Substance Use Disorder Screening Guide for Primary Care Physicians

Purpose of Screening

Substance use exists on a spectrum from non-use to risky use to substance use disorder (SUD). A validated screen identifies risk early; it does **not** establish a diagnosis. Primary care clinicians can prevent harm by screening routinely, responding without judgment, and matching intervention intensity to clinical risk.

1 in 10

Nevada adolescents ages 12-17 met criteria for a past-year SUD (10.05%). [1]

< 2 min

S2BI and BSTAD can be self- or clinician-administered in busy primary care settings. [3]

SCREEN

Use a validated tool at health supervision visits and appropriate acute visits. [2]

When and How to Screen

- Screen annually at well visits - and whenever mood, school, sleep, injury, or behavior raises concern.
- Screen privately with a validated tool; explain confidentiality and its limits.
- A negative screen does not replace clinical judgment; reassess when concerns persist.

Neutral opening: *'I ask every patient about substance use because it can affect health.'*

Validated Screening Tools

Tool	Age	Time	Format / focus	Key interpretation
S2BI	12-17	<2 min	Self- or clinician-administered. Past-year frequency across tobacco, alcohol, cannabis, prescription medication misuse, and other drugs.	Triages into no reported use, lower risk, or higher risk. Frequency guides brief intervention and follow-up. [3]
BSTAD	12-17	<2 min	Self- or clinician-administered. Reports number of past-year use days for common substances, then asks about additional substances.	Returns a substance-specific risk level and suggested clinical actions. [3]
CRAFFT 2.1+N	12-21	Few min	Self-administered or interview. Screens alcohol/drugs, riding/driving risk, and nicotine dependence (+N).	Part B: 2 or more YES responses suggests a serious problem requiring further assessment. Any +N dependence item also warrants assessment. [4]

Practice pearl: Self-administered screening may improve privacy, efficiency, and disclosure. Review results confidentially.

Responding to a Positive Screen

Immediate Safety First

Call 911 / send to the emergency department for suspected overdose, severe intoxication or withdrawal, difficulty awakening, slowed or stopped breathing, seizure, or other acute medical instability. Activate emergency psychiatric services for imminent suicide or violence risk.

Five-Step Clinical Response

Step	What to do
1. Thank and normalize	Acknowledge honesty. Use person-first, non-stigmatizing language. Ask permission to discuss the result.
2. Clarify the pattern	Substance, route, amount/potency, frequency, context, source, last use, co-use, cravings, loss of control, attempts to cut down, and consequences.
3. Assess safety	Overdose history; driving/riding; use alone; mixing substances; counterfeit pills; withdrawal; injuries; access to medications/firearms; pregnancy and sexual health risks when relevant.
4. Assess function and comorbidity	School, family, peers, sleep, legal issues, trauma, depression, anxiety, ADHD, eating disorders, psychosis, and suicide risk. Examine and order tests based on presentation rather than as a substitute for history.
5. Match action to risk	Deliver a brief intervention, involve family when safe and appropriate, arrange follow-up, and refer or treat according to severity and level-of-care needs.

Risk-Level Action

Screen / pattern	Clinical meaning	Primary care action
No reported use	No current use disclosed	Reinforce strengths and non-use; provide anticipatory guidance; re-screen routinely.
Any use / lower risk	Experimentation or occasional use without current impairment	Brief intervention using motivational interviewing; clear recommendation not to use; driving/overdose counseling; close follow-up.
Higher risk	Frequent use, CRAFFT concern, high-risk context, or emerging consequences	Complete diagnostic assessment; engage family when appropriate; treat co-occurring conditions; refer for evidence-based care; schedule prompt follow-up.
Likely SUD / OUD	Impaired control, functional impairment, hazardous use, tolerance/withdrawal, or ongoing use despite harm	Determine level of care using a multidimensional assessment; coordinate specialty treatment. For OUD, offer or rapidly connect to medication treatment and provide naloxone. [5][6]

Brief Intervention: Use the CRAFFT 5 R's

Review results; **Recommend** non-use; counsel about **Riding/Driving**; elicit the patient's **Response** and reasons for change; **Reinforce** self-efficacy. [4]

Treatment and Clinical Pearls

Evidence-Based Treatment

Match treatment to severity, developmental needs, family context, and co-occurring conditions. Recurrence of use should prompt reassessment - not judgment.

Intervention	Primary care application
Family-based therapy	Engage caregivers and the home environment when safe and clinically appropriate.
Motivational interviewing	Explore ambivalence and strengthen the patient's own reasons for change.
CBT	Build coping skills, identify triggers, and change patterns that maintain use.
Contingency management	Reinforce treatment participation and recovery behaviors.
Integrated care	Treat SUD and co-occurring conditions together; coordinate needed supports.

Medication Considerations

Condition	Clinical note
Opioid use disorder	Offer or rapidly connect to buprenorphine treatment; therapy is an additional support, not a prerequisite. Provide naloxone. [5]
Nicotine dependence	Pair behavioral treatment with developmentally appropriate cessation support; individualize medication decisions.
Alcohol use disorder	Use behavioral and family treatment; consider medication with specialist or NV PAL consultation.

Substance-Specific Clinical Pearls

Substance	Assess and counsel
Cannabis	Ask about potency and route; assess cognition, anxiety/paranoia, psychosis risk, school function, and driving.
Alcohol	Assess binge use, blackouts, injuries, co-ingestants, driving, and withdrawal history.
Nicotine / vaping	Ask what is vaped, frequency, cravings/withdrawal, quit attempts, and respiratory symptoms.
Opioids / counterfeit pills	Assess overdose, use alone, co-use, route, and naloxone access. [5][7]

Safety, Follow-Up, and Resources

Reduce Immediate Harm

USE

Avoid using alone, mixing substances, and impaired driving.

OVERDOSE

Carry naloxone; assume non-pharmacy pills may contain fentanyl. Suspected overdose: give naloxone, call 911, and begin rescue breathing/CPR.

AT HOME

Lock alcohol, cannabis, medications, and firearms; dispose of unused medication.

Follow-Up and Resources

Follow up: Reassess use, cravings, safety, function, and co-occurring symptoms. Coordinate care and adjust the level of care as needed.

- **Consult:** NV PAL
- **Find treatment:** SAMHSA
- **Crisis:** 988
- **(702) 553-4528** Monday-Friday, 9:00 AM-5:00 PM PST Text to consult

Selected sources: [1] SAMHSA Nevada estimates [2] AAP SBIRT [3] NIDA screening tools [4] CRAFFT guidance [5] AAP opioid guidance [6] ASAM Criteria [7] DEA One Pill Can Kill

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