Proceedings of the International Network on Brief Interventions for Alcohol and Other Drugs Annual Meeting 2025, San Francisco, California, September 24-26, 2025

Symposium 101: Adolescents and Juvenile Justice
Marina Tolou Shams (Chair):

Lauren Haack - What is Project ECHO® and how can it be Structured to Expand Evidence-Based Practices for Youth Substance Use Disorders?
Abstract

Authors:
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Background: *There is growing recognition of the need to develop replicable strategies connecting professionals across healthcare and other settings to increase the uptake of evidence based practices population-wide. One model undergoing rapid expansion is Project ECHO®, which stands for Extension for Community Healthcare Outcomes, highlighting its aim to enhance the wellbeing of individuals by developing capacity of local providers who serve them.*
Project ECHO ® upholds an "all-teach, all-learn" philosophy in which experts and community-based professionals from diverse disciplines and geographical locations come together to actively engage in virtual tele-mentoring sessions. Participants share knowledge and experiences with one another in a collaborative mission to advance best practices in a specified area, such as chronic diseases, mental health conditions, and substance use disorders (SUDs).
Promising preliminary evidence from numerous nationwide Project ECHO ® programs to-date suggests the model may improve patient experiences (such as care access, quality, and adherence), provider capabilities (such as knowledge and confidence), and systems-level factors (such as service costs).
Qualitative findings also suggest Project ECHO ® may have the potential to positively impact participants' job satisfaction and isolation: important targets in context of alarmingly high burnout rates reported by providers worldwide.
As a next step, efforts to document how Project ECHO ® case-based learning is structured across programs, as well as evaluate how aspects of the program structure influence outcomes, are warranted.
The objective of this presentation is to describe a framework for structuring the interactive case-based learning succeeding didactic training in Project ECHO ® sessions, with a focus on the following considerations: 1) expectations for participants, including case presenters, community providers, and experts (called "hub members,"), 2) guidelines for facilitating the case discussion and sharing of summary recommendations, and 3) procedures for soliciting and responding to feedback about the impact of case-based learning experienced by participants. We also will present emerging data from three applications of this framework in Project ECHO ® series targeting youth SUDs, as well as suggested future directions for harnessing Project ECHO ® to disseminate evidence-based public health approaches to secondary prevention of substance use problems, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).
Materials and Methods: *The "Ekstasis" framework can be utilized to establish intentional organization in the second half of a Project ECHO ® session, which focuses on group consultation to a case presenter seeking input from fellow participants and hub member experts. Borrowed from leadership training, the framework is designed to provide a learner-centric, interactive, emotionally-engaged, and non-judgmental environment for professional support. The name "Ekstasis" (Greek for "to be or stand outside oneself") represents the component of the framework in which the case presenter silently observes others engaging in deliberation and brainstorming, allowing for thoughtful reflection without interruptions. This format helps establish an ideal venue for providers to explore boundaries, reduce stress, generate collaborate problem-solving ideas, and thus protect themselves from burnout. Three teams aiming to disseminate evidence-based research into practice for*

youth in California (including those at risk for or experiencing SUDs) have used Ekstasis to structure Project ECHO® case-based learning to-date: the Juvenile inJustice and Behavioral Health (JJBH) ECHO team, the California Child and Adolescent Mental Health Access Portal (Cal-MAP) school-based ECHO team, and FostrSpace-Court Appointed Special Advocates (FS-CASA) ECHO team. Each team documented efforts made to structure the case-based learning portion of the Project ECHO ® model and also collected participant ratings about the session experience, including ratings of the impact on their feelings of connectedness and support (from 1 = "extremely negative impact - I feel much worse" to 5 = "extremely positive impact- I feel much better") using the Zoom polling feature at the end of each session, ratings about their overall comfort level participating on post-meeting REDCap surveys (from 1 = "Strongly disagree" to 7 = "Strongly agree"), and open-ended feedback responses.

Results: *Across applications, teams reported value in establishing and iteratively updating expectations for all involved in the Ekstasis case-based learning guided by hub member observation and community provider feedback. For example, teams created an introductory slide outlining shared agreements adapted from Dialectical Behavior Therapy to ensure all participants feel respected and safe to share, even when unique perspectives are encountered. All teams also reported benefit in formalizing guidelines for hub members facilitating the Ekstasis model, including sample scripts with follow-up prompts to lead discussion and redirect participants if needed, as well as an electronic template to guide notetaking during group brainstorming and share summary recommendations with case presenters. These efforts appeared effective, given that ratings of session impact on feelings of connectedness and support have averaged above 4 out of 5, ratings of comfort have averaged 6 out of 7, and qualitative feedback has been positive (e.g., ""I liked the way we had CASAs share information and you gave feedback. I think that was very helpful. Each one was individual, and even though each youth was different, we were able to obtain knowledge on different situations... in case we came across it, we would be able to have similar ways to help them." and "This is a definite work lifeline for me right now!!!").*

Conclusions*: In three applications of the Ekstasis framework guiding Project ECHO ® case-based learning to improve evidence-based practices (including identification and treatment of SUDs) acrosshealthcare and other settings, planned documentation and ongoing evaluation of efforts to structure the case-based learning coincided with promising provider experience feedback. Given that an electronic template to guide notetaking during group brainstorming and share summary recommendations with case presenters was developed, completed templates could be used in the future to derive themes across case presentations focused on SUDs, as well as assess changes in practice resulting from these case presentations. Future directions include scaling-up implementation and evaluation of structured frameworks embedded in Project ECHO ® series to allow for examination of how specific aspects of the structure produce positive patient, provider, and systems-level outcomes (such as increased SBIRT implementation leading to more service referrals and secondary prevention of SUDs), ultimately informing priority areas for policy and practice.*

Juliet Yonek - Adapting Project ECHO: A Scalable Digital Model for Building Workforce Capacity in Youth Substance Use Prevention and Intervention

Abstract:

Authors: *Juliet Yonek, PhD, Tylia Lundberg, BA, Lauren Haack, PhD, Jeanne McPhee, PhD, Evan Holloway, PhD, Margareth Del Cid, PhD, Johanna Folk, PhD, and Marina Tolou-Shams, PhD*
University of California San Francisco

Background

Gaps exist in the delivery of effective youth substance use (SU) prevention and treatment, and both frontline providers and non-clinical professionals are often not adequately prepared to support youth who use substances (Harris et al., 2016; Stanhope et al., 2018). Project Extension for Community Healthcare Outcomes program (Project ECHO®) is a telementoring model with demonstrated effectiveness in building community-based providers' capacity (knowledge, skills, and self-efficacy) to deliver best-practice care for multiple medical conditions (Zhou et al., 2016), including SU disorders (Lindsey et al., 2024). The model brings together frontline providers and expert specialists/subject matter experts via videoconference and includes didactic presentations as well as structured case presentations. In the context of youth SU, Project ECHO aims to enhance the knowledge, skills, and confidence of providers within primary care clinics and schools in areas like screening, treatment options, and referral pathways for pediatric substance use disorders.

Project ECHO® has been shown to increase providers' knowledge and skills in delivering evidence-based practices across various conditions in adult and pediatric populations (Zhou et al., 2016). However, comparatively fewer studies have reported on the determinants of implementation success, including ECHO model adaptations to suit specific needs and contexts of the target audience. In fact, scientists have recognized the need to adapt interventions or programs to improve their fit with populations and service systems, while simultaneously preserving core intervention components; existing Implementation Science (IS) frameworks (e.g., FRAME) provide conceptual guidance in operationalizing adaptation and in identifying key determinants of effective intervention tailoring (Aarons et al., 2012; Stirman et al., 2019).

Objectives

This presentation will describe how we adapted the Project ECHO model, as guided by IS frameworks, to build capacity in youth SU prevention and treatment for 3 diverse audiences in California: (1) Community behavioral health providers youth in legal and child welfare systems (JJBH ECHO), (2) School-based health center providers, educators and administrators (Cal-MAP School ECHO), and (3) Court Appointed Special Advocates (CASA) serving foster youth (ECHO-FostrSpace (FS)). We will present the tailored curricula for each ECHO program, with particular focus on how youth SU was covered for each audience. We will also present metrics to assess participant engagement and acceptability following SU-focused telementoring sessions.

Results

Model adaptations for each audience followed a similar approach and included: (1) Co-designing ECHO curricula and program logistics (e.g., open or closed cohort, sessions length, time and frequency) with stakeholders and those with lived experience to ensure alignment with the educational needs and availability of prospective participants. For example, JJBH and CASA-FS ECHO programs established a closed-cohort model in which those enrolled were expected to attend most series sessions to encourage trust and community-building amongst participants; in contrast, the Cal-MAP school-based ECHO program established an open-cohort model to reduce barriers for school staff attendance in the context of fluctuating job schedules and demands; (2) Tailoring the case presentation format to be inclusive of participants with different job roles and logistical considerations. For example, each ECHO program began with an expectation that participants take turns volunteering and completing case presentation forms in advance of each session; however, when this was discovered to be impractical for Cal-MAP school-based ECHO participants, the team successfully shifted to soliciting case presenters immediately after the didactic; and (3) Iterative adaptation to didactic content and delivery based upon participant feedback obtained during and after each session to assess participant engagement and satisfaction.

***Conclusions**: Adapting an intervention or program to match with local population needs ensures greater potential fit, including relevance and sustainability, as well as greater potential engagement from program participants. This presentation will provide a map for adapting this digital capacity-building tool to other substance use-focused professionals, supervisors, and training directors.*

Presentations 102: Interventions in with Young Women and in Maternal Health

Kristina Countryman - Screened in/Screened out: Determining study eligibility for a digital SBI to reduce alcohol/drug use and STI risk during pregnancy

Abstract:

***Authors:** Kristina Countryman, Caron Zlotnick, Ananda Sen, Dongru Chen, Christopher Kahler, Golfo Tzilos Wernette*

Department of Family Medicine, University of Michigan

***Background**: Sexually transmitted infections (STIs) and substance use during pregnancy are interconnected, yet preventable, health risks. Substance use during pregnancy is associated with greater likelihood of sexual risk engagement that can result in STIs. Screening and brief interventions (SBIs) have consistently been found to be effective tools to overcome barriers to care (i.e. stigma, access to care) for this vulnerable population. Objectives: The objectives of this study are to 1) describe the ways in which our team adapted eligibility criteria for a digital SBI study, 2) present the inclusion rates for both substance use and sexual risk behavior after eligibility criteria change, and 3) share lessons learned for screening protocols in future SBI trials.*

Methods: We screened and enrolled 180 cisgender, pregnant women (Mean age = 30.0, SD = 5.07; 25.6% Black; 10% Latina) at risk for substance use and STIs for a randomized controlled trial to test an innovative, technology-delivered brief intervention, the Health Check-up for Expectant Moms (HCEM), which seeks to reduce these health risks during pregnancy. To determine eligibility, participants completed either in person or virtually a brief screener which included validated measures to detect risk for substance use during pregnancy as well as questions regarding sexual health risk.
Results: Based on review of screener data and monitoring of study progress, as well as early participant feedback, we determined that we were enrolling participants with low sexual risk behaviors. We engaged in an iterative process whereby we consulted our study team and data safety and monitoring board members, and with experts in the field, to adapt our inclusion criteria threshold for determining sexual health risk. We added additional key questions regarding new sexual partners during pregnancy, number of multiple sexual partners in the last six months, and partner monogamy. The criteria change resulted in significant increases in self-reported rates of substance use risk, 21.3% higher (23.1% vs. 44.4%, p = 0.0026) in binge drinking in the 12 months before pregnancy, and 25% higher (19.4% vs. 44.4%, p = 0.0003) in drug use in the 3 months before pregnancy. Furthermore, we found that partner monogamy concerns (65.3%) were the leading source of sexual risk during pregnancy in our sample.
Conclusion: Results support the interconnected nature of substance use and sexual health risk behaviors. We found that changing the threshold for sexual risk behavior was not only necessary to ensure that we were enrolling our target population, but importantly, it also led to the recruitment of women at higher risk for substance use during pregnancy. Screening protocols must ensure that those enrolling and receiving an intervention are the intended population. Many challenges exist when trying to screen for risk behaviors in a vulnerable population such as pregnant women (i.e. fear of stigma, legal repercussions), and there are pros and cons to broadening eligibility criteria with a wide net approach versus one that has more stringent inclusion criteria. Adapting the inclusion criteria can be necessary during a trial, however, it is important to balance with the potential clinical implications, including limiting the study generalizability.

Steven Ondersma - Adapting SBIRT for integration in a digital intervention for reducing racial disparities in maternal morbidity and mortality

Abstract

Authors: *Steven J. Ondersma, Athena McKay, Mary K. Crawford, Jessie L. Spencer, Elizabeth Vickers, Claire Margerison*
Michigan State University

Aim: *To review cultural adaptation of electronic SBIRT (e-SBIRT) within an app for maternal morbidity and mortality prevention.*
Question to be addressed: *What does input from a Community Advisory Board and people with lived experience suggest regarding adaptation of e-SBIRT for cultural sensitivity?*
Summary of anticipated presentation: The MI MOM app is an NIH-funded, SMS-centric app for preventing maternal morbidity and mortality, especially among Black and rural mothers. It intervenes at multiple levels, including with the pregnant patient and members of her support system such as partner, parents, friend, etc. This presentation will (1) review input from the study Community Advisory Board (CAB), pregnant participants, and their family members regarding various design options for Black participants and key members of their personal support network, and (2) describe the adaptations resulting from that input. Key topics will include the process of obtaining feedback, concerns regarding perpetuation of negative stereotypes, and techniques for providing e-SBIRT in a respectful and culturally consistent manner.
Conclusions: *Input from community members is crucial. For this intervention, that input resulted in substantive changes to the content of e-SBIRT elements and the manner in which they were presented.*

Workshop103: Cost Effectiveness of Brief Interventions
Jeremy Bray/Zubab Moid/ Sujaya Parthasarathy - Economic Evaluation of Screening and Brief Intervention Programs: a How-To Guide for Non-Economists

Abstract:

Presenters: *Jeremy Bray (organizer)*, Sujaya Parthasarathy[2], Md Zubab Ibne Moid*
**UNC Greensboro, 2 Kaiser Permanente Division of Research*

Claims of cost-effectiveness or cost savings are often used to encourage the wide-spread adoption of screening and brief intervention (SBI) programs. Yet the evidence base for these claims lags far behind the evidence base for the effectiveness of SBI. In this workshop, participants will learn about the basic types of economic evaluations used in SBI research. The focus will be on helping researchers develop an understanding of economic evaluations that is sufficient for them to engage and collaborate with economists. The workshop will have four components. The first component will be an overview of economic evaluation methods geared towards non-economists. After this component, participants will have a working knowledge of the distinctions among cost of illness studies, micro-costing studies, cost-offset studies, cost effectiveness analysis, and cost benefit analysis. The second component will focus on micro-costing studies of brief interventions, using published studies as worked examples. After this component, participants will understand the purpose, utility and methods used in micro-costing studies. The third component will demonstrate how to estimate the effect of brief interventions on economic outcomes, with a focus on health care utilization and cost-offsets. After this component, participants will understand data analysis issues specific to modeling economic outcomes. The fourth component will demonstrate the importance of using simulation methods to forecast the lifetime effects of brief interventions when conducting cost effectiveness analyses. After this component, participants will understand the role of simulation modeling in cost effectiveness analyses and the basic structure of Markov models. The workshop will conclude with an open question and answer session.

Symposium 104: Technology in Pediatric Primary Care
Jordan Braciszewski (Chair) - Implementing Technology-Based SBIRT in Pediatric Primary Care
Abstract:
Authors: *Jordan M. Braciszewski, Mia L. Boulay, and Amy M. Loree*
Henry Ford Health

Adolescent use of cannabis, alcohol, cigarettes, and e-cigarettes increases four-fold throughout the high school years, putting young people at substantial risk of physical, developmental, and psychological harm. Early intervention at scale is imperative to prevent these negative outcomes and subsequent poor developmental trajectories. Over 95% of teens have a medical home and over 80% have a well visit within a year, making pediatric primary care a unique setting in which to broadly screen and intervene on early substance use. To addresses this need, we piloted the implementation of a technology-based screening and brief intervention in four large pediatric primary care sites that serve roughly 8,000 adolescents per year. Importantly, we were able to integrate our tech-based tool with the electronic health record, making data and workflow seamless in this context. Results and reports were instantly available in patient charts upon completion. Over a 21-month period, we completed over 12,000 screens and more than 800 brief interventions. Most (86%) youth found the software easy to use and over two-thirds found it helpful (69%). Provider data suggested strong support, with high ratings for usefulness (mean = 4.77 out of 5), liking the workflow (4.72), improved workflow (4.58), and willingness to use in the absence of requirements (4.81). Implementation outcomes were also favorable; while four clinics volunteered for the pilot, 12 pediatrics and 2 family medicine clinics asked to be included once hearing about the project's early success. Today, all clinics remain active in using this approach in the absence of funding support. This technology-based screening and brief intervention model had significant reach and sustainability within a large health care system. Future work should seek to replicate this approach in other settings.

Leveraging Technology and Telehealth to Promote and Sustain Implementation of Brief Interventions in Primary Care
Abstract
Authors: *Jordan M. Braciszewski, Rebecca C. Rossom, Stephanie A. Hooker, and Amy M. Loree*
Henry Ford Health

While over 90% of individuals with substance use disorders do not receive substance use treatment, close to 96% of those same people report that they do not feel in need of traditional substance use treatment services. To adequately close this gap, innovative approaches are needed that can be implemented at scale to have the largest public health impact. Even at reduced effect sizes, scalable solutions allow us to reach more people

and, thereby, reduce the burden of substance misuse and consequences on the population at large. Primary care (including internal medicine, family medicine, women's health, and pediatrics) is a unique setting with ample opportunity. Patients report feeling that their primary care clinicians are a robust and trusted source of information with whom they can share sensitive information. Substance use screening in primary care is recommended by many accreditation, licensing, and advocacy bodies, yet substantial barriers prevent this practice, including time, space, unfamiliarity with screening and intervention tools, training, and turnover. Our proposed symposium involves examples of four studies that have implemented substance use interventions in busy primary care settings that use technology and telehealth to address many of these aforementioned barriers to care. Specifically, we will present on and discuss: (1) implementation of in-clinic and at-home technology-based alcohol screening and brief intervention prior to a women's health appointment; (2) an EHR-integrated clinician-decision support tool for addressing opioid use disorder in primary care clinics; (3) a telehealth-based behavioral activation treatment to address the mental health needs of individuals receiving medications for opioid use disorder in primary care; and (4) a technology-based screening and intervention for cannabis, alcohol, cigarette, and e-cigarette use in pediatric primary care. Together, these studies will describe major successes and lessons learned in the implementation of sustainable, primary care-based substance use services.

Stephanie Hooker - Development and Open Pilot Trial of a Brief Values-Based Behavioral Activation Intervention for Patients Receiving Medications for Opioid Use Disorder in Primary Care

Abstract:

Authors: *Stephanie A. Hooker, Hanmin Kim, Mary Lonergan-Cullum, Andrew Busch, Tanner Nissly, Robert Levy*
Health Partners Institute

Background: *Medications for opioid use disorder (MOUDs) are effective treatments for opioid use disorder (OUD) and can be delivered in primary care settings. However, patients with OUD often experience comorbid mental health concerns and psychosocial needs, yet MOUDs alone may not improve well-being or quality of life. Researchers have had difficulty identifying effective adjunctive psychological treatments for this population. To address this need, our team adapted an evidence-based treatment, values-based behavioral activation (VBA), for people with OUD to be used in adjunct with MOUD treatment in primary care, to increase engagement in treatment and improve quality of life. The purpose of this study was to examine the acceptability and feasibility of conducting the treatment in a primary care setting.*

Methods:

This study used an open pilot trial with 21 patients (M age = 44 years, SD = 12; 67% female) receiving MOUDs in primary care. A VBA treatment manual was adapted for patients with OUD on MOUD. Patients received 4-6 sessions of VBA over 12 weeks from a trained social worker, either in-person or using telehealth, based on patient preference. Participants completed measures of quality of life, substance use, and mental health symptoms and completed a urine drug screening at baseline, 6 weeks, and 12 weeks. At the end of the treatment, participants rated the acceptability of treatment using the Client Satisfaction Questionnaire-8 (CSQ-8) and engaged in a qualitative interview with a research coordinator. Changes in mental health and well-being over time were examined using Cohen's d effect sizes.

Results:

Out of 109 patients contacted for participation, 32.1% scheduled an enrollment visit, and of those, 60% attended the visit and consented to participate. Participants completed an average of 5.1 VBA sessions (SD=1.6) and most (90%) completed 12-week outcome assessments. Participants rated the intervention as highly acceptable on the CSQ-8 (M=30.4/32.0, SD = 1.6). In qualitative interviews, participants reported that working with the therapist and setting values-based goals were helpful, while also recommending more tailoring to patients' needs and offering the program early in MOUD treatment. VBA was associated with small to moderate improvements in life satisfaction (Cohen's d=0.25) and positive affect (d=0.62), whereas there were no changes in depression (d=.09) or negative affect (d=-0.07) in a group with low depression at baseline.

Discussion:

VBA delivered as an adjunctive treatment to MOUD in primary care was considered feasible and acceptable and is potentially associated with improvements in positive well-being. Future work is needed to tailor

adjunctive treatments for people with OUD receiving treatment in primary care settings to improve recovery and quality of life for this population.

<u>Presentations 105</u>: Training Providers in Diverse Settings
Amy Leibowitz - Sustaining Alcohol SBI Over Time: Provider Perspectives
Abstract:
Authors: *Amy Leibowitz, PsyD, Abnette Kaffl, MPH, Thekla B. Ross, PsyD, Wendy Y. Lu, MPH,Stacy Sterling, DrPH, MSW Center for Mental Health and Addiction Research, Kaiser Permanente Northern California, Division of Research, Pleasanton, CA 94588, USA*

Background. *Hazardous drinking is a public health problem affecting approximately 20% of the U.S. adult primary care population. Clinical trials have documented the efficacy and effectiveness of Alcohol Screening and Brief Intervention (ASBI), yet widespread implementation remains elusive, and questions remain regarding optimal implementation and sustainment strategies. Kaiser Permanente Northern California (KPNC) implemented systematic ASBI in adult primary care in mid-2013. The current qualitative study used in-depth qualitative interviews to better understand KPNC providers' perspectives on facilitators and barriers to ASBI implementation and sustainment.*
Methods. *Key informants (n=19 primary care providers, 19 primary care managers, and 12 specialty addiction medicine providers) participated in semi-structured interviews about the implementation and sustainment, over 8 years, of ASBI. Interview guides and coding were informed by the Practical, Research Implementation and Sustainment Model (PRISM) framework, including factors related to the Intervention, External Environment, Implementation and Sustainability Infrastructure, and Recipient Characteristics. Interview data was analyzed using NVivo 15.*
Results. *Analyses are currently underway. Preliminary results include participant perceptions that ASBI is important, feasible, patient-centered, and associated with increased treatment options for patients. Contributing facilitators include embedding ASBI screening instruments and clinical decision support tools in the electronic health record, national financial incentives related to ASBI, and the presence of knowledgeable champions within the primary care setting. Future sustainment requires reinvigorated champion involvement, actionable performance feedback, and renewed leadership support.*
Conclusions. *Results may inform next steps to sustain ASBI in KPNC as well as future implementation and sustainment in other healthcare systems by identifying implementation factors that would benefit from targeted scaffolding.*

Jim McCambridge - How can clinical pharmacists address alcohol in medication reviews in general practice? High-level learning on training from the CHAMP studies
University of York

Abstract:
Background
Time pressured practitioners in busy health systems can easily overlook the potential impacts of alcohol on health, compounded by uncertainties about their role, knowledge and skills to address the issues. This is particularly pertinent as pharmacists (and other health professions) become prescribers in primary care in different countries, and adopt more advanced patient management roles.
Method
This paper presents a synthesis of findings from a long term research programme conducted in the UK NHS to address the many challenges of discussing alcohol within medication reviews. Twenty-three papers were selected for a thematic analysis, undertaken with specific reference to training and workforce development needs, using methods appropriate for reviews.
Results
Patients were clear about their expectations of service delivery, both about whether and how alcohol was discussed in medicine reviews, and also how pharmacists could do this work well to the benefit of patients. The training needs of pharmacists to do this work, and to undertake similarly complex consultations, both of which are essential to prescribing, are extensive. Novel interventions are urgently needed along the entirety of the UK career pathway, starting with the MPharm. The education and training needs identified here constitute a major

challenge for workforce development, which needs to be met as all newly qualifying pharmacists become prescribers. The issues encountered by pharmacists seeking to work clinically with alcohol apply to other healthcare professions in the NHS, making clear a vital but hitherto neglected workforce development need for health system planners. An agenda for meeting this need is proposed.

Conclusion

This in-depth long term study of pharmacists calls for major innovations and investments in training to work clinically on alcohol. Health systems need to develop strategies to manage alcohol's harm to health in both the existing and future workforces.

Marianne Hochet - Results of dissemination of an e-learning SBIRT training session on tobacco use
Réseau de Prévention des Addictions

Abstract:

Background:

The prevalence of smoking remains very high in France despite numerous public health initiatives implemented in recent years. 23% of people aged between 18 and 75 years old were daily smokers in 2023. One initiative implemented in France is to encourage and support hospitals and healthcare services in becoming tobacco-free. For this strategy to be efficient, healthcare professionals must be trained to screen for smokers and to support them in quitting. Moreover, in 2024, the French General Inspection of Social Affairs (IGAS) published a report highlighting the need for every healthcare professional to raise the issue of smoking and to deliver a brief intervention to every patient – a model inspired by what the NHS has developed in the UK. Thus, the French Addiction Prevention Network (RESPADD) which is the national coordinator of the tobacco-free hospitals and healthcare services strategy, has implemented training sessions to quickly disseminate knowledge and best practices regarding Screening, Brief Intervention, and Referral to Treatment (SBIRT) for tobacco use. Since in-person training sessions are not feasible in every hospital and are often difficult for healthcare professionals to attend, one solution is to offer an e-learning training, which is more flexible and easier to follow. In 2024, RESPADD developed an e-learning training to disseminate knowledge on SBIRT for tobacco use.

Materials and method:

This three-hour e-learning training session was made available in early January 2025. It is free for all to register, and hospitals are urged to register all healthcare professionals that are in contact with smokers. The hospital decides for how long the training is open for participants, and once completed, a certificate is sent to the trainees. All registered participants receive a questionnaire at the end of the training access period. This questionnaire assesses their satisfaction with the training, their willingness to recommend the training to a colleague, their confidence implementing SBIRT on tobacco use with their patients, the regularity of SBIRT use in their daily practice and the frequency of nicotine substitute prescriptions since completing the training. Moreover, data for each trainee can be monitored via the training platform, which allows for the tracking of trainee progress and performance on each of the three end-of-unit quizzes.

Results:

Since its opening, almost 1000 people have registered for the training session, representing more than 30 hospitals, healthcare services and universities or schools. Among them, one third have already completed the entire training, with the success rate for each unit reaching more than 90%.

Detailed analyses will be conducted on all trainees having registered through the end of June 2025 using the collected data. Furthermore, all questionnaires will be analyzed to know more about the efficacy and impact of this e-learning training session.

Conclusions:

In only three months, almost 1000 people have registered for the e-learning training session on SBIRT on tobacco use offered by RESPADD. The majority of those having completed the training reached the minimum score needed to validate it and obtained their certificate. These preliminary results are encouraging and will be followed by further analyses allowing to evaluate the training and its impact. The results achieved during the first six months of dissemination will be presented for the first time during the INEBRIA Conference 2025.

<u>The Nick Heather Lecture:</u> William R. Miller, Ph.D., University of New Mexico
Why Are Brief Interventions Effective?

University of New Mexico

Abstract:
It is abundantly clear from randomized trials that brief interventions are more effective than no treatment for alcohol use disorders, and are often as effective as more intensive interventions. It is equally clear that the effectiveness of brief intervention (and of psychotherapy more broadly) varies widely with the interpersonal skills of the person providing it. More effective providers are those showing high levels of skills such as empathy, positive regard, acceptance, hope, and genuineness. These characteristics are not limited to therapeutic contexts, but also cluster in ancient constructs of lovingkindness such as hesed (Hebrew) and agape (Greek) and in the modern method of motivational interviewing. Viewed in this way, effective brief intervention is not a technique, but a particular way of being with others.

Symposium 201: Models of Opioid Use Intervention
Emily Williams (Chair):
Jennifer McNeely - Patient engagement with a collaborative care intervention for risky opioid use: Findings from the "Subthreshold Opioid Use Disorder Prevention" (STOP) Trial

Authors: Jennifer McNeely (1); Travis Lovejoy (2); Lillian Gelberg (3); Donna Beers (4); Catherine Abrams (5); Rebecca Stone (1); Shayna Mazel (1); Yidan Shi (1); Margaret Kline (6); Geetha Subramaniam (7); Jane Liebschutz (8)

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Abstract:
Background: *Individuals with unhealthy drug use may require more than a single-session brief intervention to achieve meaningful behavior change, yet multi-session interventions have suffered from poor attendance. Collaborative care models, which offer longitudinal patient-centered care for multiple conditions, are a promising alternative but their potential to engage non-treatment seeking patients with unhealthy drug use is unknown. Here we present results on intervention participation from the STOP Trial of collaborative care for risky opioid use.*
Methods: *Participating primary care providers (PCPs; N=119) and their patients from 5 U.S. sites were randomized to the STOP collaborative care intervention or enhanced usual care. Eligible patients were adults (≥18 years) with illicit or non-medical opioid use, who did not have moderate-severe opioid use disorder (DSM-5). Patients received the intervention to which their PCP was assigned. Patients in the intervention arm (N=88) were offered the STOP collaborative care model, consisting of (1) brief advice delivered live by their PCP (during a primary care visit or via phone call) and by a pre-recorded 'Video Doctor'); (2) telephone health coaching (2-6 sessions) utilizing motivational interviewing and cognitive behavioral therapy; and (3) an in-clinic nurse care manager (12 months). Patient interactions were tracked by care providers.*
Results: *Most patients (62.1%) received live brief advice from their PCPs, who spent on average 4.5 minutes discussing opioid use, and 93.2% received brief advice from the Video Doctor. On average, patients completed 4.6 (SD 1.9) health coaching sessions; 90.9% completed the two required coaching sessions, and the majority (56.8%) completed the maximum of six sessions. Patients had an average of 23.4 visits (SD 22.2, range 0-161) with nurse care managers over the 12 months of the trial, with higher frequency of visits during the first four months.*
Conclusion*: High rates of participant engagement with intervention providers indicates that collaborative care may be an acceptable approach to addressing the complex needs of primary care patients with risky opioid use.*

Michael Bushey - Engaging Patients with OUD and Co-Occurring Behavioral Health Conditions: Strategies, Opportunities, and Unique Challenges of the MICARE Encouragement Trial Approach

Abstract:

Authors: *Lynn L DeBar, Michael A. Bushey, Kurt Kroenke, Morgan Justice, Douglas Zatzick, Leah K Hamilton, Carmit K. McMullen, Kevin A. Hallgren, Lindsay L. Benes, David P. Forman, Alison J. Firemark, Katharine A. Bradley*

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Background/Objectives: *MI-CARE is a randomized encouragement/Zelen trial testing collaborative care (CoCM) for non-treatment seeking patients with Opioid Use Disorder (OUD) and clinically significant depressive symptoms. Importantly, the patient-centered approach allowed 12 months for outreach and patients to guide the focus and attention to other patient-prioritized conditions and concerns as appropriate. This presentation describes engagement strategies employed by MICARE nurse care managers (NCMs). We highlight the trajectories of consent and engagement over 1 year, and focus of CoCM, in the context of multiple chronic mental health and substance use disorder conditions.*

Methods: *Adult primary care patients with OUD and depressive symptoms from two statewide health systems were identified from electronic health record data and automatically enrolled. A random 50% of eligible patients were offered the MI-CARE intervention: a 12-month nurse-driven CoCM intervention. The remaining 50% comprise the usual care comparison group and is never contacted. We measured engagement as: 1) those offered CoCM who consented for treatment, and 2) those who had ≥ 3 CoCM visits.*

Results: *MICARE enrolled 805 patients from > 40 clinics. Of 403 randomly selected for MI-CARE outreach, 53% (n=214) consented to the intervention and 65% of those completed ≥3 CoCM visits. Half of engaged patients consented only after ≥4 weeks of outreach (5.8 calls on average pre-consent). Unconsented patients received 15.4 calls on average. Among consented patients, depression was the most frequent focus of care management recorded by NCMs; other behavioral health conditions—anxiety, chronic pain, and sleep problems—were addressed more frequently than OUD or other opioid use. Although cannabis was the most frequently reported substance used; alcohol was addressed more often by NCMs.*

Conclusion: *Engaging nontreatment seeking patients with OUD and depression symptoms requires persistent care manager outreach and may be optimized by broader clinical focus on co-occurring conditions and issues of importance to patients.*

Elizabeth Austin - Engagement in Collaborative Care Among Patients with Opioid Use and Mental Health Disorders: Experiences from the CHAMP National Trial

Abstract:

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Background. *The Collaborative Care Model (CoCM) is effective for improving mental health outcomes. People with opioid use disorder (OUD) frequently experience co-occurring mental health conditions and challenges engaging in effective medications for OUD (MOUD). In a national HEAL-funded hybrid effectiveness-implementation trial in the U.S. (CHAMP), we tested whether CoCM for both OUD and mental health improved non-medical opioid use and self-reported mental health functioning relative to CoCM for mental health alone. CoCM for both conditions demonstrated fewer days of non-medical opioid use than CoCM for mental health alone; mental health functioning was improved in both arms but not differentially across arms. To help explain these findings, we sought to understand engagement in CoCM and MOUD for patients receiving care in the intervention clinics.*
Materials and Methods: *Processes and outcomes among patients receiving CoCM for OUD and mental health in the 10 primary care clinics in the trial's intervention arm were tracked using a clinical registry and patient surveys (baseline/3/6 months). From these data, we assessed patient demographic and clinic characteristics, as well as rates of patient engagement based on two key measures: 1) documented care manager visits and 2) days treated with MOUD. Descriptive analyses were conducted to understand patient engagement.*
Results*: Among 111 patients treated in the CHAMP intervention clinic, the majority self-identified as White (83%) and women (60%). All patients had both OUD and mental health symptomology, and 27% had experienced an overdose in the past six months. Patient engagement in care manager visits and MOUD was high: 94% of patients received 1+ care manager visit (e.g., initiation of care) and 79% had 90 days of MOUD coverage (e.g., engagement in care).*
Conclusions. *Patients with co-occurring OUD and mental health were very engaged with both care managers and effective MOUD treatment when treated using the CoCM. An intervention that resulted in decreased days of non-medical opioid use also appeared to be acceptable to patients and met with high engagement.*

Presentations 202: Vulnerable Populations and Hospital-Based Care

Carla Bruguera - Piloting Integrated Brief Intervention for NCD Prevention in Vulnerable Primary Care Settings: The Catalan Experience within the PEACHD Project

Abstract

Authors: *Carla Bruguera (1), Sheila Casas (1), Lidia Segura (1), Guadalupe Ortega (2), Lena Reisloh (2), Maria Manera (2) i Jordina Capella (2), Silvia Matrai (3), Fleur Braddick (3) i Jorge Palacio (3)*

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Background: *Non-communicable diseases (NCDs) account for 71% of global mortality. In Catalonia, 60% of the population presents at least one lifestyle-related risk factor—such as smoking, poor diet, physical inactivity, or risky alcohol use—with 20% having two or more. These combined risks significantly elevate the likelihood of developing NCDs. Prevention and promotion (P&P) strategies in Primary Health Care (PHC) have proven to be effective and cost-efficient in improving population health and reducing the disease burden. For years, Catalonia has implemented P&P programs promoting early detection and integrated brief advice in PHC. In 2021, these initiatives were consolidated under the SumaSalut project. While the project has successfully fostered synergies across its components (training, communication campaigns, global health days), operationalizing integrated brief counselling in routine care remains a challenge.*
Objective: The European PEACHD project aims to pilot the operationalization of the WHO-EU BRIEF integrated approach for NCD prevention, particularly cancer, across various European contexts, with a focus

on vulnerable populations. In Catalonia, within the SumaSalut framework, this pilot will be implemented in primary care centers.
Materials and Methods: *Seven PHC centers in socioeconomically disadvantaged areas with high migrant populations were selected. Over four months, the pilot will engage 6,000 individuals. Healthcare professionals will receive one hour of in-person training plus a reinforcement session. Materials include a professional intervention guide, multilingual awareness leaflets (six languages), and patient guides (four languages). The RE-AIM framework will guide evaluation through screening rates, pre-post questionnaires, focus groups, and interviews. Cultural validation of materials will be conducted with individuals of Pakistani and Maghrebi origin.*
Results: *The intervention is expected to increase screening reach compared both to the previous year and to similar centers not participating in the pilot. Training is anticipated to improve professionals' competence and confidence in delivering brief interventions by enhancing their knowledge and confidence. Furthermore, cultural validation and feedback from focus groups will inform the feasibility, acceptability, and sustainability of implementation, as well as the need for additional support strategies.*
Conclusions*: This pilot will generate critical insights into the practical implementation of integrated brief counselling for NCD prevention in PHC. Findings will directly inform the scale-up of the SumaSalut program, strengthening Catalonia's capacity to reduce NCD burden through equitable, culturally sensitive, and effective interventions.*

Jorge Palacio-Viera - Implementing Alcohol Screening and Brief Interventions in Hospitals: An Innovative approach in Catalonia

Abstract: Expanding the Drink Less Program of Screening and Brief Intervention from Primary Healthcare Services to Hospitals: A Novel Strategy in Catalonia

Authors: *Jorge Palacio-Vieira[1-2], **Lidia Segura[1],** Carla Bruguera[1]*

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Background and Objective

Alcohol consumption remains highly prevalent in both Catalonia and the wider Spanish population. In 2022, 93.2% of individuals aged 15–64 reported having consumed alcohol at least once, and 76.4% had done so within the previous 12 months. In the United Kingdom, approximately 6% of all hospital admissions are partially or fully attributable to alcohol use, representing nearly 980,000 patients. In Catalonia, the prevalence of alcohol use disorders among hospitalized patients is three times higher than in the general population. Furthermore, 25% of men aged 18–65 admitted to hospitals engage in risky or harmful drinking or meet diagnostic criteria for alcohol dependence. Evidence indicates that early identification and brief interventions (BI) targeting hazardous or harmful drinkers yield significant benefits at six-month follow-up, including reductions in weekly alcohol consumption and heavy drinking episodes. This study aimed to assess the feasibility and necessity of implementing a hospital-based screening and brief intervention (SBI) protocol for alcohol use at the Consorci Sanitari de Terrassa (CST) in Catalonia.

Materials and Methods

Two structured questionnaires were developed for hospitalized patients and healthcare professionals at CST to evaluate perceptions of the need for and feasibility of implementing an SBI strategy. The instruments assessed views on the appropriateness, content, and practicality of SBI delivery in hospital settings, as well as the availability of resources for referral and treatment. Information was also collected on patients' alcohol consumption patterns and on the alcohol-related training previously received by healthcare professionals. Additionally, data from the Hospital Discharge Minimum Data Set (HDMDS) were analyzed to quantify the burden of alcohol-attributable morbidity and hospitalizations. The dataset included all hospital admissions recorded at CST in 2022, the most recent year available.

Results

A total of 38 hospitalized patients completed the questionnaire, the majority being women admitted to the Maternity and Surgery Units (>80%). Awareness of alcohol use as a health concern was limited: only 10% of respondents recognized a possible link between their alcohol consumption and the cause of their admission. Nevertheless, approximately 80% considered hospital-based screening, brief intervention, documentation of alcohol use, and referral to treatment as important components of care. Among healthcare professionals, 53

questionnaires were completed, predominantly by women (72%); 51% were nurses and 30% physicians. Sixty-two percent acknowledged the relevance of alcohol use to hospital morbidity, although only 49% had received any formal training in alcohol-related care.
Analysis of the HDMDS indicated that nearly 20% of hospital admissions (n = 4,307) were partially or fully attributable to alcohol use. Patients aged ≥65 years and those admitted following injuries or accidents accounted for 43% of these alcohol-related cases.

Conclusions

The results indicate both a clear need and strong support for implementing a hospital-based screening and brief intervention (SBI) protocol for alcohol use at CST. Although alcohol consumption is highly prevalent among hospitalized patients, it is often under-recognized as a contributing factor to hospitalization. Both patients and healthcare professionals expressed positive attitudes toward incorporating alcohol-related screening and interventions into hospital care. However, the limited training among clinicians represents a major barrier, emphasizing the importance of strengthening education and capacity-building in this area. The substantial proportion of alcohol-related admissions—particularly among older adults and patients admitted for injuries—highlights the urgency of developing targeted hospital-based interventions. Overall, these findings support the feasibility and necessity of implementing an SBI protocol to enhance early detection, referral, and treatment of individuals at risk due to alcohol use in hospital settings.

Presentations 204: Polysubstance Use and Psychiatric Comorbidity

Camillia Lui - SBI for Tobacco, Alcohol, and Cannabis: Evidence, Gaps, and Opportunities in Community Colleges

Abstract:

Authors: *Camillia Lui (1); Niles Zoschke (1); Kimberlee Homer Vagadori (2); Sang Leng Trieu (3); Elizabeth Perelli (3), and Elisa Tong (4)*
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Background:

Tobacco, alcohol and cannabis use in college remains a serious public health issue since young adulthood is a critical developmental transition and often characterized by risky behaviors unique to college experience. Yet much of the research and evidence-based screening and interventions have been conducted in traditional four-year college settings even though community college students have comparable usage of cigarette, e-cigarette, and cannabis. Furthermore, given the increasing mental health problems, substance use is highly correlated with mental health as a mechanism for coping. Serving more than 1.8 million students, the California (CA) community college (CC) system is a prime setting to deliver comprehensive screening and brief interventions (SBI) in particular, to higher-risk groups experiencing poor health outcomes and access to health services such as racial and ethnic minorities, sexual and gender minorities, those from lower socioeconomic status, or from rural areas. Applying Levesque et al's accessibility to healthcare framework, this mixed-methods study examined what SBIs are implemented in CC student health and mental health services, and identified key barriers and facilitators to implementing SBI practices in the CC setting.

Materials and Methods

Using a convergent mixed-methods research design, data are from the annual survey of California CC student health and mental health services (n=45) and 20 key informant interviews from student health and mental health services stakeholders at 10 CCs, which were purposively selected as case studies. Quantitative survey data captured SBI practices by substance type, health service delivery model (e.g., federally qualified health center (FQHC), college-based, contract-based), organizational capacity, staffing, funding/revenue, and student programming. Descriptive analysis examined what SBIs were implemented, and bivariate analysis examined college-level factors associated with SBI implementation. For the qualitative data, content analysis was conducted with two research staff reviewing interviews and clinic documents to develop workflow processes for screening intervention and referral for tobacco, alcohol, and cannabis.

Results

Among 45 CCs surveyed, 78% screened for tobacco use, 80% for alcohol use, and 62% for cannabis use. CCs that were contract-based or part of an FQHC, reported greater organizational capacity and staffing, or had student health programming were more likely to conduct screening. Despite the higher screening, only one-third conducted brief intervention or offered referral. Preliminary qualitative findings from key informant interviews revealed that student health services often had a more structured approach for screening while mental health services had a more unstructured approach often accompanied with motivational interviewing. Key barriers include service delivery approach with limited student sessions, and building student rapport and their willingness to change behaviors.
Conclusions
Findings underscore the need to develop a systematic SBI protocol that is feasible for CC student health and mental health services to implement, and to leverage existing college resources and student-engaged strategies for SBI delivery.

Dongni Zhang - Interactions between changes in alcohol consumption and other health behaviours: findings from the Coach intervention factorial trial
Linköping University

Abstract:
Background: *Lifestyle behaviours often cluster together, shaping and reinforcing one another in complex ways. Modifying one behaviour can potentially trigger further positive changes. For example, individuals who quit smoking may reduce their alcohol consumption, while increasing physical activity may encourage healthier dietary choices. Digital health interventions have emerged as powerful tools for supporting behaviour change. While their effectiveness in modifying individual behaviours is well-established, less is known about their influence on the interactions between multiple behaviours.*
Materials and method: *This study examines how changes in fruit and vegetable (FV) consumption, moderate to vigorous physical activity (MVPA), and perceived stress was associated with alcohol consumption changes among participants of the Coach digital health intervention trial. The Coach intervention was a digital multiple health behaviour intervention that was studied among individuals from the general public who had looked online for help. Two alcohol-related outcomes were assessed: total weekly consumption (TWC) and the frequency of heavy episodic drinking (HED). The Coach trial recorded baseline characteristics of participants along with follow-up measures at two and four months, allowing us to estimate behavioural changes over two periods. Using a Bayesian regression framework, we estimated the relative change in TWC and HED when making positive changes in FV, MVPA, and stress compared to maintaining baseline levels. We also explored how baseline characteristics moderated these interactions. Analyses were conducted on the full Coach dataset and separately for each of six intervention components to examine differences across intervention strategies.*
Results: *For an average participant (baseline FV: 1.2 portions/day, MVPA: 165 min/week, stress: 8 out of 16 on PSS-4), increasing FV intake by 0.1 portions per day was associated with a reduction of TWC by 0.2% at 2 months and 0.3% at 4 months; and HED by 1% at 2 months and 1.2% at 4 months. A one-score decrease in stress showed the strongest association, with TWC reducing by 3% at 2 months and 1.9% at 4 months; and HED by 4.7% at 2 months and 5.4% at 4 months. Increasing MVPA by 10 min/week was associated with an 0.2% increase in TWC and HED at 2 months, and at 4 months TWC increased by 0.1% while HED decreased by 0.3%. Associations varied by baseline levels: higher baseline FV and stress was associated with greater reductions in TWC, while the opposite was found for HED. Changes in MVPA had the weakest associations with reductions in TWC and HED across all components. Participants with access to a screening and feedback component, as well as a goalsetting and planning component, tended to have stronger associations between FV and stress and reductions in TWC.*
Conclusion: *Digital interventions targeting multiple lifestyle behaviors, including alcohol, may gain from synergistic effects from behaviour change. However, our findings highlight that interactions among changes in different behaviours are expected to be small. Stress reduction had the strongest association with reduced TWC and HED, while changes in MVPA was associated with minimal alcohol consumption changes. These insights elucidate that leveraging potentially synergistic effects among changes in multiple behaviours in interventions is not straightforward, and future research should investigate how interventions can be promote such synergies.*

Daniel Blonigen - Stand Down–Think Before You Drink: Preliminary Findings from a Multisite Trial of a Mobile Application, with and without Peer Support, to Improve Drinking Outcomes in Veterans
Abstract:
Authors: *Daniel Blonigen, Kathryn Macia, Eric Kuhn, Eric Hawkins, Patrick Dulin, Allyson Smith, Gisselle Tamayo, Jennifer Smith, & Kyle Possemato.*
Center for Innovation to Implementation (Ci2i), VA Palo Alto Health Care System

Background: *Mobile applications (apps) can help overcome barriers to access for primary care patients with alcohol use problems and can serve as a Brief Intervention option in this population. Peers can provide supportive accountability for patients' engagement with apps. However, the effectiveness of this approach to improve drinking outcomes has yet to be evaluated in an RCT. This two-site hybrid 1 effectiveness-implementation trial is testing if a mobile app ("Stand Down"), with and without peer support, can improve drinking outcomes among Veteran primary care patients.*
Methods: *A total of 222 patients (mean age=56.13 years, SD=14.06) who screened positive for unhealth alcohol use in primary care and were not in alcohol treatment completed a baseline interview and were randomized to usual care (UC; n=73), UC plus access to Stand Down (App only; n=74), or UC plus Peer-Supported Stand Down (PSSD—4 phone sessions over 8 weeks; n=75). Effectiveness of App only and PSSD (vs. UC) to reduce Total Standard Drinks (primary) and Drinks Per Drinking Day and Heavy Drinking Days (secondary) will be determined at 8 weeks (data collection complete) and at 20- and 32-weeks (data collection ongoing).*
Results: *At baseline, most participants met criteria for an alcohol use disorder (AUD; 76%); 42% reported past-month drug use; 27% and 30% met criteria for probable PTSD or moderate depression, respectively. Per the Short Index of Problems-Revised, intrapersonal consequences from drinking were most common (e.g., feeling guilty/ashamed from drinking); 46% reported being 'unsure' or 'not ready' to change their alcohol use. Significant within-group reductions from baseline to 8 weeks were observed on all three drinking outcomes for those in the PSSD condition and on two drinking outcomes for those in the App only condition. Significant between-group effects favoring PSSD (vs. UC) was observed on the primary outcome (Total Standard Drinks) and a hypothesized mediator (readiness to change). Percent days using the Stand Down app over 8 weeks was comparable between the App-only and PSSD conditions (30% vs. 31%).*
Conclusions: *Despite being recruited from primary care, AUD diagnoses and co-occurring substance use and psychiatric problems were common. Improvements in drinking outcomes were most robust for the PSSD condition at 8 weeks, though did not appear to be driven by greater app usage. Post-treatment findings at 20- and 32-weeks will fill a gap in the literature on effectiveness of apps for primary patients who tend to be older and may lack awareness of, or motivation to change, their drinking.*

<u>Presentations 302</u>: Adolescents and Rural Health

Lydia Shrier - Training Pediatric Clinicians to Counsel Adolescents about Substance Use: Experiences from an SBIRT Trial in Pediatric Primary Care
Abstract:
Authors: *Lydia A. Shrier (1, 2); Pamela J. Burke (1); Nicholas H. McCaskill (1); Madison M. O'Connell (1); Jessica B. Calihan (3); Sion Kim Harris (1, 2)*
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Background. *Substance use is common in adolescence and is associated with risks of injury and development of substance use disorder. Most adolescents receive primary care in pediatric practices, placing pediatric health care clinicians on the front lines of screening, brief intervention, and referral to treatment (SBIRT) for this age group. As part of a randomized controlled trial of a computer-facilitated screening and brief intervention (cSBI) system for adolescents seen in pediatric primary care, we provided a training comprised of online self-study modules and live virtual sessions for pediatric clinicians on motivational interviewing (MI)-based brief counseling for adolescents with substance use or substance-related riding risk. We evaluated the*

extent to which pediatric clinicians 1) adhered to the protocol and 2) demonstrated an MI approach in mock counseling sessions following training.

Materials and method. *We developed a cSBI system for adolescents being seen for their annual well visit in pediatric primary care. The intervention consisted of electronic screening for substance use and riding risk, online psychoeducation about substance use, and an MI-based brief negotiated interview with the pediatric primary care clinician during the well visit. Prior to patient recruitment, we trained 16 pediatric primary care clinicians assigned to the intervention condition: 12 physicians, 3 nurse practitioners, and 1 physician assistant from 6 practices in 5 U.S. states. An adolescent medicine clinician-researcher and a MI Network of Trainers member developed the training, which consisted of 5 self-study modules on a web-based learning platform and live videoconference sessions with 2 trainers. The self-study modules, which included readings, written examples, video demonstrations, and knowledge checks, covered an overview of MI and brief counseling protocols for Recent Use (substance use in the past 3 months), Recent Use Follow-up, Distant Use (substance use in the past >3 to 12 months), and Riding Risk (riding with a driver who had been using substances). After challenges scheduling 5 live sessions with the clinicians in the first practice as initially planned, we added video-recorded lectures to the self-study modules and reduced the number of live sessions to 2 for the remaining 5 practices. Total training time for all intervention clinicians was 6 hours delivered over 6 weeks. All participating clinicians were asked to complete a baseline survey, which included questions on prior SBIRT and MI education or training (none, brief, extensive), comfort (1-5), and ability (1-5). Intervention clinicians were asked to complete an evaluation of the training. Prior to beginning to deliver the intervention counseling to their patients, the trained clinicians conducted the counseling protocol with mock standardized patients for Recent Use, Distant Use, and Riding Risk scenarios. Mock counseling sessions were video-recorded and rated by 2 research staff and 2 trainers . Adherence to the screening and brief intervention counseling protocol (36 items) and demonstration of MI (10 items, adapted from the Behaviour Change Counseling Index) were rated and percentages calculated for correct behavior observed; adequate adherence to the protocol/demonstration of MI was defined as a score of ≥80%.*

Results. *Completion rates were 15/16 (94%) for the baseline survey, 10/16 (63%) for the post-training evaluation, and 15/16 (94%) for the baseline mock counseling sessions (one of the intervention clinicians withdrew from the study after completing the training and did not participate in the mock sessions). At baseline, 5/15 clinicians (33%) reported receiving any prior education or training specifically on SBIRT for adolescent substance use. Most clinicians (11/15; 73%) reported a high level of comfort (4 or 5) discussing substance use in the clinical visit, with fewer (8/15; 53%) reporting a high level of ability to have these discussions. Most clinicians reported having received any prior education or training specifically on MI (11/15; 73%); fewer reported a high level of comfort (4/15; 27%) and ability (3/15; 20%) using MI with their adolescent patients. In general, respondents agreed/strongly agreed that the self-study process suited their personal learning style, took them a reasonable amount of time to complete, supported their learning, and sufficiently prepared them for the live practice sessions with the trainers (90%-100% across these items). All respondents agreed/strongly agreed that the live practice sessions were interesting and helpful, the role plays enhanced their learning, and 2 live training sessions were just right. Following the mock sessions, all but one clinician reported that they agreed/strongly agreed with feeling confident about their ability to implement the protocol. On ratings of the mock sessions, adherence to the counseling protocol (average for the three counseling scenarios) had a mean score of 82% (SD ±8.0%); 8/15 clinicians (53%) achieved ≥80% on the adherence ratings. Demonstration of MI-style counseling (averaged over the three counseling scenarios) had a mean of 91% (SD ±5.7%); all clinicians (100%) achieved ≥80% on the MI ratings.*

Conclusions. *Although SBIRT is a recommended practice in adolescent health care, few pediatric primary care clinicians in this study had prior education or training in SBIRT. Nonetheless, most felt comfortable with and able to discuss substance use with their adolescent patients. Following the study training, just over one-half of clinicians demonstrated adequate adherence to a brief MI-based counseling protocol for adolescents with substance use or substance-related risk. Repeated and more extensive training in SBIRT may be required to ensure robust implementation of SBIRT counseling protocols in pediatric primary care. Prior education or training in MI was more common, yet clinicians generally did not feel comfortable with or able to use MI with their adolescent patients. Following self-study and live practice sessions, all participating intervention clinicians demonstrated adequate use of an MI approach to counseling. The self-study with live practice sessions implemented in this study may have reinforced prior learning about MI and could be a useful approach to*

support pediatric primary care clinicians more broadly in MI-based counseling adolescents about substance use.

Verena Metz - Screening and Brief Intervention as a Prevention Tool for Adolescents – Findings of a Systematic Review

Abstract:

Authors: *Verena E. Metz*, Sidharth Arya, Marcus Bendtsen, Nancy Charvat-Aguilar, Silke Diestelkamp, Joel Francis, Abhishek Ghosh, Dagmar M. Haller-Hester, Sion Harris, Andrea H Kline-Simon, Abnette Kaffl, Sharon Levy, Rachel Luba, Tracy McPherson, Paul Toner, Samir Kumar Praharaj, Stacy A. Sterling, Elissa Weitzman, Dorothy Newbury-Birch*

**Kaiser Permanente Division of Research*

Background: *Screening and Brief Intervention (SBI) are widely used public health approaches to address substance use issues globally. However, there is a lack of evidence for effectiveness studies in adolescents. We conducted a systematic literature review of SBI studies in adolescents aged 10-17 years at receipt of BI, in any setting, published 1998-2023 in any language, including a comparison group, and excluding tobacco-only studies.*

Materials and Methods: *A comprehensive literature search in EBSCO, PubMed, Embase, Cochrane Library, bvsalud, TRIP, Proquest, Web of Science, Scopus, PsycInfo, Medline and Google Scholar yielded 9633 hits; whereof 744 duplicates and 8376 irrelevant studies were removed. Out of 513 articles that underwent full-text review, 479 were excluded, resulting in 34 studies fulfilling our inclusion criteria. All studies were uploaded into Covidence, and reviewed, assessed for bias (RoB2 for randomized studies, and ROBINS-I for non-randomized designs) and extracted by 2 independent reviewers.*

Results: *Of 34 studies, n=17 were conducted in the USA (6 in the UK, 3 in Germany, 2 in Mexico, and the remainder was distributed across other countries), 30 studies were randomized, 4 non-randomized, and n=24 focused on alcohol only, n=7 on alcohol and other substances, n=1 on illicit drugs, and n=2 cannabis. Twenty-two studies were conducted in school settings, 7 in Emergency Departments, 2 in primary care, and 1 each in a hospital setting, truancy center and virtually. Due to a great variety in methods and measures, no meta-analysis could be conducted, and beneficial effects can only be narratively synthesized, including methodological limitations. All studies had at least a moderate risk of bias (n=22 had a high overall risk of bias, and n=12 a moderate risk).   .*

Conclusions: *SBI studies in adolescents show some beneficial effects in regard to prevention of substance use disorders; however, due to a wide range of different methods/BIs and outcome measures used, it is difficult to synthesize results. Consensus on methods and outcome measures would be urgently needed to assess the effectiveness SBI in adolescents systematically and to move the field forward.*

Presentations 303: New Directions with Vulnerable Patient Groups

Gianluca De Leo - Addressing Substance Use Disorders in Rural Georgia: A Path Toward Sustainable Recovery

Abstract:

Authors: *Marlo Vernon PhD1, Vahé Heboyan PhD1, Amy Szoka1 BS ICPS, Emily Lord BS1, Gianluca De Leo PhD, MBA1*

Presenter: *Gianluca De Leo PhD, MBA*

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Abstract:

Despite ongoing efforts to develop standardized and effective treatment protocols for substance use disorders (SUD), only 13% of individuals with drug use disorders receive care. Relapse rates remain high—between 40% and 60% within a year of treatment—especially in rural areas, where individuals often lack motivation and access to professional support. While recovery advocates have made progress in expanding access to opioid use disorder (OUD) treatment, evidence from our target communities and national data highlights employment as a key predictor of successful recovery. Unfortunately, income instability and barriers to employment—often stemming from substance use history, criminal records, and stigma— do not support life fulfillment for individuals in recovery. Over the past decade, our team has worked across several rural counties in Georgia to address the challenges of opioid and substance use disorders (OUD/SUD). Building on this experience, we developed EmpowHER: A Family-Centered Approach to Address Economic Challenges in Women's OUD/SUD

Recovery Journey. This initiative expands our comprehensive, recovery-oriented model of care for pregnant, postpartum, and parenting women with OUD/SUD and their families. EmpowHER integrates innovative strategies to promote financial stability, with the goal of evaluating and supporting sustainable small business development as a pathway to recovery. EmpowHER is a small business capacity-building initiative designed to empower women in recovery and their families through entrepreneurship. The program consists of four structured training workshops and a Business Boost Competition. Workshops are held every two weeks at a partner Recovery Community Organization (RCO) facility, each lasting three hours. The sessions include: (1) Small Business 101 & Finding Your Idea, which introduces participants to the fundamentals of entrepreneurship and helps them identify viable business concepts; (2) Building Your Business Idea with Cofounder OS, a web-based platform that guides participants in developing and refining their ideas; (3) Feedback & Revision Review, offering individualized suggestions to strengthen business plans; and (4) Prepare Your Pitch, which teaches participants how to effectively present their ideas to an audience. The program culminates in the Business Boost Competition, where participants pitch their ideas for a chance to receive startup support. In Summer 2025, we successfully completed the first iteration of the EmpowHER initiative. Twenty-one individuals participated, with eight selected to present their business ideas. Of those, four received monetary awards to launch their ventures. Each workshop was carefully evaluated, and a pre- and post-assessment instrument was administered to measure impact. Results showed high levels of engagement and strong interest in the opportunity. While only a third of participants advanced to the presentation stage, the program demonstrated clear potential for replication in other rural communities. EmpowHER offers a promising, scalable model to promote financial stability and long-term recovery for individuals with SUD, addressing a critical gap in current treatment and support systems.

Isabella Fornell-Villalobos - Sweet Success Intervention Protocol: Feasibility of a Brief Motivational Interviewing Program Targeting Sugar Consumption Among Healthcare Workers

Abstract:

Authors: *Isabella Fornell, Rachel M. Radin, Juliana VanCleve, Laurie M. Jacobs, Ashley E. Mason, Kathleen Antonio, Amanda Pickett, Jamey Schmidt, Laura A Schmidt, Elissa S. Epel*
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Regular consumption of sugar-sweetened beverages (SSB) is a primary contributor to Type 2 Diabetes and obesity, particularly for individuals with high stress. Importantly, sugar affects the brain in a similar manner to substances such as alcohol, for which Motivational Interviewing (MI) has been shown to be an effective treatment. The effects of MI on reducing substance intake are likely due to improvements in motivation for change and self-efficacy. Building on MI, we developed a remotely delivered MI-informed intervention aimed at reducing SSB consumption. Our study objectives are to: (1) describe the intervention; (2) describe feasibility of intervention implementation among healthcare workers; (3) evaluate health coaches' adherence to MI principles; (4) explore the impact of the intervention on participants' motivation and self-efficacy to reduce SSB consumption and stress and cravings. We hypothesize that the intervention will be feasible (with a retention rate exceeding 60%), will adhere to MI principles, and will enhance both motivation and self-efficacy for reducing SSB consumption. This intervention is part of an ongoing multi-level randomized trial across 15 affiliated healthcare centers scheduled for completion in late 2025. Here, we report only the intervention protocol details.
Three hundred and fourteen healthcare workers participated in a four-dose, brief MI-informed intervention conducted over approximately six weeks. In dose 1, participants engaged in a 15-minute introductory call with

a trained health coach to discuss concerns and context regarding SSB intake. One week later, dose 2 involved a 30-minute counseling session designed to provide educational guidelines on sugar consumption, elicit motivational factors for change, enhance self-efficacy, and set goals for reducing SSB consumption. Booster calls in doses 3 and 4, occurring approximately one and three weeks after the counseling session respectively, were implemented to reinforce motivation, identify supportive alternative behaviors for change, and recalibrate goals. Two independent coders evaluated adherence to MI by the health coaches using the Motivational Interviewing Treatment Integrity 4 (MITI 4) scoring system.
At dose 1, 87.9% (n=276) of the sample completed the introductory phone call; 78.7% (n=247) completed dose 2, the counseling session; 71% (n=223) completed dose 3, and 65.9% (n=207) completed dose 4, one booster call per dose. Adherence to MI was fair in two global scores: technical (M = 3.24, SD = 0.48) and percentage of complex reflections (M = 41.85%, SD = 15.17). We found a statistically significant increase in self-reported motivation to reduce SSB ($p<.001$, $\eta^2_p=.237$) and self-reported self-efficacy ($p<.001$, $\eta^2_p=.098$) throughout the intervention. After listening to an introductory stress management audio, participants reported a statistically significant reduction in self-reported stress, cravings and thirst. Similarly, after listening to an introductory craving management audio, participants showed statistically significant decreases in self-reported stress and thirst but not cravings.
The brief intervention achieved good retention rates and demonstrated that our MI-informed approach effectively enhances motivation and self-efficacy to reduce SSB consumption among healthcare workers. An important aspect of our study is that not all MITI 4 scores met the "fair" benchmark. However, this outcome aligns with the fact that our approach was not a pure MI intervention but a hybrid including a psycho-educational component. In sum, our findings suggest MI-informed brief interventions may offer a cost-effective and accessible method for employers to support behavioral change for consumption. They are particularly beneficial for individuals in the workforce who might otherwise lack access to such interventions.

Presentations 304: Opioid and Other Substance Use Disorders
Shirely Stephenson - Connecting Research Participants to Care: The Unique Role Substance Use Disorder (SUD) Research Can Have on Healthcare Interventions
Abstract:
Co-Presenters: *Shirley Stephenson and Veronica Bucci*
University of Illinois

Background: *Stimulant use disorders, particularly cocaine use disorder (CUD), persist as a worldwide public health crisis but are often not met with rigorous medical attention or treatment options. CUD is linked to adverse health outcomes such as hypertension and tachycardia, and in the past decade, there has been a rise in unintentional overdoses from fentanyl contamination in the cocaine supply. Despite the urgent need for linkage to primary care and SUD treatment, shame and stigma–both internalized by CUD patients and caused by provider interactions–is common. Thus individuals living with CUD and other SUDs may utilize emergency departments, where they often feel judged, but do not seek out primary care or feel comfortable enough to discuss substance use with the providers they do have. As part of a double-blind, randomized clinical trial in which participants who self-identified as having a SUD sought pharmacological treatment for CUD, a medical clinician (MC; e.g., NP, MD, or DO) served a key role in the assessment of medical and psychiatric needs during screening and throughout the twelve-week trial. The inclusion of a primary care provider with experience in SUD treatment offered a unique opportunity to discuss options for care to meet the holistic needs of the participants. In addition to the team's provision of community resources and harm reduction materials such as fentanyl testing strips, the MC had the ability to advise participants about health concerns such as hypertension and initiate linkage to a federally qualified health center (FQHC). Medical centers such as this prioritize a non-stigmatizing approach and utilize an integrated care model to address behavioral health and addiction in primary care.*
Materials and method: *For this clinical trial, the PI embedded a primary care provider as MC and established collaborations with multiple community partners including a local FQHC with robust behavioral health and addiction services. Participants met with the MC to discuss study eligibility via assessments that included a comprehensive medical and psychiatric interview, a physical exam, clinical labs, and electrocardiogram readings. Identifying the health needs of participants while in the screening phase allowed the MC to have candid, empathetic conversations about any needed care and options for referrals. Connection to the local*

FQHC for diagnoses such as hypertension were made with the encouragement of the research team, who were in a position to build rapport over months of visits. Non-stigmatizing language and attitudes empowered participants to freely discuss their CUD and other health concerns, and inspired participants' confidence that safe and supportive clinical settings do exist.
Results: *About 30% of the participants in the clinical trial were consulted about health concerns and from there, were connected to needed primary or specialty care services. Several of these participants engaged in care that coincided with their time in the study which assisted in treatment of health outcomes related to their CUD. For example, 4 participants who presented with elevated blood pressure were advised on the risks of untreated hypertension. Two were connected to primary care where they were prescribed antihypertensives, which resulted in significant blood pressure improvement throughout the course of the study even in the setting of continued cocaine use. Two additional participants resumed taking medication they had but never took and returned to their primary care providers for follow up. Another participant was scheduled for surgery but had not previously disclosed their CUD with their providers. After discussion and assessment with the MC, the participant decided to inform their clinical teams of their substance use. A comprehensive, revised plan was implemented for a safer surgery, and psychiatric medications were adjusted. All participants additionally were receptive to harm reduction materials and often reported continued testing of their cocaine supply to ensure safer use.*
Conclusions: *Providing a safe space to discuss CUD in a clinical research setting can allow individuals to feel comfortable to not only work through substance use concerns, but overall health concerns. Research teams that build strong partnerships with local healthcare agencies and include clinicians who view participants' health holistically have a rare opportunity to build rapport and intervene during study procedures to address health concerns that could be exacerbated or in part due to substance use. The advantageous partnership with a primary care clinic that uses an integrated care model to address behavioral health and addiction further leverages community resources to serve individuals who may feel judged by and estranged from medical systems.*

Lillian Gelberg - Cannabis as a substitute for prescription drugs: A cross-sectional study of primary care patients in Los Angeles
Abstract:
Authors: *Marjan Javanbakht, Sarah Schoetz Dean, Whitney Akabike, Pamina Gorbach, Dallas Swendeman, Ziva D. Cooper, W. Scott Comulada, Lillian Gelberg (presenter)*
University of California Los Angeles

Aims. *Few studies have examined cannabis use as a substitute for prescription drugs in broader clinical populations, as most research has focused on specific groups, such as patients with pain or other chronic health conditions. The objective of this study was to examine the prevalence and correlates of cannabis use as a substitute for prescription medications among primary care patients.*
Methods. *Eligible patients were ≥18 years, reported past 3-month cannabis use, and had a primary care visit in a large university-based health system in Los Angeles, CA between May and September 2024. Self-administered questionnaires assessed cannabis use and medications for which cannabis was substituted, and responses were linked to the patient's electronic health record.*
Results. *Among 960 enrolled patients, median age was 45 years (range: 18-89), 54% were female, and 52% reported using cannabis daily or near daily with an additional 25% reporting weekly use. On a typical day of use, 62% of participants reported using cannabis once per day, 26% reported using it two to three times, and 12% reported using it four or more times. The use of higher potency products (>20% THC for inhaled cannabis and >15 mg THC for ingested cannabis) was reported by 54% of participants. Almost all (95%) reported using cannabis to manage health symptoms with sleep (82%), stress (72%), and anxiety (61%) being the most common reasons. Over two-thirds (68%) had not discussed cannabis use with their healthcare provider despite 60% reporting cannabis replacing a prescription medication, including substitutions for: sedatives/sleep aids (56%); anxiolytics (37%); opioids (24%); and antidepressants (21%). Reported reasons for using cannabis instead of prescription medications included greater perceived effectiveness (27%), fewer side effects (25%), feeling more comfortable using cannabis (18%), a desire to reduce overall medication use (17%), and easier access to cannabis (6%). Cannabis substitution for prescription medications was more common among females (66% vs. 53%; $p<.01$), those who were slightly*

older (median age: 46 vs. 43 years; p<.01), and those reporting more health symptoms (median symptoms: 5 vs. 3; p<.01), despite comparable levels of comorbidities across the two groups (based on ICD-10 codes). Those substituting cannabis for prescription medications were more likely to use cannabis daily (55% vs. 45%) and more than once per day (41% vs. 33%; p=0.01); however, no differences were noted regarding potency of products used.
Conclusions. *These findings demonstrate that substituting cannabis for prescription medications is highly prevalent among primary care patients who use cannabis, particularly among those experiencing a greater burden of health symptoms. Despite this, few patients reported discussing their cannabis use with their healthcare provider, highlighting a significant gap in patient-provider communication. This lack of dialogue raises concerns about potential risks associated with unmonitored medicinal cannabis use, including interactions with other medications and missed opportunities for clinical guidance. These results underscore the need for strategies that promote open, informed conversations about cannabis use in primary care settings.*

Jennifer McNeely - Collaborative Care Intervention to Reduce Risky Opioid Use Among Primary Care Patients: Findings From the "Subthreshold Opioid Use Disorder Prevention" (STOP) Trial Conducted in the NIDA Clinical Trials Network
Abstract:
Authors
Jennifer McNeely (1); Geetha Subramaniam (2); Rebecca Stone(1); Shayna Mazel (1); Noa Appleton (1); Yasna Rostam Abadi (1); Travis Lovejoy (3); Lillian Gelberg (4); Donna Beers (5); Margaret Kline (6); Song Zhang (6); Tobie Kim (6); Ashley Case (6); Jennifer McCormack (6); Jane Liebschutz (7);

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5) *Boston Medical Center, Boston, MA 02118, USA*
Background: *The Subthreshold Opioid Use Disorder Prevention (STOP) Trial tested the efficacy of a collaborative care intervention to reduce risky opioid use and prevent progression of opioid use disorder (OUD) in adult primary care patients.*
Methods: *A cluster-randomized controlled trial enrolled primary care providers (PCPs) and their patients at 5 sites and collected data January 2021-June 2024. Adult patients with illicit or non-medical opioid use, without moderate-severe OUD, were eligible. Patients received the STOP intervention or enhanced usual care (EUC; usual care enhanced by overdose prevention education), according to the assignment of their provider. The primary outcome, collected on monthly electronic surveys, was self-reported days of risky opioid use over the first 180 days following enrollment. A negative binomial model estimated the difference in number of days of use between groups using intent-to-treat procedures. OUD was assessed with a modified CIDI (DSM-5 criteria) with a chi-square test comparing groups at 6 months.*
Results: *The trial enrolled 119 PCPs and 202 patients. Patients were majority female (63.4%), with a mean age of 55.7 (SD 12.7) years. At baseline, patients reported high rates of moderate-severe pain (63.4%), depression (31.2%), anxiety (35.6%), and non-opioid substance use (32.7% heavy drinking, 35.6% cannabis). Mean days of risky opioid use over 180 days of follow-up was lower in STOP than EUC [12.2 (SD 27.7) versus 15.5 (SD 32.6)]; the difference was not statistically significant [rate ratio 0.95, 95% CI: 0.52, 1.74]. OUD severity was higher in EUC than the intervention group, with 13 (11.4%) versus 1 (1.1%) developing symptoms of moderate-severe OUD (P=0.02).*
Conclusion: *In comparison to EUC, the STOP intervention did not result in greater reductions in risky opioid use over 6 months of assessment, but fewer patients developed moderate-severe OUD. Longitudinal studies are needed to understand the trajectories of substance use and impact of interventions on outcomes that may take longer to manifest.*

<u>Presentations 305</u>: Alcohol Interventions in Diverse Populations

Cynthia Campbell - Effects of Primary Care-Based Brief Alcohol Interventions Among Aging Women
Abstract:

Authors: *Cynthia I. Campbell*, Ben Marafino, Nina Mulia, Derek D. Satre, Monique Does, Stacy A. Sterling, Felicia W. Chi, Kelly Young-Wolff, Alison Moore, Shruti Datta, Constance Weisner, Vanessa Palzes.*
**Kaiser Permanente Division of Research*

Background: *Heavy drinking is increasing among aging women, and there is evidence that effectiveness of brief alcohol interventions varies by age group. This study examined effects of receiving a brief intervention (BI) on subsequent drinking patterns among aging women (≥50 years).*
Materials and Methods: *We identified 66,142 women ages ≥50 years old who screened positive in primary care for heavy drinking (≥1 heavy drinking day defined as ≥4 drinks in a given day, or >7 drinks/week) in the past 3 months between 2014 and 2019, utilizing electronic health record data from Kaiser Permanente Northern California. Using a target trial framework for causal inference and a clone-censor weight approach, we compared three treatment strategies - single Index BI received, Dynamic BIs received, or No BI received - on outcomes of changes in alcohol use (number of heavy drinking days [HDD] and drinks/week) over a 3 year follow-up period. We used generalized estimating equation linear models, and models were weighted by time-varying inverse probability weights. We explored results by baseline drinking levels, age (50-64, ≥65) and race and ethnicity (American Indian/Alaska Native, Asian/Pacific Islander, Black, Hispanic/Latina, White, other/unknown).*
Results: *Of the study subjects, 63.4% were aged 50-64 years, and 80.2% were White. HDD at baseline were equivalent across groups, and all groups reduced HDD over the study period. The Index BI Group had smaller reductions in HDD compared to the No BI group (mean change difference of .65 fewer HDD, CI: 0.28, 1.01) and compared to the Dynamic BI group (mean change difference of .73 fewer HDD, CI: 0.53, 0.94). Treatment effects varied by baseline alcohol consumption level and age, but not by race and ethnicity. The mean number of drinks per week were similar across groups at baseline, around 9-10 drinks/week, and all groups reduced drinks/week from baseline to follow-up. The Index BI group had slightly smaller reductions in drinks/week than the Never BI group (mean change difference of 0.45 fewer drinks/week, CI: 0.26, 0.64) and than the Dynamic BI group (mean change difference of 0.12 fewer drinks/week, CI: 0.08, 0.16). Treatment effects varied by baseline alcohol consumption level.*
Conclusions: *In this large study of aging women with heavy drinking, aging women who received alcohol BIs had smaller or similar reductions in alcohol use than those who never received them, although group differences were small. However, there was evidence of a cumulative effect relative to single BIs, with more BIs leading to greater reductions in alcohol use. There was some variation in effect by baseline alcohol use and age, but not race and ethnicity. Future work is needed to understand the relative impact of screening and BI on alcohol use in this population in order to tailor approaches for aging women.*

Camille Hart - Barbershop Talk: Community-Engaged Implementation of CHW-Led SBIRT to Address Alcohol Use Among Men
University of Arkansas

Abstract: *Barbershops are culturally significant, trusted community spaces that facilitate open dialogue among men, including discussions related to health and well-being. Barbershop Talk leverages this unique environment to implement a community health worker (CHW)-delivered Screening, Brief Intervention, and Referral to Treatment (SBIRT) model focused on alcohol use and related health risks. Trained CHWs conduct structured screenings to assess patterns of alcohol consumption, deliver brief motivational interventions aimed at reducing harmful use, and provide facilitated referrals to specialized treatment when indicated. Integrating SBIRT into barbershop settings reduces barriers to care by offering access to early intervention in a familiar, non-clinical setting, thereby normalizing conversations around alcohol use and promoting help-seeking behavior.*
A distinguishing feature of Barbershop Talk is its community-engaged design, informed by a steering committee comprising barbers, individuals with lived experience, and public health practitioners. This committee offers iterative feedback that informs the adaptation of implementation strategies, ensuring contextual alignment and cultural responsiveness. Their input has been instrumental in refining outreach methodologies, enhancing intervention fidelity, and addressing stigma associated with alcohol-related health issues.

This presentation will detail the program's implementation processes and share preliminary outcomes, with a focus on the central role of community engagement in driving intervention relevance and acceptability. Early findings suggest that participants report increased awareness of their alcohol use and its potential health implications. Beyond individual behavior change, the program fosters community trust and engagement, highlighting the broader impact of culturally grounded, community-based health promotion strategies on the well-being of men.

Plenary Session Friday, September 26, 2025

Serge Ngekeng - Acceptability of Implementing SBIRT for Road Traffic Injury Victims at Emergency Departments in a Low-Resource Setting

Abstract:

Serge Ngekeng[1], Odette Kibu[2], Rasheedat Oke[3], Fanny Dissak-Delon[2], Nicholas Tendongfor[1,2], Stephen Shoptaw[4], Alain Chichom Mefire[1,2], Catherine Juillard[3]

1. Sustainable Trauma, Research, Education and Mentorship (STREaM) project, Faculty of Health sciences, University of Buea, Buea, Cameroon

2. Data Science Center for the Study of Surgery, Injury, and Equity in Africa (D-SINE-Africa), University of Buea, Buea, Cameroon

3. Program for the Advancement of Surgical Equity (PASE), Department of Surgery, University of California Los Angeles, Los Angeles, California, USA

4. Department of Family Medicine, , University of California Los Angeles, Los Angeles, California, USA

Background: *Cameroon has double the injury incidence of the US, with over 60% caused by road traffic injuries (RTIs); alcohol is linked to up to 17% of these. The lack of interventions like SBIRT (Screening, Brief Intervention, and Referral to Treatment), proven to reduce alcohol-related re-injury and mandated in US level I trauma centers, exacerbates the issue. Non-adapted interventions often fail in new settings, so to guide SBIRT adaptation in Cameroon for better efficacy, we explored ED healthcare workers' views on its acceptability and feasibility in their context.*

Methods: *We conducted qualitative interviews (N=18) with participants from three hospitals participating in the Cameroon Trauma Registry, including five medical doctors, three head nurses, and 10 other nurses. We explored healthcare workers' (HCWs) experiences with alcohol-related trauma, current practices, and their views on SBIRT implementation. Data were analyzed thematically to identify barriers and facilitators that may influence intervention implementation.*

Results: *HCWs reported that alcohol-related trauma cases are common, particularly during festive periods and weekends and had positive views about the efficacy of SBIRT. While HCWs acknowledged the need for interventions, they highlighted barriers such as time constraints due to heavy workloads, patient resistance to discussing alcohol misuse, and the cultural normalization of alcohol misuse which diminishes perceived risks. Participants emphasized the need for training, financial incentives, and structural changes, such as private spaces for counseling patients.*

Conclusions: *Initial evidence provides support for SBIRT for alcohol misuse in Cameroonian Eds, but requires adaptations to address structural and cultural barriers. Training for HCWs, patient sensitization, and integration into existing workflows are essential for successful implementation.*

Table 1: Some barriers and facilitators for SBIRT implementation in Cameroon

CFIR Domain	***Theme***	***Example Quote***
Intervention Characteristics	*Challenges with structured tools*	*"When the patient arrives with trauma involving alcohol, they are often unable to respond, and the people with them are strangers."*
Outer Setting	*Cultural norms around alcohol*	*"Cameroonians cannot be prevented from drinking, but awareness of the harmful consequences might moderate their consumption."*
Inner Setting	*Workflow constraints*	*"In the emergency department, it's different... At all times, patients are coming in, and staff are overwhelmed."*
Characteristics of Individuals	*Need for training and motivation*	*"Staff will see it as extra work and may not want to do it without motivation."*

CFIR Domain	Theme	Example Quote
Characteristics of Individuals	*Willingness to adopt SBIRT with training*	*"Yes, when you show me the questionnaire and tell me how to fill it, I will be ready."*

Saumya Mishra - Development and validation of culturally tailored multi-modal brief intervention for tobacco use disorders in patients with depression (MBIT-D) in Jharkhand, India

Abstract:

Authors –

1. *Saumya Mishra, Assistant Professor, Department of Psychiatry, All India Institute of Medical Sciences (AIIMS), Deoghar*
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Background. *Tribal population occupies 26.2% of total population of Jharkhand in India, with 75.9% living in rural areas[1]. Jharkhand has higher prevalence of tobacco use when compared to national prevalence rates, especially in rural areas. Studies are mostly from western countries, that have shown greater acceptability of culturally tailored interventions. Also, there is dearth of tailored intervention targeting tobacco use in depressed patients. Studies have shown that tobacco cessation in depressed patients improves depression outcomes.*

Methodology. *Study protocol was approved by Institute Research Committee and Institute Ethics Committee. Study was conducted in three phases, with phase-I comprising of focused group discussions and in-depth interviews exploring the psycho-social factors contributing to tobacco use in eastern region of India, phase – II comprised of developing culturally tailored intervention based on themes identified in phase-I, and phase-III comprised of validating the tool culturally and by subject experts.*

In phase-I six groups were made including male and female current tobacco users with depression, male and female former tobacco users with depression, tobacco users with depression unwilling to quit, and tobacco users without depression. Participants were recruited from department of psychiatry outpatient and inpatient settings, wherein patients who have taken treatment in the past were contacted telephonically, new patients interviewed the same day and tobacco users without depression were recruited from clinic as well as non-treatment seeking population from the same locality.

Phase-II comprised of developing culturally tailored intervention based on themes identified in phase-I, while phase-III comprised of validation by two subject experts (one addiction psychiatrist and one psychiatrist) and four people belonging to local community for cultural review. Subject experts rated on suitability assessment of materials (SAM) scale, and for cultural review participants rated the tool based on a questionnaire developed for the study as per Kreuter et al, 2003[2].

Results. *A total of twenty four participants participated in phase-I of the study, of which nineteen were male and five were female. There were three focused group discussions and eight in-depth interviews. Participant's belief that majority of the population takes tobacco products coupled with low harm perception and poor knowledge were important driving forces for tobacco use. Most of the participants did not believe in an association of tobacco use with depression. Practice of sharing, inappropriateness of refusing especially to an elderly, easy availability of tobacco with its presence in most traditions, and association with prestige were the cultural vulnerability factors predisposing an individual to tobacco use. Gender differences with respect to tobacco use included use for coping with emotions, dependence on family and significant others for procuring tobacco products and greater social stigma was noted in females compared to males. Most participants reported using tobacco for coping with emotions, cognitive benefits, increased energy, to suppress hunger and to facilitate passing stools, and reported craving and peer influence as main barriers for quitting. Former users*

mostly quit following advice from doctor, and distraction techniques, alternatives to eat and coping strategies, fear of illness, treatment of illness, financial burden of using, avoidance, goal setting and perceived sense of control facilitated quitting.
Phase-II comprised of developing a tool based on the findings of phase-I, that will be used while delivering brief intervention for tobacco use to the depression patients in a single session using the educational pamphlet and video, followed by text messages at one and two weeks. Phase-III comprising of validation of the developed tool reported satisfactory finding as per suitability assessment of materials (SAM) scale rating (average score of 96.58% suggestive of superior material), and an average score of 9 out of 10 in cultural review.
***Conclusion.** Considering the bidirectional relationship between depression and tobacco use, and the prevailing socio-cultural practices, quitting may be difficult in depression patients. A culturally tailored intervention targeting the socio-cultural believes and depressive symptoms can have greater acceptability and effectiveness.*

Best Abstract:
Sion Harris - Scaling up youth substance use screening and brief intervention: a pragmatic trial of computer-facilitated screening and brief intervention (cSBI) integrated into a widely-available online clinical process support system for primary care
Abstract:
Sion Kim Harris, PhD, MSN (1-3)
Lydia A. Shrier, MD, MPH (1,3)
Madison M. O'Connell, MPH (1)
Diana Kennedy, PhD, MHA, MS (5)
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***Background**: Universal youth screening and timely brief intervention in primary care is a promising strategy to prevent substance use disorders (SUD). However, primary care clinicians (PCCs) continue to face barriers to the provision of high-quality screening and brief intervention for their adolescent patients, such as lack of time and training. A computer-facilitated screening and brief intervention (cSBI) approach, comprising electronic pre-visit screenings with interactive psychoeducation, and point-of-care guidance for clinicians in providing tailored counseling, directly addresses these barriers. To evaluate effectiveness of this approach, we conducted a pragmatic multi-site cluster-randomized trial of cSBI dissemination through integration into the Comprehensive Health and Decision Information System (CHADIS), a widely-used web-based screening and clinical process support system. CHADIS electronically assigns and collects patient screening questionnaires pre-visit, scores results, and provides patient-specific clinical decision support and resources. We describe here study findings on the effect of CHADIS-cSBI on substance use outcomes among adolescent patients (ages 12-18 years) of participating PCCs during a 12-month follow-up period.*
***Materials and method**: PCCs who had ≥2 adolescent well visits per week were recruited from among existing CHADIS users. A total of 79 PCCs were enrolled and randomized 1:1 to either a Usual Care (UC) arm or Enhanced Care (EC) arm, with 35 PCCs (19 UC, 16 EC) retained in the study. UC clinicians continued to use the existing CHADIS system, which included the CRAFFT youth substance use screen (2.1+N version) but without access to the full CHADIS-cSBI module. EC clinicians received brief virtual training and then were given access to the full module to be used with all their patients aged 12-18 years at well visits. The CHADIS-cSBI module contained 1) the patient self-administered "CRAFFT Interactive" (substance use screen, interactive psychoeducation) and health questionnaires, 2) a Patient Specific Template for PCCs, which showed key screening/questionnaire results and a motivational interviewing-based counseling "teleprompter"*

to guide their brief intervention, and 3) educational and treatment referral resources that PCCs could consult and automatically send to teens and families separately via CHADIS's care portal. The study data collection period began 11/2021 for UC clinicians and 4/2022 for EC clinicians and ended in 12/2024. All 12- to 18-year-old patients seen by participating clinicians for well visits and completing CRAFFT screens in CHADIS during this period were included in the study. For follow-up assessments, patients were sent an invitation by text message at 3, 6, and 12 months post-visit to complete the CRAFFT again in CHADIS, modified to also ask about past-3-month use. When available, screening data from patients' next annual well visit were included as 12-month follow-up data. The study protocol received institutional review board approval with a waiver of parental permission as data were collected as part of routine care. Our primary outcome measures were any report of alcohol use, cannabis use, nicotine use, or use of any substance (alcohol, cannabis, nicotine, or other drugs) on any assessment during the 12 months follow-up. We also compared rates of past-3-month use of each substance reported at the 12-month timepoint. We conducted multiple logistic regression modeling with GEE to compute relative risk ratios (RRRs) between study arms for substance use rates during follow-up, while accounting for the cluster-sampling design. The analysis dataset included all EC patients demographically matched 1:1 to UC patients (based on gender, age +/- 3 months, residence in urban vs. non-urban setting, and residence in a zip code that had <40%/40%+ college graduates based on 2023 Census data). We examined the intervention effect and prevention effect separately by stratifying all analyses by past-12-month substance use status (any/none) at baseline.
***Results**: The total analysis sample included 7340 patients (3670 per group, 713 [9.7%] reporting any past-12-month substance use at baseline), with mean age 15.0 ± 2.0 years; 53% were female, 96.5% from urban settings, and 53.7% resided in a U.S. zip code with <40% college graduates. Follow-up data were available for 2501/6627 (37.7%) among those reporting no substance use at baseline, and 212/713 (29.7%) among those reporting use at baseline. Follow-up rates did not differ between study arms (37.2% UC vs. 36.8% EC, p=.717). Compared to those with follow-up data, those with no follow-up were on average older (mean 15.1 vs. 14.8 years, p<.001), more likely to be male (48.3% vs. 44.8%, p=.004), and more likely to report substance use at baseline (10.8% vs. 7.8%, p<.001). This missing data pattern occurred largely in the UC group. Among those reporting no past-12-month use at baseline, RRRs (95% CI) of any use reported during the 12-month follow-up in the EC vs. UC group were 0.91 (0.64-1.30) for alcohol, 1.09 (0.74-1.61) for cannabis, 0.98 (0.60-1.59) for nicotine, and 1.13 (0.84-1.53) for any substance. Among those reporting past-12-month use at baseline, RRRs (95%CI) were 0.98 (0.74-1.31) for alcohol, 0.83 (0.59-1.17) for cannabis, 0.86 (0.55-1.35) for nicotine, and 0.86 (0.68-1.10) for any substance use. For past-90-day use reported at 12 months, RRRs among baseline non-users were 1.25 (0.79-1.99) for alcohol, 1.09 (0.66-1.79) for cannabis, 1.33 (0.61-2.88) for nicotine, and 1.27 (0.85-1.89) for any substance. Among baseline users, RRRs were 0.93 (0.56-1.56) for alcohol, 0.67 (0.40-1.11) for cannabis, 0.95 (0.51-1.77) for nicotine, and 0.80 (0.58-1.11) for any substance.*
***Conclusions**: In this large pragmatic trial of a computer-facilitated screening and brief intervention approach for adolescent substance use, we found no significant intervention or prevention effects on substance use rates during 12 months of follow-up. However, the study had limitations, including low follow-up rates and a low incidence of substance use. With substance-using youth more likely to be lost to follow-up in the UC group compared to the EC group, it is possible that substance use rates at follow-up in the UC group were underestimated, leading to attenuated intervention effect sizes.*

Symposium 401: Brief Interventions in Latin America
Marcela Tiburcio Sainz - Key elements for implementing the ABC program for risky alcohol use and depression in primary health care in Mexico City
Abstract:
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***Introduction:** The ABC program is a protocol for the early detection of risky alcohol use and depressive symptoms in primary care settings. It is the strategy shown to be most effective in the SCALA RCT, which was conducted in 18 clinics in 5 of the 16 municipalities in Mexico City.*
***Objective:** To expand the implementation of the ABC program for the early detection and timely treatment of harmful alcohol use and comorbid depression in health centers in 8 municipalities in Mexico City.*

Method: *The ABC program consists of a) brief training on the correct application of the screening instruments (AUDIT-C and PHQ-2), b) providing feedback on the results and offering psychoeducational materials to provoke reflection and increase motivation for change, and c) community support actions. From March 2023 to June 2024, 91 two-hour sessions were held to train 1,750 healthcare professionals from different areas working in 63 clinics across eight municipalities in Mexico City. Following the training, monthly monitoring was conducted to collect screening questionnaires and support professionals who required it. The average number of screenings performed per professional was obtained, and a* $\chi 2$ *analysis was used to compare the percentages of professionals who performed screenings by sex, profession, and jurisdiction.*
Results: *45% of professionals incorporated screening into their routine practice and performed 13,906 screenings on clients over 18 during the study period. More than 60% of the population served were women, 62.4% had a score indicating a medium risk level associated with alcohol consumption, and 5.4% presented a high-risk requiring referral to specialized treatment. Furthermore, 17.6% were at risk for depression, and 10.3% were at risk for death. More than half of the patients received the expected care from healthcare professionals and received printed material to supplement their care. Training in the ABC program was replicated among colleagues; however, professionals who received direct training performed a greater number of screenings than the group of professionals with indirect training.*
Conclusions: *Given the diversity among municipalities and clinics, flexible programs that can adapt to the available human and material resources are required. Among the factors that can benefit the success of a program of this type are: a) coordination between health authorities, research team, and civil society; b) continuously informing the stakeholders about the progress and results to adjust the strategy; c) publicly recognize the commitment of the personnel involved; d) provide materials and communicate that screening and brief counseling is part of a comprehensive policy, not isolated activities that increase the workload. Healthcare professionals who could record screenings and referrals as part of their monthly productivity metrics had more detections. Institutional support from health authorities was essential to implementing the ABC program.*

Presentations 402: Young Adults and Youth
Ashli Owens-Smith - A multi-level approach to reducing substance misuse among refugee/immigrant/migrant (RIM) young adults
Abstract:
Authors: Owen-Smith, A., Paralitici, V., Fatima, H., Sirohi, A., Seal, P., Popova, L., Nyman, A., O’Connor, M.H.
Georgia State University

Young adults from refugee, immigrant, and migrant (RIM) backgrounds face higher substance misuse risks due to pre-migration trauma and post-migration stress. A multi-level intervention guided by SAMHSA’s Strategic Prevention Framework and in collaboration with a Youth Advisory Board (YAB) was designed to increase awareness about and reduce misuse of nicotine vaping, alcohol and marijuana in RIM young adults in Georgia. Intervention strategies included (1) a social media campaign targeting young adults featuring community leaders, non-profit staff, and clinical providers and disseminated through the Georgia State University Prevention Research Center Instagram account and (2) a brochure and webinar campaign targeting parents. The social media campaign demonstrated significant engagement. In its three months, total views reached 9,334, a 198% increase in activity on the GSU PRC Instagram page compared to the previous three months. The campaign reached 1,912 accounts: a 168% increase since the campaign’s launch. Of these, 46.2% were non-followers, highlighting the campaign's success in attracting new audiences. Engagement varied by content type: videos, especially one featuring an Afghan American physician, outperformed static posts; YAB members similarly reported preferring shorter videos with community leaders. The brochure and webinar campaign data will be available by the time of the conference and will also be presented.
Our findings highlight the importance of community engagement and culturally relevant content in health promotion. It remains crucial to develop and implement culturally and linguistically responsive health education resources to enhance awareness and motivate behavior change. Future efforts will focus on video content to increase reach and impact.

Ashley Helle - Tailoring Brief Motivational Interventions on College Campuses: Providers Perspective on Implementation Practices

Abstract:
Ashley Helle, PhD. & Joan Masters, M.Ed.
University of Missouri

Background: *Risky drinking among college students remains a primary focus for prevention and early intervention efforts on college campuses given the prevalence of high-risk alcohol use and alcohol-related consequences among this population. The College Alcohol Intervention Matrix is a resource developed by NIAAA to help campus professionals select evidence-based alcohol misuse prevention strategies in order to meet the needs of this population (students) in this particular setting (campuses) (Cronce et al., 2018). One highly effective strategy is Brief Alcohol Screening and Intervention of College Students (BASICS; Fachini et al., 2012), which includes brief measures and personalized feedback, followed by a brief intervention with a trained facilitator who uses motivational interviewing approaches to engage the student, review personalized feedback, and collaborate on goal setting. Higher education settings have several well-established barriers to implementing evidence-based alcohol prevention (e.g., Cimini & Martin, 2022; Helle et al., 2025). Many campus providers indicate they need to tailor evidence-based practices to fit the unique contexts of their campuses and student body. Prior work identified 48% of campuses in a statewide coalition were planning to implement a brief motivational intervention (BMI), suggesting areas for increased dissemination and adoption, with consideration of barriers and tailoring processes (Helle et al., under review). There is little research evaluating the adaptation process and outcomes of many of these programs.*
Materials and Methods*: Using an implementation science approach, we surveyed a sample of higher education prevention professionals (n=166) from the United States who reported on implementation and adaptation of brief motivational interventions (BMIs) for alcohol prevention with college students. Centering provider needs, barriers, and current practices provides important data regarding next steps in how to best support providers who need to tailor programs. Snowball sampling technique was used and all survey measures were completed remotely. Providers were compensated for their time with an electronic gift card. The data used in this proposal are part of a larger study examining adoption and implementation of evidence-based alcohol prevention and use of the CollegeAIM Tool in higher education settings (NIH funded research, K08AA028543; PI: Helle).*
Results: *Results indicate 74% of the sample reported they tailor evidence-based alcohol prevention/treatment programs on their campus. More than half (61%) endorsed use of a BMI (e.g., BASICS), and of those, most (91%) integrate motivational interviewing, protective behavioral strategies (91%), and goal setting (82%). Fewer provide psychoeducation about alcohol (62%) and discuss personalized feedback results (61%). There was wide variation in the types of professionals who provide the BMIs on campus, including health educators, counselors, student conduct officers, and residence life staff, highlighting the unique infrastructure of higher education student support and suggesting training on evidence-based BMIs and adapting programs is needed across campus offices. Qualitative feedback from participants indicates many components of alcohol BMIs are developed at and for the campus, implemented at varying times and in various offices/departments, and adapted for other topics.*
Conclusions: *Collectively, the results indicate campuses are implementing BMIs with varying components, suggesting tailoring and adaptation from the evidence-based programs. Taken together with past literature, it is understandable that many campuses would need to tailor programming to fit the needs of their own campuses. Additional support for campuses to receive regular and ongoing training for various offices on campus in the areas of program components and delivery, adaptation, and monitoring fidelity is important to the implementation process and adherence to evidence-based practices while considering the unique needs of the students and context.*

Shauna Acquavita - Incorporating SBIRT into a broader behavioral health training program targeting faculty, staff and student on college campuses: Initial findings
Abstract:
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Professor, Professor and Associate Director of the School of Human Services
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There is an urgent need to address substance use, misuse, and dependence across university campuses in the United States. High-intensity drinking (having 10 or more drinks in a row in the past two weeks) has increased over the past decade (NIDA, 2022). Rates of simultaneous use of alcohol and marijuana use have also increased, with higher use among Black students (Hai et al., 2022). Nationally, 14.5% college students reported misusing stimulants, with most students who misuse stimulants (63%) began misusing during college (Baker & Miracle, 2022). In Ohio, nearly 39% of young adults binge drink, as compared to the national average of 35% (SAMHSA, 2020). Also, over the past 15 years, there has been an increase from 29% to 36% in cannabis use (SAMHSA, 2020). Consequences of substance use among college students include lower academic performance, less likely to be employed post-graduation, and an increased risk of committing and experiencing sexual assault (Welsh, Shentu & Sarvey, 2019). University faculty, staff and students can provide a role in identifying individuals engaging in substance misuse and referring them to be assessed. Currently, there is scarce literature on examining the role of peer-led interventions to reduce substance use in college students (Lavilla-Gracia et al., 2022) and no information on training faculty and staff on the use of SBIRT.
An SBIRT training module was embedded into a larger interprofessional, evidence-based training that focused on mental health awareness, de-escalation knowledge and skills, educate on referral pathways and how to access available behavioral health services in the community. Specifically, this SBIRT training evaluation examined whether 1) SBIRT knowledge improved overall following the training and 3 and 6-months following and if there was a difference in improvement by training group; 2) training groups (general students, criminal justice students, and faculty/staff) differed by which training components they used; 3) general referrals differed by training group from the 3 to 6 month time points; 4) specific self-help referrals differed by training group. Participants (n=136), including 97 students and 39 faculty/staff completed a survey at pre, post, 3, and 6 month follow up time points. Participants were assessed for their SBIRT knowledge and completed items indicating which components of SBIRT were utilized, how many general referrals they made, and whether they made referrals to self-help groups such as Alcoholics Anonymous or the National Domestic Violence Hotline). Data were analyzed using a series of ANOVA and chi-square tests.
A repeated measures ANOVA was conducted to examine the effect of time on SBIRT knowledge scores. The main effect of time was significant, $F(3) = 3.43$, $p=.018$, partial eta-squared = .052. There was not a significant interaction between time and training group, $F(6) = .11$, $p= .995$, partial eta squared = .003. Post-hoc tests revealed that post-test and 3-month SBIRT scores were significantly higher than pre-test scores, but at 6-months, significance was no longer achieved. A repeated measures ANOVA was conducted to examine the effect of time on referrals post training knowledge. The main effects of time and interaction effects were not significant; however, the main group effect was significant ($F(2) = 4.25$, $p=.018$), with post hoc comparisons indicating referral activities were higher for faculty/staff in comparison to students. No other differences in groups were found. Chi square tests revealed no statistical differences between groups on which SBIRT components were used and specific self-help referrals.
This training is an innovative approach to preparing students, faculty, and staff to use SBIRT in combination with another general mental health awareness training. SBIRT knowledge improved following the SBIRT training, but these effects diminished by the six month training period. Referral activities differed by group; however, these may be due to their different roles. Faculty and staff may be more likely to identify students who are unable to meet their academic demands due to substance use and related mental health concerns. These individuals appear to respond well to the trainings and maintain higher referral activities, especially in comparison to students. Peer interventions remain important, as this group may facilitate discussions with students and have greater influence in changing behaviors. Examining ways for participants to retain knowledge long term on SBIRT is needed.

<u>Presentations 404</u>: Digital Strategies for Screening and Intervention

Mike Cheng - From TAPS to Treatment: Design, Development, and Implementation of the UCSF SBIRT Collaborative Care Program
Abstract:

Authors: Mike KW Cheng, MD, MAEd (1), Irina V Kryzhanovskaya, MD (2); Peggy Korpela, MPH (1); Jesse Ristau, MD (2); Emma Samelson-Jones, MD (3); Chelsea Landolin, MS, NP (4); Carolyn Stead, PsyD (5); Jason M Satterfield, PhD (1)

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Background. *Within our institution, and nationally, there is a high prevalence of people with at-risk substance use and untreated substance use disorders (SUD). Screening, brief intervention, and referral to treatment (SBIRT) provides an established process to transform frontline clinical screening and management, but various barriers to implementation have limited the clinical impact of the model. These barriers specifically include lack of provider bandwidth and knowledge, and access to SUD resources. Stepped collaborative care models have been validated for chronic behavioral conditions like depression and provide avenues of addressing such conditions in a manner that offloads some of the burden of care from providers onto a multidisciplinary team with targeted expertise and dedicated time; they hold promise for addressing SUD. Building on the University of Washington AIMS Center model, a pre-existing UCSF Depression Collaborative Care Program, and utilizing a site-specific clinic champion, we developed and piloted the UCSF SBIRT Collaborative Care Program (SBIRT-CCP). The clinic champion, through a formal needs assessment and through partnership with key clinic and enterprise stakeholders, developed a robust screening protocol and built a digital and tangible infrastructure to support this universal screening. Our program developed and implemented a new comprehensive substance use registry for those who screen positive to receive outreach from our multidisciplinary team. The program offers a referral pathway to comprehensive SUD diagnostic evaluation, medication consultation, and brief psychotherapeutic interventions, such as cognitive-behavioral therapy and motivational interviewing. We review the findings from this feasibility pilot.*

Materials and Methods. *SBIRT-CCP develops, implements, and evaluates a multidisciplinary, team-based approach to SBIRT in primary care. Universal pre-screening occurs annually using evidence-based instruments: the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) in combination with an edited version of the Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS 1 and 2). These instruments were fully integrated into the EPIC electronic health record and are followed by a more in-depth assessment and brief intervention (BI) by the Primary Care Provider (PCP), for individuals with positive screens. To further engage and guide PCPs, EPIC Best Practice Alerts (BPAs) were activated for all patients screening positive, encouraging action on the part of the PCP. PCPs were supported with EPIC dot phrases and smart sets to facilitate interpretation of screening results, review DSM criteria for SUD, and explore both in session interventions and external referrals. All at-risk individuals were then added to a clinical registry managed by patient care coordinators trained in motivational enhancement and harm reduction. Patients were triaged by the CCP to varying intensities of collaborative care follow-up based on degree of risk, unmet social needs, patient readiness, and local clinic and treatment resources. Qualifying patients were referred to a centralized "CCP Case Conference team" comprised of licensed clinical social workers, psychiatrists, psychiatric nurse practitioners, addiction medicine physicians, and clinical trainees for more in-depth assessments, brief treatment (BT), pharmacotherapy, and/or facilitated referrals to specialty care. Discussions are recorded in a care coordination note in EPIC and routed to the PCP. The SBIRT-CCP and clinical processes were developed and tested in one adult primary care clinic in collaboration with local SBIRT experts, addiction specialists, an internal clinic champion, and community members. The internal champion collected feedback via post-pilot Qualtrics survey and through verbal feedback at unit meetings.*

Results. *An adult primary care clinic in the UCSF Division of General Internal Medicine was chosen as the pilot site based on size, diversity, and leadership buy-in. This clinic is comprised of a variety of clinicians (n=11 faculty, n=13 residents, n=5 nurse practitioners) and serves a socioeconomically diverse patient population (39% White, 27% Asian, 10% Latinx, 10% Black, and 15% other). 93% are English-speaking. 56% have*

private insurance, 34% have Medicare, and 10% have Medi-Cal. The SBIRT CCP pilot started 09/2024 with a review of all QI performance data on 04/14/25.
The needs assessment survey, completed by 24% of providers, showed that the top three barriers for addressing SUD in clinic are limited access to addiction medicine referrals, inadequate time, and competing priorities. Additionally, the majority named computerized screening, medical assistant involvement, and system-wide screening with regular reminders as the most useful screening components.
During the pilot period, n=4,164 unique patients were seen in the clinic. N=1,119 were screened for alcohol use with the AUDIT-C (26.8%). N=1,938 were screened for illicit and prescription drug misuse with the TAPS 1 and 2 (46.5%). Of those screened, n=237 (19.6%) screened positive for at-risk alcohol use only and n=386 patients (19.9%) screened positive for at-risk drug use only. A total of n=1,074 patients successfully completed both the TAPS 1&2 and AUDIT-C screenings, and out of those successful completions, n=60 patients screened positive on both instruments (5.58%). 34.7% of providers took action and responded to the BPAs and only 4.72% of patients who screened positive declined contact.
At present, n=37 patients have been presented in case conference and n=20 have participated in brief treatment. Qualitative pilot feedback from medical assistants mentioned that the screening process has been easy and brief with suggestions to include electronic survey administration, non-English resources, and revision of a few screening questions for clarity. Provider feedback on the screening process included two suggestions. One was to lower the level of TAPS sensitivity relative to what constitutes at-risk substance use as it was considered too "sensitive;" a second was greater use of patient communications to increase awareness of the program and give patients a mechanism to directly opt-out of the screening process.
***Conclusions.** The UCSF SBIRT-CCP team designed, implemented, and executed a pilot program incorporating universal screening and brief interventions for alcohol and drug use in a primary care clinic through the use of a strong guiding model, a needs assessment, lessons learned from other behavioral health screening programs, and close coordination with pilot site leadership and a site-specific champion. Screening rates for SUD were well below 100% but were seen as notable given this first pass for implementation. Staff noted minimal burden, providers were highly engaged with the new best practice alert, and few patients declined care. Future improvements guided by feedback will include development of non-English resources, increasing the score threshold for the TAPS surveys that trigger CCP engagement with patients, rapid review of QI data, developing strategies to promote better direct patient communication. Overall, the multidisciplinary CCP team brings expertise and dedicated bandwidth to support primary care providers. The program has been seen as filling a long-unmet need and is well-positioned to scale to serve more clinics. We aim to expand to 4 other adult primary care clinics within UCSF in 2025.*

Katarina Gunnarsson - The Impact Of Research Participation Effects On Simulations Of Long-Term Outcomes Of A Digital Alcohol Intervention Targeting Online Help-Seekers
Abstract:
Katarina Ulfsdotter Gunnarsson, Martin Henriksson, Marcus Bendtsen
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***Background:** The term 'research participation effects' (RPEs) is intended to capture features and artifacts of study design that may affect measured outcomes in ways that introduce bias into findings from randomised controlled trials (RCTs). As findings from RCTs provide a foundation for assessing the cost-effectiveness of interventions, this study aimed to quantify the impact of four RPEs on simulated long-term outcomes of a digital alcohol intervention by accounting for their impact on the intervention's estimated effect.*
***Study design and Setting:** We used an individual-level simulator to estimate the long-term outcomes and cost-effectiveness of a digital alcohol intervention compared to treatment-as-usual. We adjusted the estimated relative effect of the digital alcohol intervention to account for four potential RPEs that was identified in a systematic review. The four potential RPEs induced by study design choices were: informed consent, assessment, group allocation, and waiting list. We ran simulations incorporating each RPE individually and in combination, comparing outcomes with a base scenario where no RPEs were accounted for.*
***Results:** When accounting for RPEs stemming from the use of waiting lists, the hazard ratios for alcohol-related liver disease and liver cancer were shifted towards the null. Conversely, when accounting for assessment, hazard ratios were shifted away from the null. This suggests that not accounting for RPEs may result in both over- and underestimation of long-term outcomes where the causal link between alcohol and*

incidence is strong. This notwithstanding, overall, the impact that RPEs had on the simulation of long-term outcomes was minimal, and the digital alcohol intervention remained cost-effective across all scenarios.
***Conclusion**: Accounting for RPEs did not markedly alter the estimated cost-effectiveness of a digital alcohol intervention, however, there were differences in incidence rates which could be relevant when analysing interventions with more modest effects. RPEs can impact participants in ways that are not fully addressed by accounting for them in analyses; thus, additional measures are needed to protect participants from potential negative consequences of trial participation.*

Presentations 405: Innovative Screening Methods

Felicia Chi - Self-reported alcohol use through screening by medical assistants versus self-administration: a population-based retrospective study in a healthcare system with systematic alcohol screening in adult primary care

Abstract:

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***Background.** Unhealthy alcohol use is common among primary care patients and is associated with numerous medical and mental health comorbidities and social and legal issues. Systematic alcohol screening in clinical settings has been found to be an effective way to identify those drinking at unhealthy levels, with several screening instruments shown to be valid and reliable. However, some recent studies suggest that screener self-administration may elicit franker and more accurate reports of alcohol consumption quantity and frequency than clinician-administered screening. Kaiser Permanente Northern California, a large US health system, implemented systematic alcohol screening in adult primary care in 2013. The current study takes advantage of changes in modality of screener administration which occurred as a result of the COVID-19 pandemic.*
***Methods.** A retrospective observational study of adult primary care patients aged 18+ with an alcohol screening between 1/1/2023 and 12/31/2024, by Medical Assistant (MA) or self-administered through secure messaging (n=2,265,588). We compare responses of self-reported alcohol use (heavy drinking days/past 3M, typical drinking days/weeks, typical drinks/drinking day, drinks/week) acquired through screening by MA versus self-administered, using inverse probability weighting to account for selection of screening modality. Patient demographic and clinical characteristics extracted include age, sex, race and ethnicity, body mass index, smoking, Charlson index, substance use and mental health comorbidities.*
***Results.** Compared with those screened by MA, there were higher proportions of female (55.3% vs. 54.0%) and age <45 years (43.4% vs. 33.5%), and lower proportions of non-White (50.5% vs.62.7%), smokers (3.8% vs. 6.1%), Charlson≥1 (28.7% vs. 38.8%) and substance use comorbidities (0.8% vs. 1.1%, 0.8% vs. 1.0% and 1.9% vs. 2.9% for alcohol, drug and tobacco use disorders, respectively) among patients who self-administered the screening through secure messaging. Results from inverse probability weighted robust Poisson models indicated that those who self-administered the screening were more than 6 times as likely to report exceeding daily drinking limits (adjusted prevalence ratio [aPR]=6.70, 95% confidence intervals [CI]=6.62, 6.77), more than 4 times as likely to report ≥5 heavy drinking days/past 3M (aPR=4.77, 95% CI=4.68, 4.86), and 1.7 times as likely to report exceeding weekly drinking limits (aPR=1.71, 95% CI=1.69, 1.74). We also found significant variations in associations between screening results and screening modality by type of drinking outcomes across age and sex groups.*
***Conclusion.** Our findings suggest that self-administration of primary care-based alcohol screening may appeal to and result in higher screening rates among some patient sub-populations, compared to clinician screening. Self-administered screening instruments may also be more likely to result in self-disclosure of unhealthy alcohol use. Screening modality and patient populations are important factors to consider when planning implementation of alcohol screening programs. More research is needed into how best to destigmatize alcohol screening and facilitate patient comfort and frank disclosure.*

Maha Mian - Substance use, mental health and other comorbidities among people with HIV who use cannabis: A latent class approach

Abstract:

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***Background**: Cannabis use is prevalent among people with HIV (PWH). Many PWH who use cannabis co-use other substances and experience mental health concerns, which can complicate HIV management. Yet, little is known about specific comorbidity patterns and their effects on care. The present study applied a latent class analysis (LCA) approach to better understand complex patterns of mental health (MH), substance use (SU), health comorbidity, and HIV biomarkers , and associations with health care utilization.*
***Methods**: Data were from a cohort of N=978 adult PWH who used cannabis (94.1% Male; 58.3% White; Age $_{Mode}$=51-60) recruited from 3 HIV primary care clinics in Kaiser Permanente Northern California. Participants completed computerized SU and MH risk screening. Electronic health records (EHR) data were extracted to assess medical comorbidities (Charlson Comorbidity Index), HIV biomarkers (CD4 cell count; viral load [VL]), and utilization (specialty care and emergency department [ED] visits). Latent class analysis (LCA) was used to identify latent classes indicated by SU (alcohol, tobacco, and other), MH (depression, anxiety), health comorbidities, and HIV biomarkers. Effects of demographic predictors (sex, age, race) on the likelihood of profile membership were examined. Class membership was then used to predict specialty care and ED visits in the 12 months post-screening.*
***Results**: Five classes were identified: Health Comorbidities [58%]; Alcohol/Other SU [25%]; Tobacco/Other SU [6%]; MH [5.2%]; and MH+SU (MH+SU) [5%]. Relative to the MH class: men compared women were more likely to be in the Health Comorbidities and Alcohol/Other SU class; older patients (61+) were more likely to be in the Health Comorbidities and Tobacco/Other SU classes compared to younger patients; and Black patients compared to all other groups were more likely to be Tobacco/Other SU, MH+SU, and Alcohol/Other SU classes. Significant differences were found across class membership in both specialty care visits (c^2 = 46.00; p<.001) and ED visits (c^2 = 9.57; p <.05). Pairwise comparisons showed that the MH+SU and MH classes had a significantly greater proportion of specialty care visits compared to the Health Comorbidities and Tobacco/Other SU classes, MH+SU had a greater proportion compared to Alcohol/Other SU, and the MH classes had a significantly greater proportion compared to the Alcohol/Other SU class.*
***Conclusions**: By adopting a person-centered approach, we identified unique classes of MH, SU, and HIV biomarkers, and found notable associations between demographic characteristics and healthcare utilization. Providers may consider more targeted screening and identifying PWH who use cannabis in relation to other MH and SU behaviors. Such screening could indicate demographic subgroups with varying degrees of risk as well as barriers to effective care, to inform strategies to improve care.*

Katherine Karriker-Jaffe - Simulating effects of universal alcohol screening and brief intervention in primary care: Reduced population-level impacts for uninsured people and those covered by Medicaid

Abstract:

Katherine J. Karriker-Jaffe[1], Ivette Rodriguez Borja[2], Andy Kawabata[2], William Dowd[2], Rainer Hilscher[2], Michael Long[2], Carolina Barbosa[2], Nina Mulia[3]
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Introduction: *Primary care-based alcohol screening and brief intervention (ASBI) is an evidence-based strategy for reducing heavy alcohol use. This study simulates effects of universal ASBI in primary care to estimate impacts on alcohol consumption and alcohol use disorder (AUD) for people with different types of health insurance coverage.*
Methods: *Parameterized using representative survey data, the model simulates access to alcohol health services across the care continuum. We model outcomes for a spatially explicit synthetic population of 1.7M individuals in the greater Sacramento, CA metropolitan area. Under simulated conditions of universal screening in primary care and then universal brief intervention when indicated, we project changes in alcohol consumption and AUD over a 15-year period compared to the status quo.*
Results: *Under the status quo, across population subgroups defined based on age and type of health insurance (none, private, Medicaid, or other public insurance including Medicare and Tricare), 27.7-48.5% of the population with light alcohol use and 32.1-53.7% with heavy alcohol use were screened, and just 1.8-3.6% with heavy alcohol use received BI over 15 years. Young adults ages 18-25 were least likely to be screened or to receive BI. Among adults ages 26 and older with heavy alcohol use, under the status quo, those with private insurance (55.8%) and non-Medicaid public insurance (54.7%) had higher rates of being screened than people with Medicaid (49.8%) and those without insurance (33.3%). Under universal screening, 2.7-5.1% of the population with heavy alcohol use received BI; those with Medicaid had higher rates of receiving BI (5.1%) than people with other public insurance (3.5%), private insurance (2.7%) or no insurance (2.7%). Universal screening produced no change in heavy alcohol use (ranging from 8.2% for those with non-Medicaid public insurance to 16.5-16.8% for other groups) or AUD (4.3% and 10.6-11.3%, respectively) after 15 years. However, adding universal BI reduced the proportion with heavy alcohol use (5.7% for those with non-Medicaid public insurance and 11.6-13.1% for other groups) and the proportion with AUD (3.5% and 8.8-9.7%, respectively) after 15 years. In this simulated population, implementation of universal ASBI might avert over 71,000 cases of heavy drinking and over 26,000 cases of AUD after 15 years, with the smallest reductions in cases of heavy drinking among people who are uninsured and the smallest reductions in cases of AUD among people who are covered by Medicaid or who are uninsured.*
Conclusions: *Simulated interventions suggest universal ASBI may lead to a reduction in heavy alcohol use and AUD, but differences in care receipt would impact subgroup outcomes for young adults, uninsured people and people covered by Medicaid. To reduce population burden of heavy alcohol use and AUD, providers should intervene when screening indicates risky drinking.*

Presentations 501: Mental Health Comorbidity and Legal System Involvement
Alexandra Bakou - Supporting adults with problematic drug and alcohol use (PUAD) who present to A&E with self-harm or suicidal ideation: Reflections from the ASSURED study
University of London

Abstract:
Background
People with self-harm and suicidal ideation are increasingly presenting in Emergency Departments (ED) in the UK. Self-harm (SH) and suicidal ideation (SI) are key risk factors for suicide. NICE recommends that people who present with self-harm receive a psychosocial assessment conducted by specialist mental health practitioners in the ED. However, while many people need further support, there is often limited capacity and access to resources and treatment. Additional barriers to treatment and participation in research are experienced for people who experience problematic drug and alcohol use (PUAD). The aim of this presentation is to reflect on researcher and practitioner experiences with screening, enrolling and delivering treatment to participants of the ASSURED study who experience SH/SI and problematic drug and alcohol use. ASSURED is a randomised controlled trial conducted in EDs for people who present with self-harm and/or suicidal thoughts. The aim of this trial is to assess the clinical and cost-effectiveness of the ASSURED intervention; a rapid, solution-focused intervention that is delivered as follow-up care by mental health practitioners in liaison psychiatry teams, compared to Treatment as Usual (TAU). ASSURED is an NIHR-funded study and has received National Health Service (NHS) Ethical and Health Research Authority (HRA) approval (IRAS: 279991).

Materials and Methods
This presentation will focus on the delivery of the intervention (narrative interviewing, enhanced safety planning and the solution-focused approach) and the experiences of people with PUAD and practitioners receiving / delivering the ASSURED intervention.
Results
Data collection and data extraction for the ASSURED Trial is ongoing and scheduled to finish in June 2026.
Conclusions
Despite organizational and practical barriers with screening, approaching and enrolling people with PUAD in the ASSURED study, we successfully enrolled people with PUAD in our study and managed to successfully deliver the ASSURED intervention.

Akemi Mii - Trauma Symptoms and Substance Use Among Youth in the Legal System: Implications for Tailored Brief Intervention
Abstract:
Authors: Sophia Garcia-Meza, Akemi E. Mii, Johanna B. Folk, Marina Tolou-Shams
Department of Psychiatry and Behavioral Sciences, University of California San Francisco, San Francisco, CA

Background
Substance use is highly prevalent among youth in the legal system, with approximately 50% of detained youth meeting criteria for a substance use disorder (Tolou-Shams et al., 2021). Youth in the juvenile legal system also report high rates of exposure to childhood adversity, which can result in psychiatric symptoms such as dissociation, anger, posttraumatic stress disorder (PTSD), and varying internalizing symptoms (Folk et al., 2021). Research suggests that youth may use substances as a way to cope with the impacts of traumatic experiences. Importantly, adolescent substance use is also known to be a risk factor associated with continued system involvement and engagement in continued delinquent behaviors (Teplin et al., 2002).Initial contact with the juvenile legal system is initiated by petitions filed for status or delinquent offenses. Delinquent petitions result from behaviors that are criminalized for all individuals (e.g., assault, larceny) whereas status petitions are behaviors that are criminalized only for minors (e.g., truancy, underage alcohol use). Research among youth involved in the legal system has predominately focused on those with delinquent offenses and less is known about youth with a status offense. Public perception of delinquent offenses being more "severe" than status offenses could explain this discrepancy. Youth who incur a status versus delinquent offense may have a different array of behavioral health needs when first making contact with the legal system. Examining potential differences in substance use and trauma symptoms among youth receiving status versus delinquent petitions is crucial for successfully implementing brief interventions at first time legal contact that promote wellbeing, reduce substance use, and ultimately reduce likelihood of further system entrenchment and recidivism. This study aimed to investigate the association between trauma symptoms and substance use among youth who have first time legal system contact and examine how this association may differ across petition type.
Materials & Methods
Youth (ages 12-18) were recruited from a northeastern Family Court in the United States with a first-time, open status and/or delinquent petition between June 2014 to July 2016. Youth and their caregiver were asked to complete assessments every four months during a 24-month period. This analysis focuses on data collected at the first four timepoints (baseline, 4-months, 8-months, and 12-months).
Youth's age, gender, ethnicity, and petition type were assessed in the demographics survey.
Trauma exposure and posttraumatic stress symptoms were gathered through the 9-item National Stressful Events Survey PTSD Short Scale (NSESSS; Kilpatrick et al., 2013). Responses were collected on a 5-point Likert scale: none (0), mild (1), moderate (2), severe (3), and extreme (4). A response option of "I have never experienced a stressful event" was included, and a negative response indicated trauma exposure. Raw scores were summed and then converted to the average total score indicating level of clinical symptomology.
Substance use was assessed through the Adolescent Risk Behavior Assessment (ARBA). At baseline, youth self-reported whether they had used alcohol and/or cannabis in their lifetime. Additionally, youth reported on their frequency of alcohol and cannabis use in the past 120 days at baseline and 8-month assessment timepoints. Lastly, youth were asked to rate how likely they were to use alcohol or other drugs in the future on a 10-point scale (1 – unlikely to 10 – very likely) at baseline and 8-month assessment timepoints.
Results

Youth (N = 401) were 14.53 years on average (SD = 1.54) at the time of enrollment. The sample consisted of 56.6% males and 42.9% females. Youth self-identified as 46.9% White, 18.0% Black, 17.8% Other, and 17.5% Multiracial. Youth identifying as Latine comprised 42.9% of the sample. Youth who received a status petition constituted 48.5% of the sample (n = 194) and 51.5% of youth received a delinquent petition (n = 206). One participant had missing data regarding their petition type.
At baseline, a majority of youth reported exposure to at least one traumatic event (79.3%). Additionally, youth had a mean score of 1.145 on the NSESSS (SD = 1.063), indicating youth reported mild trauma symptoms across the sample at baseline. At baseline, approximately one third of the sample (32.9%) reported lifetime alcohol use (on average 1.2 days, SD=5.6 days in the past 120 days) and 49.3% reported lifetime cannabis use (on average 13.6 days, SD=32 days in the past 120 days).
NSESSS baseline scores were positively correlated with lifetime use of alcohol, $r(333) = .145$, $p = .008$, lifetime use of cannabis, $r(329) = .131$, $p = .017$, likelihood to use drugs in the future, $r(333) = .249$, $p < .001$, and past 120 day use of cannabis reported at baseline, $r(318) = .166$, $p = .003$, and at 8-months, $r(242) = .144$, $p = .025$. There were no significant associations found with the frequency of alcohol use at baseline or 8-months.
Bivariate findings. When analyzing differences by first-time petition type (status versus delinquent), youth with first-time status petitions reported more severe baseline trauma symptoms (M = 1.285, SD = 1.102) than youth with a first-time delinquent petition (M = 1.026, SD = 1.034); $t(333) = 2.213$, $p = .028$. Alternatively, youth who received a first-time delinquent petition were more likely to have ever used cannabis than youth who received a first-time status petition, $\chi 2$ (1, N = 401) = 3.967, $p = .046$.
Among youth with a status petition, trauma symptom scores at baseline were also positively correlated with self-reported likelihood to use cannabis in the future, $r(153) = .248$, $p = .002$. Further, likelihood of using cannabis use in the future was correlated with more cannabis use, $r(153) = .490$, $p < .001$ and alcohol use at 8-months, $r(152) = .263$, $p < .001$.
Among youth who received a delinquent petition, trauma symptom scores at baseline were positively correlated with lifetime use of alcohol, $r(180) = .164$, $p = .027$, cannabis, $r(176) = .238$, $p = .001$, and likelihood to use drugs in the future, $r(180) = .263$, $p < .001$, and past 120 days use of cannabis reported at baseline, $r(172) = .236$, $p = .002$. Likelihood to use alcohol was positively correlated with 8-month alcohol use, $r(145) = .177$, $p = .033$ and cannabis use, $r(148) = .250$, $p = .002$. Finally, likelihood to use other drugs was positively correlated with 8-month alcohol, $r(145) = .173$, $p = .037$ and cannabis use, $r(148) = .465$, $p < .001$.
Conclusions
These results indicated that a significant proportion of youth report trauma exposure and substance use at first time contact with the legal system. Interestingly, youth with a first-time status petition reported more trauma symptoms than youth with a first-time delinquent petition. Despite that, youth with delinquent petitions reported more cannabis use. Across both status and delinquent petitions, an increase in trauma symptoms was associated with increased future likelihood of cannabis use. This increase in likelihood of cannabis use was positively associated with increased substance use over the 8-month follow-up. Findings suggest that trauma symptoms may precipitate a desire to use cannabis among youth in first time contact with the legal system. This population, particularly those with status offenses, shows a clear need for intervention despite them being categorized as “less severe” and subsequently dismissed from receiving mental health and substance use treatment and services. Research thus far reveals a gap in knowledge surrounding brief trauma treatments and their utility, suggesting that considering adapting brief substance interventions to be trauma-responsive could be useful. Varying research has supported the finding that substance use is a common way to cope with trauma (Johnson et al., 2023), further emphasizing the importance of targeting externalizing trauma symptoms to reduce substance use (Tolou-Shams et al., 2023). Implementing targeted interventions that address substance use within a trauma-responsive perspective, especially for youth with early contact with the legal system, could help to reduce substance and future entrenchment in the legal system for this population. Particularly, brief substance use interventions may incorporate emotion regulation skills and psychoeducation about trauma responses and substance use consequences.

Cristina Loria Alfaro (Marcela Tiburcio Sainz) - The severity of substance use-related problems: A proposal for its assessment
Ramón de la Fuente Muñiz National Institute of Psychiatry, Calzada Mexico-Xochimilco 101, San Lorenzo Huipulco, Tlalpan, 14370 Mexico City, Mexico.

Abstract:
This research sought to address a gap in addiction research by developing a psychometrically sound instrument to measure the perceived severity of problems associated with substance use. The study was divided into three phases: in the first one, problem areas were identified through focus groups, considering the perception of people who use substances; in the second phase, a Likert scale was developed; and in the third phase, this scale was validated. The study included 264 participants from Mexico City, San Luis Potosí, and Mérida, all of whom were undergoing treatment for substance use and could give informed consent.
The study resulted in a concise (33-item) and self-applicable instrument with adequate psychometric properties. It assesses how substance use affects various areas of life, including physical, psychological, social, professional, academic, and family. Men tend to report more serious problems in almost all areas, except psychological well-being, which is mostly reported as problematic by women. Its value lies in its ability to provide a more nuanced, individualized assessment of the impact of substance use by focusing on perceived severity rather than just presence. This tool can be used by mental health professionals in clinical settings as an initial screening and diagnostic aid to prioritize interventions and inform treatment planning, helping to track patient progress in a sustained and meaningful way.
The findings reinforce the idea that recovery is a complex, multi-faceted process that requires a holistic approach, as outlined by the biopsychosocial model. Substance use assessment is crucial for identifying individuals with substance-related problems, especially for early identification and brief interventions.

Presentations 502: Reaching Youth Across Modalities and Settings
Andrea Kline-Simon - Provider use of a Centralized, Virtually-Delivered Modality of SBIRT in Adolescent Medicine
Abstract:
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Background.
Screening, Brief Intervention and Referral to Treatment (SBIRT) for adolescents is an effective approach to early identification and intervention in pediatric primary care (an opportune setting for delivering SBIRT, as many adolescents have access to healthcare services). However, despite strong support, large-scale adoption and implementation of SBIRT for adolescents has not been achieved. Some factors contributing to these sub-optimal rates of implementation include time constraints, provider availability and training, and lingering hesitancy about addressing behavioral health problems. Previous research found an in-person clinician modality of SBIRT to be successful, resulting in positive patient outcomes. However, concerns of cost-effectiveness and an increased workload burden for providers limited full scale implementation. One potential solution is a centralized, virtually delivered modality of SBIRT that is rapidly accessible by multiple pediatric primary care clinics. However, its feasibility and acceptability are unclear, and it is unknown whether providers will use this type of resource if it's not physically located in their clinic.
Methods.
This study examined referral, assessment and intervention rates achieved using different modalities of SBIRT including in-person modalities where after screening positive for alcohol or drug use, SBIRT was delivered by the Primary Care Provider or an embedded Behavioral Clinician as well as a virtual modality with a centralized, Behavioral Clinician who supplied interventions virtually for a group of clinics. Both studies took place at Kaiser Permanente in Northern California where screening for substance use and mood symptoms is conducted routinely during all primary care visits for adolescents. The in-person modalities were part of a randomized controlled trial where pediatricians within one medical center were randomized to one of the in-person provider SBIRT delivery arms or to usual care. The study examining the virtual modality is part of an ongoing pragmatic, non-randomized trial which implemented a centralized, virtual modality of SBIRT delivery to assist pediatricians in treating adolescent patients who are at risk of an alcohol or other drug (AOD) use disorder. We examined referral and intervention rates across the various intervention modalities – pediatrician delivered, embedded behavioral clinician delivered, or centralized, virtual behavioral clinician delivered – for adolescent patients (aged 12-17) who endorsed past year alcohol and/or drug use.

***Results**. Both in-person SBIRT modalities had higher percentages of eligible patients referred for intervention compared to the current centralized virtual clinician study (16% referred to the in person behavioral clinician, 22% had substance use symptoms addressed by their pediatrician, 9% referred to the centralized, virtual behavioral clinician). In both studies, the percentage of patients referred in the usual care group (~2%) was much lower than that in any of the active intervention arms, indicating that adolescent patients receiving care from pediatricians trained in SBIRT or with access to SBIRT resources are far more likely to have those problems addressed than patients in usual care.*
***Discussion.** Prior work indicates that brief interventions with a clinician result in positive outcomes for adolescent patients at risk for substance use. Having trained clinicians who are available immediately and are focused on alcohol and other drug use can increase the access to prevention and early intervention resources. Our findings suggest that a centralized, virtual model of SBIRT was convenient and feasible as an alternative to an in-clinic clinician resource. A virtual central SBIRT modality may be a good option to cost-effectively implement SBIRT in pediatric primary care across multiple locations to improve early identification and treatment for AOD and comorbid mental health problems among adolescents.*

Debby Jones - Moving from Screen and Refer (SRT) to Screening, Brief Intervention, and Referral to Treatment (SBIRT) Implementation with Fidelity among Youth in Oregon

Abstract:

- Debby Jones, Certified Prevention Specialist, Wasco County Youth Services, The Dalles, OR. 97058 541-506-2673
- Tracy McPherson, Principal Research Scientist, Public Health Department, NORC at the University of Chicago, Bethesda, MD 20814, USA
- Molly Rogers, Youth Services Director, Wasco County Youth Services, The Dalles, OR. 97058 USA 541-506-2667
- Giana Calabrese, Senior Research Associate II, Public Health Department, NORC at the University of Chicago, Bethesda, MD 20814, USA
- Hildie Cohen, Senior Research Director II, Health Sciences Department, NORC at the University of Chicago, 55 East Monroe Street, 30th Floor, Chicago IL 60603
- Ken C. Winters, Senior Scientist, Oregon Research Institute, Falcon Heights, MN 55108, USA

Background

Youth substance use is a public health concern in Oregon. Substance use disorder rates for youth remain above the national average, with alcohol, marijuana, and tobacco products, including vaping, being the most commonly used substances in the past 30 days. YouthThink, a community-based organization in Wasco County, Oregon has partnered with juvenile justice, schools, and community settings to prepare youth-serving professionals to shift from a screening and referral only model, to implementation of the full SBIRT model, that includes Teen Intervene, a 3-session SBIRT program that also includes a parent component), to engage the family/caregiver to prevent and reduce youth substance use and promote healthy behaviors.

Materials and methods

Youth-serving professionals in partnering organizations received training on SBIRT and Teen Intervene to build confidence and skills in the delivery of brief intervention with youth and families. Youth (N=136) were screened using the CRAFFT screening tool between 2022-2024. Screening was conducted at Youth Services (n=82), Northern Oregon Regional Correctional Facilities Juvenile Detention Center (n=13), and What's Strong With You middle school program (n=41). Youth who scored at low (0), moderate (1-2), or high risk (3+) were provided BI, RT, and/or follow-up based on their level of substance use risk. As part of the delivery of the brief intervention, a subset of youth were offered participation in Teen Intervene.

Results

At the start of the program, only screening and referral were conducted. At three years post-implementation, youth-serving professionals implemented the full SBIRT model, including follow-up. 39% scored at low risk (n=52), 35% scored at moderate risk (n=47), and 26% scored at high risk (n=35) on the CRAFFT. Among youth who screened at moderate risk (n=47) and high risk (n=35), 83% and 26% were provided BI, respectively. Among youth at moderate or high risk who endorsed making changes in their substance use during the BI (n=77), 29% reduced their use, 32% attempted to quit, 34% employed coping strategies, and 23% abstained from risk behaviors. Referral to treatment was provided to almost all (97%) of youth who scored high risk

(n=35). Among youth with referral plans (n=56), 63% accepted referral, 39% agreed to schedule, and 18% agreed to attend an appointment within one week. 57% of youth who screened at moderate risk (n=47) and 29% of youth who scored at high risk (n=35) received a follow up visit.

Conclusions

By preparing the workforce to implement the full SBIRT model, youth-serving professionals are better equipped to conduct BI at the time of the screening, as opposed to referring out when substance use risk is present. Success of this county-wide prevention and early intervention initiative offers a strong example of how cross-sector partnerships can facilitate SBIRT implementation and promote positive outcomes among youth. It underscores the potential for statewide expansion of youth SBIRT in Oregon.

Workshop 503: Sustainable Implementation in Health Care

Jim Winkle - SBI in Medical Settings - Why is Sustainable Implementation so Elusive?

Abstract:

This workshop will lead a discussion about the barriers and possible solutions involved in sustainably implementing brief Interventions in primary care and emergency medicine settings. The presenter will describe common Screening and Brief Intervention (SBI) clinical workflows and examine how each distinct role (reception, medical assistant, clinician, triage, behavioral health specialist, etc.) can both help and hinder this workflow. Participants will be asked to brainstorm what interventions could improve each role's performance and evaluate ideas offered by the presenter and other participants.

The promises and pitfalls of delivering SBI electronically will also be discussed, including demonstrations of SBI applications. Clinical education tools, such as reference sheets and pocket cards, will be shared with participants.

The presenter, Jim Winkle, MPH, has trained hundreds of medical and behavioral providers how to implement SBI with primary care and emergency medicine patients. As the creator behind the SBIRT Oregon website, Jim has designed screening forms, clinic tools and training videos used by health professionals across the country.

Presentations 504: Brief Interventions for Alcohol and Related Problems

William Burrough - Development and Implementation of a Novel Three-Part SBIRT Training Series for School-Based Health Center Teams: Enhancing Identification, Intervention, and Collaborative Care for Youth Substance Use

Abstract:

Authors: William B Burrough, MD, MPH. Assistant Professor Pediatrics, UCSF. Evan Holloway, PhD, MA; Assistant Professor Psychiatry, UCSF. Petra Steinbuchel, MD; Professor Psychiatry, UCSF.

Background

Adolescents with substance use disorders often face significant barriers to care, including stigma, fragmented services, and limited access to youth-focused treatment options. School-Based Health Centers (SBHCs) are uniquely positioned to identify and address early substance use through integrated, team-based care and have been shown to improve health outcomes. This oral presentation will outline the development and implementation of a novel three-part training series for SBHC providers—pediatricians, health educators, social workers, and mental health therapists—focused on the Screening, Brief Intervention and Referral to Treatment (SBIRT) model.

Materials and Methods

In this proposed training curriculum, the first 60-minute session introduces evidence-based screening tools tailored for adolescent populations, contextualized by regional language and substance use patterns. It will guide providers in assessing substance use risk levels and identifying co-occurring mental health concerns, with a review of relevant diagnostic criteria. A second 90-minute session emphasizes the practice of brief intervention using motivational interviewing, incorporating hands-on skill-building and case-based learning. The final 60-minute session brings together community-based youth substance use organizations and treatment providers to strengthen referral pathways and foster interagency collaboration.This training series will be piloted in an urban, Federally Qualified Health Center (FQHC)-sponsored SBHC affiliated with a large academic institution. While this setting offers unique advantages, by partnering with the regional Child Psychiatry Access Program (CPAP), a training and consultation model now available in most U.S. states, the

implementation framework is designed to be replicable across diverse clinical environments, providing a scalable model for integrating this behavioral health training into SBHCs nationwide.

Conclusion

This novel training series aims to build the SBHC capacity to deliver early, empathetic, and evidence-informed responses to adolescent substance use, ultimately improving health outcomes through integrated, community-connected care. The collaboration with state, academic, and community-based partners helps to extend the reach of evidence-based practices while helping to break down silos and improve interprofessional collaboration. This presentation will share implementation strategies, curricular content, and anticipated outcomes, with practical insights for replication in diverse clinical settings.

POSTER PRESENTATIONS:

Trauma Symptoms and Substance Use Among Youth in the Legal System: Implications for Tailored Brief Intervention

Authors: Sophia Garcia-Meza, Akemi E. Mii, Johanna B. Folk, Marina Tolou-Shams

Department of Psychiatry and Behavioral Sciences, University of California San Francisco, San Francisco, CA

Background: *Substance use is highly prevalent among youth in the legal system, with approximately 50% of detained youth meeting criteria for a substance use disorder (Tolou-Shams et al., 2021). Youth in the juvenile legal system also report high rates of exposure to childhood adversity, which can result in psychiatric symptoms such as dissociation, anger, posttraumatic stress disorder (PTSD), and varying internalizing symptoms (Folk et al., 2021). Research suggests that youth may use substances as a way to cope with the impacts of traumatic experiences. Importantly, adolescent substance use is also known to be a risk factor associated with continued system involvement and engagement in continued delinquent behaviors (Teplin et al., 2002).Initial contact with the juvenile legal system is initiated by petitions filed for status or delinquent offenses. Delinquent petitions result from behaviors that are criminalized for all individuals (e.g., assault, larceny) whereas status petitions are behaviors that are criminalized only for minors (e.g., truancy, underage alcohol use). Research among youth involved in the legal system has predominately focused on those with delinquent offenses and less is known about youth with a status offense. Public perception of delinquent offenses being more "severe" than status offenses could explain this discrepancy. Youth who incur a status versus delinquent offense may have a different array of behavioral health needs when first making contact with the legal system. Examining potential differences in substance use and trauma symptoms among youth receiving status versus delinquent petitions is crucial for successfully implementing brief interventions at first time legal contact that promote wellbeing, reduce substance use, and ultimately reduce likelihood of further system entrenchment and recidivism. This study aimed to investigate the association between trauma symptoms and substance use among youth who have first time legal system contact and examine how this association may differ across petition type.*

Materials & Methods: *Youth (ages 12-18) were recruited from a northeastern Family Court in the United States with a first-time, open status and/or delinquent petition between June 2014 to July 2016. Youth and their caregiver were asked to complete assessments every four months during a 24-month period. This analysis focuses on data collected at the first four timepoints (baseline, 4-months, 8-months, and 12-months). Youth's age, gender, ethnicity, and petition type were assessed in the demographics survey. Trauma exposure and posttraumatic stress symptoms were gathered through the 9-item National Stressful Events Survey PTSD Short Scale (NSESSS; Kilpatrick et al., 2013). Responses were collected on a 5-point Likert scale: none (0), mild (1), moderate (2), severe (3), and extreme (4). A response option of "I have never experienced a stressful event" was included, and a negative response indicated trauma exposure. Raw scores were summed and then*

converted to the average total score indicating level of clinical symptomology. Substance use was assessed through the Adolescent Risk Behavior Assessment (ARBA). At baseline, youth self-reported whether they had used alcohol and/or cannabis in their lifetime. Additionally, youth reported on their frequency of alcohol and cannabis use in the past 120 days at baseline and 8-month assessment timepoints. Lastly, youth were asked to rate how likely they were to use alcohol or other drugs in the future on a 10-point scale (1 – unlikely to 10 – very likely) at baseline and 8-month assessment timepoints.

Results: *Youth (N = 401) were 14.53 years on average (SD = 1.54) at the time of enrollment. The sample consisted of 56.6% males and 42.9% females. Youth self-identified as 46.9% White, 18.0% Black, 17.8% Other, and 17.5% Multiracial. Youth identifying as Latine comprised 42.9% of the sample. Youth who received a status petition constituted 48.5% of the sample (n = 194) and 51.5% of youth received a delinquent petition (n = 206). One participant had missing data regarding their petition type. At baseline, a majority of youth reported exposure to at least one traumatic event (79.3%). Additionally, youth had a mean score of 1.145 on the NSESSS (SD = 1.063), indicating youth reported mild trauma symptoms across the sample at baseline. At baseline, approximately one third of the sample (32.9%) reported lifetime alcohol use (on average 1.2 days, SD=5.6 days in the past 120 days) and 49.3% reported lifetime cannabis use (on average 13.6 days, SD=32 days in the past 120 days). NSESSS baseline scores were positively correlated with lifetime use of alcohol, r(333) = .145, p = .008, lifetime use of cannabis, r(329) = .131, p = .017, likelihood to use drugs in the future, r(333) = .249, p < .001, and past 120 day use of cannabis reported at baseline, r(318) = .166, p = .003, and at 8-months, r(242) = .144, p = .025. There were no significant associations found with the frequency of alcohol use at baseline or 8-months.*

Bivariate findings. When analyzing differences by first-time petition type (status versus delinquent), youth with first-time status petitions reported more severe baseline trauma symptoms (M = 1.285, SD = 1.102) than youth with a first-time delinquent petition (M = 1.026, SD = 1.034); t(333) = 2.213, p = .028. Alternatively, youth who received a first-time delinquent petition were more likely to have ever used cannabis than youth who received a first-time status petition, χ2 (1, N = 401) = 3.967, p = .046.

Among youth with a status petition, trauma symptom scores at baseline were also positively correlated with self-reported likelihood to use cannabis in the future, r(153) = .248, p = .002. Further, likelihood of using cannabis use in the future was correlated with more cannabis use, r(153) = .490, p < .001 and alcohol use at 8-months, r(152) = .263, p < .001 .

Among youth who received a delinquent petition, trauma symptom scores at baseline were positively correlated with lifetime use of alcohol, r(180) = .164, p = .027, cannabis, r(176) = .238, p = .001, and likelihood to use drugs in the future, r(180) = .263, p < .001, and past 120 days use of cannabis reported at baseline, r(172) = .236, p = .002. Likelihood to use alcohol was positively correlated with 8-month alcohol use, r(145) = .177, p = .033 and cannabis use, r(148) = .250, p = .002. Finally, likelihood to use other drugs was positively correlated with 8-month alcohol, r(145) = .173, p = .037 and cannabis use, r(148) = .465, p < .001.

Conclusions: *These results indicated that a significant proportion of youth report trauma exposure and substance use at first time contact with the legal system. Interestingly, youth with a first-time status petition reported more trauma symptoms than youth with a first-time delinquent petition. Despite that, youth with delinquent petitions reported more cannabis use. Across both status and delinquent petitions, an increase in trauma symptoms was associated with increased future likelihood of cannabis use. This increase in likelihood of cannabis use was positively associated with increased substance use over the 8-month follow-up. Findings suggest that trauma symptoms may precipitate a desire to use cannabis among youth in first time contact with the legal system. This population, particularly those with status offenses, shows a clear need for intervention despite them being categorized as "less severe" and subsequently dismissed from receiving mental health and substance use treatment and services. Research thus far reveals a gap in knowledge surrounding brief trauma treatments and their utility, suggesting that considering adapting brief substance interventions to be trauma-responsive could be useful. Varying research has supported the finding that substance use is a common way*

to cope with trauma (Johnson et al., 2023), further emphasizing the importance of targeting externalizing trauma symptoms to reduce substance use (Tolou-Shams et al., 2023). Implementing targeted interventions that address substance use within a trauma-responsive perspective, especially for youth with early contact with the legal system, could help to reduce substance and future entrenchment in the legal system for this population. Particularly, brief substance use interventions may incorporate emotion regulation skills and psychoeducation about trauma responses and substance use consequences.

Difference between professional and Twelve-step/TSFacilitation programmes

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There is a diversity between Evidence-Based clinical and 12-Step approaches. Founding events of 12-Step meetings (12-SMs) are the spiritual experience, with an appeal to a Higher Power generated by a feeling of powerlessness; and the encounter with the other - people with whom to share problems with alcohol or other drugs in the context of a meeting.
Key constructs from these two models appear contradictory. Also, there is often a misunderstanding of 12-SMs principles among social and health workers. Nevertheless, experiences of TSF, i.e. interaction between 12-SMs and professional treatment, are common.

Questions
1- Why should patients and family members be referred through SBIRT to undergo 12-SMs or TSF interventions?
2- Upon what criteria should healthcare providers refer patients to 12-SMs/TSF?
3- How to motivate healthcare providers to refer patients to 12-SMs/TSF programmes, and motivate providers to motivate patients?
4- What are the outcomes of the interaction between health providers and 12-SMs/TSF?

Answers
1- AA/TSF interventions appear superior to other addiction treatments, in both sustained abstinence and healthcare costs reduction.
2- Referral criteria for healthcare providers are: moderate/severe AUD/SUD; local 12-SMs/TSF availability; patient's willingness to work on oneself in a group.
3- Clinicians should increase their knowledge of 12-SMs programme through attending open meetings. If patient chooses to join a 12-SM, the clinician should arrange a one-on-one encounter at the clinic with a 12-SMS member or accompany him/her to a group meeting.
4- Implementing AA interaction with clinical treatment is likely to enhance abstinence for AUD patients; referral to Narcotic Anonymous elicits comparable evidence.

Conclusion
Healthcare professionals, when applying SBIRT, should include referral to Twelve Steps/TS Facilitation programmes among the options for moderate or severe AUD/SUD patients.

TITLE: Demonstration of an Integrated SBIRT Model for Early Intervention, Emotional Wellbeing, and Family Support

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BACKGROUND: *Through funding from the Substance Abuse Mental Health Service Administration (SAMHSA), a team from Azusa Pacific University (APU) launched Project TREE (Enhancement and Expansion of Treatment and Recovery Services) in Los Angeles County catchment areas that experience significant behavioral health crisis needs among at-risk youth populations experiencing co-occurring substance use, mental health and intergenerational family trauma issues. Project TREE improves access gaps to address such issues among youth and family systems by hiring and training Youth Recovery Coordinators to implement SBIRT-early intervention substance use risk reduction services, as well as, include emotional well-being health promotion and family education support services through community partnerships, including behavioral health agencies, local schools and community based organizations that serve at-risk youth and caregivers. Project TREE's programming utilizes the structured implementation of the SBIRT model as Youth Recovery Coordinators use a screening tool to identify substance use (including tobacco), mental health risks and family functioning (with items adapted from evidence based tools). Upon risk identification, the Youth Recovery Coordinators implement personalized early intervention programming with youth and caregivers utilizing A HealthyYOUth award winning Curriculum that includes substance use and mental health risk reduction through psychoeducation, skill building and support facilitation. Appropriate referrals are also made to ASAM levels of SUD treatment as needed.*

MATERIALS AND METHOD: *A screening tool was developed for use in Project TREE by Youth Recovery Coordinators to identify substance use (including tobacco), mental health risks, and family functioning adapted from the following evidence based tools: CRAFFT 2.1+N, Generalized Anxiety Disorder [GAD]-2, PROMIS Emotional Distress - Calibrated Anger Measure, McMaster Family Assessment Device [FAD]-2, Patient Health Questionnaire [PHQ]-3 with Columbia-Suicide Severity one item screen, and ASAM 0.5 functioning domains. Project TREE also utilizes an outcome measure from SAMHSA's called the CSAT GPRA Client Outcome Measures for Discretionary Programs Questionnaire. This outcome measure collects information from youth across the following areas: 1) demographic data, 2) substance usage in the past 30 days, 3) living conditions, 4) education, employment, and income, 5) legal status, 6) mental and physical health problems and treatment recovery, and 7) social connectedness. Data collection using this outcome measure for Project TREE occurs at baseline, discharge, 3-month follow-up, and 6-month follow-up.*

Participants were recruited from three different HYC sites (Liberty Community Plaza, Whittier CRC site, and the Commerce site bordering East Los Angeles) via a Recovery Support Coordinator, who facilitated screenings for early intervention, treatment services, and recovery support services. Prior to receiving services, participants were screened for substance use, emotional wellbeing, family functioning, and suicidality. After completing the screeners, youth were administered the GPRA for baseline, then received services. Three-month and 6-month follow-up GPRA were administered to youth three months and six months from their baseline intake, respectively. Discharge GPRA was provided to youth upon youths' exit from receiving TREE services.

RESULTS: *By June 2025, a total of 162 youths had participated in Project TREE. Participants ranged in age from 13 to 24 years (M = 14.9, SD = 5.3), with most between ages 14 and 17. The sample included slightly more males (n = 95, 58.6%) than females (n = 63, 38.9%). The majority of youths identified as Hispanic, Latino/a, or of Spanish origin (n = 141, 87.0%), and over half (n = 88, 54.3%) reported Spanish as the primary language spoken at home. All enrolled youths (n = 162) completed a baseline outcome GPRA assessment along with mental health and family functioning screenings. All participants were identified as having substance use risk, with reported use spanning alcohol, marijuana, methamphetamine, sedatives, hypnotics, MDMA, synthetic cannabinoids, anxiolytics, and tobacco. Nearly half of the youths (n = 71, 43.8%) screened positive for co-occurring mental and substance use disorders as well as emotional and family support challenges. Generalized Linear Mixed Models (GLMMs) were utilized to examine improvements in substance use, mental*

health and social outcomes using GPRA data from discharge, 3-month and 6-month follow-ups. Note: follow-up retention rates for Project TREE remain high: nearly all discharged youth completed the 3-month follow-up (N=41, 97.6%), and 75.6% (n=31) completed the 6-month follow-up. Youth who participated in Project TREE early intervention services had good retention, as 75% remained engaged for at least 90 days (~3 months), 50% stayed more than 125 days (~4 months), and 25% stayed enrolled for over 210 days (~7 months).
The implementation of the SBIRT approach was associated with statistically significant improvements across multiple mental health and substance use outcomes from baseline to discharge and follow-up assessments ($p < 0.05$). Mental health outcomes showed significant reductions in anxiety at discharge, 3-month, and 6-month assessments; serious depression at 3 months; brain functioning issues at 3 and 6 months; violent behavior at 3 and 6 months; and hallucinations, which were eliminated by 6 months ($p < .0001$). Psychiatric medication use also declined significantly over time. Substance use outcomes demonstrated significant reductions in marijuana at discharge, 3 months, and 6 months; alcohol at 6 months; and complete elimination of both synthetic cannabis and methamphetamine by discharge and 6 months ($p < .0001$). Non-significant but clinically meaningful reductions were also observed across several outcomes, including depression, brain functioning issues, violent behavior, psychiatric medication use, and early follow-ups for alcohol, synthetic cannabis, and methamphetamine. Beyond symptom and substance use outcomes, perceived familial support remained strong, with supportive family and friend interactions consistently high across assessments, while satisfaction with personal relationships steadily increased, reaching nearly all youth by discharge. Though not statistically significant, these patterns suggest supportive connections strengthened throughout services.
***CONCLUSIONS:** Results from Project TREE demonstrate the effectiveness of using a SBIRT model within early intervention service programming for addressing co-occurring substance use and mental health risks among at-risk youth in community settings by Youth Recovery Coordinators. In addition, results underscore the importance of family engagement in early intervention support services for achieving improved youth participation in services (retention) and outcomes across mental health, social connectedness and substance use over time. In the future, Project TREE aims to incorporate caregiver perspectives through events, workshops, and structured feedback. Future studies should examine the long-term effectiveness of SBIRT on co-occurring disorders and expand services to system-impacted youth (e.g., unhoused, justice-involved).*

TITLE: Exploring Recovery Processes Among Youth in Recovery from Substance Use Disorders who participated in a Technology-based Recovery Support Project

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***Background:** Although engaging in recovery support programming after treatment for substance use disorders (SUD) can lead to positive outcomes, participation is very low in such services among young people. Low engagement in recovery support programming is concerning given that substance use relapse remains a critical issue among youth populations who transition out of SUD treatment, averaging approximately 60-80%. Increasing attention has been directed at utilizing alternative methods for accessing recovery support among young people to address such issues. This research explored recovery processes that could play a role in improving outcome trajectories among young people in SUD recovery using a youth sample that participated in Project ESQYIR (Educating and Supporting inquisitive Youth in Recovery) - a 3-month mHealth recovery support program.*
***Materials and method:** Cross-sectional data was obtained from 80 youth aged 14 to 26 who participated in Project ESQYIR's randomized controlled pilot trial (n = 40 mHealth texting intervention vs. n=40 aftercare as usual control condition). The youth in the sample were in SUD recovery who completed treatment at local agencies throughout Los Angeles County. The mHealth 3-month recovery support intervention included "SBIRT components" spanning monitoring [screening] of critical relapse areas (mood, stress, recovery*

confidence, recovery behaviors, and substance use), personalized feedback (text messages specific to motivational appraisal, positive coping skills, and encouragement), educational wellness reminders about recovery-directed behavior change, and ongoing recovery support/educational messages with integrated recovery coach calls to address recovery needs and necessary referrals. The control condition comprised standard aftercare practice provided by the treatment program which was often a facilitated engagement in recovery support community meetings (12-step model). Data collection occurred a week before program admission (baseline), during the program (month 1 and month 2), at program discharge (12-weeks), and at 3-, 6-, and 9-months following program discharge. We explored the following recovery process measures: Drug Avoidance Behaviors (including enhanced items of spirituality) from the Brief Addiction Monitor (BAM) and recovery perceptions from the Recovery Assessment Scale (RAS) in relation to substance use relapse outcomes.

Results: *Using mixed modeling, we examined Project ESQYIR group differences in recovery process measures over time across data collection time points. Results showed that spirituality was a significant predictor of improved recovery perceptions as measured by the RAS: personal determination (Odds ratio = 1.56; 95% CI [1.06, 2.31] ; p= 0.025), skills for recovery (Odds ratio = 1.35, 95% CI [1.01, 1.82]; p=0.049), self-control in recovery (Odds ratio = 2.02; 95% CI [1.16,3.50]; p= 0.012), and social support and moving beyond recovery (Odds ratio = 1.82; 95% CI [1.12, 2.97]; p=0.015). Results showed that the mHealth intervention youth participants with higher spirituality practices (i.e., a score higher than 5) were less likely to relapse over time compared to those in the aftercare as usual control group (OR = .97, p = .03). When including self-help participation into the model, a significant 4-way interaction (time x treatment x spirituality x self-help) was found, such that the mHealth intervention youth participants with higher spirituality practices, who engaged in more self-help meetings, were less likely to relapse across time (OR = .98, p = .033). Overall, results showed better recovery outcomes as a function of participating in the 3-month mHealth recovery support program compared to standard recovery programming (12 step facilitation).*

Conclusions*: While there is a growing body of literature on SUD recovery among youth post-treatment, there is very limited understanding of recovery processes that improve outcomes. These findings offer greater insight into specific recovery processes that support youth recovery outcomes, including spirituality and youth-driven perceptions of elements that are critical to positive recovery outcomes (e.g., personal determination, skills for recovery, self-control in recovery, and social support and moving beyond recovery). Findings also support the utility of recovery support programming that includes SBIRT components, as well as, providing youth in SUD recovery with alternative programming models that integrate technology to address barriers of engagement.*

TITLE: Enhancing Youth Behavioral Health Services through Academic-Community Collaboration: A Focus on SBIRT Integration using a Mental Health Trainee Practicum Model

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Background: *A partnership between Helpline Youth Counseling (HYC) and Azusa Pacific University (APU) was established to strengthen behavioral health services through the integration of SBIRT workforce development and capacity-building using a mental health trainee practicum model to provide co-occurring mental health and substance use disorder (COD) services to transitional aged youth in Los Angeles County. This partnership was supported by the California Community Foundation's funding initiative called the Stone Family Young Adults Forward Fund of a 1-year academic-community collaboration Project called ISPACE:*

Increasing Service Professional Aptitude & Competency through Education. This project responds to persistent barriers such as insufficient mental health workforce capacity, fragmented service integration, and limited access to training in evidence-based practices, including SBIRT and case management.
Materials and Method: *APU and HYC implemented an innovative mental health trainee internship model that consisted of instituting 5 paid mental health graduate-level clinical interns recruited from APU's PsyD and MSW programs within HYC's clinical settings throughout LA County. In addition, HYC hired a dedicated case manager to integrate specialized team-based care alongside the clinical trainees (2 PsyD, 3 MSW). The interns and case manager received specialized training in SBIRT and trauma-informed case management care coordination practices for early identification and intervention among transitional aged youth with co-occurring mental health and substance use risks. Interns were also trained in conducting follow-up mental health specialized assessment practices utilizing a comprehensive neuropsychological battery (WAIS, Brown ADD Scales, TSI-2, and Trauma Symptom Checklist), as well as, the Treatment Effectiveness Assessment (TEA) to better ensure that the services delivered met the client's ongoing needs across mental health functioning and substance use recovery. The intern and case management team utilized a technology-based platform that sent clients the TEA electronically weekly to monitor progress and adjust accordingly. Interns and the case manager were provided weekly clinical supervision using a team-based model of licensed mental health professionals to address system integration service planning needs.*
Results: *A total of 53 transitional aged (TAY) youth were enrolled Project ISPACE through targeted outreach conducted by the case manager and HYC staff weekly through partnerships with community organizations such as East Los Angeles Community College, LA Care, and Jovenes Inc. The average age of the TAY clients was M = 26.3, SD = 3.9, range: 18-30 years old. Roughly half (53.2%) of the TAY clients were female (12.7% male, and 34% not reporting gender). Ethnic backgrounds of the TAY clients comprised the following diverse areas: White (41.9%), Hispanic (38.7%), Asian (12.9%), and Black (6.4%). The most commonly reported substances among the TAY included marijuana and nicotine (27.7%, respectively), with other substances less frequently cited (including cocaine, prescription opioids, inhalants). The most pervasive mental health challenges reported among the TAY clients were depression (72.3%), stress (76.6%), anxiety (66.0%), disinterest in activities (66.0%), with a quarter (25.5%) disclosing thoughts of self-harm. Socially, TAY clients reported relational (48.9%) and financial (23.4%) challenges, but also noted having strong connections with church (78.7%) and school (70.2%). The evidence based services the clinical trainees and case manager provided to TAY clients included SBIRT (with psychological assessments), motivational interviewing, counseling services, and care coordination. Supervision provided to the trainees has been intensive (29 sessions totaling 58 hours). Care continuity is a critical part of care for Project ISAPCE, with only 3 clients of the 53 being discharged early. TEA recovery monitoring showed significant progress and improvements across 4 domains (substance use, health, lifestyle, and community involvement), reflecting early signs of recovery and increased client stability.*
Conclusions: *The ISPACE initiative demonstrates a promising mental health clinical trainee model for integrating academic-to-practice training with frontline service delivery to expand SBIRT and trauma-informed care coordination. Preliminary findings suggest this approach strengthens behavioral health system capacity, as well as improves engagement and behavioral health outcomes among TAY populations or within under-resourced communities.*