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

William H James, Ph.D.[1,2*]

[1]*Substance Use Disorder Specialist (SUDP), Licensed Mental Health Counselor (LMHC), Executive and Clinical Director-Community Counseling Institute-Tacoma, Washington, USA.*

[2]*Student Assistance Counselor, Puget Sound Educational Service District-Renton, Washington, USA.*

***Correspondence:**

William H James, Ph.D, Substance Use Disorder Specialist (SUDP), Licensed Mental Health Counselor (LMHC), Executive and Clinical Director-Community Counseling Institute-Tacoma, Washington.

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ABSTRACT

The likelihood of engaging in risky behavior is higher during adolescence, a critical developmental stage. Motivation, learning and memory are critical issues for adolescents as well as school expectations. By carefully screening and using brief intervention and referral to treatment or services (SBIRT), adolescents can be provided with support and counseling for risky behaviors. Motivational interviewing is used with adolescents We acknowledge concerns about this model, but concerns about addiction and risky behavior are addressed in this approach and intervention. Adverse Childhood Experiences are reviewed as well as Social Determinates of Health, Adolescents and Addiction, Adolescents and SBIRT, Life Skills Training, Discussion and Conclusions.

Keywords

Adolescence, Adverse Childhood Experiences, Risky behavior, Addiction.

Motivational Interviewing

Motivational interviewing is a client-centered, goal-oriented counseling approach designed to enhance an individual's motivation to change by exploring and resolving ambivalence. Motivational interviewing is a collaborative communication style that is focused on helping individuals find their own reasons for making positive behavior changes. It was originally developed by William Miller and Stephen Rollnick in the 1980s, primarily for treating alcohol addiction, but has since been applied in various fields, including mental health, and lifestyle changes. The key principles include asking permission for collaboration, a partnership between the therapist and the client, where the client's perspective and experiences are central to the conversation. Other principles include eliciting "change talk", exploring importance and confidence, opened-ended questions, reflective listening, normalizing, decisional balancing, statements supporting self-efficacy, readiness to change, affirmation, and advice/feedback.

Adverse Childhood Experiences

Adverse childhood experiences can have a tremendous impact on lifelong health outcomes and fall into the following areas where recovery and healing are needed in adulthood. This is due to early life trauma in the following categories. Sexual abuse; Physical abuse; Emotional abuse; Physical neglect; Emotional neglect; Loss of a parent; Witnessing family violence; Incarceration of a family member; Mentally ill, depressed, or suicidal family member; Drug addicted or alcoholic family member.

Sexual abuse defined by an act of a sexual nature where the child is used for sexual gratification including molestation, pornography, rape, prostitution, or other forms of sexual exploitation of children. Physical abuse is the result of non-accidental physical injuries including hitting, kicking, biting, or burning. Emotional abuse is defined as psychological or emotional harm resulting in a change in behavior and an emotional response such as anxiety, depression, anger or acting out. Physical neglect is the result of failure by the parent or caregiver to provide shelter, food, clothing, education, and/or medical care regarding health and safety. Emotional neglect is defined as the failure of the parent or caregiver to provide emotional support, love, recognition, and empathy related to healthy development. Loss of a parent or caregiver is a result of

abandonment, separation, divorce, or death. Another category is Witnessing or exposure to physical or emotional violence in the family. Another trauma can result from Incarceration of a family member in detention, jail, or long-term confinement. A Mentally Ill, Depressed or Suicidal family member can lead to fear, anxiety, depression, grief, and loss. A Drug addicted or alcoholic family member can impact family stability, safety, connectedness, and attachment. The American Psychiatric Association's Diagnostic and Statistical Manual [1] reports that ACEs and attachment styles are psychological risk factors for developing social anxiety disorders in adolescents.

Adverse Childhood Experiences (ACEs) are linked with substance use problems, mental, and physical conditions [2-5]. ACEs refers to ten highly stressful, and potentially traumatic events or situations or experiences that may occur in childhood or the adolescent period [6]. The Adverse Childhood Experiences (ACEs) assessment is a ten-question assessment developed by the Centers for Disease Control and Prevention and Kaiser Permanente. The study collected heath information from over 17,000 members in Southern California from 1995 to 1997. By using this data, researchers were able to predict health outcomes based on the frequency of answers to the questions. Females represented 54% and males represented 46% of the sample. The ethnic breakdown was: White=74.8%; Black=4.5%; Asian/Pacific Islander=7.2%; Hispanic=11.2%; Other=2.3%. The educational data was as follows: No High School=7.2%; High School=17.6%; Some College=35.9%; College Graduate or Higher=39.3%. Eighty-six percent of the members were over 40 years old. A retrospective analysis showed that children with 3 or more ACEs are five times more likely to have school attendance issues, six times more likely to have behavioral problems and three times more likely to have experienced academic failure. In the study, two-thirds had at least one ACE and one-fifth had three or more ACEs [7].

Current research into ACEs has targeted updating and changing what is considered ACEs and understanding how the data can be used. For example, some researchers want investigation of the other experiences such as poverty, gang engagement and violence, parental gambling, peer bullying, cyber bullying and intimate partner violence [8]. While most of the research on ACEs and health use retrospective reports from adult populations on their current situations, research involving adolescents has shown that cumulative ACEs are related to increased risk of substance use, depression, and behavioral problems. These may include self-harm (cutting and burning), suicidal thoughts, anxiety, and other traumatic mental stressors.

Social Determinates of Health

Social determinates of health (SDOH) are the non-medical factors that influence health outcomes, including socioeconomic status, education, and environment. Social determinates of health refer to the conditions in which people are born, grow, live, work and age. These factors significantly impact a wide range of health, functioning, and quality-of-life outcomes and risks. Addressing SDOH is crucial for improving health equity and reducing health disparities. Key domains of SDOH include economic stability, education access and quality, health care access and quality, neighborhood and environment, and social and community support and engagement [9].

Adolescents and Addiction

Addiction is an incredibly complex issue, particularly for adolescents [10]. There is an abundance of evidence that adolescent addiction is impacted by several factors including biological, psychological, social, spiritual, and cultural issues. Some of the most profound studies are the Adolescent Childhood Experiences (ACEs) studies [2-5]. The ACEs study is a sweeping investigation of childhood abuse, neglect, and trauma. Adverse childhood experiences, or ACEs, are events that are potentially traumatic that take place in childhood (0-18 years). For instance, experiencing violence, abuse, or neglect, being a witness to violence in the home or neighborhood, or having a family member attempt or die by suicide. Other issues include growing up in a family where the environment is undermined by substance use, mental health issues, or instability due to parents separating or a household member going to jail or prison.

Adverse childhood experiences can lead to lasting negative effects on overall well-being and health as well as educational aspirations. ACEs can increase the propensity for injuries, sexual issues, and chronic diseases and can lead to major causes of death such as heart disease, cancer, diabetes, and suicide. ACEs and other social determinates of health can cause prolonged or toxic stress. ACEs can be impacted by living in a poor neighborhood, racially segregated housing, frequent moving, hunger, and lack of resources such as clothing, money, healthcare, and good schools. Additional issues include unstable family relationships, and lack of employment and mental stress like anxiety and depression. Some children are also exposed to substance use, domestic violence, and poor parenting.

Finkelhor [11], did a search of academic data bases by combining the term "trend" with a variety of terms referring to childhood adversities. Trend data on ACEs show multi-decade declines in parental illness and death, sibling death and poverty, but increases in in parental divorce, parental drug abuse and parental incarceration. Narayan, Lieberman and Masten [12] examined intergenerational transmission and prevention of adverse childhood experiences (ACEs) and found that preventing intergenerational transmission of ACEs calls for attention to screening and assessment of the adverse and positive childhood experiences of parents as parents who have experienced childhood adversity have increased risk for post-traumatic stress disorder symptoms as well as additional victimization over the lifespan.

Screening and teaching social-emotional skills in school using the Screening, Brief Intervention and Referral to Treatment [13] or services as outlined in the piece, "Check Yourself Before You Wreck Yourself" [14] can lead to creating or strengthening safe and stable relationships at school and home. This strategy can serve to promote social-emotional learning, strengthen school-

family relationships, and prevent problem behaviors. The idea behind the screening tool is to promote a safe and nurturing school environment where youth feel secure in sharing their feelings, thoughts, and behaviors to a member of the school counseling team. In this manner, counselors can focus on risk and protective factors at school and at home. Hawkins, Catalano, and Miller [15]; Hawkins and Catalano, [16] have extensively written and researched risk and protective factors based on individual, family, media, community, and school influences.

Family risk factors include challenges related to special needs, youth who feel that they cannot talk to their parents or caregivers about their feelings; youth who start sexual activity; those who engage in delinquent behavior, those who are involved in neglectful or abusive situations, those living with families with low or limited income, single parents or grandparents raising children; parents with poor or limited understanding of child development; poor discipline and punishment; isolated parents and negative communication style; and families that accept violence and aggression.

A recent research study by Scheuer and others [17] investigated parent-focused prevention of adolescent health risk behavior in a multisite cluster-randomized trial implemented in pediatric primary care. It has become clear that evidence-based parenting interventions can play a significant role in reducing adolescent risk behaviors going beyond the "Check Yourself" tool [14]. Glowa et. al., [18] sought to explore the feasibility of implementing the ACEs screening of adults during routine family medicine office visits. The 10-question ACE screen was used, and the results indicated that the risk of ACEs was present in 62% of 111 patients. The researchers concluded that primary care interventions are needed and that trauma experiences in early adolescence have lasting impacts. In another study, Metzier [19] and others examined data from 10 states and the District of Columbia that used the ACEs module in the 2010 Behavioral Risk Factor Surveillance System to review the connection between ACEs and adult education, employment, and income. They compared individuals who had ACEs scores with those with no ACEs. They found that those individuals with higher ACEs scores were more likely to report non-completion of high school, unemployment, and low income. Tseshay and others [20] examined the role of childhood experience on depression symptom, prevalence and severity among school going adolescents and found that exposure to ACEs is related to an increased risk of depressive symptoms up to a decade later. Bae [21] studied the long-term effect of ACEs on school disengagement and reasons for leaving school. Their study found a relationship between delinquency in adolescents who drop out of school and a relationship between ACEs and lack of school engagement.

Anda et. al., [22] found that the ACEs score increased the risk of chronic obstructive pulmonary diseases (COPD), and Anda, Tietjen, Schulan, Felliti and Croft [23] found that each of the ACEs score was associated with increased prevalence and risk of frequent headaches. Barile et. al., [24] in their study had findings that suggested that intervention efforts designed to provide positive emotional supports for adults who have experienced ACEs may prevent health issues during adulthood. Brown et. al., [25] found a relationship between ACEs and the risk of lung cancer in adulthood; Campbell et. al., [26] found associations between ACEs and morbidity in adulthood; Corso et. al., [27] determined that health-related quality of life among adults was related to ACEs; Cunningham et. al., [29] discovered sex-specific relationships between ACEs and chronic obstructive pulmonary diseases in five states; Dong et. al., [30] found a connection between ACEs and liver diseases; Edwards et. al., [31] evaluated wide-ranging health consequences of ACES; Foege [32] reviewed ACEs from a public health perspective; Metzier et. al., [19] examined life opportunities and ACEs; Ports et. al., [33] studied the relationship between ACEs and suicide risk. Barile and colleagues [24] examined the associations among county-level social determinations of health, child malnutrition, and emotional support on health-related quality of life in adulthood and found that ACEs were related to low emotional support, physical and mental functioning. Berger and others [34] conducted a review of interventions for mental health and substance use service delivery to youth and found substantial gaps in service delivery to youth.

Community risk factors include high rates of crime and violence, high rates of poverty and limited educational and economic options, high rates of unemployment, easy availability of alcohol and other substances, low community involvement, limited community activities for youth, unstable housing and frequent moves for families, hunger, and elevated levels of social disorder. All these factors are related to ACEs and understanding trauma. Protective factors for youth and young adults include those families that establish stable and safe relationships, have caring adults who are able to take care of basic needs like clothes, food, and shelter, provide supervision and monitoring, problem-solving, and support school requirement and engage in fun and enjoyable activities as a family. Additional research is needed on parent-focused prevention of adolescent risk behavior linked to the impact of ACEs as well as risk and protective factors.

Adolescents and SBIRT

Method

Data were collected and analyzed using interpretative phenomenological analysis (IPA), an approach based on Heideggerian phenomenology [35]. The method is phenomenological based on the focus on understanding how adolescents attempt to make sense of their life experiences about barriers and enablers to help-seeking for hypothetical substance use problems. The approach is interpretive and based on hermeneutics, the theory of interpretation, especially of patterns. Within this context, helpers were involved in a "double hermeneutic", attempting to understand the adolescents attempting to make sense of their experiences [36]. IPA is idiographic due to the focus on starting with the individual and slowly developing themes [36,37]. IPA was selected for this study as it is useful where the issues are complex or not clear, or where the issue is new or not well researched, and where researchers strive to comprehend process and change.

Participants

Participants were recruited from a middle school (grades 6-8) with a culturally diverse population near a major urban area in the Pacific Northwest. Participants were part of the "Best Start for Kids" research program funded by the county. Students in this study were in the 7th grade and were informed of the study through oral presentations in classrooms and a letter to parents/caregivers detailing the study and the screening tool (Check Yourself) and the voluntary nature of participation. The aim was to understand and intervene before the development of substance use problems, mental health issues or risky behaviors.

Procedure

Ethic approval was obtained from the local school district and the educational service district. Participants took the computer-generated "Check Yourself" screener on their Chromebooks in their early morning homeroom lasting approximately 20 minutes so that review of responses and follow-up could occur during the school day. The screener was developed from a review of screeners, a literature review, and a series of meetings and trainings with a multidisciplinary work group, school counselors (help givers) and administrators. The work group factored in cultural considerations in the adaptation of the questions related to the development of the tool as well as assuring diverse perspectives from both parents and students. Questions explored adolescent's attitudes, thoughts, feelings, and experience in substance use, mental stress, risky behaviors, and help-seeking experiences from formal and informal sources. (Table 1) lists the primary interview questions that were asked in relation to each area which included: About Me; My Health and Safety; and My Stress and Coping.

Table 1: Interview Questions.

About Me	My Health and Safety	My Stress and Coping
1. Background 2. Home 3. School 4. Sleep 5. Strengths	1. Frequent Pains and Aches 2. Substances Used 3. Likelihood of Using Marijuana 4. Likelihood of Drinking Alcohol 5. Likelihood of Vaping/ Using E-Cigarettes 6. Vaping Frequency-Days/ Month 7. Likelihood of Smoking Cigarettes 8. Feeling Harassed or Threatened	1. PHQ-2 Depression Screen 2. GAD-2 Anxiety Screen 3. On Most Days Feel 4. Self-Harm Indicated 5. Last Hurt Yourself 6. Suicidal Thoughts Past Year
Emotions (Feedback)	Wants to Speak with a Counselor	Wants to Speak with a Counselor

About Me

The age range was 11 to 13, with 63% of students at age 12; 34% of students at age 13; and 3% of students age 11. All the students were in 7th grade. The students were evenly divided between female and male. 68% of students reported speaking English at home, 30% reported speaking English and Spanish at home, 11% speaking English and Vietnamese, and 20% reported speaking English and another language. 64% of students reporting getting along with the people they live with, 34% of students reported sometimes getting along with the people they lived with and 2% said no. 55% of students reported feeling safe at school, 40% reported sometimes feeling safe at school, and 5% reported not feeling safe at school. 81% reported getting between 7.5 and 11 hours of sleep on an average night, with the range from 4 hours to 11 hours. 62% of students reported no stomach aches, headaches or other pains preventing them from being in school or class over the past 30 days, while 32% of students reported several days of preventing them being in school or class. Students reported at home sometimes or always experiencing: 61% eating dinner as a family; 61% playing games together; 60% spending time together; 53% watching a movie/show together; 53% cooking together; 47% taking care of family members; and 44% reporting family traditions we do together. Students reporting on top goals included: 93% improving/keeping up grades; 56% improving in sports/athletics; 54% get/stay healthy; 33% spend more time with friends; and 28% reported getting along better with family.

Table 2: About Me.

I Would Describe Myself As	Percentage
Mexican, Mexican American, Chicano	24%
Black or African American	23%
White	17%
Filipino	11%
Other Latino/a/x	10%
Chinese/Asian	5%
Pacific Islander/Hawaiian	5%
Somali	3%
American Indian or Alaska Native	2%

Table 3: About Me (Duplicated Counts).

The Biggest Supports in My Life Are	Percentage
Mothers	85%
Fathers	61%
Friends	54%
Siblings	48%
Aunt/Uncle (s)	34%
Grandparents (s)	32%
Cousin (s)	29%
Teacher/Coach (s)	22%
Virtual/Online Friend (s)	17%
Stepmother (s)	6%
Mentor/Counselor (s)	6%
Stepfather (s)	3%
Other (Write In)	2%

My Stress and Coping

One way students deal with stress and coping is substance use. However, the response of substance use was very low as small percentages of students reported using. When asked "In the past year I have used at least once; one student reported using marijuana in the past year, one reported smoking cigarettes or using tobacco in the past year, one student reported using alcohol (more than a

sip), and three students reported vaping or e-cigarette use. Two students reported using other drugs and ninety-three (93) percent reported no substance use in the past year. When asked "How likely are you to use marijuana in the next year, ninety-eight (98) percent reported unlikely, two (2) percent reported likely alcohol use in the next year. When asked about past 30-day marijuana use, one student reported yes and one student reported alcohol use in the past 30 days, and one student reported past 30-day use of smoking cigarettes.

Students were asked "in the last year has anyone bullied or harassed you in real life or on social media", twenty-two (22) percent reported yes while seventy-eight (78) percent reported no. When asked "do you feel that your safety is at risk right now", fourty-seven (47) percent reported yes and fifty-three (53) percent reported no.

Table 4: My Stress and Coping (Duplicated).

What Others Said You Are Good At or What Makes You Proud	Percentage
Being a Good Friend Exercise and Sports	56% 55%
School	49%
Gaming	46%
Helping at Home	45%
Using Technology	41%
Writing and Reading	35%
Music	34%
Arts/Crafts	26%
Taking Care of Animals	22%
Leadership	22%

Table 5: My Stress and Coping (Duplicated).

On Most Days I Feel	Percentage
Ok	38%
Good	66%
Tired	36%

Table 6: My Stress and Coping.

Over the Last Two Weeks, Feeling Nervous, Anxious, On Edge	49% Not at All; 36% Several Days; 15% No Response
Over Last Two Weeks, Feeling Down, Depressed	64% Not at All; 21% Several Days; 15% No Response
During Past Year Hurting Self	19% Yes; 81% No
When Did You Last Hurt Self?	19% This Week; 19% Past Month; 25% More Than A Month Ago; 37% More Than A Year Ago
During Past Year Thinking About Ending Life	14% Yes; 86% No
Have You Ever Tried to Kill Yourself	25% Yes (3 responses); 75% No (9 responses)

Additionally, under the stress and coping category, 68% of students felt hopeful about the future, 34% reported feeling worried and 56% reported being excited with 41% ok and 24% scared. 67% felt there was an adult at school that would help them, 28% said sometimes and 5% said no. 7% of students reported that they were seeing a school counselor in school, 7% outside of school and 86% said no. 4% said there was something they wanted to talk about in private as soon as possible, 6% said in the next few weeks and 90% said no thanks.

Table 7: My Stress and Coping (Duplicated).

When Things Are Stressful I Get Through By	Percentage
Makin/Listening to Music	66%
Gaming	54%
Relaxing/Taking A Break	48%
Hanging with Family/Friends	45%
Social Media	44%
Talking to Someone I Trust	29%
Exercise	28%
Making Art/Drawing	33%
Reading/Writing	24%
Prayer	22%

Data Analysis

Smith & Osborn's [36] IPA framework was used to analyze the data presented in computer-generated transcripts, coded in considerable detail. Transcripts were coded into "red flags" and "yellow flags" as preliminary and conceptual themes. Saturation of themes occurred when there were either red or yellow flags noted in the responses. Red flags indicated concerns such as suicidal thoughts and behaviors, harming oneself by cutting or other self-harming behaviors. Yellow flags conveyed feeling unsafe at school, getting into fights regularly, or having ongoing depression and/or anxiety. This process determined the number of follow-ups needed to be completed in the school day as an important aspect of the study.

Rigor

The methodological rigor of the study was established in three ways. Dependability and confirmability were established by developing an audit trail to connect raw data and codes with themes [38]. Initial analysis was undertaken by the first author followed by an independent review of the process by the second author [39], an expert in qualitative research. Identified themes were discussed until a consensus was achieved. Credibility (like internal validity) or truthfulness of the findings were enhanced by using a semi structured interview guide and one interviewer to maintain a standardized approach to interviewing [38]. Credibility was also strengthened by reviewing the data for negative cases (e.g., elements of the data that are contrary to the patterns that emerged) to ensure that the data captured a range of options about help-seeking. Credibility was also increased by member checking or participant verification, which involved summarizing responses to ensure they had been correctly interpreted.

Results

Eighty adolescents provided written parental consent. Participants were aged between 11 and 13 years. Rates of substance use were low, as was prior help-seeking experience. Several overlapping themes or patterns related to the characteristics of the help source (informal and formal) were identified as potential help-seeking

enablers or barriers. (Table 2) Indicates the diversity of the student population as 24% were Mexican, Mexican American or Chicano, 23% Black or African American, 17% White, and another six (6) ethnic populations. (Table 3) Presents the biggest supports in life (duplication) as among the responses mothers were the highest percentage at 85%, followed by fathers at 61%, then friends and siblings at about 50%, followed by other relatives such as teacher/coach, virtual online friend, mentor, and counselor. (Table 4) indicates what others say the student is good at or what made them proud. Responses included being a good friend, exercise and sports, school, and gaming. (Table 5) Provides information on student feelings on most days and 66% of the students said they felt good, 38% said ok, and 36% indicated tired. (Table 6) Reports on nervousness, anxiety or on edge, feeling down or depressed, hurting self, and thinking about ending life. (Table 7) Reports on what students do when things are stressful. 66% indicated that making/listening to music was what they did, 54% gaming, 48% relaxing/taking a break.

Discussion

Several overlapping themes emerged from the data. The first theme was perceived approachability. A help source was identified as being approachable if they were viewed as kind and understanding, tried to create rapport and relate to the student and provided reliable and unconditional support. These characteristics were discussed in relation to informal help sources such as family and friends. Perceptions of approachability were reduced when it was determined the help source would react negatively by being judgmental. Students were concerned about discussing substance use and expressed concern about being judged by doing so. The fear of judgment and or stigma is a common finding in studies of adolescents sharing information. Another theme was confidentiality and trustworthiness. Although confidentiality and trust played an important role in getting help from friends and family, this theme indicated concerns regarding the confidentiality of the information disclosed to counselors. Students were reluctant to disclose substance use to counselors in case they told the parents or caregivers or other school staff members. In the current study, students appeared to have limited knowledge regarding the circumstances in which confidentiality could be breached. Students need to be ensured that substance use problems will remain confidential. The basic information for mandatory reporters such as school counselors is to report suspected child abuse and neglect, and plans to harm self or a specific other person. Otherwise, adolescents need to understand that all other information is to remain confidential unless the student asked that it be shared with parents or caregivers. A theme emerged about the perceived expertise of the counselor or help source. A perceived lack of expertise was a barrier to seeking help from some informal sources such as teachers or school staff members. Adolescents often lack knowledge of education and treatment options for substance use disorders. This theme suggests that there is a need for health professionals to share their expertise and experience. This sharing could take place in the classroom with presentations, education, and tailored school-based services.

Several limitations of the current study need to be acknowledged. First, while evaluating the views of adolescents was a key aim of this research, it remains unknown whether the same barriers continue to exist during the later stages of adolescent development. Second, the questions on the Check Yourself tool were hypothetical and aimed at adolescents in general. Additional research is needed to examine barriers among adolescents who are already in need of education and treatment for substance use disorders. Third, although the qualitative methodology used was rigorous, we cannot generalize about behaviors from this sample of adolescents. However, we can generalize about the themes that emerged about young people's perception of approachability, confidentiality and trustworthiness and expertise. Fourth, students were recruited from one middle school in a suburban area and there may be differences between the help sources and counselors available to adolescents across the region and the nation. Finally, while most participants were aged 12 years, a smaller number of older adolescents were included (aged 13 years old). Future studies may wish to examine older adolescents separately, as experiences and attitudes toward substance use and help-seeking are likely to change as students enter other developmental stages.

In conclusion, this study provides insight into how formal and informal help sources such as school counselors can assist with early help-seeking during the adolescent period, before the emergence of serious substance use problems. These findings are likely to have implications for the planning, developing and implementation of programs that support early help-seeking behavior.

Life Skills Training

The Botvin Life Skills Training (LST) program [40] has been designed for use with middle/high school students. The program consists of 12 units (class period) that are designed to be taught is sequence. Each unit contains measurable student objectives, content, and classroom activities. The program can be integrated into any subject asea, although health education and science are usually considered the most appropriate. The major units are, Self-Image, Making Decisions, Smoking: Myths and Realities, Smoking and Biofeedback, Alcohol: Myths and Realities, Marijuana: Myths and Realities, Advertising, Violence and the Media, Coping with Anxiety, Coping with Anger, Communication Skills, Social Skills (A), Social Skills (B), Assertiveness, and Resolving Conflicts. The Life Skills Program supplies the learners with appropriate ways in which to handle situations, provides documents and lessons for later use, and allows one-on-one attention to the individuals taking the course. Life skills has been selected as an exemplary, research-based prevention program. The results of over a dozen studies show the effectiveness of the Life Skills Program in reducing drug use and risky behaviors.

Conclusion

In conclusion, these findings help our understanding of the complexity and the intersection between adverse childhood experiences and behavioral health outcomes. The results of many studies have indicated that adverse childhood experiences can have

a negative impact on psychological, social, emotional, cultural, and spiritual later life outcomes. However, those who experience adverse childhood experiences and overcome the negative impact have at least several external and internal factors at work. Several external factors include family support from non-abusers, at least one role model in the family, unconditional love and family-focused belief in God or a strong faith tradition. Internal factors include a resistant and resilient personality. Oral and others [41] advanced the notion that Adverse Childhood Experiences (ACEs) are related to short-term and long-term negative physical and mental health consequences among children and adults. They indicate that studies over the past three decades on ACEs and mental stress disorders have emphasized the importance of preventing and addressing trauma in early childhood. Petruccelli and colleagues [42] conducted a systematic review of the association between the CDC-Kaiser ACE scale and health outcomes and found support for associating ACEs with poor health outcomes and increased risks.

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