/misuse.  Societies that advertise pills as solutions to problems will find its youth turning to illicit substances for solutions (Duncan & Gold, 1982).

The Office of National Drug Control Policy [ONDCP] Web site (n.d.) recognizes the value of prevention efforts and promotes such approaches as the most cost-effective, common-sense ways to encourage healthy and safe communities.  Research continues to show the relationship between substance use and poorer academic performance, lost productivity, traffic-crash deaths, sexually transmitted infections (STI), hepatitis C, human papillomavirus (HPV), etc.  Substance use further contributes to rates of human immunodeficiency virus (HIV) transmission and puts children at risk for abuse and neglect.  Preventing substance use and dependence before it ever begins can help save lives and reduce costs related to health care and criminal justice.

# Prevention Principles

There are 16 principles of prevention.  They have been revised based on research funded by the National Institute on Drug Abuse (NIDA) as well as the core

There are 16 prevention principles (NIDA, 2003).

elements observed in research on effective prevention programs (NIDA, 2003).  The principles dictate that prevention programs:

1. Should reverse or reduce risk factors while enhancing protective factors

2. Should address all forms of substance use and/or abuse, in combination or alone, including the underage use of legal substances (e.g., alcohol or tobacco); the use of illicit drugs (e.g.,

heroin or marijuana); and the inappropriate use of prescription medications, substances legally obtained (e.g., inhalants), or over-the-counter drugs.

3. Should speak to the type of substance abuse problem in the local community, strengthen identified protective factors, and target risk factors that can be modified.

4. Should be tailored to address risks to audience characteristics or specific populations, such as gender, ethnicity, and age to improve program effectiveness.

5. If family based, should improve family relationships including bonding and incorporate practice in developing, discussing, and enforcing family policies on substance abuse; training in substance information and education; and parenting skills.

6. Might be designed to intervene as early as preschool to address risk factors for substance use and/or abuse, such as poor social skills, aggressive behavior, and academic difficulties.

7. If designed for elementary school children, should target improvement of social-emotional and academic learning to address risk factors for substance abuse, such as academic failure, early aggression, and school dropout. The educational component should focus on the following:

    • academic support, especially in reading;

    • communication;

    • emotional awareness;

    • self-control; and

    • social problem-solving.

8. If designed for middle school/junior high or high school students, should enhance academic and social competence with the following :

    • communication;

    • substance resistance skills;

        o   reinforcement of antidrug attitudes; and

        o   strengthening of personal commitments against substance abuse.

    • peer relationships;

    • self-efficacy and assertiveness; and

    • study habits and academic support.

9. If aimed at the general public at key transition points, such as transition from elementary school to middle school, can produce beneficial effects even among high-risk children and

families. These types of interventions do not single out risk populations and thus reduce labeling and increase bonding to school and community.

10. If community based and a combination of at least two effective programs, they can be more effective than a single program alone.

11. If community based and focused on populations in multiple settings, e.g., faith-based organizations, schools, and clubs, they are most effective when they present community-wide messages in each setting that are consistent.

12. Should retain core elements of the original research-based intervention when communities adapt programs to match their needs, differing cultural requirements, or community norms.

13. Should be long-term and provide repeated interventions (i.e., booster programs) to reinforce the original prevention goals. It has been shown that gains from middle school prevention programs diminish if there are no follow-up programs in high school.

14. Should include teacher training on effective classroom management practices, such as rewarding appropriate student behavior. These techniques help to enhance academic motivation, achievement, positive behavior, and school bonding in students.

15. Demonstrate the greatest effectiveness when they employ interactive techniques such as parent role-playing and peer discussion groups that allow for active involvement in learning about substance use and/or abuse and reinforcing skills.

16. If research-based, they can be cost-effective. A savings of up to $10 in substance abuse has been observed for each dollar invested in prevention (NIDA, 2003).

NIDA's principles for prevention are based on longitudinal research studies on the origins of substance use/abuse behaviors as well as the common elements of effective prevention programs. In sum, the principles affirm:

- Prevention programs should reduce or reverse risk factors and enhance protective factors.

- Prevention programs should be tailored to address risks targeted to audience characteristics or to the whole population.

- Prevention programs should be long-term, incorporating repeated interventions such as booster programs to reinforce the original prevention goals (Medina-Mora, 2005).

# Levels of Prevention

The three types of prevention are:

- **Primary** – At this level, at-risk individuals are helped to avoid developing addictive behaviors (NIDA, n.d.) so new cases are prevented (Kane & Ballue, 2013). This is the level where every reasonable effort is made to stop substance abuse/use/misuse from happening in the first place (Duncan & Gold, 1982). Primary care physicians are highly encouraged to reinforce this level of prevention efforts. Youth might be encouraged to seek out and/or

participate in educational and informational opportunities that address the consequences of tobacco and/or substance use. If programs such as Students Taught Awareness and Resistance (STAR) are operating in the young person's school, he or she might be encouraged to participate. These programs teach skills that help young people avoid high-risk activities. School based programs that involve youth supports such as peers, family, and community, tend to raise the level of effectiveness (NIDA, n.d.). Such programs might be referred to as multiple-component programs (Medina-Mora, 2005).

Some experts have recommended using the Problem Oriented Screening Instrument for Teenagers (POSIT) to screen for substance use and development risk factors in youth (NIDA, n.d.). It can be administered to youth 12 to 19 years of age and is available from the National Clearinghouse for Alcohol and Drug Abuse Information (NIDA, n.d.). However, the POSIT is lengthy (i.e., 139 items) and there is no computerized administration or scoring. Reliability estimates are acceptable, though lower for males on two of the subscales (Knight, Goodman, Pulerwitz, & DuRant, 2001). Screening should assist with the identification of risk factors, which falls under primary prevention (Kane & Ballue, 2013).

This type of prevention should be considered for adults who might be entering or involved in risky situations, e.g., the adult is in or planning to enter a close relationship with an individual who abuses alcohol or other substance, as well. It is also imperative that women of childbearing potential are reminded about the extreme risks associated with substance use and/or abuse during pregnancy (NIDA, n.d.).

Because of the potential impact of this level of prevention, it has been said that its priority needs to be raised. The 2013 budget of the Substance Abuse and Mental Health Services Administration (SAMHSA) for treatment was nearly four times the prevention budget, e.g. In dollar amounts, the 2013 SAMHSA treatment budget was $1,813 million, compared to $470 million for the prevention budget (Kane & Ballue, 2013). Additionally, this level of prevention would reduce the amount of dollars spent on "preventable law enforcement, health care, crime, and other costs" (NIDA, 2007)

- **Secondary** – This level of prevention involves uncovering potentially harmful substance use before onset of overt problems or symptoms (NIDA, n.d.). Here new cases are identified very early and typically before the affected individual notices that there may be a problem. At this level, the clinician would screen for the disease and help the affected individual seek out appropriate resources (Kane & Ballue, 2013). This level where early treatment occurs (Duncan & Gold, 1982).

- **Tertiary** – Treatment of the medical consequences of substance abuse and facilitation of enrollment into treatment to minimize further disability is the aim of this level of prevention (NIDA, n.d.). Rehabilitation as well as prevention of disability or death is the aim of this level of prevention (Duncan & Gold, 1982).

# Preventive Interventions

These interventions, as described in the 2009 *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities*, were classified based on the people they aim to reach.  It should be noted that most preventive interventions are aimed at young people because earlier messages do a better job of delaying or preventing the onset of substance use and/or abuse. *Universal preventive interventions* focus on a population at large (Kane & Ballue, 2013; Medina-Mora, 2005).  For example, using direct messaging to women or those who might influence women addressing elimination or reduction of alcohol consumption during pregnancy fits this type of preventive intervention.  There are likely many pamphlets, videos, public service announcements (PSAs), pins, and buttons to communicate the message.  There may even be classes for children, educating them on the benefits of alcohol avoidance (Clarren & Salmon, 2010). *Selective preventive interventions* are targeted toward specific individuals or groups (Kane & Ballue, 2013).  The risk of developing a substance use disorder (SUD) for these targeted individuals or groups is significantly higher than average.  These individuals or groups are at imminent or lifetime risk of developing an SUD (Medina-Mora, 2005).  Motivational interviewing and brief interventions as incorporated in SBIRT that encourage change in risky substance use patterns are examples of such interventions (Clarren & Salmon, 2010). *Indicated preventive interventions* are aimed at extremely high-risk persons with early signs, symptoms, or biological markers that are precursors but not yet diagnosable (Kane & Ballue, 2013).

*Examples of Universal Prevention:*

Community policies that promote access to early childhood education and education for physicians on prescription drug misuse and preventive prescribing practices are examples of universal prevention (CAPT, 2012).

One program that fits universal prevention description is **Guiding Good Choices (GGC)**. Formerly known as Preparing for the Drug-Free Years, the curriculum educates parents on how to strengthen bonding in their families and reduce risk factors. The parents are engaged in five, two-hour sessions that focus on setting clear expectations, monitoring behavior, and maintaining discipline; family involvement and interaction; and other bonding and family management approaches (NIDA, 2003).

*Examples of Selective Prevention:*

Providing peer support groups for adults with a history of substance abuse or prevention education for new immigrant families living in poverty with their young children are examples of selective prevention (CAPT, 2012).  **Focus on Families (FOF)** is a notable selective program.  Designed for parents receiving methadone treatment and their children, the program seeks to reduce parents' use of illegal substances and teaches family management skills to reduce their children's risk for future drug abuse.  It has been demonstrated to show early reduction in family-related risk factors with an overall trend toward positive program effects on child outcomes (NIDA, 2003).

*Examples of Indicated Prevention:*

Among indicated prevention strategies are screening, consultation, and referral for families of older adults admitted to emergency departments with potential alcohol-related injuries, as well as information and referral for young adults who violate community and/or campus policies on alcohol and drugs (CAPT, 2012).

**Project towards No Drug Abuse (Project TND)** is an indicated prevention intervention. It targets young people of high school age who attend traditional or alternative high schools. This program is designed to prevent the transition from drug use to drug abuse through the consideration of developmental issues faced by older youth (NIDA, 2003).

Additionally there are *tiered* approaches to substance abuse prevention. It is believed that this approach to service delivery provides individuals a better understanding of the linkages between different parts of the system, relative to level of competence/sophistication and need (TADPEMDG, 2010). Many tiered programs incorporated all three levels of intervention. An example is the **Adolescent Transitions Programs (ATP)**. Designed to provide prevention services to students in middle and junior high school and their parents, ATP includes all three levels of prevention. The universal level is directed to parents of all youth in a school and shows up as a *Family Resource Center*. The *Family Check-Up* is the selective intervention that offers both family assessment and professional support. The indicated level yields direct professional help to the family. Some tiered approaches incorporate only two of the three intervention levels (NIDA, 2003).

# Prevention Strategies Unique to Alcohol.

The preconception period is the time that child-bearing women should be screened for alcohol use and/or abuse and, if necessary, offered brief interventions and/or referral to treatment to reduce or completely stop alcohol consumption. No evidence-based studies even hint that any amount of alcohol use is safe during pregnancy, so educating and intervening early is critical (Keegan, Parva, Finnegan, Gerson, & Belden, 2010). Social regulations have demonstrated effectiveness as prevention strategies. Especially effective has been measures that limit the availability of alcohol through establishment of a minimum legal age for consumption, e.g. Regulations on driving and drinking have also shown effectiveness, including institution of sobriety check points and random breath testing. Regulation of promotion, which includes control of content or

> Social regulations have demonstrated effectiveness as (alcohol) prevention strategies (Medina-Mora, 2005).

advertising bands have some effect if they are monitored and enforced. Persuasion and education through the use of warning labels, e.g., have shown changes in attitudes and knowledge, though the effect on drinking has not been sustained. Integrated approaches appear to be most effective (Medina-Mora, 2005).

## Environmental Prevention.

Many of the prevention approaches aimed at delaying or preventing alcohol use fall under the rubric of environmental prevention. This form of prevention employs policy interventions to create an alcohol environment that supports safe, healthy behavior. Research over several decades demonstrates that these type of policy reforms work. They have been especially successful in reducing problems associated with youth drinking (AlcoholPolicyMD.com, 2005).

The following are examples of environmental prevention approaches:

- Decreasing the number of alcohol outlets in a community.
  - ✓ Reduces the rates of alcohol-related youth violence

- Holding retailers liable for damage inflicted on individuals by underage and/or intoxicated patrons.
  - ✓ Responsible server practices are promoted and alcohol-related crashes are reduced

- Increasing taxes on alcohol and reducing discount drink specials
  - ✓ Reduces hazardous and heavy drinking among high school and college students

- Increasing enforcement of laws prohibiting sales to underage drinkers
  - ✓ Reduces access to alcohol by young people

- Increasing the minimum legal drinking age to 21
  - ✓ Reduces alcohol-related motor vehicle crashes involving young people

- Reducing the amount of youth exposure to alcohol advertising and increasing the number of alcohol counter-ads
  - ✓ Positively impacts beliefs and intentions young people have regarding alcohol use and may affect their decisions about drinking (AlcoholPolicyMD.com, 2005)

- Reduce the number of public settings where drug use is occurring
  - ✓ Directed patrols, proactive arrests, and problem-solving at high-crime "hot spots" have served to reduce crime associated with substance use.

- Reduce the availability of drug paraphernalia in retail alcohol outlets
  - ✓ This effort has shown to be effective in ensuring merchant compliance with existing laws (Sonoma County Department of Health Services, 2007).

Environmental approaches are typically implemented at the local level in response to community pressure and concern for action. These strategies serve to complement rather than replace strategies that target individual behavior (e.g., social norms and other educational programs). Environmental approaches enhance individually based strategies, creating a social climate that reinforces the educational messages (AlcoholPolicyMD.com, 2005).

The community coalitions program is one through which Substance Abuse Prevention Coalitions (SAPCs) have demonstrated their understanding of the Strategic Prevention Framework (SPF) and the capacity to complete a comprehensive community plan that includes: an Assessment of Need; Capacity Assessment; Planning Process; Implementation Plan; and Evaluation Plan as described by the SAMHSA's SPF process. Environmental strategies incorporate prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies. The TDMHSAS utilizes the SPF to assist community coalitions and prevention providers in developing the infrastructure needed for community-based, public health approaches that can lead to effective and sustainable reductions in alcohol, tobacco and other drug (ATOD) use and abuse (S. Cooper, June 24, 2016, personal communication).

# Prevention Resources

## National Substance Abuse Prevention Month.

The month of October was designated through Presidential Proclamation as national Substance Abuse Prevention Month in 2011.  This was the first time for such a designation and allowed for a full-month observance of the role that substance abuse prevention plays in promoting healthy and safe communities.  This month is a time of tribute to everyone that works to prevent substance abuse in communities.  It further is a time for individuals to rededicate themselves to building a safer, drug-free country (ONDCP, n.d.).

## National Prevention Week.

This time is set aside to increase public awareness and action around substance abuse.  The goals are: 1) foster collaboration and partnerships with national and federal entities dedicated to behavioral and public health; 2) disseminate and promote quality behavioral health publications and resources; and 3) involve communities in implementing prevention strategies while raising awareness of behavioral health issues (SAMHSA, 2014).

The third week in May has been set aside each year.  The timing allows schools to take part in prevention-themed events in advance of the end of the school year, thus giving the opportunity to raise awareness for students across all ages.  Youth drug use, especially alcohol, cigarette, and marijuana use, spikes between spring and summer so this week is a pivotal time to provide education to the young people and their families.  Communities are asked to get involved in this week.  Provide health fairs, block parties, educational assemblies, town hall meetings—the list can go on and on—to help raise awareness about the importance of preventing substance use/abuse (SAMHSA, 2014).

### "I Choose" Project.

During National Prevention Week each year, individuals get to "choose" how to be a positive example, make a difference, and inspire other people.  **And it's easy to do**.  The individual takes a picture of himself/herself holding a sign showing a personal message about why he or she believes substance abuse prevention is important.  Then the person should send the photo/message to NewMedia@samhsa.hhs.gov.  The following information should be included in the message:

- Name
- State
- Zip code
- The "I Choose" message with the individual's photo.
- Optional:  Include an organizational name.

When the photo/message is received, SAMHSA will review it for posting to the "I Choose" photo gallery.  Make certain that the photo/message does not violate conditions set forth for submission (SAMHSA, 2014).

# Coalition for Healthy and Safe Campus Communities (CHASCo).

The Coalition for Healthy and Safe Campus Communities (CHASCo) is a prevention service designed to address the problem of high-risk drinking among college students and young adults in the state. According to the National Institute on Alcohol Abuse and Alcoholism's (NIAAA's) Update on College Drinking report, these students continue to demonstrate disturbing increases in unhealthy and binge drinking driving while intoxicated, and alcohol-related injuries and deaths. The report also highlighted the fact that college students continue to put themselves at risk with their level and frequency of alcohol consumption. Moreover, college students that do not drink are still exposed to negative alcohol-use consequences, including assaults, increased traffic crashes, property damage, and other crimes (TDMHSAS, 2013).

CHASCo's vision is to be recognized nationally as a model for effective statewide coalitions of institutions of higher education that address campus safety and prevention issues. They proactively address these issues by providing high-quality consultation and training, research support, technical assistance, and policy development to member institutions. Further, CHASCo actively seeks partnerships with community and state agencies to assist campuses in having a variety of options in alignment with their alcohol, substance, and violence prevention efforts (CHASCo Web site, n.d.).

Prevention services are provided at various campuses across the state—public as well as private, four-year versus two year, and in each of the three grand regions. Funding is provided through TDMHSAS (TDMHSAS, 2013).

# National Youth Anti-Drug Media Campaign.

This campaign was established by Congress in 1998 to prevent and reduce youth drug use. Originally there were two distinct areas of focus: a teen-targeted Above the Influence (ATI) Campaign, and a young adult-targeted Anti-Meth Campaign. The campaign was later redirected and expanded to focus on marijuana use (GAO, 2006). Federal oversight has ceased and the campaign is currently affiliated with the non-profit *Partnership for Drug-Free Kids* (Abovetheinfluence.com, n.d.).

## *Above the Influence (ATI).*

This brand was created to strengthen the anti-drug beliefs of young people. It was designed to speak to teens, encouraging them to live "above the influence" of substances, including alcohol, and to reject the use of any substance that slows or hinders reach of their life goals. Early reports about the effectiveness of the ATI media campaign were not favorable. Those results indicated that no campaign exposure effects were found on rates of quitting or use for prior users of marijuana (GAO, 2006). Hence, an ATI media campaign re-launch occurred in 2010. This campaign was much broader in scope and incorporated national-level television, Internet advertising, and a strong online presence through an ATI Facebook page, AboveTheInfluence.com, and the Above the Influence (ATI) YouTube channel. More than 75 percent of young people said this re-launched message spoke to someone like them, regardless of gender, ethnicity, or race. Results from the re-launch were also more positive. Young people in the new ATI campaign were observed to be less likely to initiate use of marijuana compared to those who had not been exposed to the campaign. Moreover, the young people who viewed the ads were more likely than their peers to say that marijuana

ec

use was not consistent with being independent and autonomous, and that it would interfere with their aspirations and goals (ONDCP, 2012).

The *Anti-Meth Campaign* was developed through comprehensive research and testing with members of the target audience.  This campaign continues to be viable through print, TV, radio, and online anti-meth advertising in areas of the country hardest hit by meth.  A mobile/texting component provides linkages to local resources.  Mobile SMS (or "text") codes have been added to out-of-home methamphetamine ads. Those viewing the ads can use their mobile phones to send a text message and receive a reply with information and links to local methamphetamine prevention and treatment resources.  Research has shown stronger anti-methamphetamine beliefs for adults 18-35 years of age with more ad exposure compared to adults with less exposure (ONDCP, 2011).

All messaging served as vital prevention resources.  The Media Campaign used paid advertising to ensure effective media placement of messages and required media outlets to "match" each paid advertisement placement with a donated (or free) placement (ONDCP, 2011).

## National Prescription Drug Take-Back Day.

This event is an initiative of the Drug Enforcement Administration (DEA) that provides safe, responsible, and convenient ways to dispose of over-the-counter and prescription drugs using a variety of designated locations.  The initiative further is designed to educate the general public on prescription drug abuse and misuse (SAMHSA News Release, 2014).  Among items appropriate for take back are pet medications; medicated ointment, lotions, or drops; prescriptions; liquid medications (in leak-proof containers); over-the-counter medications (if liquid, use leak-proof containers); and pills in any packaging, including plastic containers, glass bottles, plastic bags, etc. (TDMHSAS, n.d.a).

Held twice yearly, National Prescription Drug Take-Back Day helps raise awareness around the permanent prescription-drug disposal boxes that have been established around the nation.  As of February 24, 2016, there were 155 permanent prescription drug disposal boxes located at law enforcement facilities in 85 counties across the state.  A list of permanent locations can be found by visiting the following Web link at the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS):  http://tn.gov/assets/entities/behavioral-health/sa/attachments/Tennessees_Permanent_Prescription_Drug_Take-Back_Locations.pdf (TDMHSAS, 2016a; TDMHSAS, 2016b).
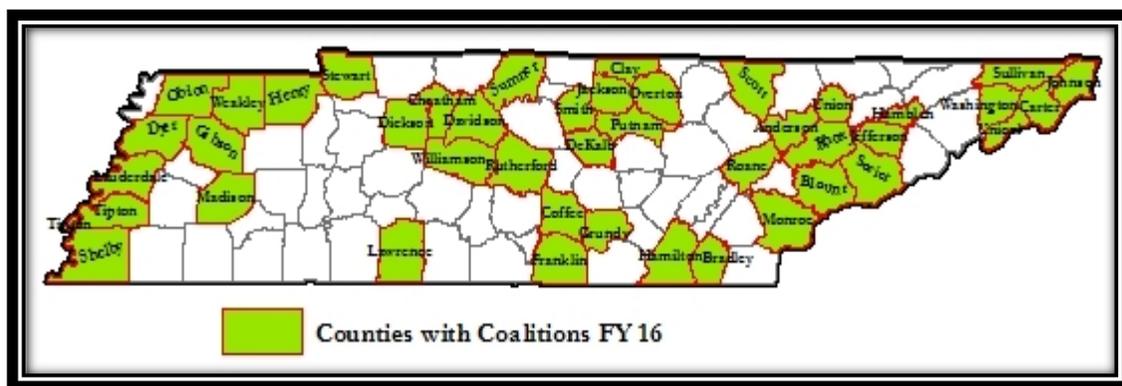
## Coalitions

The TDMHSAS Office of Prevention Services funds a total of 45 anti-drug coalitions across the state, 43 community-based and two statewide coalitions (TDMHSAS, n.d.b;

TDMHSAS, 2016a; TDMHSAS, 2016b; thechattanoogan.com, 2016)  [Bradley County and Polk County share a coalition (the chattanoogan.com, 2016.)].  Coalitions assemble individuals from diverse groups to brainstorm and plan effective solutions in reaching the goal of safe, healthy, drug-free communities (TDMHSAS, n.d.b).  These coalitions focus on environmental prevention strategies, such as public awareness campaigns, policy development and work with law enforcement. The goal is to create community environments where people are less likely to abuse or misuse substances.  Substances of focus to the state's prevention coalitions include prescription drugs, alcohol, and tobacco (TDMHSAS, 2014).  Strategies used by coalitions to effect change in communities include the following:

- Change or modify community policies to discourage negative behaviors and promote positive behaviors.

- Change the environment or the physical design of space to encourage or discourage targeted behaviors.

- Increase barriers to substance abuse and misuse and reduce access to substances.

- Increase incentives for behaviors that should be encouraged while increasing penalties for behaviors that should be discouraged.

- Increase prevention skills among coalition members and staff, service providers, community members, law enforcement, educators, and young people.

- Provide information that enhances understanding of negative consequences of substance use and abuse and positive impacts on substance abuse prevention efforts.

- Provide support to organizations or individuals to take action (TDMHSAS, 2014).

Coalitions funded for the 2016 fiscal year (FY) are shown in the map below.



Some coalitions are subrecipients of the state's current Partnership for Success (PFS) grant funded through the Substance Abuse and Mental Health Services Administration (SAMHSA).  The map below shows the location of funded PFS coalitions:

Counties with PFS-Funded Coalitions
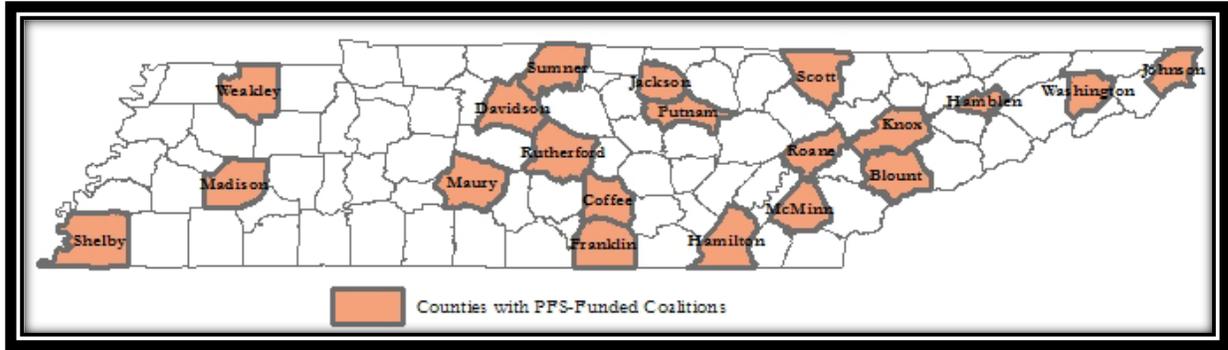
The PFS project is aimed at reducing alcohol binge drinking among 14-25 year olds. Through the project, participating Community Prevention Coalitions (CPCs) were to implement evidence-based and emerging practices to positively impact the policies, practices and attitudes that support unsafe alcohol consumption and create a hazard to public safety in the state. The project's goals are to reverse the state's upward trend in binge drinking; prevent the onset and progression of substance abuse among 14-25 year olds; strengthen prevention capacity and infrastructure at the state and county levels; and leverage, redirect, and realign Tennessee's funding streams for prevention services (S. Cooper, June 24, 2016, personal communication).

# Early Intervention

Early intervention is included in the scope of prevention, focusing on persons that have experimented with substances but are not severely dependent. Such individuals can be re-educated through a variety of learning interventions (Medina-Mora, 2005). Thus, early intervention is a strategic activity within the risk-focused prevention framework where individuals at risk are identified, observed, assessed, and referred to intervention and/or treatment, as necessary (Deed, 2007). Early treatment interventions such as mandatory treatment for drivers who continue to drink and drive, for example, have proven effective (Medina-Mora, 2005).

Typically persons who might benefit from early intervention have not yet spun out of control in their substance use. They have likely encountered negative consequences as a result of their involvement with substances, such as dealing with a first-time driving-under-the-influence (DUI) charge or minor possession charge, however. The early intervention is employed in an attempt to reduce the probability of more serious substance use behaviors (SAMHSA/CSAT, 1999).

## Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is perhaps the most popular buzz word associated with early intervention. It is a public health approach to the delivery of early intervention (and treatment services) for individuals with substance use issues, including those at risk (SAMHSA/SBIRT, 2014).

In the 2001 landmark report, "*Crossing the Quality Chasm: A New Health System or the 21st Century",* the Institute of Medicine (IOM) specifically cited Screening, Brief Intervention, and Referral to Treatment (SBIRT) as a promising practice (SAMHSA/HRSA/CIHS, 2013). Today SBIRT has

achieved evidence-based status. It is used to identify, reduce, and prevent issues with use, abuse, and dependence on alcohol and illicit drugs. The model promotes community-based screening for risky health behaviors, including substance use. It consists of three major components:

- **Screening** – Assessment of individuals' risky substance use behaviors using standardized screening tools

  This component provides a quick and easy way to identify persons who use substances at hazardous or at-risk levels and who many already have a substance use disorder (SUD). The screening tool provides specific information and feedback to the individual about his or her substance use. Typically the process starts with the use of one to three screening questions. If the individual obtains a positive screen of one of the instruments, he or she is then given a longer alcohol or substance use measure that involves the use of a standardized risk assessment tool such as Alcohol Use Disorders Identification Test (AUDIT) or Drug Abuse Screening Test (DAST)-10. The questions and instruments are easily administered and provide self-reported information that can be scored easily (SAMHSA/HRSA/CIHS, 2013). In our state, the Patient Health Questionnaire (PHQ)-4 is also administered to identify any co-occurring anxiety and/or depressive issues (A. McKinney-Jones, personal communication, August 5, 2014).

- **Brief Intervention** – Engagement of individuals that show risky substance use behaviors in brief conversation, providing feedback and advice

  The brief intervention is designed to motivate individuals to change their behavior(s) and prevent the progression of substance use. During the intervention, patients are:

  - Given information about their substance use based on their risk assessment scores.
  - Advised in clear, respectful terms to reduce or abstain from substance use.
  - Encouraged to set goals to reduce substance use and to identify specific steps that will help them reach those goals.
  - Taught behavior change skills that will decrease substance use and associated negative consequences.
  - If necessary, given a referral for further care (SAMHSA/HRSA/CIHS, 2013).

  Typically brief interventions are used with individuals reporting less severe alcohol or substance use who are not presently in need of a referral to additional treatment and services. Only minimal training is required to conduct these interventions (SAMHSA/HRSA/CIHS, 2013). Brief interventions involve counseling sessions that last between five and 15 minutes. They are designed to enhance an individual's awareness of his or her alcohol and/or drug use and its consequences, with the intention of motivating the individual to reduce risky drinking or drug-seeking behaviors and getting treatment (APHA, 2008). In the case of individuals with addictions, more intensive interventions may be needed. Conversations around intensive intervention are similar to that of the brief interventions but the sessions tend to be longer (20-30 minutes). It is possible that multiple sessions, referral to an addiction treatment program, and/or the provision of pharmacological therapy may be necessary (SAMHSA/HRSA/CIHS, 2013).

- **Referral to Treatment** – Provision of a referral to therapy or other treatments to individuals whose screening results suggest the need of additional services (CMS, 2013).

  > This component includes a more advanced treatment option so the individual is referred to a higher level of care. Often this care is provided at addiction treatment centers. The referral to treatment process consists of helping individuals to access treatment, selecting treatment facilities, and facilitating the navigation of any barriers such as cost of treatment or lack of transportation or child care that would hinder them from receiving treatment in this type of treatment setting. In order for this process to occur smoothly, the referring agent must initially establish and cultivate relationships with specialty providers, and then share pertinent patient information with the referral provider. Handling the referral process properly and ensuring that the individual receives the necessary care coordination and follow-up support services are critical to the treatment process and to facilitating and assisting in maintenance of recovery (SAMHSA/HRSA/CIHS, 2013).

As an early intervention, SBIRT targets individuals with moderate to high risk of substance use, providing effective strategies for intervention before there is a need for more extensive or specialized treatment. The approach is not designed for individuals with more severe substance use or those who meet the criteria for a diagnosis of Substance Use Disorder (SUD) (CMS, 2013).

The goal of SBIRT is to prevent the unhealthy consequences of alcohol and substance use for persons whose use may not have reached the diagnostic level of SUD and to assist those with the disease of addiction enter and stay with treatment. SBIRT can be used easily in a variety of settings, including primary care settings, to systematically screen and deliver services to persons who may not be seeking help for a substance use problem, but whose alcohol consumption or substance use may cause or complicate their ability to successfully handle family, work, or health issues (CMS, 2013). Since its inception in 2003, 19 percent of screened individuals have required brief intervention, brief treatment, or referral to specialty treatment services (SAMHSA/SBIRT, 2014).

Despite its promise especially in reaching pregnant women who otherwise may go unidentified, the literature has noted that implementation of the brief intervention component of SBIRT in real-world settings is very slow. Some studies have suggested that doing all recommended screening and prevention SBIRT tasks would take a primary care provider more than four hours per working day, time not in the schedule of primary care physicians. As a result, few physicians, including obstetricians, actually fully implement the recommended brief intervention strategies. To counteract these problems, a computer-delivered intervention has been proposed. Brief education that emphasizes current information regarding negative outcomes of both mother and newborn is presented as part of the intervention. Pilot outcomes were promising, showing reports of reduced substance use for the mothers and higher birth weights for the newborns. Further research is still warranted for computer-based delivery of brief interventions (Tzilos, Sokol, & Ondersma, 2011). In Tennessee, licensed alcohol and drug abuse counselors (LADACs), social workers, and/or master's level counselors may be used to complete SBIRT activities.

There are manifold resources to educate prospective providers about SBIRT as well as assist them in implementing the intervention (SAMHSA/HRSA/CIHS, 2013). A few of them are listed below.

- **SBIRT App**. This tool was developed at Baylor College of Medicine to support the use of SBIRT by physicians, other healthcare workers, and mental health professionals. Free to download, it provides evidence-based questions to screen for use of alcohol and other substances including tobacco. The app includes a screening tool to further evaluate specific

substance use, if warranted.  Also included are steps to complete a brief intervention and/or referral to treatment for the client based on motivational interviewing.  The app can be downloaded from https://itunes.apple.com/us/app/sbirt/id877624835?mt=8.

- **TAP 33: Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment** (SBIRT).  This TAP provides a description of core elements of screening, brief intervention, and referral to treatment (SBIRT) programs for individuals with or at risk for substance use disorders.  The TAP further includes general administrative and managerial information relevant to implementing SBIRT services.  Among the covered information are implementation models, challenges and barriers to implementation, and issues around cost and sustainability.   The document can be downloaded as a PDF, at no cost, from http://store.samhsa.gov/shin/content//SMA13-4741/TAP33.pdf.

- **Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide**.  Developed by NIAAA, this guide introduces a quick, simple, empirically derived tool for identifying young people at risk of alcohol-related problems.  Designed for clinicians who work with youth between the ages of nine and 18, the guide can help detect risk early using the first tool to include a "friends" drinking question.  Research has identified friends as an important risk factor in drinking behaviors of youth.  The guide was produced in collaboration with the American Academy of Pediatrics (AAP), clinical researchers, and health practitioners.  It can be accessed from http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf.

## SBIRT in Tennessee.

Our state's SBIRT program is funded by a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) (TDMHSAS, 2014).  The main goals of SBIRT Tennessee are to:  1) identify individuals using substances at risky levels and 2) implement SBIRT services for these individuals in primary care and community health settings.  The project aims to expand and enhance the state's continuum of care for substance misuse services and reduce unhealthy levels of alcohol and substance consumption and associated negative consequences, increase abstinence, and reduce costly health care utilization, promote sustainability and behavioral health information technology (SBIRT Tennessee Evaluation Report Summary, personal communication, 2014).

As of August 1, 2015, SBIRT services were being implemented at East Tennessee State University (Bristol, Johnson City, and Kingsport TN), Meharry Medical College (Nashville, TN), Neighborhood Health Services (Madison, TN), and a variety of Tennessee National Guard sites in middle and east Tennessee.  These implementation sites universally pre-screen all adult patients/soldiers at least once annually.  All patients/soldiers seen by a participating site are eligible for a full screen if pre-screen results indicate harmful levels of alcohol use and/or abuse of other drugs (SBIRT Tennessee Evaluation Report Summary, personal communication, 2015).  Only validated screening tools can be used in SBIRT Tennessee.  Among the validated instruments include the Alcohol Use Disorders Identification Test (AUDIT) for adult alcohol use; the Drug Abuse Screening Test (DAST-10) for adult substance use; and the CRAFFT for adolescent alcohol and substance use (State of Tennessee SBIRT Guidelines, 2010).  Also included in the full screen is the four-item, Patient Health Questionnaire for Depression and Anxiety (PHQ-4).  The four-item tool combines two validated two-item screeners.  Full screens are administered by a Behavioral Health Specialist (BHS) located at each implementation site.  If the patient/soldier has a moderate

or high risk score on the full screen assessment, he or she is categorized, for the purposes of services, into one of three groups (SBIRT Tennessee Evaluation Report Summary, personal communication, 2014; SBIRT Tennessee Evaluation Report Summary, personal communication, 2015):

1. Brief Intervention
   ✓ This strategy is conducted by the BHS utilizing motivational interviewing techniques focused on raising an individual's awareness of his or her substance use and its consequences to motivate a positive behavioral change.

2. Brief Treatment
   ✓ Also conducted by the BHS utilizing motivational discussion and patient/soldier empowerment. The process includes patient goal-centered assessment and education as well as development of problem-solving and coping skills within a supportive social environment.

3. Referral to Specialty Treatment
   ✓ Patients/Soldiers who require a more intensive level of care are linked to various substance abuse and mental health treatment agencies for a formal diagnosis and possible treatment (SBIRT Tennessee Evaluation Report Summary, personal communication, 2014).

By March 1, 2016, SBIRT Tennessee had screened 39,290 individuals of diverse ethnicity, race, and age across all five sites and the Tennessee National Guard (TNNG). Of the screenings, 82 percent (32,260 screens) were conducted across the five primary care sites. Moreover, the total number represented more than twice the number of persons that SBIRT TN projected to serve by this date, per the request for funding announcement. Almost half of those screened were female (18,578 or 47 percent). Very few patients/soldiers self-identified as Hispanic/Latino (7 percent). The majority (57 percent) were white, followed by 21 percent that identified as African-American. The average age at intake was 42 years, based on an age range from 18 to 100 years old. Close to 20 percent of the 28,819 persons reflected positive prescreens and were recommended to receive the full screen (i.e., AUDIT/DAST/PHQ-4). Slightly more than seven percent was recommended for Referral to Specialty Treatment (C. Brown & B. Hayes, personal communication, June 28, 2016).

# References

Abovetheinfluence.com/about/. (n.d.). About. Retrieved August 1, 2016, from http://abovetheinfluence.com/about/.

AlcoholPolicyMD.com. (2005). The environmental approach to prevention: Implementing alcohol policies. Retrieved July 18, 2014, from http://www.alcoholpolicymd.com/alcohol_policy/effects_ep.htm.

American College of Obstetricians and Gynecologists (ACOG). (2008). At-risk drinking and illicit drug use: Ethical issues in obstetric and gynecologic practice. Committee opinion No., 422. *Obstetrics & Gynecology*, *112*, 1449-1460.

American Public Health Association and Education Development Center, Inc. (APHA). (2008). Alcohol screening and brief intervention: A guide for public health practitioners. Washington, DC: National Highway Traffic Safety Administration, United States Department of Transportation.

Butler Center for Research. (2010, June). Preventing adolescent substance abuse. *Research Update.* Center City, MN: Hazelden. Retrieved July 18, 2014, from http://www.hazelden.org/web/public/substance_abuse_prevention.page.

Center for the Application of Prevention Technologies (CAPT). (2012). CAPT fact sheet.  Retrieved March 3, 2015, from http://captus.samhsa.gov/sites/default/files/capt_resource/capt_behavioral_health_fact_s heets_20122.pdf_-_adobe_acrobat_pro.pdf.

Coalition for Healthy and Safe Campus Communities (CHASCo) Web site. (n.d.). Retrieved September 19, 2014, from http://www.tnchasco.org/home.

Deed, C. (2007). Policy implications of teacher perspectives on early intervention for substance misuse.  *Drugs: Education, Prevention and Policy*, *14*(5), 415–428.

Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS). (2013, January). Screening, brief intervention, and referral to treatment (SBIRT) services. ICN 904084.

Duncan, D.F. & Gold, R.S. (1982). Primary prevention of drug abuse. *Drugs and the Whole Person.* New York: John Wiley & Sons.

Government Accountability Office (GAO). (2006, August). ONDCP media campaign: Contractor's national evaluation did not find that the youth anti-drug media campaign was effective in reducing youth drug use. Washington, DC: US Government Printing, GAO-06-818. Retrieved August 11, 2016, from http://www.gao.gov/new.items/d06818.pdf.

Kane, G. & Ballue, M. (2013, February 27). The prevention of substance use disorders 1: Part one – overview and terminology. National Council on Alcoholism and Drug Dependence, Inc. Retrieved July 18, 2014, from http://geoffkane.com/the-prevention-of-substance-use-disorders-part-one-overview-and-terminology/.

Keegan, J., Parva, M., Finnegan, M., Gerson, A., & Belden, M. (2010). Addiction in pregnancy. *Journal of Addictive Diseases*, *29*(2), 175-191. doi:10.1080/10550881003684723

Knight, J.R., Goodman, E., Pulerwitz, T., & DuRant, R.H. (2001). Reliability of the Problem Oriented Screening Instrument for Teenagers (POSIT) in adolescent medical practice. *Journal of Adolescent Health*, *29*(2), 125-130.

Medina-Mora, M.E. ((2005). Prevention of substance abuse: A brief overview. *World Psychiatry*, *4*(1), 25-30.

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2015, October). Alcohol screening and brief intervention for youth: A practitioner's guide. NIH Publication No. 11-7805. Rockville, MD: Author.

National Institute on Drug Abuse (NIDA). (n.d.). Diagnosis & treatment of drug abuse in family practice. Retrieved July 18, 2014, from http://archives.drugabuse.gov/diagnosis-treatment/diagnosis7.html.

National Institute on Drug Abuse (NIDA). (2003). Preventing drug use among children & adolescents: A research-based guide for parents, educators, and community leaders (2nd ed.). Bethesda, MD: Author. Retrieved June 1, 2014, from http://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf.

National Institute on Drug Abuse (NIDA). (2007). Drug abuse prevention: A research update from the national institute on drug abuse (NIDA). *Topics in Brief.* Retrieved July 18, 2014, from http://www.drugabuse.gov/sites/default/files/prevention.pdf.

Office of National Drug Control Policy (ONDCP). (n.d.). National substance abuse prevention month. Retrieved July 18, 2014, from http://www.whitehouse.gov/ondcp/prevention-intro/prevention-month.

Office of National Drug Control Policy (ONDCP). (2011). National youth anti-drug media campaign progress report. Retrieved July 18, 2016, from https://www.ncjrs.gov/pdffiles1/ondcp/fy10_mc_progress.pdf.

Office of National Drug Control Policy (ONDCP). (2012, June). Above the influence (ATI) fact sheet. Retrieved July 18, 2014, from http://www.whitehouse.gov/sites/default/files/page/files/ati_fact_sheet_6-26-12.pdf.

Office of National Drug Control Policy (ONDCP) Web site. (n.d.) A comprehensive approach to drug prevention. Retrieved December 31, 2014, from http://www.whitehouse.gov/ondcp/prevention-intro.

Sonoma County Department of Health Services. (2007, January). Environmental prevention of alcohol and other drug problems: A resource guide. Retrieved June 12, 2016, from http://www.sonoma-county.org/health/publications/pdf/aod_resourceguide.pdf.

State of Tennessee SBIRT guidelines. (2010, February). Retrieved March 14, 2014, from http://www.tnpcaeducation.org/resourcelibrary/clinical/Tennessee%20SBIRT%20Guidelines.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). Partnerships for success. Retrieved September 9, 2015, from https://captus.samhsa.gov/grantee/capt-clients/pfs.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014, July 17). About national prevention week. Retrieved July 18, 2014, from http://beta.samhsa.gov/prevention-week/about.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Systems-level implementation of screening, brief intervention, and referral to treatment.* Technical Assistance Publication (TAP) Series 33. HHS Publication No. (SMA) 13-4741. Rockville, MD: Author.

Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT). (1999). *Brief interventions and brief therapies for substance abuse.* Treatment Improvement Protocol (TIP) Series 34. HHS Publication No. (SMA) 99-3353. Rockville, MD: Author.

Substance Abuse and Mental Health Services Administration, Health Resources & Services Administration, Center for Integrated Health Solutions (SAMHSA/HRSA/CIHS). (2013). SBIRT: Screening, brief intervention, and referral to treatment: Opportunities for implementation and points for consideration. *Issue Brief.* Retrieved June 1, 2014, from http://www.integration.samhsa.gov/SBIRT_Issue_Brief.pdf.

Substance Abuse and Mental Health Services Administration, Screening, Brief Intervention, and Referral to Treatment (SAMHSA/SBIRT). (2014, August 29). *Screening, brief intervention, and referral to treatment* (SBIRT). Retrieved March 7, 2015, from http://www.samhsa.gov/sbirt.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). (n.d.a). Find a prescription drug take-back box. Retrieved September 9, 2015, from https://www.tn.gov/behavioral-health/article/Prescription-Drug-Take-Back-Boxes.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). (n.d.b). Join a coalition. Retrieved September 9, 2015, from http://tn.gov/behavioral-health/article/Join-a-Coalition.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). (2013, Winter). High-risk drinking remains a concern on college campuses. *TDMHSAS Update*, *16*(4), 6.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). (2014, Summer). Prescription for success: Statewide strategies to prevent and treat the prescription drug abuse epidemic in Tennessee. Nashville, TN: Author. Retrieved September 9, 2015, from https://www.tn.gov/assets/entities/behavioral-health/sa/attachments/Prescription_For_Success_Full_Report.pdf.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). (2016, February 24). Tennessee's permanent prescription drug take-back locations. Retrieved May 9, 2016, from http://tn.gov/assets/entities/behavioral-health/sa/attachments/Tennessees_Permanent_Prescription_Drug_Take-Back_Locations.pdf.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). (2016a, August 19). Tennessee increases anti-drug coalitions to prevent substance abuse. Retrieved August 22, 2016, from http://tn.gov/behavioral-health/news/44906.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). (2016b, June 30). Prescription for success update.

The Alcohol and Drug Prevention and Education Model Development Group. (TADPEMDG). (2010). Greater Glasglow and Clyde alcohol prevention and education model: Working towards a model of good practice. Retrieved March 3, 2015, from http://www.glasgowgrand.org/media/1556/PE%20Event%20Report.pdf.

thechattanoogan.com. (2016, August 22). Bradley and Polk counties have anti-drug coalitions to prevent substance abuse. Retrieved August 22, 2016, from http://www.chattanoogan.com/2016/8/19/330269/Bradley-And-Polk-Counties-Have.aspx.

Tzilos, G.K., Sokol, R.J., & Ondersma, S.J. (2011). *Journal of Women's Health*, *20*(10), 1517-1524. DOI: 10.1089/jwh.2011.2732

ec

This page
was intentionally
left blank

ec