

Alcohol Use in Adolescents (13 through 17) Screening and Intervention Guideline

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Guidelines are systematically developed statements to assist patients and providers in choosing appropriate health care for specific clinical conditions. While guidelines are useful aids to assist providers in determining appropriate practices for many patients with specific clinical problems or prevention issues, guidelines are not meant to replace the clinical judgment of the individual provider or establish a standard of care. The recommendations contained in the guidelines may not be appropriate for use in all circumstances. The inclusion of a recommendation in a guideline does not imply coverage. A decision to adopt any particular recommendation must be made by the provider in light of the circumstances presented by the individual patient.

Major Changes as of October 2016

We have incorporated an updated version of the CRAFFT questionnaire, which includes three preliminary questions in Part A to determine whether the teen has used any alcohol, marijuana, or other drugs during the past year. If the teen answers yes to any of the questions in Part A, proceed with the next six questions in Part B. If the teen answers no to all of the questions in Part A, only the first question in Part B should be asked.

There is new, stronger evidence supporting brief interventions for adolescents.

Background

There is no healthy level of alcohol consumption for adolescents (ages 13 through 17). Many adolescents engage in experimentation with alcohol use. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) reported in 2012 that the 30-day prevalence of alcohol use was 14.9% for 8th graders, 30.4% for 10th graders, and 43.5% for 12th graders. The risks of underage drinking include impaired judgment, serious injuries, and increased risk for physical and sexual assault (NIAAA 2012).

Definition

Alcohol use disorder (AUD) is a problematic pattern of alcohol use leading to clinically significant impairment or distress with at least two symptoms over the last 12-month period. AUD is a DSM-5 diagnosis that ranges in severity from mild (2–3 symptoms) to moderate (4–5 symptoms) to severe (6–11 symptoms); for a list of DSM-5 diagnostic criteria, see Table 6 (p. 9). The Alcohol Symptom Checklist in Epic has corresponding questions.

Previously, DSM-IV used the terms “alcohol abuse” and “alcohol dependence,” but research showed that symptoms of abuse and dependence were all symptoms of a single disorder.

Role of Primary Care

Primary care physicians (PCPs) are often the only medical providers who interact with adolescents who drink, placing them in a prime position to identify and counsel these patients, and to help prevent alcohol-related morbidity and mortality. For teens at low risk of AUD, PCPs can help to modify drinking behavior and prevent development of alcohol use disorders. However, for teens who are at high risk for AUD, referral to the Adolescent Center or BHS for treatment is recommended.

Confidentiality Considerations for Adolescents

Patients at least 13 years of age may consent to confidential treatment for substance use without parental involvement. However, logistical barriers may make this challenging. Patients seeking treatment will usually permit limited information sharing with their families.

For patients who agree to a treatment referral, let them know what to expect: weekly sessions (individual and/or group) for at least 3 months. With their permission, tell the parent: “[Pt] has been honest with me about his use of alcohol and has agreed to talk to a specialist about it.” Avoid getting into specific details related to the use.

For patients who are *not* willing to see a behavioral health provider **and request confidentiality** that you are willing to grant (see following paragraph), consider scheduling a 1-month follow-up with you for a medical reason (such as follow-up of acne). If the patient is willing, ask them to commit to a 1-month trial of abstinence or decreased use in between visits. The results may help to inform further follow-up.

When an adolescent’s safety is at risk, it is necessary to breach confidentiality and involve their family. In almost all situations when an adolescent’s alcohol use has escalated to this level, the parents are already aware. Determining what constitutes a safety risk is a matter of the individual provider’s clinical judgment and should be based on all available information, not the results of a screening questionnaire alone. Examples of safety risk include: daily use, hospitalization due to alcohol use, polysubstance use, escalating use, drinking and driving in the absence of a commitment to stop, and the presence of serious comorbid conditions such as depression, suicidality, or poorly controlled insulin-dependent diabetes.

When it is necessary to breach confidentiality, it is important to inform the patient as soon as possible that you intend to do this, and to review with the adolescent the exact information you intend to disclose and the recommendations you will make. Speaking with the parents and patient at the same time may help retain the patient’s trust.

Screening with the CRAFFT

According to the U.S. Preventive Services Task Force (2013), there is insufficient evidence to recommend for or against screening adolescents to prevent or reduce alcohol misuse. Based on expert opinion, this guideline recommends that clinicians screen adolescents annually using the CRAFFT tool. (CRAFFT is a mnemonic acronym of first letters of key words in the six screening questions in Part B.)

The evidence supports the use of CRAFFT as a screening tool for identifying adolescents with substance use disorder, and at a cutoff point of ≥ 2 (Pilowsky 2013, Mitchell 2014).

The CRAFFT tool is designed to screen for high-risk alcohol **and** other drug use behaviors in adolescents. (If screening detects illicit drug use, consult Mind Phone.)

The CRAFFT is not intended to be used to monitor the effectiveness of treatments over the short term.

Table 1. Screening to detect high-risk alcohol use behaviors

Eligible population	Recommended screening tool	Recommended frequency
Adolescents (ages 13 through 17)	CRAFFT	Annually

The CRAFFT Questionnaire

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Smoke any marijuana or hashish?	<input type="checkbox"/>	<input type="checkbox"/>
3. Use anything else to get high? (“Anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff.”)	<input type="checkbox"/>	<input type="checkbox"/>

If the patient answered NO to ALL of the questions in Part A, ask the CAR question only. If the patient answered YES to ANY of the questions in Part A, ask ALL SIX CRAFFT questions.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you ever FORGET things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

CONFIDENTIALITY NOTICE:

The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

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Interpreting screening results

Score 1 point for each “yes” response.

Table 2. Interpreting the CRAFFT	
CRAFFT scoring	Interpretation
0–1	Low risk of drug and/or alcohol use disorder
2 or higher	High risk of drug and/or alcohol use disorder

For patients who have a score of 2 or higher on the CRAFFT, it may be helpful to follow up with additional questions to make a provisional diagnosis of alcohol use disorder, and to determine whether or not a referral to BHS or the Adolescent Center is warranted.

Suggested questions include:

- “What substances do you use?”
- “How, where, and with whom do you use?”
- “How often do you use?”
- “Because of your alcohol use, how often have you had trouble at school or with grades, had arguments with family or friends, or gotten into fights?”
- “What types of risky behavior have you displayed while drinking?”

Note that CRAFFT scores are **not** used to diagnose alcohol use disorder. A clinical interview is needed to make a diagnosis using the Alcohol Symptom Checklist. See the Assessment for Alcohol Use Disorder section (p. 9).

Management of Comorbidities

For patients with suspected or diagnosed alcohol use disorder, treatment/management of one or more comorbidities can occur either simultaneously or sequentially. There is insufficient evidence to recommend one way over the other.

Screen all patients with suspected or diagnosed health concerns related to alcohol use for the following comorbidities:

- Anxiety: Screen through clinical interview.
- Depression: Screen using the PHQ-9 for Adolescents (PHQ-9A). Evidence suggests that patients with depression are less likely to be adherent to recommended management plans and less likely to be effective at self-management. See the Depression Guideline for additional guidance. Patients with major depression can be treated in Primary Care or offered a referral to BHS for counseling and/or drug therapy.

About Brief Counseling Interventions

Primary Care teams can help adolescents to modify drinking behavior and reduce the harms associated with drinking, such as driving while intoxicated or unwanted sex. All adolescents should be offered brief counseling interventions, in the form of anticipatory guidance for those with low scores on the CRAFFT or brief interventions for those whose score is 2 or higher.

There is good evidence that brief alcohol interventions lead to significant reductions in self-reported alcohol use in adolescents (Tanner-Smith and Lipsey 2015). In young adults and college students, evidence suggests that brief interventions result in greater reductions in alcohol consumption and heavy drinking days compared with usual care (Jonas 2012).

For adolescents, the primary goals of brief interventions are to prevent or reduce alcohol use and to reduce harms.

CRAFFT Score 0 or 1: Anticipatory Guidance

Key considerations	<ul style="list-style-type: none">Review CRAFFT score with patient.Discuss alcohol and substance use risks and consequences (e.g., motor vehicle crashes).Recognize and commend the patient for avoiding alcohol and drug use.
Talking points	<ul style="list-style-type: none">“Do you have any questions for me about alcohol or drug use?”“What do you do when you are in a situation where you feel other people want you to drink or use drugs?”“I know that there can be a lot of peer pressure around alcohol and/or drug use. It seems like you are doing a good job avoiding high-risk situations.” (And commend them for thinking about it.)“It is great you have thought about this issue and have made the decision to avoid alcohol. If that ever changes, I hope you trust me enough to tell me.”

CRAFFT Score 2 or Higher: Brief Interventions and Referral

Duration	5 to 15 minutes
Number of sessions	1 to 4 Repeated sessions are more effective than a one-time intervention. Use clinical judgment to determine the appropriate follow-up interval.
Clinicians	Primary care physicians, nurses, medical assistants, health educators.
Target population	People who score 2 or higher on the CRAFFT.
Goal	Increase patient readiness for referral to BHS or the Adolescent Center.

Table 5. Brief interventions for CRAFFT score of 2 or higher

Express concern	<p>Review the CRAFFT score with patient.</p> <p>Discuss with the patient in an empathetic, patient-centered manner that—based on the screen—you are concerned about their use of alcohol.</p> <ul style="list-style-type: none">▪ “Kids who have this score may be drinking in a way that could cause problems at home or at school, or could lead to criminal activity.”▪ “I’m concerned that you are drinking enough to cause other serious problems in your life.” <p>Acknowledge that alcohol use has pros and cons for the patient. Ask what they like most—and least—about drinking.</p> <p>When the parent is also in the room, ask if they have any concerns about the adolescent’s moods, school, friends, or alcohol use in general (with no disclosure of the actual patient conversation).</p>
Provide feedback linking drinking to safety	<p>Describe how the drinking might impact the patient’s health and safety:</p> <ul style="list-style-type: none">▪ “Mixing alcohol and drugs or mixing different drugs is dangerous.”▪ “Unwanted sex (and sexual abuse) is more likely to happen after drinking alcohol or using drugs.”▪ “Alcohol affects healthy brain development, which continues into your 20s.”▪ “Drinking from an early age increases the risk for serious alcohol problems later in life.”▪ “Alcohol directly affects your brain and your ability to think clearly.”▪ “Teens sometimes make decisions when they are drinking that they later regret.”
Offer advice	<p>Advise the patient:</p> <ul style="list-style-type: none">▪ “Do not drink and drive. Do not ride in a car driven by someone who has been drinking. Make a plan for safe transportation.”▪ “Plan how to say no if you are offered alcohol or drugs.”
Elicit response, assess readiness to change, and support goal setting, if ready	<p>Support the patient in selecting a goal (e.g., monitoring drinking or filling out a drinking diary, decreasing drinking, or identifying triggers). The NIAAA Rethinking Drinking website can be useful: rethinkingdrinking.niaaa.nih.gov. For adolescents who drink, the ideal goal is abstinence, but patients should be engaged in thinking about their drinking even if they are interested only in reducing their drinking or if they are not interested in making changes now.</p>
Encourage referral	<p>Tell the patient:</p> <ul style="list-style-type: none">▪ “I would hate to see alcohol get in the way of your future and the things you care about [refer to patient’s goals]. I would like you to consider talking to someone who could help you explore your use of alcohol and help you decide whether or not it is a problem. If it is, you could work together to come up with a plan to deal with it. Are you willing to go?” <p>Refer to BHS or the Adolescent Center, unless the patient is reluctant to see another provider.</p> <ul style="list-style-type: none">▪ Offer to refer the patient to a behavioral health professional for assessment of alcohol use and/or other potential mental health comorbidities, or for treatment of alcohol use disorder. BHS is also able to process authorization for drug and alcohol assessment and treatment with providers in the community who specialize in working with teens.▪ The Adolescent Center is preferred if the patient has multiple (medical and psychological) diagnoses or if the patient prefers not to go to BHS.

Gauging patient response to one or more brief interventions

Although referral to BHS or the Adolescent Center is preferred, some patients may not be willing to see another provider. For these patients, continue to offer regular brief interventions. At the beginning of each visit, gauge patient response to the brief interventions:

If adolescents are responding positively to brief interventions by increasing their readiness to change drinking behavior and/or reducing drinking:

- Reinforce the patient's progress and congratulate on changes to drinking behavior.
- Continue with brief interventions as needed.
- Rescreen annually with the CRAFFT through age 17.

If adolescents are **not** responding to brief interventions, consider assessing them for alcohol use disorder (see Assessment, p. 9).

If patient meets AUD criteria,

- Explain the diagnosis, **and**
- Refer to a chemical dependency program through BHS.

If patient does not meet AUD criteria,

- Continue with brief interventions, **and**
- Refer to BHS or the Adolescent Center.

Resources for Changing Alcohol Use

Teen Link Help Line: <http://866teenlink.org/issues/drugs-alcohol>

Confidential and anonymous, available nightly from 6 to 10 p.m.

Toll-free: 1-866-TEENLINK (833-6546)

Teen Link also has a resource guide, Where to Turn for Teens: <http://866teenlink.org/resources/wtftf/>

NIDA for Teens: <http://teens.drugabuse.gov>

Information and resources on drug and alcohol abuse, created by the National Institute on Drug Abuse for teens.

Washington Recovery Help Line: www.warecoveryhelpline.org

Confidential and anonymous. Available 24 hours. Support and resources for youth struggling with substance abuse, problem gambling, and/or mental health.

Toll-free: 1-866-789-1511

Greater Seattle Alanon/Alateen: www.seattle-al-anon.org

Support groups for youth struggling with addiction in King, Pierce, Snohomish and Kitsap counties.

24-Hour hotline: 206-625-0000

Assessment for Alcohol Use Disorder

For most adolescents, assessment for AUD will be done as part of referral to BHS or the Adolescent Center. For patients who are unwilling to be referred, assessment for AUD can be done by the primary care provider.

Note: Use Alcohol Symptom Checklist (Table 6)—**not** CRAFFT scores—for diagnosing alcohol use disorders.

The DSM-5 lists 11 symptoms as criteria for diagnosing for alcohol use disorders. The severity of the **alcohol use disorder** is defined as:

Mild: 2–3 symptoms present

Moderate: 4–5 symptoms present

Severe: 6 or more symptoms present

Table 6. Alcohol Symptom Checklist (also available as an Epic flow sheet)
Based on DSM-5 criteria. 2 or more “yes” responses are diagnostic of AUD.

- Do you find that drinking the same amount of alcohol has less effect than it used to, or do you have to drink more alcohol to get intoxicated?
- When you cut down or stop drinking, do you get sweaty or nervous, or have an upset stomach or shaky hands? Do you drink alcohol or take other substances to avoid these symptoms?
- When you drink, do you drink more or for longer than you planned to?
- Have you wanted to or tried to cut back or stop drinking alcohol, but been unable to do so?
- Do you spend a lot of time obtaining alcohol, drinking alcohol, or recovering from drinking?
- Have you continued to drink even though you know or suspect it creates or worsens mental or physical problems?
- Has drinking interfered with your responsibilities at work, school, or home?
- Have you been intoxicated more than once in situations where it was dangerous, such as driving a car or operating machinery?
- Do you drink alcohol even though you knew or suspected it causes problems with your family or other people?
- Do you experience strong desires or cravings to drink alcohol?
- Do you spend less time working, enjoying hobbies, or being with others because of your drinking?

If you are unsure of the diagnosis, consult with Mind Phone. Refer the patient to BHS to obtain an assessment.

Documenting an AUD diagnosis in adolescents

The AUD diagnosis **must** be entered as an encounter diagnosis in the patient’s medical record (it can be a secondary diagnosis), and it must be included in the **top 6** diagnoses. *Note:* To comply with patient confidentiality requirements, consider waiting to add the AUD diagnosis in Epic until after the After Visit Summary is printed.

Management of Alcohol Use Disorder

Explain the diagnosis and refer the patient to a chemical dependency program through BHS. Encourage the patient to make an appointment as soon as possible and make a follow-up appointment with the patient to confirm that he or she engaged with the specialist. The follow-up can be by phone or in person.

Note: Chemical dependency treatment may not be covered by all insurance plans. Members should contact Member Services to examine their certificate of coverage.

There is insufficient evidence on the efficacy and safety of pharmacotherapy in treating alcohol use disorder in adolescents.

Evidence Summary

The Alcohol Use in Adolescents Screening and Intervention Guideline was developed using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis.

Screening for alcohol misuse

According to the U.S. Preventive Services Task Force (2013), there is insufficient evidence to recommend for or against screening adolescents to prevent or reduce alcohol misuse.

There is insufficient evidence to determine who to screen for alcohol misuse, in what setting, and how often.

The literature shows that there are several tools for screening adolescents for substance abuse. These instruments screen for both illicit drug and alcohol abuse, and can be administered either by paper—as are DUSI-A, POSIT, PESQG, DAST-A, SASSI-A2 and others—or by a brief oral questionnaire, as is CRAFFT.

Pilowsky and Wu (2013) systematically reviewed the literature to examine the substance use screening instruments used in primary care settings to identify adolescents with unhealthy alcohol and drug use. They also reviewed the literature on screening, brief intervention and referral to treatment (SBIRT). The authors concluded that:

- Adolescents preferred paper forms and computerized questionnaires over interviews with physicians or nurses.
- CRAFFT (with a sensitivity of 80% and specificity of 86%) was the best studied instrument for screening for alcohol and drug use and related problems, and is the only tool with data to support its use in medical settings.
- AUDIT also had high sensitivity (94%) and specificity (80%), but it only targets alcohol use and related problems in contrast to CRAFFT, which screens for both alcohol and drugs.
- The effects of SBIRT in adolescents have not been adequately evaluated.

Mitchell and colleagues (2014) examined CRAFFT performance relative to DSM-5 criteria among 525 adolescents aged 12–17 years. The authors examined the performance of the CRAFFT in identifying any problem use (defined as 1 or more DSM-5 criteria) and any DSM-5 substance use disorder (2 or more DSM-5 criteria) for alcohol or drugs other than tobacco. They examined sensitivity, specificity, and receiver operating characteristic areas under the curve (AUC) to determine the optimal CRAFFT cut-point(s) for predicting any problem use and any DSM-5 substance use disorder (SUD).

The results showed that the previously recommended CRAFFT cutoff point of 2 had the optimal performance for both DSM-5 and problem use SUD. At a CRAFFT score of 2 the sensitivity and the specificity for identifying an SUD were 91% and 93%, respectively.

Electronic screening

There is growing but insufficient evidence to recommend the use of internet, computer and/or mobile phone technologies in screening adolescents for alcohol misuse or in delivering brief interventions for reducing alcohol consumption among adolescents.

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

Sterling and colleagues (2015) examined the effect of SBIRT implementation on reducing substance abuse among adolescents treated in pediatric primary care. The study was an open-label cluster randomized controlled trial (RCT) conducted in a pediatrics department at Kaiser Permanente Northern California, Oakland. The trial randomly assigned 1,871 adolescents (mean age 15 years) treated by 47 pediatricians to one of three study arms:

1. Pediatrician-only: Pediatricians trained to assess substance use risk and consequences, provide brief intervention (BI), and refer patients to specialty substance use or mental health treatment.
2. Pediatricians working in coordination with embedded trained behavioral health care practitioners (BHCPs).
3. Usual care (UC): Care provided as usual; no CRAFFT assessments were made, and pediatricians had no SBIRT training or access to BHCPs.

In the embedded-BHCP arm, more brief interventions containing mental health content were provided than in the pediatrician-only arm. On the other hand, BIs in the pediatrician-only arm contained more substance use content than the embedded-BHCP arm. Assessment was made using the CRAFFT plus questions about use of alcohol or other substances in the past 6 months, and other substance-related family, social and legal consequences (CRAFFT+). The primary outcome of the trial was SBIRT implementation, which included assessments, BIs, and referral to treatment among eligible patients.

The results showed that the intervention arms had better screening assessment and intervention than did usual care. The referral rates to specialty treatment were higher in the pediatrician-only and usual care groups compared with the embedded-BHCP group.

Behavioral intervention

A 2012 review from the Agency for Healthcare Research and Quality (AHRQ) found that there is insufficient evidence to determine the efficacy of behavioral intervention for adolescents (Jonas 2012).

A more recent meta-analysis (Tanner-Smith and Lipsey 2015) that included 185 studies (24 among adolescents and 161 in young adults) showed that brief alcohol intervention in adolescents had a modest statistically significant effect on reducing alcohol consumption and its related problems, and that the observed effects persisted for up to 1 year.

An update of the previous meta-analysis (Tanner-Smith and Risser 2016) included 5 additional trials and showed that brief alcohol interventions led to significant reductions in self-reported alcohol use in adolescents ($g = 0.25$, 95% CI, 0.13–0.37).

There is a lack of published studies to date on the use of electronic brief interventions for reducing alcohol consumption among adolescents.

Pharmacological treatment for alcohol use disorders in adolescents

There is insufficient evidence on the use of pharmacological treatment for alcohol use in adolescents. The literature search did not identify any randomized controlled trials with high methodological quality that evaluated the safety and efficacy of pharmacological agents for adolescents with alcohol use disorder.

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Guideline Development Process and Team

Development process

The guideline team developed the Alcohol Use in Adolescents Screening and Intervention Guideline using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis.

This edition of the guideline was approved for publication by the Guideline Oversight Group in October 2016.

Team

The Alcohol Use in Adolescents Screening and Intervention Guideline development team included representatives from the following specialties: adolescent health, behavioral health, family medicine, Group Health Research Institute, nursing, and pharmacy.

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Disclosure of conflict of interest

Kaiser Permanente requires that team members participating on a guideline team disclose and resolve all potential conflicts of interest that arise from financial relationships between a guideline team member or guideline team member's spouse or partner and any commercial interests or proprietary entity that provides or produces health care–related products and/or services relevant to the content of the guideline.

Team members listed above have disclosed that their participation on the Alcohol Use in Adolescents Screening and Intervention Guideline team includes no promotion of any commercial products or services, and that they have no relationships with commercial entities to report.