

School-Based Health SBIRT Quick Guide

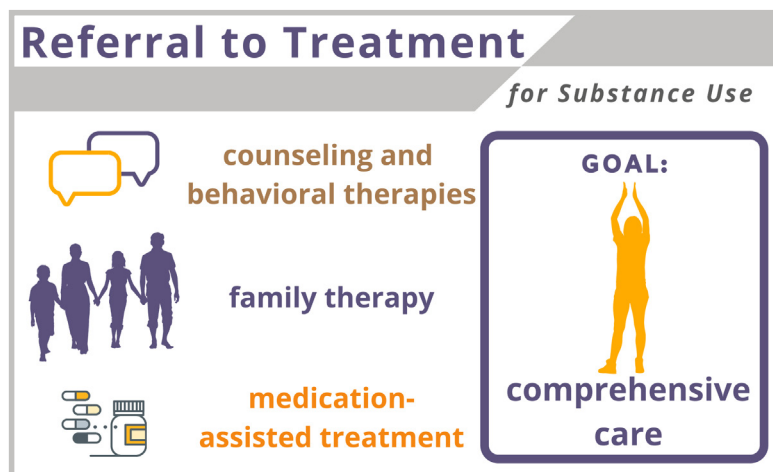
Referral to Treatment for Substance Use

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based approach to the screening and identification of individuals engaged in substance use, the delivery of early brief interventions in order to reduce use, and the referral to treatment for high-risk use. The California School-Based Health Alliance (CSHA), with funding from the California Youth Opioid Response Grant, created this quick guide for SBIRT in school-based health centers (SBHCs) in an effort to reduce youth opioid use. **This quick guide focuses on referral to treatment, including referral to medication-assisted treatment in response to opioid use disorder (OUD).**

Why adopt referral to treatment for substance use?

- Nationwide, 30% of high school students report having used alcohol in the previous month.¹
- Fourteen percent of high school students report illicit drug use.²
- Between 1991 and 2012, the rate of non-medical use of opioids by youth, and the rate of OUD, more than doubled.³

Referral to treatment is intended for youth who have a substance use disorder (SUD) and therefore need specialty SUD treatment that is typically beyond the scope of primary care settings such as SBHCs.



What are the different types of SUD treatment?

There are many different types of treatment for youth with SUDs. The treatment types can fall into these general categories:

- **Behavioral approaches** – Psychosocial approaches address the underlying causes and impacts of SUD, ranging from individual counseling to group therapy. One common approach to OUD and other SUDs is Cognitive-Behavioral Therapy (CBT). Short-term behavioral treatment is sometimes provided by trained and qualified behavioral health providers at SBHCs.

This service is supported by a federal grant under the State Opioid Response program, with funding provided by the California Department of Health Care Services.



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- **Family-based approaches** – When possible, including a young person’s family in treatment is highly recommended. One evidence-based approach is Brief Strategic Family Therapy. Family treatment can also sometimes be provided by a behavioral health provider at the SBHC.
- **Medication-assisted treatment (MAT)** – These are medications that are effective in helping treat people with SUDs. There are medications for OUD as well as alcohol and nicotine use disorders. MAT uses FDA-approved medications that treat withdrawal symptoms and physiologic cravings. Stabilizing patients with OUD medically first often helps them recover and engage in ongoing treatment. Research has shown medications used in MAT do not adversely impact physical or mental functioning.⁴

Why MAT?

Medical professionals recommend MAT for adolescents 16 and older. The American Academy of Pediatrics and other trusted professionals recommend that adolescents with OUD be offered pharmacotherapy with buprenorphine, naltrexone, or methadone. No age-specific safety concerns have been identified, and MAT is consistent with a harm reduction approach that most adolescent providers embrace in other aspects of care. SBHC providers should know about therapies such as buprenorphine and be able to make a productive referral to someone who offers MAT when indicated. Some adolescent providers should even consider prescribing MAT to their youth patients when indicated.

We know that MAT works. Decades of studies of MAT and adults with OUD unequivocally show that MAT contributes to significant reductions in opioid use, criminal activity, overdose, and other risky behaviors in adults. It reduces morbidity and mortality by two thirds, reduces progression to intravenous drug use and therefore decreases the risk of HIV and hepatitis C transmission. MAT has been shown to reduce drug dependence and decrease the risk of overdose and relapse by as much as half.⁵



MAT studies with youth are more limited. There have been few randomized clinical trials, but they have demonstrated that timely receipt of buprenorphine, naltrexone, or methadone is associated with greater retention in care among youth with OUD compared with behavioral treatment only.⁶

How does MAT (specifically buprenorphine) work?

Opioids disrupt the brain’s reward-learning pathways. Over time the body adapts and exposure to the drug is necessary to maintain baseline. Buprenorphine is a partial opioid receptor agonist, activating opioid receptors in the brain and at low doses blocking pain receptors, preventing painful opioid withdrawal symptoms but not causing euphoria like full opioid agonists (e.g., heroin, morphine, Vicodin, or OxyContin). Partial agonists ameliorate the highs and lows associated with full agonists. They also have a “ceiling,” so using more of them is not very different than using a prescribed dose. Buprenorphine binds opioid receptors tightly and

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blocks the effects of full agonists as well as helping prevent overdose if a person goes back to using. Buprenorphine is often combined with naloxone which prevents it from being abused or diverted. This makes it less likely to cause respiratory distress or death.

What are the different types of MAT?

Buprenorphine

- A partial opioid agonist and a controlled substance that can be prescribed by all providers who have a current DEA registration that includes Schedule III authority. For more information, visit the [SAMHSA web page on Waiver Elimination](#).
- Available through Medi-Cal and most other insurance plans without prior authorization and dispensed at most pharmacies.
- Initiated when a patient is in opioid withdrawal.
- Can be initiated at home, but is more commonly initiated in a clinical setting.
- Many clinicians find that managing buprenorphine is more straightforward than other medications routinely used in primary care.

Naltrexone XR (extended release)

- Case reports show that it has good results when used to treat youth with OUD, especially those with co-occurring alcohol use or living in less stable circumstances. This is important because youth generally have lower rates of treatment retention compared with adults, underscoring the need to deliver developmentally appropriate treatment to achieve the best outcomes.

Metadone

- Rarely used with minors since there are strict federal guidelines related to its dispensing.

The best medication to use depends on patient needs, and individual treatment planning should dictate the particular course of action.

Although studies have shown that MAT can be effective alone, optimally MAT should be combined with psychosocial interventions such as CBT, peer support, and other social and behavioral support services specific to youth and addressing unique risk factors. These services can help improve emotional regulation and support young people in developing more adaptive stress responses.

What are best practices when implementing referral to treatment?

Do youth need parent or guardian consent to receive replacement narcotic abuse treatment?

If a young person is an emancipated minor or is an adult age 18 or older, they can consent to replacement narcotic abuse treatment for themselves under California law. Otherwise, minors

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(youth under age 18) typically need parent or guardian consent to receive replacement narcotic abuse treatment. For more information about consent laws, please refer to the California School-Based Health Alliance website at www.schoolhealthcenters.org.

Best practices suggest that family involvement is helpful to ensure support for young people and to address the underlying factors that can maintain addiction. Evidence points to the effectiveness of family-based interventions in preventing and treating substance use in youth, and some recent research suggests that health settings are a good place to engage parents.

What if a minor does not want to be referred to replacement narcotic abuse treatment because they do not want their parent or guardian to know?

Minors 12 and older can consent to many SUD services on their own and obtain those services confidentially; however, most minors cannot obtain replacement narcotic abuse treatment without parent or guardian involvement. If a young person does not want to be referred to replacement narcotic abuse treatment because they do not want their parent or guardian to know, then the provider should respect that decision. However, it is important to share the benefits of parent/guardian involvement with the young person. For example, a provider could explain to a young person that MAT can be a long process, and it is important that the family knows so they can help provide support. Regardless, it may be a good idea for the provider to offer counseling as a first step.

When should we conduct referral to treatment?

Referrals to SUD treatment, in conjunction with brief interventions, should begin at age 12. Youth should receive referrals to treatment whenever they have a SUD, need specialty treatment beyond the scope of the SBHC, and have the appropriate consents. The sooner a provider links a young person to treatment, the more likely they are to show up to their appointment, stick with treatment, and experience good outcomes.⁷

Who should conduct and record the referral to treatment?

The provider (medical or behavioral health) should conduct the referral to treatment with the young person while they are in a private room. If possible, the provider should call the referral while the young person is in the room and their parent/guardian is on the line. The provider should record the referral to treatment in their chart notes.

What should we do after the referral to treatment?

A follow up appointment should be scheduled so the SBHC provider can check in with the young person and ensure they are receiving the care they need. Treatment often takes many attempts, so providers with trusted relationships should try to maintain continuity and inquire non-judgmentally whether their patient is continuing treatment. In the case of treatment lapses, providers can use motivational interviewing to help re-engage youth and also consider whether different referrals are needed. For more information on motivational interviewing, please refer to the CSHA brief intervention quick guide at bit.ly/BIQuickGuide.

What should we consider when referring a young person for MAT?

Treatment should be voluntary and the patient must be motivated. Youth may be reluctant to try something new and give up something they perceive to be working for them as a coping mechanism. They may not be ready for treatment, especially if they have not suffered from significant personal consequences because of their use. If the youth is not ready, there is the opportunity to provide brief intervention as an alternative. Please refer to the CSHA brief intervention quick guide at bit.ly/BIQuickGuide.

Young people should expect to be on MAT for a long period of time. MAT can last at least 8-12 weeks before gradual tapering can be introduced. Longer treatment with MAT produces better outcomes, and tapering too quickly off any opioid can have unfortunate or even tragic consequences.

The best treatment for youth with OUD addresses both biology and experience. This helps young people improve function in their prefrontal cortex; decrease the reward pathway carved out by opioid addiction; reduce stress and cravings; and regulate emotions. Providers should consider referrals to both a behavioral health provider and a medical provider who has the ability to provide MAT.

What should I do now?

- **Learn about the treatment community in your area**, especially centers that serve youth and offer MAT.
- **Get to know providers currently providing MAT in your area**, especially those that have training or experience with youth.
- **Share this fact sheet and your perspective about MAT with youth-serving colleagues.** Help raise awareness and reduce stigma about MAT in the adolescent primary care community.
- **Encourage parents and families to safely store opioid prescriptions** and safely dispose of prescriptions that are expired/no longer needed.
- **Ensure you are reviewing the [updated educational requirements](#)** so you can continue to prescribe buprenorphine.
- **Encourage your medical and dental colleagues to avoid prescribing opioids** for acute pain and to explore alternatives for treating chronic pain.

Naloxone is a life-saving medication that reverses an opioid overdose with little risk. Obtain a [free supply of naloxone](#) for distribution to patients and others – and encourage other organizations to do the same. You could save a life.

Key Resources

Department of Health Care Services, Medication Assisted Treatment Toolkit for Counselors: www.dhcs.ca.gov/individuals/Documents/MAT_Toolkit_for_Counselors.pdf

California Primary Care Association, Frequently Asked Questions about Medication Assisted Treatment within Community Clinics and Health Centers: www.cPCA.org/CPCA/CPCA/HEALTH_CENTER_RESOURCES/Value_Based_Care/Behavioral_Health.aspx

California Health Care Foundation, California's Public Substance Use Disorder Treatment System for Youth: An Overview: www.chcf.org/wp-content/uploads/2017/12/PDF-Californias-Public-SUD-Treatment-Services-for-Youth.pdf

California Health Care Foundation, MAT for Opioid Use Disorder: Overcoming Objections: www.chcf.org/wp-content/uploads/2019/06/MATOpioidOvercomingObjections.pdf

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