Prevention Brief

Vol. 4, No. 1, July 2009 Published by the Center for Applied Research Solutions for the California Governor's Program SDFSC TA Project

Targeting Prevention: Alcohol and Other Drug Screening and Referral

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Introduction

Social service providers who collaborate with schools to provide a range of substance abuse prevention services are confronted with this challenge:

How can we provide the most efficient and effective services to a diverse group of potential participants?

Safe and Drug-Free Schools and Communities (SDFSC) grantees are providing services in this context, where they are tasked with determining who should be included in their programs. Viewed through the lens of prevention strategies, these service providers can focus their tactics on individuals most at-risk for alcohol and other drug abuse. AOD screening is one such tactic that can clarify and confirm the risk of substance-related problems and direct resources more equitably.

This Prevention Brief reviews the definition and role of AOD screening as part of an overall framework of substance abuse prevention services. It examines and explores the dynamic processes of screening, brief intervention, and referral that advances participants towards the services they may need. It presents youth-focused AOD screening tools and referral approaches, and offers direction to those who want to implement and manage a screening program.

Towards a Common Definition of Screening

Charles Curie, administrator for the Substance Abuse and Mental Health Services Administration (SAMHSA), describes screening in this way:

> *"The purpose of screening is not diagnosis. A screening instrument does not enable a clinical diagnosis to be made, but rather indicates whether there is probability that key features of the target problem are present in an individual. Used intelligently and sensitively, with respect for privacy and confidentiality, screening can provide vital information and can enable people to lead longer, healthier, and ultimately more rewarding lives."*[i]

When this description is unpacked, certain elements stand out. Most importantly, a screening instrument, or tool, is used as an *indicator*, not as a diagnosis. What might screening indicate? It might show that an individual demonstrates behaviors or possesses attributes shared by a group of people who are at-risk for alcohol and other drug (AOD) substance abuse or dependence. Because of the restricted nature of the screening tool, it does not indicate much more than this. But this information serves as an essential jumping off point for the prevention specialist. Armed with some knowledge that the individual may be at risk, further resources can be directed to determine if a referral for treatment assessment is necessary.

Screening serves as an effective tool for identifying at-risk populations and efficiently using limited resources. Youth who are not at-risk for substance abuse are identified with little time and effort, and those who are at-risk can have resources directed to their needs.

California's Call for Screening

At the state level, AOD screening has been addressed by the California State Interagency Team (SIT) for Children and Youth. The SIT was established in 2003 to coordinate policy, services, and strategies for the state's children, youth, and families. A subset of the team, the SIT Alcohol and Other Drug (SIT AOD) Work Group, strives to "improve screening, identification, and intervention regarding AOD risk in families and children." The AOD Work Group defines screening as:

> *"…a formal process to determine whether an individual warrants further attention to address their AOD use. The goal of screening individuals for AOD use is to identify potential candidates for AOD services as early as possible to reduce their risk of significant substance-related problems."*[ii]

The SIT AOD Work Group was created to improve "services for children, youth, and families where there is a nexus between AOD use and child safety, education, workforce readiness and success, maternal/child health, and mental health."[iii] In 2006 and early 2007, the SIT AOD Work Group conducted a survey to learn more about how their agencies used screening. The SIT AOD Work Group singled out six California counties in diverse geographic regions to determine what AOD screening policies and practices were in effect.

They found conflicting standards for AOD screening across state agencies, as well as different practices among agencies in the same county. There were variations in the definitions of *screening*, as well as inconsistent written policies for screening, referral, and the tracking of referrals. Where screening did take place, a variety of instruments were employed leading to inconsistent implementation.

These findings prompted a number of recommendations on screening, endorsed by the State Interagency Team leadership on August 24, 2007:

- Prevention programs working with individuals should put screening protocols into place.
- To improve communication and evaluation, common definitions for *screening* should be utilized.
- The use of standardized, validated screening tools should be promoted.

How Screening Fits into the Continuum of Services (COS) Approach

The California Department of Alcohol and Drug Programs (ADP) focuses on the Institute of Medicine's prevention classifications[1]: universal, selective, and indicated. SDFSC grantees have been utilizing a variety of science-based approaches to serve "selected" populations and "indicated" youth most at-risk for alcohol, tobacco, and other drug use, as well as violence. The intent of the Round 3 SDFSC grant program is to address the unique AOD service needs of specific under-served populations of school-aged (kindergarten through twelfth grade) children and youth up to eighteen years of age.

To do this, grantees must establish interventions that fall within the "selective" and "indicated" approaches as defined in the Institute of Medicine (IOM) prevention categories to address identified subsets and individuals. It is usually at the level of indicated prevention that AOD screening takes place. The intent of AOD screening is to identify individuals who are at risk for substance abuse or dependence, and then either implement a prevention strategy for those individuals, or refer them on for further treatment assessment.

SDFSC grantees are focusing prevention services at these high priority populations:

- Youth in foster care
- High-risk experimental users (e.g., binge drinkers)
- Children of known substance abusers

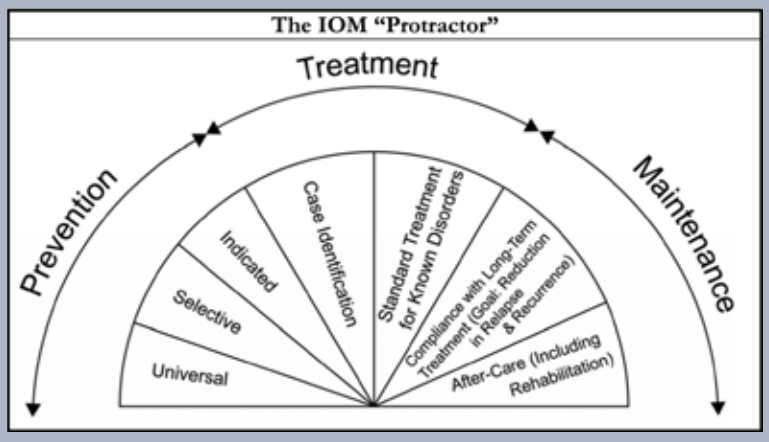
The IOM Model's Three Prevention Categories

Universal: Universal prevention addresses an entire population (national, local community, school, neighborhood), with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs.

Selective: Selective prevention addresses subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment--for example, children of adult alcoholics, high school dropouts, or students who are failing academically.

Indicated: Indicated prevention is designed to prevent the onset of substance abuse in individuals who do not meet DSM-IV criteria for abuse or dependence, but who are showing early danger signs, such as falling grades and consumption of alcohol and other drugs. The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to offer them special programs.

-Adapted from "Drug Abuse Prevention: What Works," National Institute of Drug Abuse, 1997, pp. 10-15. Available online at www.captus.org/western/resources/bp/step5/bptype.cfm



[1] For a fuller discussion of the IOM model, see the article "*How Does the Institute of Medicine Continuum of Care Model Translate to AOD Prevention Practices?*" in the October, 2007 Prevention Brief available at www.ca-sdfsc.org/Web Area - Publications/prevention_brief.htm

Implementing AOD screening procedures for youth can enable service providers to identify low- to moderate-risk individuals within these broad groups, and provide them with indicated services *before* substance abuse and problem behaviors spin out of control.

Within many SDFSC programs however, grantees see youth who potentially need more services than they can provide in a school setting or a Student Assistance Program (SAP) setting. What these youth need is a smooth transition to the next step: formal, clinical assessment of their AOD use. Where called for, school interventions should, for example, provide a bridge to more intensive services. An AOD screening program with clear referral procedures can provide such a bridge.

Implementing a Screening Program: Lessons from Maine

The State of Maine is considered the first state to implement a standardized system for substance abuse prevention within its child welfare system. A common set of screening policies and procedures were developed to guide the family assessment process. Maine's Child Welfare and Substance Abuse Committee selected the UNCOPE, a tool consisting of six questions found in existing instruments and assorted research reports. This tool met the committee's objective of using a tool that was short, easy to administer, and valid and reliable. A demonstration project was set up in three county child welfare offices to field test the UNCOPE.

In April 2005, Maine's Department of Health and Human Services decided to make screening for substance abuse a universal part of their family assessment protocol. The experience in Maine can assist other communities in planning their own AOD screening policies, procedures and tool selection. The following are some key lessons learned from the Maine experience:[iv]

"A sustained commitment from the top administrators is responsible and required to develop a uniform system of screening and assessment."

The on-going commitment of elected officials and top administrators, combined with the participation of leading professionals in substance abuse and child welfare, simultaneously gave the committee creditability and access to decision-makers.

"Making a timely and informed decision when adopting a screening tool can save a significant amount of effort and time."

Early in its process, the committee realized that there was no perfect tool and that "endless analysis can lead to needless work." Maine's Department of Health and Human Services supported a uniform screening process, but insisted the tool be brief, reliable, and require minimal training.

"Training staff members is crucial to the successful implementation of a screening system."

On-going training and orientation of new staff should be built into the system. Training should not only emphasize the technical aspects of the screening tool, but also the more complex dynamics of substance abuse. Service providers should bear in mind that the screening tool is just one avenue that can be taken to reveal a potential substance abuse problem. Finally, instilling a sense of "buy-in" to the system is essential. If staff are not invested in screening or do not see it as having a purpose, it quickly becomes a meaningless exercise.

"The single most significant lesson learned from the demonstration project was the importance of administrative supervision."

In one county, where the supervisor was part of the Committee and very committed to the screening system, the AOD screening tool was consistently used. In the other two counties, supervision was inconsistent. Consequently, when the system was put into effect, it was incorporated into an overall policy on safety assessment, elevating it to a level that requires consistent supervisory attention.

While circumstances in Maine cannot automatically be replicated in other locales, the experience of setting up a universal AOD screening system illustrates some of the practical steps other institutions might follow to establish their own screening policies and procedures.

AOD Screening in Practice

As described above, screening is not a formal diagnosis of AOD abuse or dependence, but a determination of risk in order to refer the individual to prevention services or further treatment assessment. Information gathering for AOD screening may include screening instruments, interviews, and personal contact. The particular form of screening is determined by the setting, the population, and, perhaps most importantly, by the screener's ability to refer the individual to follow-up services. While there is a fair amount of research on specific screening instruments used by medical professionals in primary care and emergency department settings (Knight, 2003[v]; and Winters, 2002[vi]), there is a scarcity of literature on the effectiveness of screening in environments such as schools or community organizations. Still, strategies for implementing effective screening can be inferred from the experiences of medical practitioners, especially those working with adolescents.

The most common screening technique is the structured interview. Not only does the interview's face-to-face format provide a quick way to gather information; it also offers a chance to observe the participant's nonverbal behavior. In addition, the interviewer can gauge the individual's verbal skills, which might be an important factor for referring the student for follow-up treatment assessment. When interviews are used, a formal protocol must be followed. Unstructured interviews present administrative problems that could contribute to erroneous information and/or scoring. When using paper-and-pencil or computer-based screening instruments, clients should read the instructions aloud to ensure they understand what is expected and to determine if their reading ability is appropriate for the instrument.

In general, the entire screening process should take no longer than 30 minutes, and preferably less. The basis of screening depends on the use of a single screening instrument. (See sample screening tools on page 6.) SAMHSA recommends that screening instruments be:

- Administered in about 10-15 minutes
- Broadly applicable across diverse populations
- Simple enough that it can be administered by a wide range of professionals[vii]

An appropriate AOD screening program has to consider the individual's characteristics, such as age, gender, ethnicity, culture, gender orientation, socioeconomic status, and education.

Not all screening tools are the same. Before selecting a standardized interview or screening instrument, consideration must be given to its reliability and effectiveness for populations being addressed by the prevention program. Providers should consider the characteristics of the screening tool and the practical limitations of test administration and scoring.

Different screening tools will reveal different levels of alcohol or other drug-related risks. That is, some tools are more sensitive than others. According to Knight, "sensitivity may be the single most important characteristic to consider when screening for alcohol disorders…"[viii] His research, for example, indicates that commonly used cut-off scores for adults must be lowered when alcohol screens are used for adolescents.

Three Sample Screening Instruments

AUDIT (Alcohol Use Disorders Identification Test)
This ten-question screening tool is available in various forms: interview, self-administered, and computerized versions. It is used with adolescents and young adults, and is highly sensitive for different populations, including women and minorities. It has been validated cross-culturally and translated into several languages.

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?
4. How often during the last year have you found that you were not able to stop drinking once you had started?
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

CRAFFT
The CRAFFT was developed specifically for adolescents. During a clinical interview, the participant is asked about alcohol and drug abuse, risky behavior, and the consequences of use.

1. Have you ever ridden in a ***C****ar* driven by someone who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to ***R****elax*, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself ***A****lone*?
4. Do you ever ***F****orget* things you did while using alcohol or drugs?
5. Has your ***F****amily* or **F***riends* ever told you that you should cut down on your alcohol or drug use?
6. Have you ever gotten into ***T****rouble* while you were using alcohol or drugs?

POSIT (Problem-Oriented Screening Instrument for Teenagers)
Written at a fifth-grade reading level, this instrument is geared specifically for use with adolescents.

Despite the fact that it contains 139 questions, the average administration and completion time is about 25 minutes. Designed to identify potential risk areas that require further in-depth assessment, the POSIT identifies risk in ten domains:

* Substance use and abuse
* Physical health
* Mental health
* Family relations
* Peer relations
* Educational status (i.e., learning disabilities/disorders)
* Vocational status
* Social skills
* Leisure/recreation
* Aggressive behavior/delinquency

The entire set of POSIT questions can be found in Appendix C of ***TIP 24: A Guide to Substance Abuse Services for Primary Care Clinicians***, available online at www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.45979#46033

The Alcohol and Drug Abuse Institute at the University of Washington maintains an extensive database to help clinicians and researchers find instruments used for screening and assessment of substance use and substance use disorders. It is available at http://lib.adai.washington.edu/instruments/

Once the screening tool is selected, it is essential for program staff to be trained in its use. Many instruments come with training manuals, and some offer alternative questions to pose for unique audiences, such as younger children or diverse cultural groups. In general, screening procedures must incorporate provisions to sensitively address individual differences that might affect the reliability of responses.

The prevention provider's procedures should also include a system for recording and communicating the information gleaned: participant details, screening results, and how the case was handled. A protocol for conducting screening should be established by the agency or institution. A protocol is a detailed plan that includes the steps the service provider follows for conducting the screening, as well as what will be done with the results. In other words, the protocol specifies the questions asked and methods followed.

Additionally, it details the scoring criteria, sometimes called a cut-off score, for a specific risk factor. For example, if a cut-off score indicates the participant falls in a low-risk or no-risk range, the protocol would state that the service provider conducts a brief education session. If the score points to a high-risk, the protocol guides the service provider to refer the participant to a health center for treatment assessment.

In the case of adolescent screening, time might be allotted for soliciting other information from the youth and, if possible and appropriate, a parent or guardian. While the screening tool might focus primarily on the teen's substance abuse risk, a short interview could reveal associated factors such as mental health issues, educational achievement, living situation, or involvement with the justice system. The protocol should indicate how this additional information is collected, recorded, and how it fits into the overall screening program.

SDFSC Grantee Case Studies: Be a Part of the Solution

The **Be A Part of the Solution** program focuses on reducing binge drinking among 9th and 11th graders in five high schools in the Mt. Tamalpais School District. The project's goal is to screen 50% of all 9th and 11th graders.

In the comprehensive high schools, the indicated population (binge drinkers) is targeted by an adapted form of the World Health Organization's AUDIT screening tool. Students with a score of four or more are encouraged to contact a project staff member to receive brief intervention services (using the Teen Intervene early intervention curriculum). Students that do not score 4 or more, but are concerned about their drinking, are also encouraged to contact a staff member. Students that need more serious treatment intervention receive appropriate referrals to those services. At the District's continuation school, *Project SUCCESS* is being offered. Through *Project SUCCESS* all students are offered prevention education, and are also screened using the AUDIT. Students that are concerned about their drinking or are referred by a staff member are assessed using the *Project SUCCESS* assessment tool, and offered a series of prevention groups and referrals to treatment if necessary.

Marin County has contracted with Bay Area Community Resources to implement Problem Identification, Screening and Brief Intervention at five high schools. The organization has been working with ADTP and the Tamalpais Union High School District office to establish needed connections and obtain information to begin their work. Bay Area Community Resources will implement *Project SUCCESS* in conjunction with *Class Action* to include the screening and brief intervention and parent components.

Challenges…

Based on a pilot done over the summer (one in which students responded to a paper version of the screening tool rather than the computerized version, which is the desired form of administration), it became clear that students did not always score the tool correctly. The pilot pointed out even more strongly the need for and value of a computerized version. Responses to the tool were anonymous. By having a computerized, web-based system, it will be possible to track aggregate student scores and basic demographic information (gender, grade) even though respondents will not have a unique identifier. This data will provide important information about the extent of binge drinking among students in the District.

Another issue in Marin and throughout the State is the lack of adolescent treatment available. By focusing program efforts on identifying indicated and selective populations among the county's high school students, it is likely the number of students needing treatment services will increase, but there are limited resources available to respond to the increased demand.

Contributed by Gary Najarian, M.S.W.
AOD Prevention Coordinator
County of Marin, Department of Health and Human Services

A Closer Look at Brief Intervention

Ideally, prevention providers want to help their participants move towards positive change, and give them the opportunity to set goals around getting help and following up on a referral. Brief intervention is a tool that prevention providers can use with those students who are identified in screening as needing some intervention, but their use has not triggered a referral for further treatment assessment. These students may benefit from the use of brief intervention to help them modify and limit their AOD use. In cases where the participant may be unready for a referral, or does not admit that AOD use is an issue, motivational interviewing or brief intervention strategies can be helpful intermediary strategies.
Brief intervention is a low-intensity, short-duration technique used by prevention providers when meeting with participants individually. It uses a motivational interviewing style that incorporates a readiness to change model. It also includes feedback about the screening results and advice for the participant.

Risk Level	Intervention
Low	Reinforcement
At Risk *"Primary Target"*	Brief Intervention
High	Brief Treatment
Severe	Referral to Outside Agency

The California Screening, Brief Intervention, Referral and Treatment (CASBIRT) project has successfully incorporated brief intervention strategies into its service delivery model. CASBIRT is part of a national effort by the Substance Abuse and Mental Health Services Administration (SAMHSA) to conduct alcohol, tobacco and other drug (ATOD) screenings in emergency and trauma departments, and health care clinics. (See **Interview with the Expert** on page 10.)

CASBIRT uses highly trained, bilingual health educators to conduct health screens of patients during emergency and primary health care visits. Health educators use a "scripted screening infused with motivational enhancement techniques." Patients receive intervention depending on the risk level. If screening score indicates a low risk level, the patient is encouraged to continue their behavior. Patients are considered a "primary target" if their score indicates they are at risk. These patients are directed towards a brief intervention that features these elements:

- Educate about doctor's role
- Provide feedback on risk level
- Discuss short and long term risks
- Consider possible changes
- Create a plan, with assistance of the health educator

Participants whose scores point to high receive brief treatment; those with severe risk level are referred to an outside agency for services.[ix]

Through the CASBIRT screenings, health educators quickly assess the severity of substance use and identify the appropriate level of treatment; provide a brief intervention[2] that focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change; and offer referral to treatment to patients with more severe substance use.

[2] The Safe and Drug Free Schools and Communities (SDFSC) Technical Assistance Project offers training on brief intervention techniques. For more information visit the project website at www.ca-sdfsc.org/index.htm

Interview with the Expert

We asked Raymond DiCiccio, Program Director of the California Screening and Brief Intervention Project (CASBIRT) for his input of AOD screening and some tips he might share with SDFSC grantees.

1. How does your organization define AOD screening? How do you follow up on the information gathered during screening?

In the case of CASBIRT, ATOD screening is gathering information using a valid and reliable screening tool, scoring the result to determine the level of risk incurred by the patient as a result of their use pattern. The level of risk determines the response:

- No/low risk – Congratulations, support and education
- At risk – education and brief motivational intervention
- High risk – education, brief intervention & referral to brief treatment
- Severe risk – education, brief intervention & referral to ATOD treatment

Our Health Educators are trained to follow through with all clients regardless of the risk level. However, our emphasis is on "At Risk" patients. Research indicates that brief motivational interventions provided to patients who are at risk but not yet dependant are effective in reducing drinking and drug taking behavior and can make a substantial reduction in alcohol and drug related problems within the community.

2. What policies and procedures are in place for AOD screening?

Our agency does have written policies and procedures and tools in place for AOD screening. In addition we train our Health Educators to memorize scripts and responses to the most typical questions asked by patients. The same is true for the brief interventions and referrals that are made by the Health Educators.

Very little is informal in our services. Our Site Supervisors constantly monitor and shadow Health Educators to prevent drifting from the model and to ensure the quality of services. When service modification is needed at one or all of the sites we discuss those changes as a team and monitor their effect methodically.

3. What screening instrument do you employ, and how is it utilized?

CASBIRT uses a modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) that is the World Health Organization's screening instrument. We added two questions to the ASSIST related to the frequency and dosage of recent use to better determine the current risk level particularly as it relates to drinking alcohol.

We initially used a preprinted, bubbled scanning form to record patient responses. We have begun the process of switching to notebook computers. Several of our sites are currently using computers that automatically score the screening results and upload data to the server daily.

4. How do you make the transition from screening to intervention and/or referral?

CASBIRT uses formal processes to collect data and score the responses immediately. The Health Educator uses some discretion in probing for more information when they are in doubt about the

accuracy of the information. The Health Educators provide the patient feedback regarding their score and their risk level. They immediately provide education about the possible risks the patient is facing and launch into a brief intervention for all patients that screen "at risk" or at a higher level. The Health Educator moves immediately into making a referral for high and severe risk patients using scripted referral language.

5. When making a referral, how does the screening data get communicated to the referring agency?

The screening forms and/or screening data for patients who are at High Risk are sent to the CASBIRT Brief Treatment program via secure fax modem. All other referrals are made with only the indication that the patient has screened at a severe risk level and needs further assessment for substance abuse and co-occurring disorders. All of our referrals are made to County funded providers who by contract are required and trained to assess for both substance abuse and mental health issues.

6. What evidence, anecdotal or otherwise, do you have that screening has lead to effective interventions?

We sample 10% of patients who screen "At Risk" or higher and complete a six-month follow-up for the Government Performance Reporting Act (GPRA). The data collected to date indicates there are a meaningful reduction in past thirty-day use, some improvements in reduced criminal activity, and a reduction in homelessness.

7. What advice or tips do you have for prevention providers who implement AOD screening within their prevention programs?

- Keep the focus of your program and services on the "At Risk" population. This population traditionally receives no AOD services. However, research clearly indicates a brief motivational intervention for this population provides the most benefit in reduced medical and other AOD related costs.
- Provide a supportive educational intervention for those at no and low risk of substance abuse (including a brochure).
- Do everything possible to keep the services brief, motivational, and scripted. Hire and train Health Educators with the skill necessary to succeed using scripted methodology rather than counselors or therapists. These strategies will help your program stay focused on the larger low and at risk populations.
- Ensure a smooth hand off to other services. The tendency for both medical and program personnel are to focus on those patients who are at severe risk or obviously dependant or addicted.

Those patients need to be referred to other programs qualified to help them with their serious AOD or co-occurring issues. The hand off should be smooth and brief so the Health Educator can get back on the floor to continue screening and providing brief interventions that are designed to help the larger population of at risk drinkers and users who most benefit from the services.

- Work closely with your County funded treatment programs to ensure that the referrals made to treatment are made in a way that provides the most incentive for both patients and treatment providers to get these patients in the most appropriate level of treatment.

For more information about the CASBIRT program, visit the Center for Alcohol and Drug Studies website at http://centerforaod.sdsu.edu/casbirt.html

Editor's Note: The ASSIST was originally developed for use by health practitioners in primary care settings. While it has been shown to be a valid and reliable screening tool with adults[x], its validity with children and adolescents remains untested.

ABOUT THE EXPERT

Raymond DiCiccio is the Program Director of the California Screening and Brief Intervention Project (CASBIRT), based at the Center for Alcohol and Drug Studies, San Diego State University Research Center. Mr. DiCiccio received his Masters degree in Social Work from San Diego State University in 1997. He is currently the Executive Director of the San Diego County Alcohol Policy Panel, a coalition of community leaders and youth advocates committed to reducing binge and underage drinking and related problems since 1994. As Executive Director of the Policy Panel he has been responsible for developing and coordinating the San Diego County Underage Drinking Initiative (UDI). Mr. DiCiccio's expertise in organizational development and community organizing was instrumental in making the UDI a sophisticated, award winning prevention system with regional structures that support an environmental approach to addressing underage drinking. Mr. DiCiccio also works with substance abuse treatment centers to improve organizational and programmatic effectiveness and efficiency, counselor effectiveness and program evaluation.

Managing the Referral Process

When screening identifies an individual with a potential substance abuse problem, the prevention provider has the responsibility to link that person to resources for further treatment assessment. Familiarity with local community resources is needed on the part of the service provider.

Prior to implementing a screening procedure, service providers should build relationships with various local agencies and programs. Individuals whose AOD screening indicates further services are required, should be smoothly transitioned to the appropriate, recommended agency. To assist those individuals, the referring provider should take a proactive role in learning about the availability of appointments, costs, transportation needs, and the names of contact people at the agencies to which referrals are made. This kind of knowledge requires close cooperation among agencies.

Because many individuals identified as having possible substance abuse problems receive attention from more than one service provider, it is important that agencies cooperate in taking responsibility for that individual. Agencies that develop procedures to guide referral decisions for AOD treatment assessment, mental health assessment, and other community services are better able to help their participants. The sharing of information must be done so in a manner that demonstrates concern for confidentiality and respect for privacy.

When making referrals, the service provider must bear in mind that a short screening often does not take into account the participant's entire life experience. Determining risk for substance abuse problems should be seen within the larger context of the individual's other current and past problems. Immediate problems such as failing academic performance, lack of employment, homelessness, and hunger can be viewed by the participant as more pressing than substance abuse. Past crises, such as incest, rape, and sexual abuse, can also affect how an individual responds to screening questions.

The screening process alone may benefit participants who have not previously considered their own situation in light of behavioral norms and expectations. In general, however, screening instruments or interviews are more effective if the process includes adequate referral. Service providers should put in place the procedures and structures that will enable the participant to receive the appropriate follow-up services. Fostering good communication and cooperation between local agencies is the foundation for effective referral strategies.

Conclusion

The experience of service providers demonstrates that a carefully planned and implemented AOD screening program can effectively serve the needs of their participants and reduce the risk for alcohol and drug abuse and dependence. Service providers will want to further explore how they incorporate screening as part of their prevention services, bearing in mind the issues discussed in this Brief:

- AOD screening is used to identify individuals at risk for substance abuse. Screening, an indicated prevention strategy, is part of the broader continuum of care model.
- AOD screening enables prevention and early intervention efforts to be focused on youth who are identified as being at risk.
- In 2007, the State Interagency Team Leadership endorsed recommendations for screening to encourage prevention programs to put screening protocols into place.
- The State of Maine is on the forefront of implementing a standardized system for screening individuals in the child welfare system. Lessons learned from Maine's experience can guide other service providers to avoid pitfalls and successfully tailor screening programs to suit their population.
- Strategies for effective screening can also be inferred from the experiences of the medical field. Brief, structured interviews that follow a formal protocol are proven and valuable techniques.
- Following screening, brief intervention can be a successful strategy for addressing the needs of individuals whose score indicates a low risk for substance abuse.
- Before selecting a specific tool, consideration must be given its reliability and effectiveness for the subject population. Screening procedures must be sensitive to individual difference that could affect the reliability of the tool.
- When possible, one agency should assume primary responsibility for screening, referral, and record keeping. Fostering good communication between local agencies is the foundation of effective referral strategies.

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The SDFSC TA Prevention Brief is a publication of the California Governor's Program Safe and Drug-Free Schools and Communities Technical Assistance Project, managed by the Center for Applied Research Solutions (CARS) and funded by the California Department of Alcohol and Drug Programs (ADP).

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