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Using SBIRT as an Intervention for Adolescent Substance Use in Public Schools

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Abstract

In Kalamazoo County, youth substance use is on the rise. In recent years (2012-2014), alcohol use has nearly doubled in the adolescent population. With the easy accessibility of alcohol in Kalamazoo, alcohol use among adolescents will continue to rise if early intervention protocols are not implemented. Screening, Brief Intervention, and Referral to Treatment (SBIRT), could be the model of intervention within Kalamazoo public schools, if implemented correctly. According to the Substance Abuse and Mental Health Service Administration (SAMHSA), SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Public schools provide opportunities for early intervention, using SBIRT, with at-risk adolescents. The effectiveness of SBIRT in adolescents has been observed through randomized clinical trials in various settings, including public schools. However, there are many challenges to be addressed for successful SBIRT implementation within the Kalamazoo public school system including feasibility, adoptability, and economic sustainability. By training school-based health providers and Communities in Schools site coordinators, SBIRT provides an accessible mode of intervention for at-risk students.

Keywords: SBIRT, adolescent substance use, public schools

SBIRT: Intervening Substance Use in Public Schools

Introduction

Alcohol is the number one drug of choice for Kalamazoo adolescents (Malta, Wendt, Kothari, Jones, Brusk...Bensley, 2015). In recent years (2012-2014), it has been reported that alcohol use by middle schoolers has risen from 4.2 to 7.8 percent (Malta et al., 2015). These high rates of alcohol use are alarming due to the potential impact on the developing adolescent. Potential consequences of alcohol misuse/abuse include delayed or stagnant brain development, death or intoxication, motor vehicle accidents, trauma, and hepatitis (Lubman, Yucel, & Hall, 2007). Secondary consequences of alcohol misuse in adolescents may include unplanned pregnancy, violence, poor academic achievements; all which may affect family and peer relationships (Miller, Naimi, Brewer, & Jones, 2007). Lastly, alcohol use during adolescence is correlated to drug experimentation later in life (Englund, Egeland, Oliva, & Collins, 2008). For purposes of this paper, at-risk drinking is defined for men as having more than 4 drinks on any day or 14 drinks per week and for women as having more than 3 drinks on any day or 7 per week (National Institute of Health [NIH], n.d.).

In 2009, out of the 1.8 million U.S. youths between the ages of 12 and 17 who needed substance abuse treatment, only 150,000 of them had received it (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Addressing this gap is necessary in moving forward to ensure a positive outcome for the affected adolescents in the Kalamazoo community. The purpose of this paper is to review the literature of the effectiveness of SBIRT on adolescents and to propose a model of implementation of SBIRT in Kalamazoo public schools (KPS) by integrating the components of SBIRT into Kalamazoo's school-based health clinics.

SBIRT

A promising model of intervention developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), includes the three components of a successful intervention: Screening, Brief Intervention, and Referral to Treatment (SBIRT). According to SAMHSA, SBIRT is a “comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders” (SAMHSA, n.d.).

Screening.

The first component of SBIRT provides a brief method of identifying individuals with or at risk for substance abuse issues. An individual would first undergo a short prescreen which consists of three questions. An example of a prescreen is as follows:

- (1) Do you drink any alcohol (more than a few sips)?
- (2) Smoke any marijuana?
- (3) Use anything else to get high?

If the individual has a positive response to the prescreen questions, a number of longer screening tools are available for use, but the CRAFFT has been recommended by the American Academy of Pediatrics’ Committee on Substance Abuse and is designed for adolescents under the age of 21 (Center for Adolescent Substance Abuse Research [CeASAR], 2009). Developed by the Children’s Hospital in Boston, in affiliation with Harvard Medical School, the screening portion of SBIRT would be as follows using the CRAFFT tool,

1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or other drugs?
2. Do you ever use alcohol or other drugs to **RELAX**, feel better about yourself, or fit in?
3. Do you ever use alcohol or other drugs while you are **ALONE**?
4. Do you ever **FORGET** things you did while using alcohol or other drugs?
5. Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into **TROUBLE** while you were using alcohol or other drugs?

The CRAFFT questionnaire is based on a point system, with each “yes” answer to a question being worth one point. If an individual has a score of more than two points on the CRAFFT, the adolescent would need further assessment. Any screening tool could be used as a longer assessment if an individual tests positive during the prescreen, but the CRAFFT is recommended for adolescents under the age of 21 and would be the most appropriate screening tool for this proposal. The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Alcohol Use Disorders Identification Test (AUDIT), Michigan Alcoholism Screening Test (MAST), and Drug Abuse Screening Test (DAST) are a few examples of instruments used for substance use screening. Lastly, there are a variety of behavioral health screening tests also available to identify individuals who have comorbid mental health conditions that may be useful for

identifying behavioral health issues that accompany the substance use problem (CeASAR, 2009).

Brief intervention.

The goal of brief intervention (BI) is to motivate at-risk individuals to change their behavior. BI's are used to inform individuals of their high risk behavior, educate the individual on potential consequences, and promote reduction or complete abstinence of substance use. The typical length of intervention can vary from 5-30 minutes of advice or brief counseling. BIs are used when appropriate for moderate to high risk use of alcohol or drugs and involves about 4-6 sessions of motivational discussion, assessment, education, coping strategies, and support (SAMHSA, n.d.). The implementation of successful BI is essential to an effective SBIRT model.

An example of a Brief Intervention discussed involves the Brief Negotiated Interview Model, developed by Stephen Rollnick. This model is composed of four components that involve the use of open ended questions, affirmations, reflections, and summaries (OARS). When raising the subject to an adolescent, it is important to ask permission and avoid conflict. When raising the subject, a provider may ask, "Would you mind if we talked for a few minutes about your alcohol (or drug) use?" This reflects the use of OARS by using an open-ended question. Using educational tools is important when providing feedback to the patient. Keeping OARS in mind, providing feedback involves reviewing reported substance use patterns, using comprehensible education tools to provide information about the effects of substance use and health, and advising the patient to refrain from substance use (Miller & Rollnick, 2002).

Assessing the patient's readiness to change, identifying pros and cons of abstaining substance use, and exploring ambivalence are all motivational interviewing (MI) techniques that are an essential part of the BI process. MI guides providers to listen for change talk from the adolescent. Change talk is represented by the acronym, DARN-C, which represents desire, ability, reasons, need, and commitment to change. As a provider, listening for change talk may be difficult because it is usually expressed subtly through phrases such as "I want", "I wish", "I can", "I have to", and "I will." If an individual is categorized by high risk or dependent alcohol or drug use, more than BI will be necessary and referral to treatment will be used for an individual to receive specialty care (Miller & Rollnick, 2002).

Referral to treatment.

The last step of SBIRT is Referral to Treatment (RT), which is only necessary for high-risk substance users. It consists of aiding the adolescent with resources to select the proper specialized treatment program or facility that will best meet the individual's needs. Using warm handoffs, the primary care provider introduces the patient to a behavioral health consultant. Potential treatment barriers such as cost and transportation need to be taken into consideration. Lastly, establishing a follow-up plan with the individual involves an active support system. The RT component of SBIRT is crucial in the success of a patient's treatment program in reducing at-risk behaviors (SAMHSA, n.d.).

Effectiveness of SBIRT on Adolescent Populations

It has been hypothesized that the SBIRT model could be a useful way to screen at-risk adolescents for substance abuse disorders and provide intervention when appropriate, to limit the risky behaviors and academic consequences that are associated with substance abuse disorders within the adolescent population (Mitchel, O'Grady, & Schwartz, 2012).

Three studies reviewed by Mitchell et al. (2012) examined the effectiveness of SBIRT in the public school setting and the results were promising. In the first, Walker, Roffman, Berhuis, and Kim (2006) conducted a study with 97 adolescents using delayed feedback control trials. The researchers found that school-based motivational interviewing sessions reduced marijuana use at the three month follow up for 9th and 10th grade students who fell within the preparation/action stage of change category (Walker et al., 2006).

Similarly, 629 New Mexico High School students received SBIRT and other support services during a multi-site, repeated measures study. From baseline to six-month follow-up, participants receiving any intervention treatment service were shown to have a decrease in drinking to intoxication and drug use, but not alcohol use (Mitchell, Gryczynski, Gonzales...Schwartz, 2012).

Additionally, a specific study focusing on the brief intervention component of SBIRT was conducted by Winters, Leitten, Wagner, and Tevyaw (2007). Previously identified at-risk adolescents between the ages of 14-17 received two brief interventions (BI) within the public school setting and were assessed after six months. The assessment conducted six-months post-intervention revealed positive outcomes on their alcohol use behaviors, compared to the control group. The evidence from this study revealed the advantages of implementing the BI component

of SBIRT in the public school system for at-risk populations (Winters et al., 2007). Winters also concluded that SBIRT in public schools increases accessibility to adolescents. Most importantly, BI in schools can identify and address issues of U.S. adolescents whose substance use has not exceeded problematic experimentation into substance dependence, utilizing SBIRT as a proactive approach in preventative care. (Winters et al., 2007).

A feasibility test of SBIRT implementation in the public school setting revealed promising outcomes for future review and guided this proposal for SBIRT integration within KPS. Curtis, Mclellan, and Gabellini (2014) studied the feasibility and economic sustainability of SBIRT implementation in two New York public schools. This analysis took place over the course of 18 months and included no control groups, meaning that all participants were screened. The eligible population of interest included 998 students between 6th and 12th grade.

Of those 998 students, 248 were screened during non-academic classes using a 15-20 minute computerized CRAFFT screen. The interactive web-based program was appealing to students as it used a video game style to cater to the adolescent population. The program provided individual feedback for the student, individualized animated videos on blood-alcohol poisoning, effects of alcohol and marijuana, as well as peer pressure. Lastly, the program provided a blood-alcohol calculator based on a variety of individual factors, such as height, weight, age, etc.

A concerning 42% of students screened positive (n=105) for substance use, compared to only 28% who anonymously reported substance use in a school-wide paper survey. All but one of the 105 positively-tested students then agreed to participate in one or more BI sessions. The BI process took between 10-30 minutes and involved discussing the results of the screen and using a

combination of MI techniques and computer-assisted counseling protocols to develop goals for the student.

The computer-assisted counseling protocol involved a feedback report for the counselor to use as an aid during the BI process. The feedback report consisted of the student ID number, CRAFFT score, risk level, discussion prompts, and one of three B/MI sessions based on the individual's risk level. Only two out of the 105 positively-tested students were referred to treatment. The outcome of this study revealed that SBIRT did not interfere with academics and was feasible to implement, and was attractive and accessible to students, teachers, and administrators. (Curtis, B., McLellan, A., & Gabellini, B., 2014)

Adolescents spend about 40% of their waking hours in school (Caldwell, Simon, & Swisher, 2013). Behavioral problems, including substance use, can interfere with academics if not treated when appropriate. SBIRT in the public school setting provides an efficient and accessible way to effectively identify and address at-risk students. The preceding studies provide substantial support for the integration of SBIRT into school-based clinics in Kalamazoo.

Kalamazoo Youth: The Effects of Alcohol on Academic Performance and Risky Behaviors

Based on data from the Michigan Profile for Healthy Youth (MiPHY), Kalamazoo County (2011-2012), Kalamazoo has reported lower alcohol usage in comparison to the state of Michigan. The data reveals that alcohol use in Kalamazoo is strongly correlated with poor academic performance. Of the 4.2% Kalamazoo middle school students reporting recent alcohol use over the past 30 days, 6.7% of those students had grades of Ds/Fs, compared to 3.2% reported students with grades of As/Bs. 20.5% of Kalamazoo County middle school students reported riding in a car driven by someone who had been drinking alcohol. Of those students,

27.1% had poor academic performance (Michigan Profile for Healthy Youth [MiPHY], 2011-2012).

Of the 21.4% of Kalamazoo high school students reporting recent alcohol use over the last 30 days, over 30% of those students had grades of Ds/Fs, compared to 19% of reported students with grades of As/Bs. 20.3% of Kalamazoo high school students with grades of Ds/Fs reporting having their first drink of alcohol other than a few sips before age of thirteen surpassed the Michigan average of 18.8% and 7.1% of reported students with grades of As/Bs.

Additionally, 4% of Kalamazoo high school students with grades of Ds/Fs reporting having at least one drink of alcohol on school property in the past 30 days also exceeded the Michigan average of 3.7% and the 1.5% of students who reported with grades of As/Bs. As it is evident that students who perform at a lower academic level tend to be involved in alcohol use, the data also suggests that Kalamazoo high school students with Ds/Fs are more likely to drive drunk (11.8%) in comparison to the Michigan average (8.4%) and students with grades of As/Bs (4.7%) (MiPHY, 2011-2012).

Although alcohol use amongst adolescents is a multifactorial issue, the data suggests that there may be a relationship between Kalamazoo students who perform lower academically and higher alcohol use. Implementation of SBIRT in the public school system may provide an accessible and effective method of reducing alcohol use and potentially increasing academic performance of the affected adolescent population, as well as limiting risky behaviors such as drunk driving that are associated with alcohol use.

Integration of SBIRT into FHC's school-based clinics will secondarily improve Kalamazoo public school's prestigious, world-class education reputation by providing an

integrative approach to the delivery of early intervention and treatment services for underserved adolescents with substance use disorders or at-risk adolescent populations. Addressing the problematic correlation between alcohol use amongst Kalamazoo's adolescents and poor academic performance will contribute to the progressive goals of Kalamazoo Public Schools to ensure student-oriented education, where students may reach their academic potential.

Proposed Model Framework

Although SBIRT is easy to implement within any healthcare setting with proper initial training and feasibility considerations, SBIRT in the public school setting provides an efficient and accessible way to effectively identify and address at-risk students. Within public schools, the student would receive integral support between parental support, professional involvement and collaboration between educators, health professionals, and behavioral health services.

With the support of the Family Health Center and Communities in Schools, Kalamazoo Public Schools would provide an accessible and promising setting to integrate SBIRT intervention for high risk substance use, promoting a healthy environment for students to maximize their potential to succeed.

School-based health clinics, Kalamazoo.

The Family Health Center (FHC) of Kalamazoo is a federally funded, non-profit health center that serves approximately 70,000 underprivileged citizens of the Kalamazoo community (Family Health Center [FHC], n.d.). The goal of the FHC is to “create a ‘medical home’ for families, children, and adults who seek answers to healthcare needs.” (FHC, n.d). Currently, the FHC has one service catering to the adolescent populations in Kalamazoo through Kalamazoo Public Schools (KPS): the Mobile Health Unit (MHU).

FHC recognizes the need to have access to basic healthcare to succeed in school and aims to provide quality care to the underserved adolescents within Kalamazoo Public Schools. Funded by the Learning Network of Greater Kalamazoo, the Mobile Health Unit (MHU) is a 40-foot-long, 300 square foot mobile doctor's office that contains two exam rooms, and a check-in/waiting room (FHC, n.d.).

Staffed with a Nurse Practitioner (NP) and medical assistant (MA), the MHU travels throughout the Kalamazoo public school district on a specific schedule, providing accessible care to students and their families. At the beginning of the school year, MHU consent forms are mailed as part of the student's orientation packet. This parental consent permits MHU care as needed for the student and their family throughout the student's time at KPS. Insurance information is also addressed and documented on the medical consent form. For those students who are uninsured, the FHC provides a sliding fee scale based on the Federal Poverty Guidelines so the student and their family may still receive care at a reduced fee based on family size and income. In coordination with KPS, the MHU works with a school-based organization, Communities in Schools, to effectively deliver care to students without it impinging on their academic success (E. Grewe, personal communication, 2016).

Communities in Schools (CIS) is an organization that places site coordinators in each of the schools within the Kalamazoo district to identify the needs of students. Taking a holistic approach, CIS supports students with their basic needs, academic assistance and health initiatives. The goal of CIS is to help students overcome the barriers that may impinge on students as well as to give them confidence to succeed in school,

graduate, and be prepared for life (Communities in Schools [CIS], n.d.). As part of their health initiative, a CIS site-leader coordinates between the student receiving care and the MHU. When a student needs care, the CIS site-coordinator is notified and an appointment is set for a convenient time in the student's schedule. This ensures the student misses as little class time as possible. At the appointment time, the CIS coordinator escorts the student to the MHU to receive care (E. Grewe, personal communication, 2016).

Once in the clinic, the student is asked a thorough list of behavioral assessment questions prior to receiving care, none of which are related to substance use. Upon physical examination, the NP uses a behavioral assessment, the PHQ-9, to screen for depression and an informal prescreen for substance use on patients who are ages 12 and older. After the appropriate services have been given, the CIS coordinator escorts the student back to their classroom (E. Grewe, personal communication, 2016).

Additionally, the Kalamazoo County Human Services Department (KCHSD) facilitates the Edison School-Based Health Center. Similar to the MHU, the Edison Clinic also provides accessibility for students to receive care during the school day at its school-based location. Although the Edison clinic is not mobile, the clinic offers more interdisciplinary services and private patient rooms (E. Oliver, personal communication, 2016).

At the Edison School-Based Clinic, clinical appointments are offered within the Edison, Washington, and El Sol schools within Kalamazoo. The clinic is staffed with professionals able to provide an array of services such as dental care, behavioral health

services, and primary care. Staffed with limited pediatric practitioners contracted through *WMed*, students and their families are able to receive walk-in services or make an appointment.

In addition to the primary care providers, clinicians include a behavior therapist, nurse, dental hygienists, and dentist. Due to the elementary student population, the providers at Edison do not focus on substance use screening, despite its potential importance for the recognition of familial substance use problems that may put the student at risk (E. Oliver, personal communication, 2016). In the proposed model addressed ahead, the Edison clinic and MHU are fundamentally important for training school-based health providers and CIS coordinators on SBIRT as an accessible mode of intervention for at-risk students in Kalamazoo.

Proposed model.

Within the Mobile Health Unit and Edison Clinic, SBIRT would be best implemented by training the on-site CIS coordinators, primary care providers (PCP), and clinical support staff. Communities in Schools site-coordinators and the Edison on-site behavioral therapists are an integral component of the school-based clinics and would be useful when monitoring progress of at-risk students in this proposal. To make the SBIRT screening protocol accessible for the providers, the prescreen and screening questions would be made available as part of the electronic health record (EHR) system for easy access when assessing the patient.

Clinical support staff could perform the initial prescreen and the results of that screen would be automatically documented on the patient's EHR for the PCP to view.

For the Edison clinic, the initial prescreen would focus on screening for potential substance use behaviors within the student's family instead of the child themselves. After viewing the results of the initial prescreen, the PCP may provide an additional CRAFFT screen for adolescents age 12 years and older when appropriate that will also be accessible on the patient's EHR. The patient's score on the CRAFFT screen will be automatically calculated for the PCP to review. If the patient is categorized as 'mild', only BI is necessary and the provider will use the Brief Negotiate Interview Model to provide feedback for the patient. If the patient is categorized as 'severe' in the CRAFFT screen, further assessment would be needed, followed by a RT if appropriate. In the unlikely case of a RT, the provider could utilize the Michigan Child Collaborative Care program as a warm handoff to a specialist for advance treatment or contract with other specialist providers in the area for referral.

Recently, University of Michigan Hospital Depression Center has extended their resources to primary care providers throughout the state of Michigan through an incentive called the Michigan Child Collaborative Care Program (MC3). The MC3 is a non-emergency referral service that aims to provide psychiatry support to primary health care providers in Michigan who are managing patients with mild behavioral health problems up to through the age of 26 years. Through phone consultations, psychiatrists offer providers guidance on diagnoses, medications, interventions, and referrals. This accessible telephone service is available Monday – Friday from 9 am – 5pm, excluding holidays. Participating providers must sign a consent outlining the scope of practice for both the provider and psychiatrist (University of Michigan, 2016). This type of

interdisciplinary support system may improve patient outcomes for at-risk adolescents throughout the RT process.

Providers would be responsible for monitoring patients' at-risk behavior from the screening process and throughout the BI/RT, as well as following up with the patient's progress. The providers may monitor the patient's substance use trends at follow-up appointments for adolescents who are mild (BI only), or severe (BI/RT). If the patient is at no-risk for substance use, a prescreen performed at a yearly physical appointment would be sufficient.

Challenges

Although public schools may be the most effective and evidence-based way to reach a large population of Kalamazoo adolescents, it is accompanied by many challenges. It has been acknowledged that more research needs to be conducted on the feasibility, adoptability, and economic sustainability of SBIRT with adolescent populations. By addressing these barriers, SBIRT could fill the gap present in the primary care delivered in these school-based locations. Sincere there is no specific tool being used at the MHU or Edison clinic, SBIRT is necessary in these clinics to identify and screen at-risk individuals to reduce substance use and its corresponding negative consequences.

To address the costs of SBIRT implementation, there are several reimbursement codes available for each component, depending on the screening tool used and the type of brief intervention. Additionally, there is grant funding available through SAMHSA.

Another potential challenge to be considered is that adolescents may feel uncomfortable with self-reporting. As one clinician describes it, "some patients may perceive this program to be

intrusive and may intentionally downplay the extent of their substance abuse.” (Liu, 2015). The clinical coordinator at the Edison clinic agrees that self-reporting is an issue, especially with elementary students because of their age and family influences. Also because of the age group focused on at Edison, substance use screening is not the primary focus of the providers at the clinic. The only substance use screening done at the Edison clinic is by the behavioral therapist who screens adolescents ages twelve or older (E. Oliver, personal communication, 2016). It is suggested that during the prescreen, the student is asked a question about their family and substance use. A modified form of SBIRT for the pediatric population at Edison would be useful for identifying potential substance use problems within the family of the children being treated, which may secondarily affect them.

Consent is also an issue in the school setting. A Michigan Law, 330.1707, discusses the rights of a minor receiving mental health services. In this legislation, a minor the age of 14 years or older are able to receive behavioral health services without the consent of a parent or legal guardian for up to 12 sessions or four months. This law opens opportunity for SBIRT services to bypass any parental consent issues (Michigan Legislature, 2015).

Another concern is the inaccessibility of behavioral specialist providers within the Kalamazoo area. As mentioned previously, the MC3 program through University of Michigan Hospital could bridge that gap. Additionally, SBIRT may be used to identify comorbid conditions between substance use and mental health issues when utilizing referral services. It is commonly seen to have a substance abuse issue as a result of an unaddressed mental health issue.

Lastly, there are staffing challenges at the school-based locations because there are no permanent providers currently at either location, which may affect the longevity of SBIRT

integration (E. Oliver, personal communication, 2016). Contracting with local resources such as Bronson Hospital, Borgess Hospital, and WMed would be necessary to ensure the sustainability of these school-based health centers to continue serving the student population in Kalamazoo. Overall, the primary care providers and clinical support staff agreed that SBIRT would be a useful tool within both school-based clinics.

Discussion

According to Juszczak, Melinkovich, and Kaplan (2003), “School health clinics are over 21 times more likely to elicit visits for behavioral health issues than are general community health clinics, particularly for minority and other ‘hard to reach’ adolescents” (Juszczak et al., 2003). The literature reviewed in this proposal has strongly acknowledged the potential of SBIRT for adolescent populations to address substance use and its negative effects on academic performance and health development. Kalamazoo Public Schools in coordination with the school-based health clinics and Communities in Schools opens the opportunity for SBIRT implementation.

Kalamazoo Public Schools is an ideal place for SBIRT integration and sustainability. As referenced in this proposal, MiPHY data provides evidence that substance use is on the rise among adolescents and correlates with poor academic performance. SBIRT integration will help progress KPS learning initiatives by addressing underlying issues that may affect academic performance. Currently, Kalamazoo possesses the resources to ensure the feasibility, adoptability, and sustainability of SBIRT in the public school system. Without the cooperation of the Family Health Center and Communities in Schools, SBIRT integration would not be a viable

option. Utilizing the MHU and Edison clinic provides a pathway for SBIRT to be assimilated into KPS as an accessible and effective mode of intervention.

In addition to serving students, the Edison clinic and the MHU are able to see the family of the student during their time at KPS, which provides another opportunity for screening of family members. Although a child may not primarily be involved in substance use or experimentation themselves, a family member may be, which could secondarily put the student at-risk.

The resources available to Kalamazoo are abundant for SBIRT integration, including the school-based clinics, grant funding for SBIRT integration, Communities in Schools, and the MC3 program. With the driving force of the imminent potential of our developing adolescents, SBIRT will provide new direction for addressing adolescent substance use in Kalamazoo Public Schools.

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