

# Substance Use in Adolescent Populations

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# Disclosures

Nothing to disclose

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# NORC at University of Chicago

- ▶ If you would like a copy of SBIRT training materials by NORC at University of Chicago, you can obtain them at <http://sbirt.webs.com/curriculum>

Young adults may be less likely to develop serious alcohol and other drug problems if the age of first use is delayed beyond childhood or adolescence

# Use is Often Undetected

- ▶ A survey of health professionals indicated that only 33-43% of pediatricians and 14-27% of family practitioners routinely asked adolescent patients about alcohol use.
  - ▶ 11-14 year olds asked even less often
- ▶ National Survey of Drug Use and Health (NSDUH) estimates:
  - ▶ 1.7 million youth age 12-17 are not receiving the treatment they need
  - ▶ overall rate of unmet need for intervention for adolescents under 15 years of age = 96.3%

# Overview



Current Statistics  
on Teen Substance  
Use



Diagnostic Criteria  
for of Substance  
Use



Neurobiology of  
Substance use in  
Adolescent Brain



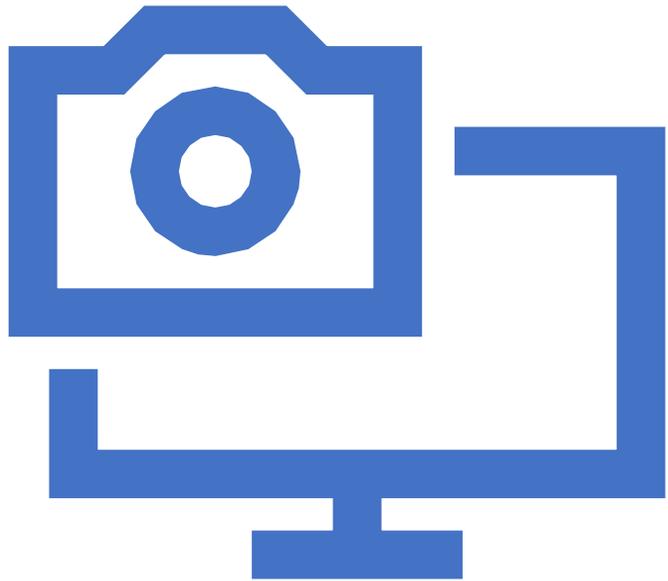
Overview of  
CRAFT and SBIRT



Motivational  
Interviewing



Important Issues  
to Consider



# Why Screen for Substance Use in Minors?

# Substance Use

Is increasing among teens

Is risky and leads to risky behaviors

Tends to increase with time

Effects last into adulthood

# Statistics on Substance use in Adolescents

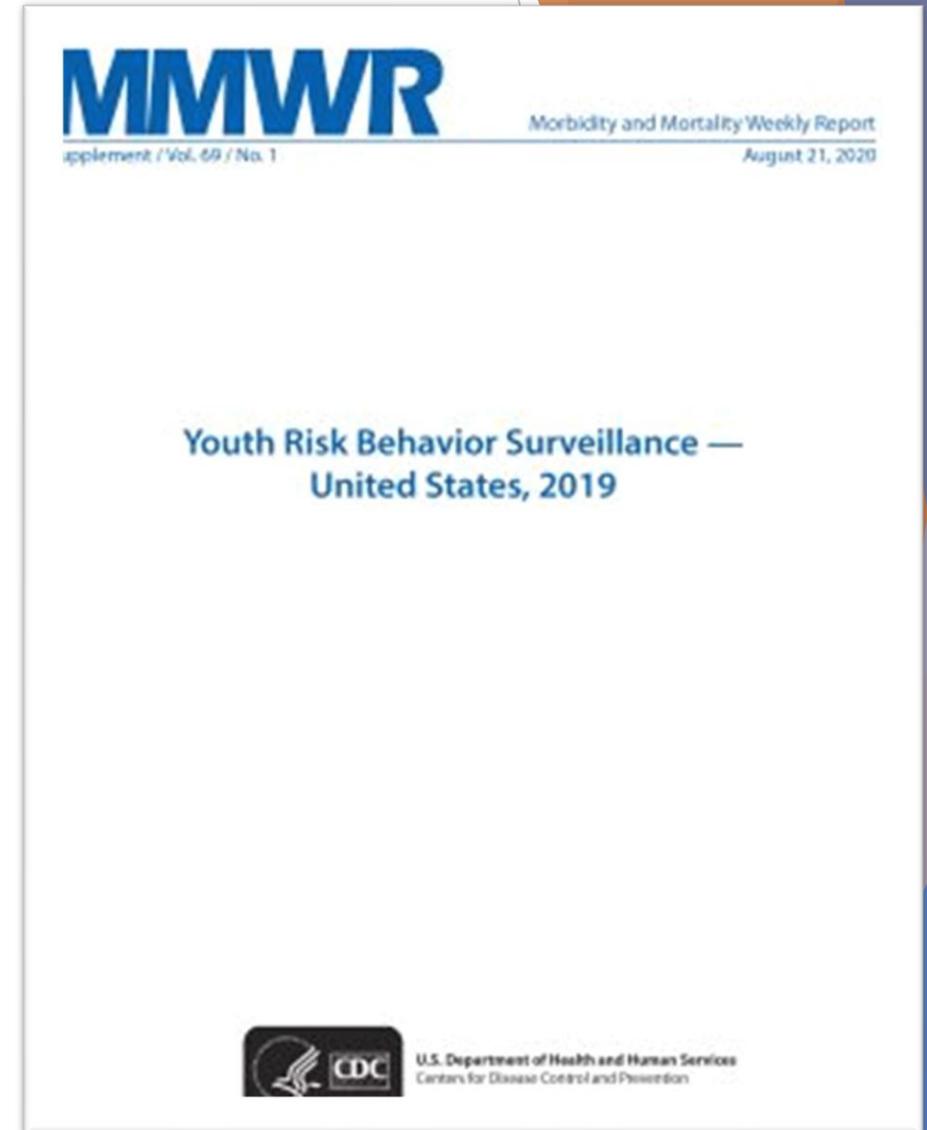


# Youth Risk Behavior Survey

[www.cdc.gov/yrbs](http://www.cdc.gov/yrbs)

- Focus on behaviors among youth causing the most important health problems
- Assess how risk behaviors change over time
- Provide comparable data
- 9<sup>th</sup> - 12<sup>th</sup> grade students
- Anonymous, self-administered, computer-scannable questionnaire or answer sheet
- Conducted biennially usually during the spring

From YRBSS 2019



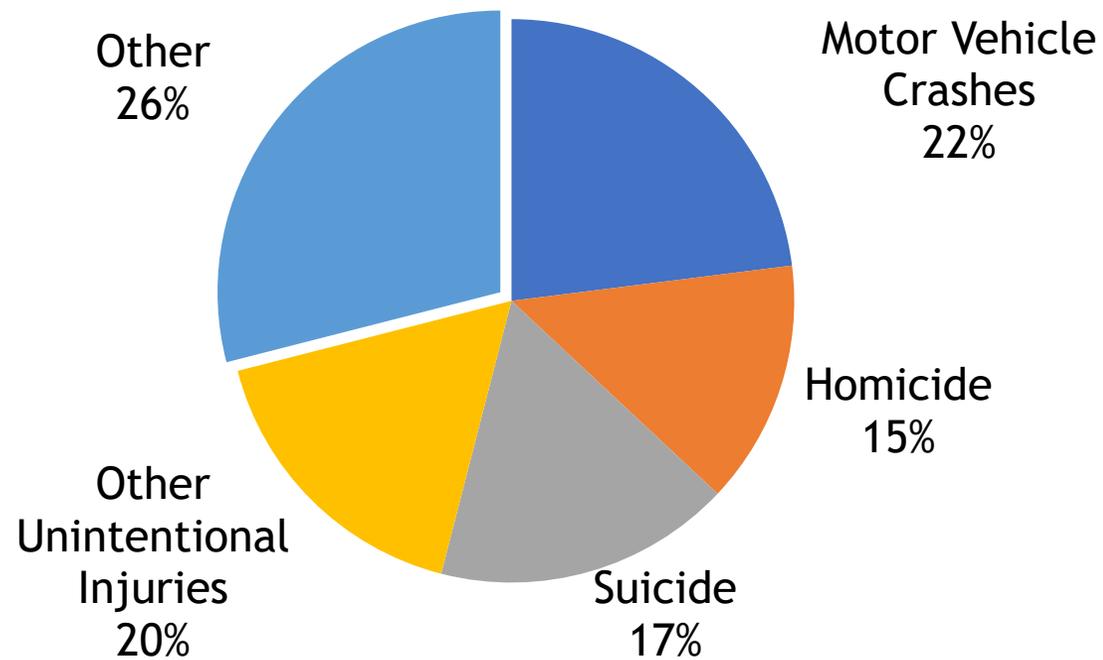
# Priority Health-Risk Behaviors and Health Outcomes Monitored by YRBSS

- Behaviors that contribute to the leading causes of mortality and morbidity
  - Unintentional injuries and violence
  - Sexual behaviors
  - **Alcohol and other drug use**
  - **Tobacco use**
  - Unhealthy dietary behaviors
  - Inadequate physical activity
- Obesity
- Asthma
- Other priority health issues

From YRBSS 2019

# Substance use either directly or indirectly affects the 4 leading causes of death in youth

**Leading Causes of Death Among Persons Aged 10 - 24 Years in the United States, 2016**

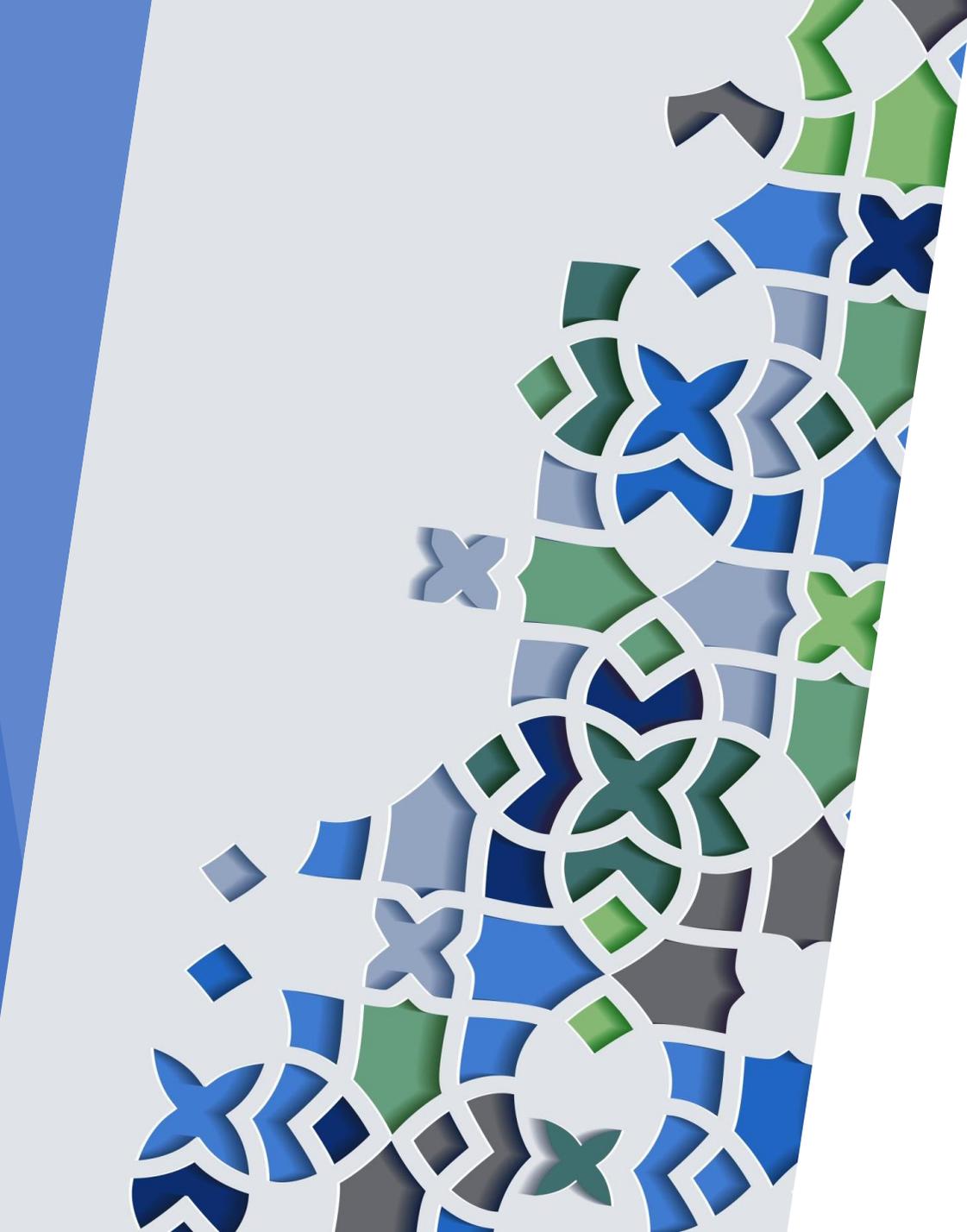


From YRBSS 2019



# Monitoring the Future Survey Results

- ▶ Rates of e-cigarette use
  - ▶ greatly increased in the last year
  - ▶ doubled in the last 2 years.
- ▶ Drug use in college-age adults ages 19-22
  - ▶ Increase in marijuana use (past 5 years)
  - ▶ Increase in vaping both nicotine and marijuana



# Diagnosing Substance Use



# DSM-5 Criteria

## Impaired control

- ❑ Substance is often taken in larger amounts or over a longer period than was intended.
- ❑ There is a persistent desire or unsuccessful efforts to cut down or control substance use
- ❑ A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- ❑ Craving, or a strong desire or urge to use the substance.

## Social impairment

- ❑ Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home.
- ❑ Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- ❑ Important social, occupational, or recreational activities are given up or reduced because of substance use.

## Risky use of substance

- ❑ Recurrent substance use in situations in which it is physically hazardous.
- ❑ Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

## Pharmacological criteria

- ❑ Tolerance, as defined by either: a need for markedly increased amounts of the substance to achieve intoxication or desired effect OR markedly diminished effect with continued use of the same amount of the substance.
- ❑ Withdrawal, as manifested by either: the characteristic withdrawal syndrome for the substance OR the substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Mild: 2-3  
Moderate: 4-5  
Severe: 6+

**TABLE 30-1 ASAM Criteria Assessment Dimensions**

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute intoxication and/or withdrawal potential	Assess for intoxication or withdrawal management. Manage withdrawal in a variety of levels of care and preparation for continued addiction services.
2. Biomedical conditions and complications	Assess and treat co-occurring physical health conditions or complications. Treatment is provided within the level of care or through coordination of physical health services.
3. Emotional, behavioral, or cognitive conditions and complications	Assess and treat co-occurring diagnostic or subdiagnostic mental health conditions or complications. Treatment is provided within the level of care or through coordination of mental health services.
4. Readiness to change	Assess the stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change.
5. Relapse, continued use, or continued problem potential	Assess readiness for relapse prevention services and teach where appropriate. Identify previous periods of sobriety or wellness and what worked to achieve this. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
6. Recovery environment	Assess the need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, and childcare services. Identify any supports and assets in any or all of the areas.



## Substance use and the Adolescent brain

# Some reasons for substance use



DESIRE FOR NEW  
EXPERIENCES



ATTEMPT TO DEAL  
WITH PROBLEMS



HOPE TO PERFORM  
BETTER IN SCHOOL



TRY TO FIT IN (PEER  
PRESSURE)

# Some of the factors that influence whether an adolescent tries drugs:



availability of drugs within the neighborhood, community, and school



friends are using them



difficult family environment

Abusive

Mental Illness

Substance use



Genetic vulnerability



Personality traits

Impulse control

High need for excitement



Mental Health conditions

Depression

Anxiety

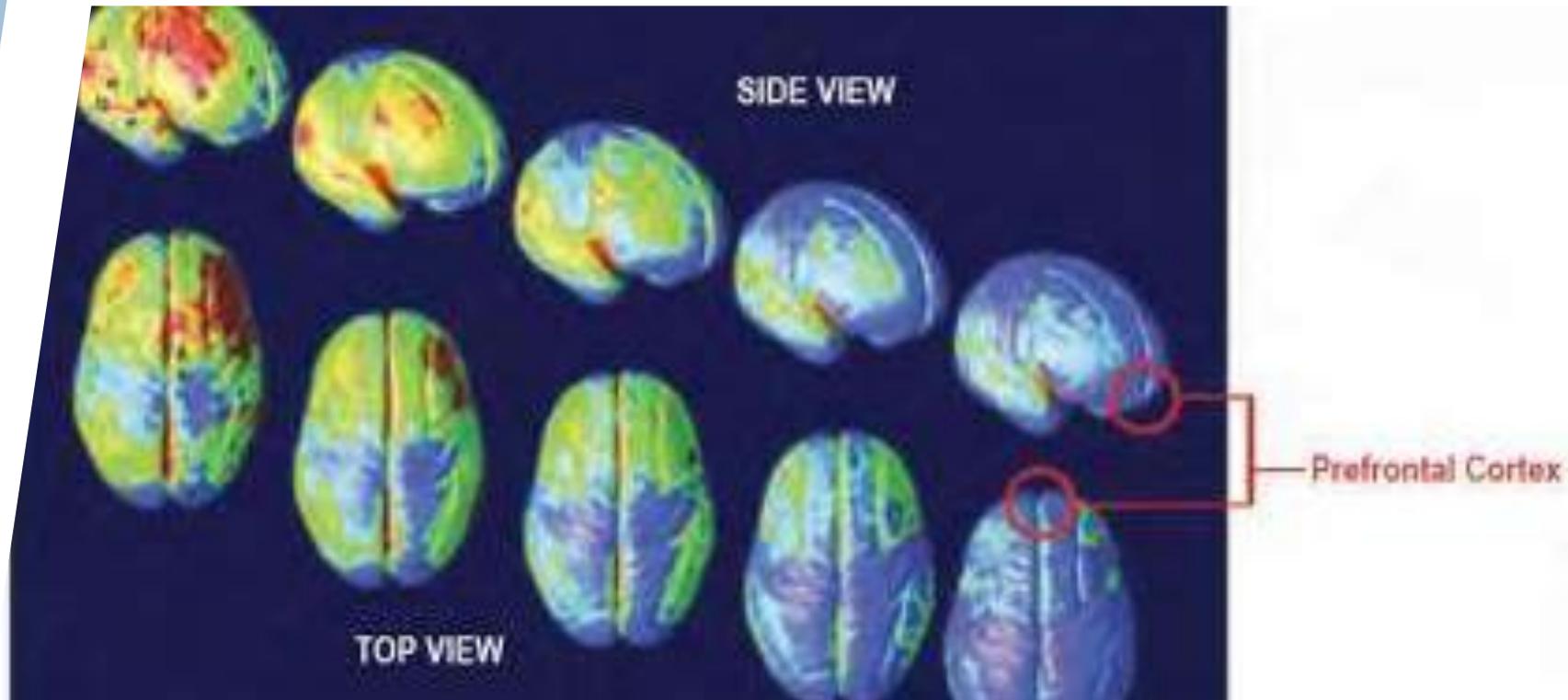
ADHD



Low perceived harm

“cool”

harmless



## Images of Brain Development in Healthy Children and Teens (Ages 5-20)

NIDA:

The brain continues to develop through early adulthood. **Mature brain regions** at each developmental stage are indicated in blue. The prefrontal cortex (red circles), which governs judgment and self-control, is the last part of the brain to mature. Source: PNAS 101:8174-8179, 2004.



The prefrontal cortex governs judgment and self-control and is the last part of the brain to mature

NIDA

# Developmental and Risk Patterns



Risk of substance abuse peaks at ages 18-22 except for cocaine, decline after age 25.



Substance use before age 15: at highest risk for chronic substance use/substance use disorder



substance use/substance use disorder associated with other risky outcomes

Violence, sexual promiscuity, STD's including HIV/ AIDS (also from IVDU), motor vehicle accidents, mortality from OD, school failure, depression, and SI/ completed suicide

# Adolescence: Normal Developmental Factors

## ▶ Socio-cultural

- ▶ Adolescence not recognized as stage of development until 1600's Europe
- ▶ Previous: Rapid transition from childhood to adulthood (apprenticeship model, rituals)
- ▶ Merchant class in Italian city-states introduced formal education and delay of adult duties
- ▶ Greater extension during industrial revolution and urbanization
- ▶ Globalization has contributed to development of a worldwide Youth Culture (fashion, music, social media)
- ▶ Still very linked to SES (poor have little adolescence)

# Adolescence: Normal Developmental Factors

- ▶ Physical Development
  - ▶ Early onset of puberty (nutritional)
  - ▶ Rapid linear growth (false sense of maturity)
  - ▶ Pubertal impact on cortical “pruning” process and later development of “neuronal super-highways” (especially on pre-frontal cortex and impulsivity)
- ▶ Neuronal and Neuropsychological Development
  - ▶ Neuronal pruning: Reduction in redundant connections as result of pubertal hormones
  - ▶ Limitations in executive function (pre-frontal cortex); results in impulsivity and problems with affect regulation
  - ▶ Problems with fully abstract thought
  - ▶ Problems with cause and effect learning (too self-referential for external comparisons)
  - ▶ Establishment of “neuronal super-highways” and improved abstraction and judgment (later adolescent)

# Adolescence: Normal Developmental Factors

- ▶ Psychological
  - ▶ Early adolescence: Normal narcissism and heightened self-awareness/ awkwardness
  - ▶ Compensatory sense of invulnerability/ omnipotence
  - ▶ Efforts to establish separate identity
  - ▶ Rejection of parental beliefs/ values and experimentation/ trial with other beliefs/ values (middle adolescence)
  - ▶ Eventual consolidation of self as unique blend of own temperament, parental/ familial values, and others' influences (late adolescence)
  - ▶ Development of internalized ideal self (advanced conscience) with secure internal moral and spiritual compass

# Adolescence: Normal Developmental Factors

## ▶ Psychosocial

- ▶ Conflict with parents (early and middle)
- ▶ Isolation and self-exploration (early)
- ▶ Peer over-identification (middle; cliques to gangs)
- ▶ Seeking out role models in older peers and non-parental adult mentors (middle)
- ▶ Beginning experimentation with intimacy with peers, both friendships and sexual (middle to late)
- ▶ Re-establishment of closer relationships with parents (late)

# Adolescent Risky Behaviors: Normal Developmental Factors

## ▶ Behavioral

- ▶ Higher impulsivity and mood lability, but episodic and reactive (early to middle)
- ▶ Experimentation with risky behaviors, both for self-definition and rejection of established norms (early to middle)
- ▶ Responsiveness to consistent external limits (throughout adolescence) as well as others' adverse or positive experiences (middle to late)
- ▶ Eventual development of self-control and responsiveness to education and reasoning

# Adolescent Risky Behaviors: Psychopathological Factors

- ▶ Pathological processes for aggravation of risky behaviors (one or more)
  - ▶ Impairment of judgment, logic, and impulse control (brain disorder or substances further impairing pre-frontal cortex)
  - ▶ Thrill-seeking to enhance catecholamine release and focus/ internal control
  - ▶ Self-concept/ esteem deficits and lack of internal definition and controls, seeking mastery through externalization
  - ▶ Need to externalize unbearable pain/ distress, through adverse action (compensating for internal states)
  - ▶ Extreme rejection of parental norms/ values (negative identity formation)
  - ▶ Search for external limits/ support through externalizing behaviors

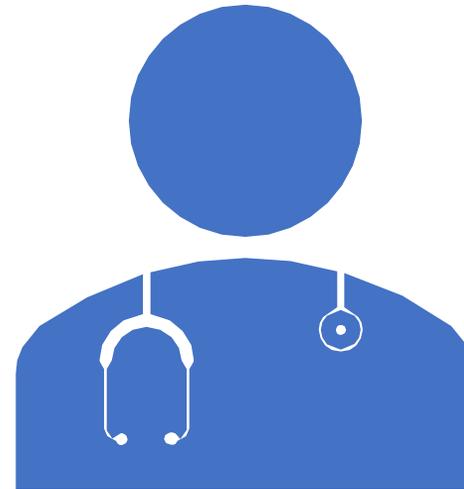
# Adolescent Risky Behaviors: Psychopathological Factors

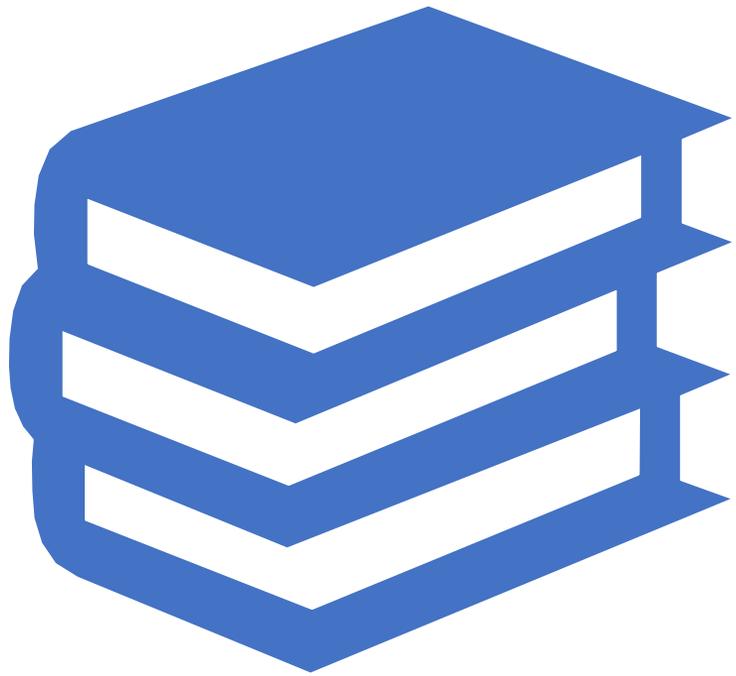
- ▶ Adverse Environmental Factors
  - ▶ Poverty
  - ▶ Abuse and neglect (early and chronic)
  - ▶ Family chaos and role malfunction
  - ▶ Parental mental illness/ SA
  - ▶ Parental criminality
  - ▶ Exposure to domestic and community violence
  - ▶ Losses in family (death, divorce, etc.)
  - ▶ Peer culture and media/ marketing (all teens)
  - ▶ Acculturation in immigrants and minorities (reduction of cultural taboos, increased influence of peer culture, conflict within families)

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



**American Academy of  
Pediatrics Recommends  
Substance Abuse  
Screening as Part of  
Routine Adolescent Care  
(2011)**





AACAP published  
“Practice Parameter  
for the Assessment and  
Treatment of Children  
and Adolescents With  
Substance Use  
Disorders” (2005)

# Why SBIRT with Youth?

SBIRT for adolescent alcohol and other substance use is growing across a range of medical and behavioral health settings.

The SBIRT model for teenagers is attractive given that it is an efficient and cost-conscious approach that can be taught to a wide range of service providers.

SBIRT is particularly fitting for adolescents: the content can readily be organized around a developmental perspective; many substance-using teenagers do not need intensive, long-term treatment; and the client-centered, non-confrontational interviewing approach common to SBIRT is likely appealing to youth.

# Overall Aims of SBIRT

Increase	Increase early identification of adolescents and young adults at-risk for substance use problems.
Build	Build awareness and educate adolescents and young adults on U.S. guidelines for low risk drinking and the risks associated with substance use.
Motivate	Motivate those at-risk to reduce unhealthy, risky use and adopt health promoting behavior.
Motivate	Motivate individuals to seek help and increase access to care for those with (or at-risk for) a substance use disorder.
Link	Link to more intensive treatment services for adolescents and young adult at high risk.
Foster	Foster a continuum of care by integrating prevention, intervention, and treatment services.

# SBIRT Studies with Adolescents

Study	Results- conclusions	Reference
Meta-analysis	<ul style="list-style-type: none"> <li>Brief interventions reduced drug and alcohol use as well as problem and criminal behaviors related to substance use in adolescents</li> </ul>	Carney & Myers, 2012
Meta-analysis	<ul style="list-style-type: none"> <li>Brief interventions to address alcohol misuse was associated with reduced alcohol use and presence of alcohol-related problems</li> </ul>	Tanner-Smith & Lipsey, 2015
Literature review	<ul style="list-style-type: none"> <li>SBIRT may be effective with adolescents but further study is needed</li> </ul>	Mitchell et al, 2013
Literature review	<ul style="list-style-type: none"> <li>SBIRT may be effective with adolescents in acute care settings, but further study is needed particularly around intervention and implementation</li> </ul>	Yuma-Guerrero, et al., 2012
Primary care computerized screening and brief advice	<ul style="list-style-type: none"> <li>lower past-90-day alcohol use and any substance use at 3 and 12 months</li> <li>44% fewer adolescents who had not yet begun drinking had started drinking during the 12 month study period</li> </ul>	Harris et al, 2002
Community health center	<ul style="list-style-type: none"> <li>decrease in marijuana use</li> <li>lower perceived prevalence of marijuana use and fewer friends using marijuana</li> </ul>	D'Amico et al., 2008
Emergency department	<ul style="list-style-type: none"> <li>decrease in marijuana use and greater abstinence at 12 months</li> </ul>	Bernstein et al., 2005

# SBIRT Studies with Individuals Age 18+

Study	Results- conclusions	Reference
Emergency department	<ul style="list-style-type: none"> <li>• Reduced DUI arrests</li> <li>• 1 DUI arrest prevented for 9 screens</li> </ul>	Schermer et al, 2006
Meta-analysis	<ul style="list-style-type: none"> <li>• Adaptation of motivational interviewing reduced alcohol, drug use</li> <li>• Positive social outcomes: substance-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems (e.g., driving under the influence)</li> </ul>	Burke et al, 2003
Meta-analysis	<ul style="list-style-type: none"> <li>• Brief alcohol intervention was effective in reducing alcohol consumption in primary care setting</li> </ul>	Bertholet et al, 2005
Literature review	<ul style="list-style-type: none"> <li>• Interventions can provide effective public health approach to reducing tobacco and unhealthy alcohol use</li> </ul>	Goldstein et al, 2004
Meta-analysis	<ul style="list-style-type: none"> <li>• Brief interventions for alcohol use disorders generally found to be effective compared to control conditions and to extended treatment</li> </ul>	Moyer et al, 2002
Trauma center	<ul style="list-style-type: none"> <li>• 47% fewer re-injury (12 months)</li> <li>• 48% less likely to re-hospitalize (36 months)</li> </ul>	Gentilello et al, 1999

# Overview of Screening

- ▶ The process of assessing risk
  - ▶ Valid, brief (5 minutes or less) standardized questionnaire about quantity, frequency, and consequences of use.
  - ▶ Can be administered in paper-and-pencil, verbally, or by computer
  - ▶ Can be delivered face-to-face or by telephone
- ▶ Many tools available:
  - ▶ AUDIT-C and AUDIT, GAIN-SS, S2BI, DAST, NIDA Modified ASSIST Levels 1 and 2, NIAAA Youth Guide Screen and the CRAFFT

# Many evidence-based screening tools are available

Tool	Substance type		Patient age		How tool is administered	
	Alcohol	Drugs	Adults	Adolescents	Self-	Clinician-
					administered	administered
<b>Screens</b>						
<a href="#">Screening to Brief Intervention (S2BI)</a>	X	X		X	X	X
<a href="#">Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)</a>	X	X		X	X	X
<a href="#">Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)</a>	X			X		X
<b>Assessments</b>						
<a href="#">CRAFT</a>	X	X		X	X	X
Drug Abuse Screen Test (DAST-20: Adolescent version)*		X		X	X	X
<a href="#">For use of this tool - please contact Dr. Harvey Skinner</a>						
<a href="#">Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)</a>	X			X		X

<https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools>

# Why the CRAFFT tool?



efficient and effective



designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21



Widely used



Reveals information for early intervention and patient-centered counseling



It is the most well-studied adolescent substance use screener available



has been shown to be valid for adolescents from diverse socioeconomic and racial/ethnic backgrounds



Recommended by:

American Academy of Pediatrics' Bright Futures Guidelines for preventive care screenings and well-visits  
Center for Medicaid and CHIP Services' Early and Periodic Screening Diagnostic and Treatment (EPSDT) program  
National Institute of Alcohol Abuse and Alcoholism (NIAAA) Youth Screening Guide.

# CRAFFT+N 2.1 tool

Developed by a team at The Center for Adolescent Substance Abuse Research (CeASAR) at Harvard Medical School and Boston Children's Hospital

We have received written permission to use the CRAFFT tool in our clinic

CRAFFT is not a diagnostic tool

CRAFFT will help you to efficiently assess for substance use related problems

Note that CRAFFT has a patient administered version (CRAFFT Questionnaire) and a Provider-administered version (CRAFFT Interview)

# The CRAFFT

- ▶ The CRAFFT tool is the most popular alcohol and drug use screening tool for adolescents 14-21 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse.
- ▶ The questions should be asked exactly as they are written to ensure accuracy of the screening. The CRAFFT and all validated screening tools have been tested using the specific wording and any deviation from the original wording may alter the type of response given by the adolescent.

# The CRAFFT Screening Questions

- ▶ It is a mnemonic acronym where each first letter represents a key word in the six screening questions:
  - ▶ **C** - Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
  - ▶ **R** -Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
  - ▶ **A**- Do you ever use alcohol/drugs while you are by yourself, ALONE?
  - ▶ **F** -Do you ever FORGET things you did while using alcohol or drugs?
  - ▶ **F** -Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
  - ▶ **T** -Have you gotten into TROUBLE while you were using alcohol or drugs?

# Using the CRAFFT

- ▶ The CRAFFT may be administered via interview or self-administered either electronically or in paper-form.
- ▶ There are two parts to the CRAFFT.
  - ▶ Part A - three opening questions: If the adolescent answers “No” to all of the three opening questions, only the “C” question of the CRAFFT (referred to as the “Car question”) should be asked.
  - ▶ Part B - six CRAFFT questions: If the adolescent answers “Yes” to any of the three opening questions, all six CRAFFT questions (referred to as Part B) should be asked.

# Risky Adolescent Substance Use

- ▶ The American Academy of Pediatrics has identified four general patterns of substance use based off the CRAFFT screening tool that is described in further detail later:
- ▶ **Low Risk (Abstinence):** Adolescents who report no use of tobacco, alcohol or other drugs and report that they have not ridden in a car with a driver who has been using alcohol or other drugs.
- ▶ **Driving Risk:** Adolescents who report driving after alcohol or drug use or riding with a driver who has been using alcohol or other drugs.
- ▶ **Moderate Risk:** Adolescents who have begun using alcohol or drugs (CRAFFT score 0 or 1)
- ▶ **High Risk:** Adolescents who use alcohol or drugs (CRAFFT score  $\geq 2$ )

# Overview of Brief Intervention

- ▶ A behavior change strategy focused on helping the adolescent reduce or stop use of alcohol and other substances.
  - ▶ You may provide feedback on risks of alcohol and drug use, information on how drinking or drug use compares to others, offer simple advice, explore the pros and cons of use, and ask if willing to make a change.
  - ▶ Can take as little as 1-3 minutes for those at no or low risk, or range from 15 to 30 minutes or longer for those at moderate or high risk.
  - ▶ Can be 1 session or extend to several sessions.
  - ▶ Alcohol or drug use may not be the adolescent's primary presenting problem, it may be a factor that complicates the problems that the adolescent came to resolve.
  - ▶ Can help many, but certainly not all, adolescents to make changes.
  - ▶ Some will not be ready to change or may need specialized treatment.

# Brief Intervention

- ▶ Goal: delay substance use during adolescence
- ▶ Motivational interviewing is effective

## The “5R’s”: Brief Counseling Talking Points



1. **REVIEW:** Screening Results



2. **RECOMMEND:** Not to use



3. **RIDING/DRIVING:** Risk Counseling



4. **RESPONSE:** Elicit self-motivational statements



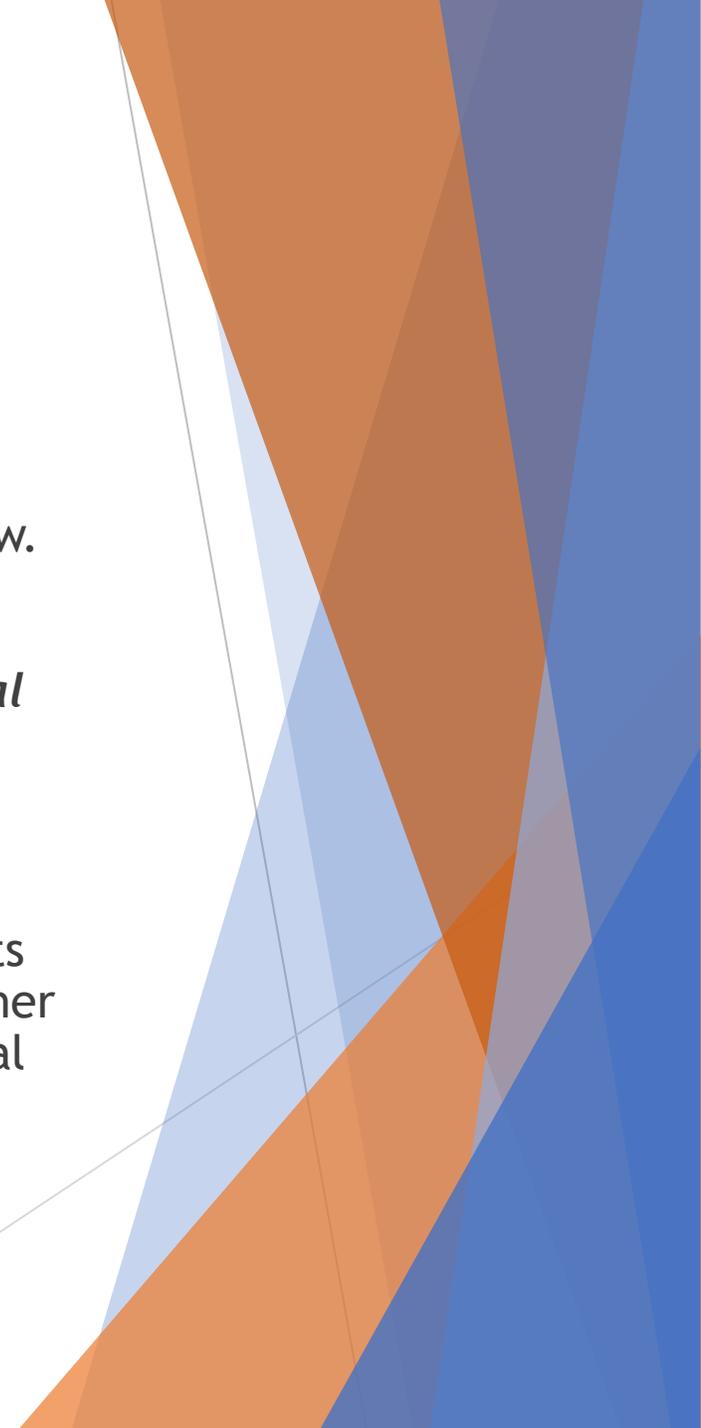
5. **REINFORCE:** Self-efficacy



# Motivational Interviewing

# Motivational Interviewing

- ▶ The skills necessary to provide effective brief interventions for adolescent substance use are not new.
- ▶ Some practitioners already know and use *Motivational Interviewing (MI)* skills in their work.
- ▶ The information in this Learner's Guide may simply organize and sharpen existing skills to help adolescents and young adults who engage in use of alcohol and other substances. For practitioners early in their professional development, the information may be new and will complement other course work or field experience received as part of your training.



## Motivational Interviewing strategies

- ▶ Assess readiness to change
- ▶ Ask open-ended questions
- ▶ Affirm
- ▶ Utilize reflective listening
- ▶ Summarize thoughts and feelings
- ▶ Elicit change talk
- ▶ Ask permission and give advice
- ▶ Generate options
- ▶ Manage pushback

# Other therapies used for SUDs

- ▶ Brief Advice
- ▶ Supportive-Expressive Therapy
- ▶ Cognitive-Behavioral Approaches
- ▶ Community Reinforcement Approach
- ▶ Contingency Management
- ▶ Individual Drug Counseling
- ▶ Twelve-Step Facilitation
- ▶ Medical Management

# Overview of Referral to Treatment & Follow-Up

- ▶ Linking the adolescent to specialized substance use treatment and staying with the adolescent to support sustained success
  - ▶ Many health professionals offer brief, solutions-focused services.
  - ▶ When substance use problems are more serious or complicated more intensive, substance use disorder treatment may be a good option.
  - ▶ “Referral to treatment” means connecting the adolescent to a physician and/or other licensed mental health professionals for comprehensive assessment, medical and behavioral health treatment, or specialty treatment program.
  - ▶ “Follow-up” means care management as well as supporting the adolescent during treatment and post-treatment follow-up contacts. Follow-up in the form of brief contact is appropriate for all adolescents.

# Summary

SBIRT effectively used within a variety of settings can detect risky and problematic alcohol and other substance use early.



SBIRT aims to expand services for youth engaged in risky behavior or early stage substance use involvement.



SBIRT can enable effective intervention strategies to prevent longer-term problems.



Early identification in youth can lead to health-related cost savings.

# Confidentiality



# Let's review Confidentiality/Privacy Laws

- ▶ **Federal confidentiality laws** protect the disclosure of medical records pertaining to alcohol and drug abuse prevention (42 CFR Part 2)
  - ▶ substance abuse education, treatment, or prevention
  - ▶ if regulated or assisted by the federal government (42 U.S.C. § 290dd-2; 42 C.F.R. § 2.11-2.12)
- ▶ requires **written** patient consent, or the consent of a minor patient's parent, for disclosures of protected health information even for the purposes of treatment, payment, or health care operations

## 42 CFR PART 2 CONSENT TO DISCLOSURE OF INFORMATION THAT IS PROTECTED BY FEDERAL LAW

Clinicians involved in the care of patients with substance use issues need to be aware of federal confidentiality laws around the disclosure of information concerning drug and alcohol treatment, specifically 42 CFR Part 2. Substance use history, assessment, laboratory data and treatment plans can only be released if a patient, or a minor patient's parent, signs a specialized 42 CFR Part 2 compliant release form. Importantly, this release only applies to the person or organization named on the signed consent. The patient's information cannot be forwarded or re-released without a new, signed form naming additional care providers or recipients. This also applies when a primary care provider refers a patient for a substance abuse evaluation or treatment. A consultation note cannot be shared without a signed formal 42 CFR Part 2 compliant release of information.

# Confidentiality

- ▶ Research has shown that adolescents who are aware of confidentiality are more willing to seek health care compared to their peers who may not have the same confidentiality.
- ▶ State laws govern minor patient rights to confidentiality of information shared with health care providers about alcohol and drug use, but states vary as to whether or not a minor can confidentially receive drug treatment services.
- ▶ You should explain the full confidentiality policy regarding the disclosure of sensitive issues directly to the adolescent at the very beginning of the screening or assessment.
- ▶ If the adolescent is willing it can be helpful to explain the confidentiality policy to both the adolescent and the parent or guardian at the same time.

# Summary of Confidentiality

- ▶ the screening tool by itself would be strictly confidential under Florida Law **unless the minor patient presents voluntarily specifically seeking substance abuse services**
- ▶ Florida law allows a minor voluntarily seeking substance abuse services to control their record and maintain privacy, even from their parents.
- ▶ **This is not true if the patient is receiving other treatment and the diagnosis is revealed during the course of that treatment.**
- ▶ If a minor is not voluntarily seeking substance abuse services, and in the course of providing other services you diagnose a substance use disorder through use of the tool, **the parents can be notified.**