SBIRT[1] EPIS[2] Workbook

An Implementation Science-Based Guide to Maximizing the Effectiveness of Your SBIRT Program

Part 1: Exploration and Preparation

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[1] Screening, Brief Intervention, and Referral to Treatment

[2] Exploration, Preparation, Implementation, and Sustainment Implementation Framework

Foreword

Drawing from a large research literature, implementation scientists recommend EPIS (https://episframework.com/) as a framework for initiating, implementing, and sustaining new clinical programs. This workbook draws on the EPIS model and on ample practical experience in designing and carrying out alcohol and drug screening, brief intervention, and referral to treatment (SBIRT) programs in real-world, busy primary care settings.

The EPIS model suggests 4 phases of work:

E = Exploration: examine needs, resources, and the new program's fit with your organization's mission, and decide whether to initiate the program

P = Preparation: Gain internal and external support for the program, and plan how the new program will be carried out and integrated into current activities

I = Implementation: Initiate the program, collect data on key program outcomes and other deliverables, and iteratively modify the program to optimize those outcomes and deliverables

S = Sustainment: Identify the resources and put into action the activities necessary for long-term program continuation and effectiveness

Of course, every primary care clinic is different. Without first-hand knowledge of a particular clinic's operations, staff, patients, resources, and constraints, nobody could design an optimal SBIRT program. Nevertheless, there are certain design elements that seem to have been helpful across many diverse settings, from few to many providers, from urban to rural environments, and from commercial clinics to federally qualified health centers (FQHCs).

We hope this workbook will be helpful in at least two ways. One is to put forward recommendations based on what has worked in many clinics, though such recommendations may or may not be appropriate for your clinic. If you have already implemented an SBIRT Program, this guide can help you assess how things are going and where you may want to make changes. The second and most important way is to pose questions for you to consider as you attempt to implement, improve and/or sustain SBIRT in your clinic's unique environment.

Richard L. Brown and Karen Anderson Oliver

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I. THE EXPLORATION PHASE

1. Establish an Implementation Team

   Who among your organization's administrators, providers, staff, board, and other supporters would be effective members of a group that explores whether your organization should initiate an SBIRT program and, if so, oversees efforts to prepare for, implement, improve, and sustain it? Consider including in this group representation from a wide variety of segments of your organization's workers – administration, providers, and staff. Convene this group to consider the remaining questions in this section and help guide all SBIRT program management.

SBIRT Implementation Team	
Chair	_____
Administrator	_____
Manager	_____
Provider	_____
Nurse	_____
Medical Assistant (MA)	_____
Receptionist	_____
Referral coordinator	_____
Billing staff	_____
Lab	_____
X-ray	_____
Behavioral Health/Social Work	_____
Pharmacist	_____
Tele-health Staff	_____
Others	_____

2. Assess Benefits to your Patients from SBIRT

It would be preferable to use clinical data to answer the questions shown below. If prevalence data are not available, consider conducting a brief study in which all of your patients are screened over one to several typical workdays. To the extent that data cannot be obtained, arrive at a consensus on estimates that consider population data from national surveys, such as the state-based results from SAMHSA's National Survey on Drug Use and Health.

How many active adult patients are you currently serving? _____

How many of these patients engage in unhealthy drinking and drug use, including patients in the high-risk use, problem use, and possible addiction/dependence categories? _____

How many are in the high-risk and problem use categories and should receive brief interventions? _____

How many are in the likely dependent category and should receive a referral to treatment? _____

How many are alcohol dependent and should be offered pharmacotherapy? (FDA-approved medications are acamprosate, disulfiram, and naltrexone.) _____

How many are opioid dependent and should be offered pharmacotherapy? (FDA-approved medications are naltrexone, buprenorphine, and methadone.) _____

3. Consider "Readiness" at Your Organization

The Texas Association of Health Centers (TACHC) outlines the importance of assessing readiness in their instructions on *Developing a Successful SUD Program*[3].

Readiness in your Health Center: Readiness Surveys can measure universal needs and gaps that can make a successful program if/when identified early and addressed during planning of the program. The readiness items listed in the box may be measured (ideally) before implementation. These key points can 'make or break' the success of any program; therefore, discussions surrounding these measureable points as potential challenges and strategies should be considered and discussed while formulating an implementation plan for an SUD program.
Discussion points on readiness can be found in the guide on page 2-3 including:

1. Motivation
2. SUD Program Capacity
3. Organizational Culture and Climate
4. Innovativeness
5. Resourcefulness
6. Leadership
7. Staff Capacity and Development

4. Consider the Scope of your SBIRT Program

Some primary care setting decision makers are not swayed by arguments in favor of implementing SBIRT and would feel more positive about a program that would screen and intervene for a wider scope of behavioral risks and disorders. Such a program is called Behavioral Screening and Intervention (BSI).

a. Depression and Anxiety – BSI can include screening and Collaborative Care for depressive and anxiety disorders. Collaborative Care is a specific, evidence-based program, usually administered in primary care settings, that optimizes services and mental health outcomes. It involves expanding the healthcare team with health coaches and, if possible, psychiatrists. Health coaches:

- Serve as first responders to patients who give positive responses to screening questions (for example, the PHQ-2 and the GAD-2)

- Administer additional assessment questions (for example, the PHQ-9 and the GAD-7)

- Give patients feedback on their responses to the assessment questions

[3] https://repo.tachc.org/legacy/Clinical%20Care/Developing_an_SUD_Program_TACHC.PDF

- Educate patients on their disorders and the causes and possible treatments for those disorders

- Instill optimism for treatment

- Help patients decide whether to pursue counseling and/or pharmacotherapy

- Make appropriate referrals for counseling and pharmacotherapy

- Administer behavioral activation, where patients choose to change behaviors that help lift symptoms, such as socializing, exercising, engaging in fun activities, engaging in relaxing activities, eating healthier, and following tips for improving sleep

- Readminister assessment questions regularly to track progress and alert other treatment professionals when patients are not improving

- Regularly touch base with patients to help maximize their adherence to the treatment modalities they chose – counseling, pharmacotherapy, and/or behavioral activation

In the Collaborative Care model, psychiatrists do not see most patients. Typically, at weekly meetings, they confer with Health Coaches and others who are treating patients' mental health disorders and make recommendations regarding diagnosis, pharmacotherapy, and counseling, especially for patients who do not improve with initial therapy.

Over 100 randomized controlled trials have found that Collaborative Care significantly improves outcomes for patients with depression, anxiety, and many other mental health disorders.

How many active adult patients are you currently serving? _____

How many of these patients have a depressive disorder? Please consider diagnoses in your EHR, prior studies that have found up to 50% underdiagnosis found previously in primary care settings, and/or prevalence data from the state-based results of the National Survey on Drug Use and Health. _____

Consider conducting a prevalence study by asking every patient to respond to a PHQ-9 for one to several days. What proportion of your adult patients have a PHQ-9 score of 10 or above and might therefore benefit from Collaborative Care? _____

How many of these patients have an anxiety disorder? Please consider diagnoses of generalized anxiety disorder, panic disorder, and obsessive-compulsive disorder in your EHR, prior studies that have found up to 50% underdiagnosis in primary care settings, and/or prevalence data from the state-based results of the National Survey on Drug Use and Health. _____

Consider conducting a prevalence study by asking every patient to respond to a GAD-7 for one to several days. What proportion of your adult patients have a GAD-7 score of 10 or above and might therefore benefit from Collaborative Care?? _____

b. Smoking – Smoking is the leading preventable cause of death in the United States. Smoking cessation can prevent many common chronic diseases. For patients with common chronic diseases, including coronary artery disease, stroke, heart failure, hypertension, diabetes, and chronic lung disease, smoking cessation can improve outcomes, prevent many hospitalizations, and reduce healthcare costs. Optimal smoking cessation includes motivational interviewing, pharmacotherapy, and 9 or more one-on-one support sessions with each patient who is trying to quit.

How many active adult patients are you currently serving? _____

How many of your patients currently smoke? If data are not available from your EHR, consider state-based prevalence data from the National Survey on Drug Use and Health. _____

According to your EHR, how many patients who currently smoke have a chronic disease that would likely improve with smoking cessation? Please include coronary artery disease, stroke, other vascular disease, heart failure, hypertension, diabetes, asthma, and COPD. _____

If your EHR cannot give you the above information, consider conducting a prevalence study by asking every patient over one to several days if they have smoked one or more cigarettes in the past 7 days and whether they have any of the above diseases.

What proportion of your patients smoke? _____

What proportion of them have a disease that would benefit from smoking cessation? _____

5. Consider The Needs of Those You Serve and Local Conditions

As you establish your program and\or improvements, consider the needs of those you serve in relation to what you plan to implement. Review the program with the intended audience to determine the cultural appropriateness of the program. The National Cancer Institute has a brief checklist for making program adaptations such as these: *Guidelines for Choosing and Adapting Programs*, available at: https://rtips.cancer.gov/rtips/assets/rtips/reference/adaptation_guidelines.pdf. For materials, this may include language or reading level. Consideration of personal experiences, historical events, myths and misinformation, or cultural backgrounds that shape people's beliefs and values in the design of your program will help ensure that it is relevant to your audience's experiences.

This step includes consideration of potential disparities in the access to, delivery of, or quality of services provided. The Veterans Administration implementation facilitation manual [4] provides a section on consideration of health disparities and how they may impact health equity with a *Table of Health Equity Factors with Relevance to Healthcare Implementation* (page 25). The authors emphasize that:

> *"Implementation efforts that do not take such disparities into account may end up inadvertently perpetuating them – these are implementation disparities." Health and healthcare disparities inhibit health equity, which occurs when there is a just opportunity for the well-being of all people."*

More information is available at: https://www.queri.research.va.gov/tools/implementation.cfm

6. Take an Inventory of Stakeholders

Who would care whether your patients receive SBIRT and/or BSI, and what benefits and downsides would they perceive?

a. People you serve
   - Patients: _____

- [4] Ritchie MJ, Dollar KM, Miller CJ, Smith JL, Oliver KA, Kim B, Connolly, SL, Woodward E, Ochoa-Olmos T, Day S, Lindsay JA, Kirchner JE. Using Implementation Facilitation to Improve Healthcare (Version 3). Veterans Health Administration, Behavioral Health Quality Enhancement Research Initiative (QUERI), 2020. Available at: https://www.queri.research.va.gov/tools/implementation/Facilitation-Manual.pdf

- Patients' family members: _____

b. People who work for and/or with you
   - Healthcare providers: _____
   - Other staff: _____
   - Administrators: _____
   - Board members: _____

c. Your Community
   - Government officials: _____
   - Healthcare organizations: _____
   - Hospitals and their Emergency Departments: _____
   - MH/SUD treatment agencies: _____
   - Social services organizations: _____
   - Law enforcement entities: _____
   - Other: _____

d. State and Federal Government
   - Medicaid program: _____
   - State health agencies: _____
   - State social services agencies: _____
   - State law enforcement agencies: _____
   - Other state government agencies: _____
   - HRSA: _____
   - Medicare: _____
   - Other federal government agencies: _____

e. Others: _____
   _____
   _____
   _____

f. How could pleasing each of those stakeholders help your organization serve its mission? What stakeholders might be willing to support your new program with financing or other resources, perhaps because an SBIRT program in your clinic might improve their bottom lines?

g. On balance, what would likely be the advantages and disadvantages of implementing SBIRT/BSI? Are there sufficient net advantages to continue with Exploration?

If no, stop here. If yes, continue to the next page.

7. Assess Facilitators and Barriers

This next section provides a guide to assessing the strengths and needs in your organization related to the important components of your SBIRT Program. At the end of the section is a Barriers and Facilitators Table that may help you document your findings (page 16).

a. Staffing

It takes time to administer SBIRT/BSI in the robust, population-wide manner that research has found optimal for effectiveness. Cutting too many corners can severely reduce the effectiveness and reach of SBIRT/BSI. Adequate staff time and training is essential for an effective program.

Please use the table below to estimate the amount of staff time it would take to deliver robust, effective interventions to all patients who would benefit.

		Alcohol and/or Drugs	Depression and/or Anxiety	Cigarette Smoking
a	Total # of active adult patients (enter the same number in each column)			
b	Prevalence (%)			
c	Total # of patients with the behavioral condition (a x b)			
d	Average # of sessions with each patient			
e	Average duration of each session (hours)			
f	Average # of hours needed per patient (d x e)			
g	Total # of hours needed to serve all patients (c x f)			
h	Total # of hours needed to serve all patients with all conditions (the sum of the numbers in all columns in row g, above)			

Notes:

For row d, consider that a few patients will decline sessions completely, others will participate in just the initial session, and others will appreciate as much support as possible. Typical average numbers of sessions are 4 for alcohol and drugs, 6 for depression and anxiety, and 4 for cigarette smoking.

For row e, a typical average duration of a session is a half-hour, which takes into account inefficiencies in patient scheduling, no-shows, paperwork, and differences between initial and follow-up sessions.

Nationally, the vast majority of clinics that have succeeded in delivering effective SBIRT/BSI to a large number of patients have hired dedicated staff to do so.

Do you have, or could you acquire, staff to administer SBIRT/BSI for all of your patients? **NO YES**

If NO:

Who among your current staff could deliver SBIRT/BSI, and how much time could they spend doing so?

In view of the time limitation, how many patients will you aim to serve? _____

Which patients would you target?

How would you identify the patients you wish to target? _____

_____

If YES:

Consider qualifications for your staff who will deliver SBIRT. Prior research has shown that low-cost paraprofessionals with little to no prior training and experience can be trained to deliver SBIRT/BSI. Bachelor's-level individuals tend to perform better than high school graduates, but high school graduates who did not attend college solely because of limited opportunity can also be effective. Nevertheless, some healthcare payers will reimburse only certain professionals, and some clinical settings have a culture that favors service delivery by degreed professionals.

What qualifications would you set for your staff who will deliver SBIRT/BSI?

What language(s) should your SBIRT/BSI interventionist speak, and what cultural background(s) would be ideal for serving your patients?_____

To what extent are candidates for these positions available within your organization or in your community? _____

What would such staff need to be paid? _____

Do you have the financial resources to assign current staff or hire new staff for this/these new position(s)? Might any stakeholders contribute resources? _____

If you realize now that you are unable to have dedicated staff deliver SBIRT, please return to the top of this page, answer "NO", and answer the questions under "If NO".

b. Training

Individuals who deliver SBIRT/BSI should be well-trained. One important aspect of training is knowledge transfer, which can be accomplished by online educational programs. An Internet search of "online SBIRT training" programs will turn up several options.

Another important aspect of training is skills development, which requires demonstration, practice, and feedback. Possible sources of training are TACHC, the Opioid Response Network (ORN), SAMHSA-funded Addiction Technology Transfer Centers (ATTCs), and members of the Motivational Interviewing Network of Trainers (motivationalinterviewing.org).

From whom could your receive SBIRT training? _____

Can you afford the cost of that training? _____

If not, can you seek free trainings or trainings with other clinics and split the costs? ____

c. Space

Where in your clinic would you have your staff deliver initial interventions and follow-up sessions? _____

Do you have sufficient space available? _____

d. Telephone and other Telehealth Services

To enhance convenience for patients and/or reduce space requirements, it would be helpful to conduct at least some services via telephone or telehealth. HIPPA-compliant telehealth platforms are available for well less than $100 per month per staff member. Such platforms can be easily identified by Internet searches.

Can you provide your SBIRT/BSI interventionist(s) with a computer with access to high-bandwidth Internet, speakers or headphones, and a camera? _____

Can your SBIRT/BSI interventionist(s) have dedicated, quiet space? _____

Would your patients' payers reimburse for telehealth-administered services? _____

Can you afford a telehealth platform? _____

e. Provider and Staff Cooperation

Champion – An important way to elicit cooperation with a new clinical program is to designate a champion, an individual in your organization who can help overcome indifference or resistance and elicit support from administrators, providers, and staff. An ideal champion would be an individual in your organization who is:
1) highly respected by others and is able to influence their attitudes and behaviors;
2) has the knowledge of the program to communicate benefits to providers and staff;
3) is strongly supportive of the new program; and
4) is willing to serve as a champion.
A champion may or may not have a formal leadership position in your organization and may or may not be involved in the day-to-day implementation of the new program.

Who in your organization might be a willing and effective champion? _____

Stigma – Stigma can hinder SBIRT implementation. Possible manifestations of stigma are preferences to avoid addressing unhealthy drinking and drug use, fear that SBIRT will elicit hostility from patients, and denial that patients have substance use disorders.

To what extent might stigma among your administrators, providers, and staff reduce cooperation with an SBIRT/BSI program?

_____

How would you attempt to address such stigma? _____

_____

_____

Drinking and Drug Use Culture – A culture of unhealthy substance use among providers and staff can reduce willingness to identify and address unhealthy substance use in patients. To what extent is there a culture of unhealthy drinking or drug use among your providers and staff?

_____

If present, how would you attempt to address it? _____

Other factors – What other factors might hinder provider and staff cooperation with an SBIRT/BSI program, and how would you address those factors? _____

_____

_____

f. Ease of Documentation

Electronic health records (EHRs) can facilitate SBIRT delivery and documentation or engender frustration and opposition. The ideal EHR would:
- Prompt screening for patients who are due
- Help administer screens and assessments to patients
- Record patients' responses to screens and assessments
- Score screens and assessments
- Guide interventions, referrals, and follow-up sessions
- Document delivery of each service
- Track key behavioral outcomes for each patient over time
- Generate reports on service delivery and outcomes for all patients and various demographic and clinical subgroups of patients, which would guide quality improvement efforts and performance reporting to HRSA and other stakeholders
- Collect and report data necessary for submitting reimbursement claims

Which of these functions does your EHR currently support? _____

_____

_____

What modifications could be made to your EHR to carry out other functions?

_____

_____

_____

Of the functions that your EHR cannot support, which could be handled by your staff, other computer resources, or other low-technology resources?

_____

_____

_____

_____

_____

g. Billing and Reimbursement

Maximizing reimbursement for SBIRT can help offset expenses and enhance sustainability.

To what extent do your patients' key payers reimburse SBIRT? _____

_____

_____

How much revenue would you expect from SBIRT/BSI reimbursement? _____

_____

_____

Would the potential revenue justify an effort to establish a systematic approach to submitting claims for SBIRT? _____

_____

If so, what staff and resources would be necessary? _____

_____

_____

Are such staff and resources available? _____

_____

h. Treatment Resources – The "Referral" step of SBIRT/BSI requires that patients be able to access local treatment resources. Unfortunately, such resources are limited in most locations. However, because brief interventions are effective for many patients who do not need referral, and brief interventions may be effective for some patients who would do best with referral, a lack of referral resources should not be considered a barrier to initiating SBIRT/BSI. Therefore further consideration of treatment resources is deferred until the Preparation Phase of EPIS.

i. Summary Table of Possible Facilitators and Barriers

After completing this exercise of considering potential facilitators and barriers, this table may help to summarize your findings, and plan to address these in the II. Preparation Phase.

Health Center/Site:	Summary of Facilitators and Barriers	
Topic	Facilitators	Barriers
a. Staffing		
b. Training		
c. Space		
d. Telephone and Tele-health		
e. Staff Cooperation		
f. Documentation		
g. Billing/Reimbursement		
h. Treatment Resources		

8. Summary and Decision Making

What would be the likely benefits of implementing or improving SBIRT? _____

_____

_____

What would be the likely disadvantages of implementing or improving SBIRT? _____

_____

_____

What factors in your organization and your environment would facilitate SBIRT implementation or improvement? _____

_____

_____

What would be significant barriers to implementing or improving SBIRT, and to what extent could you overcome those barriers? _____

_____

_____

Given the above benefits, disadvantages, facilitating factors, barriers, and potential to overcome barriers, what is the group's recommendation about implementing or improving SBIRT?

_____

If the group does not recommend moving forward, what changes could be made to move forward in the future?

_____

_____

Write up a final summary of the group's proposal. Include important benefits to all stakeholders. This summary would help an organizational leader make a final decision, and it might help the organization reconsider a decision in the future.

II. THE PREPARATION PHASE

1. Consider (or Reconsider) Alcohol and Drug Screening Questionnaire Options

   These questionnaires are intended to quickly identify patients who likely drink or use drugs in an unhealthy manner and should therefore undergo further assessment.

   The table below lists some of the most commonly used screening questionnaires:

Substances	Name	Screening Questions	Notes
Alcohol	Single Alcohol Screening Question	How many times in the past year have you had men: 5 or more drinks in a day? women: 4 or more drinks in a day?	Any response greater than zero is a positive screen
Alcohol	AUDIT-C*	3 multiple choice questions on quantity and frequency of drinking	The first 3 questions of the AUDIT
Drugs	Single Marijuana Screening Question	How many times in the past year have you used marijuana or a related product?	Any response greater than zero is a positive screen
Drugs	Single Drug Screening Question	How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	Any response greater than zero is a positive screen
Alcohol and Drugs	Two-Item Conjoint Screen (TICS)	In the last 12 months, did you ever drink alcohol or use drugs more than you meant to? In the last 12 months, did you ever feel you should cut down on your drinking or drug use?	A positive response to either or both questions is a positive screen

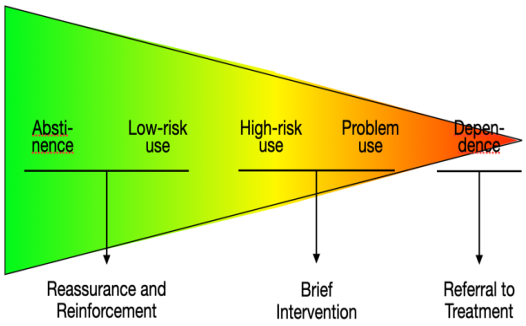
* See Appendix 1 for the AUDIT. The AUDIT-C is the first 3 questions of the AUDIT.

Most experts recommend a combination of the above screening questions. Commonly used combinations are:

- Single Alcohol Screening Question + Single Marijuana Screening Question + Single Drug Screening Question
- AUDIT-C + Single Marijuana Screening Question + Single Drug Screening Question
- Single Alcohol Screening Question + Single Marijuana Screening Question + Single Drug Screening Question + TICS

Which SBIRT screening questions will you use? _____

2. Consider SBIRT assessment questionnaires – These questionnaires are longer than screening questionnaires and are intended to more precisely determine whether patients with positive screens fall into the high-risk use, problem use, or likely dependent categories. They guide whether to deliver Brief Intervention or Referral to Treatment.



The table below lists some of the most commonly used assessment questionnaires:

Substances	Name	Assessment Questions	Notes
Alcohol	AUDIT*	10 multiple choice questions on quantity and frequency of drinking, negative consequences of drinking, and dependence symptoms	Very well validated for diverse primary care populations
Drugs	DAST*	10 yes-no questions on quantity and frequency of drug use, negative consequences of drug use, and dependence symptoms	Contains awkward and judgmental wording; poorly validated for primary care pts
Alcohol and Drugs	ASSIST*	7 questions on each of ten categories of substances with complicated skip logic	Best administered by computer
Alcohol and Drugs	Short Index of Problems – Alcohol & Drugs (SIP-AD)*	15 questions on negative psychosocial consequences of alcohol and drug use, each with 4 multiple choice options on frequency; no questions on health consequences	Any score greater than zero suggests problem use
Alcohol and Drugs	Severity of Dependence Scale (SDS)*	5 multiple choice questions on symptoms of dependence, which should be asked for each of the top 3 substances used by a patient	For adults, a score of 3 or more suggests a need for treatment

* See Appendix 1 for copies of these questionnaires

Commonly used combinations of SBIRT assessment questions are:

- AUDIT and DAST
- ASSIST only
- SIP-AD, a question on negative health consequences of substance use, and SDS

Which SBIRT assessment questionnaires will you use? _____

3. Consider screening and assessment questions for other behavioral topics

SCREENING

Have you smoked at least one cigarette in the past 7 days? __Yes __No

Depression (PHQ-2) *(do not include this header in your actual questionnaire)*

Over the last 2 weeks, how often have you been bothered by little interest or pleasure in doing things? __ Not at all __ Several days __ More than half the days __ Nearly every day

Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless? __ Not at all __ Several days __ More than half the days __ Nearly every day

Anxiety (GAD-2) *(do not include this header in your actual questionnaire)*

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? __ Not at all __ Several days __ More than half the days __ Nearly every day

Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying? __ Not at all __ Several days __ More than half the days __ Nearly every day

ASSESSMENT

Do you smoke daily? __Yes __No

If NO: How many cigarettes did you smoke in the previous 7 days _____

If YES:
How many cigarettes do you smoke in a typical day? _____

Compute: Cigarettes smoked in the previous 7 days = above response x 7 = _____

See Appendix 1 for the recommended brief assessment questionnaires for depression and anxiety – the PHQ-9 and GAD-7.

What is your plan regarding incorporating these screening and assessment questions into your SBIRT/BSI Program?

_____

_____

_____

4. Plan (or Revisit) Staff Roles: Who will conduct interventions, referrals, and follow-up visits?

   Most providers and nurses have little interest in this role, are not well trained for it, cannot obtain release time to receive sufficient training, are appropriately focused on patients' other pressing medical needs, are paid more than is necessary for this role, and are best reserved for work that other team members cannot address. However, motivated providers and nurses with limited clinical responsibilities can be effective.

   Although medical assistants can be trained for this role, most are unable to spend the uninterrupted time (blocks of 15 to 30 minutes or more) to serve patients well.

   Most primary care clinics that excel in SBIRT/BSI create one or more full-time positions for this role and refer to it as Health Coach, Health Educator, Prevention Specialist, or the like. College-educated individuals perform best in these roles, even if they lack healthcare training and experience, but bright high school graduates can perform well if they did not attend college because they lacked opportunity. The best predictors of success as a Health Coach are personality and attitudinal factors: warmth, excellent listening skills, a non-judgmental stance, and lack of "an axe to grind" toward patients who engage in unhealthy behaviors. Many excellent Health Coaches are described by their family members and friends as a preferred person to talk to about their problems.

   Health Coach compensation is typical for an entry-level position requiring a bachelor's degree. However, since Health Coaches will obtain valuable skills and experience, increases in compensation may be necessary for retention.

   Who will conduct interventions, referrals, and follow-up visits for your SBIRT/BSI program?

   _____

   _____

   _____

   If your plan is to have current providers and/or staff conduct interventions, referral, and follow-up visits:

   - How much "free" time do these individuals have now? _____
   - How should they prioritize this new responsibility versus current responsibilities? ____
   - Given the potential tension between new and current responsibilities, how many patients can they serve as patients screen positive in real-time during patient care times? _____

5. Assess Trauma Informed Care Principles in your SBIRT Program

SAMHSA's guidance for a trauma-informed approach to care describes key principles for ensuring that your organization is trauma-informed:

"A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." HHS Publication No. (SMA) 14-4884[5]

This document outlines six principles of, and provides guidance on delivering a trauma-informed approach:

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

The guide also provides sample questions to consider when implementing a trauma-informed approach on pages 14-16.

How does your approach to SBIRT need to be modified with regard to Trauma-Informed Care principles?

_____

_____

_____

_____

_____

_____

[5] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

6. Plan (or revisit) training and ongoing support

a. Clinical SBIRT Training

Ideally, initial SBIRT training lasts for 2 weeks. The training includes didactic sessions on the continuum of substance use, the basic neurobiology of addiction, treatment modalities, referral resources, each step of the SBIRT process, and the motivational interviewing approach to promoting and sustaining behavior change. Most of the training involves skills demonstrations, practice, and feedback. Such training needs to be extended to 3 or 4 weeks if Health Coaches will be addressing behavioral issues beyond alcohol and drug use.

When such extensive training is not possible, shorter trainings may be sufficient for individuals with strong clinical skills and high emotional intelligence. There are ample online SBIRT learning opportunities, but most do not provide critical opportunities for skills practice, feedback, and coaching.

Ongoing support is critical to develop excellent SBIRT/BSI practitioners. Ideally, ongoing support consists of:

- Weekly meetings with staff and a trainer to celebrate successes, discuss challenging cases, and learn more advanced skills
- Review of and feedback on 6 to 12 audiotaped sessions with patients over 3 to 6 months – with patients' written consent for audiotaping
- Quarterly review of behavioral outcome measures (see section 7, below)
- Regular updates of an improvement plan based on audiotape reviews and behavioral outcome measures

Free SBIRT Training with skills practice, feedback, and coaching may be available through:

- SAMHSA's Opioid Response Network - https://opioidresponsenetwork.org
- SAMHSA's Addiction Technology Transfer Centers - https://attcnetwork.org
- Individual members of the Motivational Interviewing Network of Trainers - https://motivationalinterviewing.org

How will those who conduct interventions, referrals, and follow-up visits be trained and supported?

b. General Staff Training on Substance Use Disorders, Stigma, etc.

To foster an organizational culture of understanding and acceptance of individuals who suffer from risky substance use and\or Substance Use Disorders (SUDs), it's important to consider whether all staff in your organization has been trained to reduce stigma. The SAMHSA-funded Providers Clinical Support System (PCSS) provides free online training that all staff can access free of charge: https://pcssnow.org/education-training/sud-core-curriculum/.

A crash course in SUD, titled "Understanding Substance Use Disorders," is geared towards providers and other staff: https://pcssnow.org/education-training/training-courses/module-1-understanding-substance-use-disorders/.

Twenty-one other modules are geared toward providers and convey an overview of evidence-based practices in the prevention, identification, and treatment of substance use disorders and co-occurring mental disorders.

SUD Core Curriculum

1. Overview of Substance Use Disorders
2. Changing Language to Change Care: Stigma and Substance Use Disorders
3. Screening, Assessment and Treatment Initiation for SUD
4. Pharmacotherapy for Alcohol Use Disorder
5. Medication for Opioid Use Disorder
6. Integrating Opioid Use Disorder Treatment in Clinical Care
7. Treatment of Tobacco Use Disorder in Primary Care
8. Standard Medical Management for Opioid Use Disorder in Primary Care
9. Principles of Motivational Interviewing Useful for Primary Care Physicians
10. Helping Patients Get to and Utilize Twelve-Step Programs
11. Opioids for Pain: Understanding and Mitigating Risks
12. Lab Testing in Assessment of Substance Use Disorders
13. Regulatory Issues and Medication Assisted Treatment
14. Medical Considerations for Patients with Opioid Use Disorder
15. Managing Common Psychiatric Conditions in Patients with Substance Use Disorders
16. Management of Other Substance Use Disorders: Benzodiazepines, Cocaine and Other Stimulants, and Cannabis
17. Nicotine and Stimulant Use in Adolescents
18. Adolescent Substance Use
19. Substance Use Disorders in Older People
20. Treating Women for Opioid Use Disorder During Pregnancy: Clinical Challenges
21. Introduction to the Criminal Justice System and MAT
22. Preventing Opioid Overdose with Education and Naloxone Rescue Kits

Most providers who complete these modules report increases in competence and confidence in managing their patients with substance use disorders.

c. Training for Specific SBIRT-Related Roles

Beyond the above training, various staff should be trained to carry-out specific tasks for SBIRT. Brief, specific training, including practice and feedback, should be delivered for staff who will:

- Conducting and eliciting patient cooperation with screens
- Scoring and giving feedback on screens
- Conducting and eliciting patient cooperation with brief assessments
- Scoring and giving patients feedback on brief assessments

- Conducting brief interventions, referrals, and follow-up sessions
- Documenting for clinical and billing purposes

Who among your providers and staff will receive what training and from whom?

_____

_____

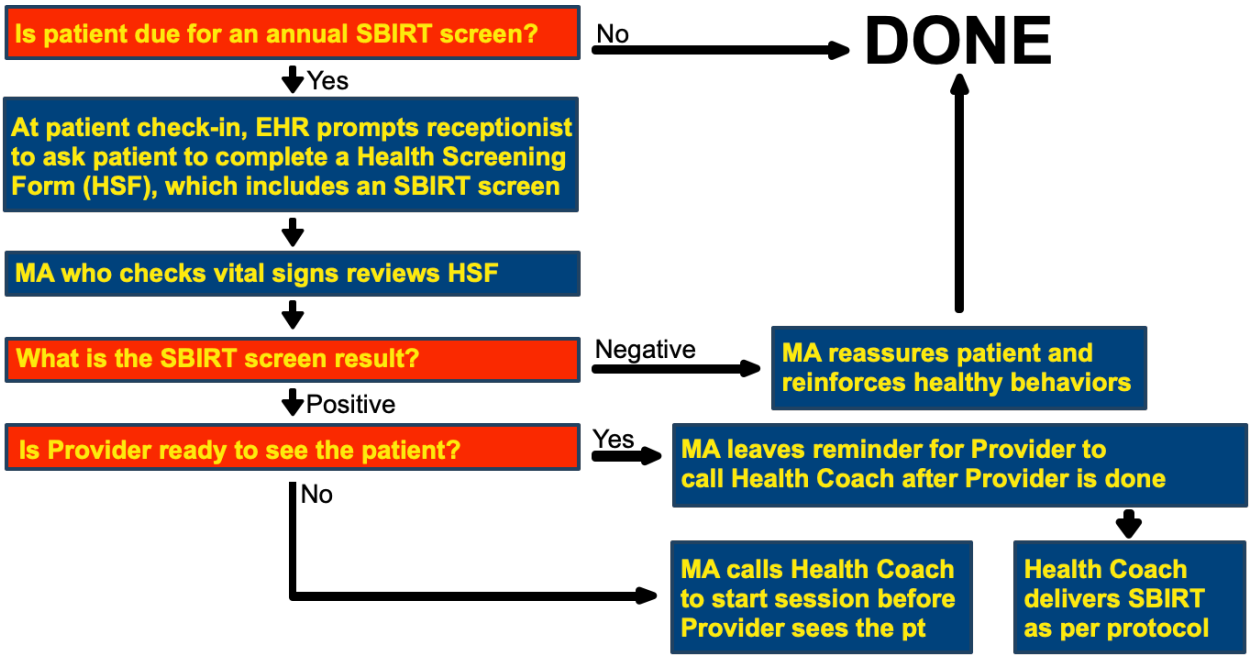
_____

_____

_____

7. Map out (or revisit) Workflow

Most primary care clinics that excel in delivering SBIRT/BSI have one or more dedicated Health Coaches and use the following workflow:



- The EHR prompts receptionists to ask patients to complete a screening questionnaire, henceforth referred to as the Health Screening Form (HSF). ("Form" suggests a standard clinic procedure. Avoid words like "questionnaire" and "survey," which suggest a research procedure that is optional for patients.) The prompt occurs for patients who have never completed the HSF or who last completed it at least one year ago. ALTERNATIVELY: Receptionists ask patients to complete the HSF when they ask

patients to sign an annual HIPAA notification form.

A recommended script for receptionists is: "Your [doctor/provider] would like you to fill out this form before [he/she] sees you today." This script is recommended for its brevity, so that receptionists can fulfill their SBIRT responsibilities in only a few seconds per patient. It is also recommended because it minimizes questions and push-back from patients.

- When receptionists ask patients to complete the HSF, they ask if patients would like help completing it. If so, they notify the staff member who checks vital signs, henceforth referred to as the medical assistant (MA), and the MA helps the patient complete the HSF. This step accommodates patients with language, literacy, or vision issues. IN ADDITION: Clinics that serve significant numbers of patients who speak languages other than English should offer HSFs in those languages.

- The MA reviews the patient's completed HSF.

- If screens for any of the behavioral issues are positive, the MA notifies the staff member who conducts assessment, intervention, referral, and follow-up, henceforth referred to as the Health Coach (HC). Also, the MA documents the screen results in the EHR, and brings the patient to the appropriate exam room.

  Various clinics have their MAs notify HCs of positive HSFs in different ways:
  - Automated EHR process
  - Cell phone or pager
  - Public address system calling the MA to the patient's exam room
  - Colored flags outside of exam room doors
  - Face-to-face notification
  - Adding the patient's name to an ongoing written list

  Different notification procedures may be needed when the HC is free and when the HC is with a patient.

- <u>If the provider is not ready to see the patient</u>, the HC enters the exam room, introduces him/herself to the patient, and reassures the patient that the HC will not delay the provider visit. A possible introduction is, "Hi, I'm [name], a health coach. My job here at [clinic name] is to go over the Health Screening Questionnaire you filled out in the waiting room and help all of our patients be as healthy as possible. I don't judge anyone or try to get people to do things they don't want to do. All decisions will always be up to you. And I won't delay your visit with [provider name]. When [he/she] is ready to see you, I'll leave the room, and if I can, I'll come back afterward to see if we can finish up then. OK?"

- <u>If the provider is ready to see the patient</u>, the HC quickly introduces him/herself to the patient. A possible introduction is, "Hi, I'm [HC name], a Health Coach. After [provider name] is done seeing you today, [he/she] would like me to come back and go over with

you the Health Screening Questionnaire you filled out in the waiting room. If I can, I'll come back and check in with you after [provider name] is done." The HC leaves a brightly colored piece of paper on the desk with the following reminder: "Health Coach to see patient." When the provider is done with the patient, he/she asks the patient to stay and lets the HC know that the patient is ready.

- If the patient declines to see the HC, their decision is respected, and the MA or provider makes a note in the EHR. If the patient agrees to see the HC, the HC proceeds with the session.

- At the conclusion of each session with the patient, the HC adds documentation to the EHR, and the provider is prompted to sign off on that documentation. The HC has his/her schedule and can book patients for follow-up sessions.

What will be your initial workflow? We recommend including as many features as possible from the workflow shown at the beginning of this section.

To prevent confusion among your providers and staff, it is important that there be a single "source of truth" for your current workflow. A document that describes your current workflow should always be readily available to your providers and staff.

Who will be responsible for producing your current workflow document and updating it as changes are made?

How will you make the current version of this document readily available to all clinic staff?

8. Plan (or revisit) data collection and review

for quality improvement, program evaluation, and reporting

SBIRT/BSI Service Delivery

We suggest collecting the following data on each patient who is seen at your healthcare setting:

a. Was the patient eligible to complete the HSF? yes/no

b. Did the patient complete the HSF? yes/no

c. What was the screen result for each behavioral issue? positive/negative
(Consider alcohol and drug use a single behavioral issue.)

d. For each behavioral issue for which the patient screened positive, did the patient complete a brief assessment? yes/no

e. What was the result of each brief assessment? positive/negative

f. For each behavioral issue for which the patient had a positive brief assessment, did the patient receive an initial intervention or referral, as appropriate? yes/no

g. For each initial or subsequent intervention session, was a follow-up session recommended? yes/no

h. For each recommended follow-up session, did the follow-up session take place? yes/no

In addition, for troubleshooting, it may be useful to record which receptionist and MA were involved in screening for each patient.

We recommended using the above for calculating the following metrics on a daily, weekly, monthly, and quarterly basis:

- Screen completion rate: Of patients who were eligible to complete the HSF (a = yes), how many completed the HSF (b = yes)? (b = yes)/(a = yes)

  This metric should be ≥90%. When it falls below 90%, the implementation team should identify and address the barriers. For the recommended workflow, common barriers are glitches in the system that prompts receptionists to ask patients to complete the HSF, problems in the way that receptionists are asking patients to complete the HSF, and failure of the MA to record the HSF results in the EHR.

- Assessment completion rate: Of patients who had a positive screen (c = positive), how many completed a brief assessment (d = yes)? (d = yes)/(c = positive)

This metric should be ≥90%. When it falls below 90%, the implementation team should identify and address the barriers. For the recommended workflow, common barriers are an unwieldy system for notifying HCs to see patients and failure of individual MAs to notify HCs to see patients. For workflows without dedicated Health Coaches, the most common barrier is that the staff member who conducts assessments forgets or is too busy with other tasks.

- Intervention rate: Of patients who had a positive brief assessment for a particular behavioral issue (e = positive), how many received an intervention or referral, as appropriate, for that behavioral issue (f = yes)? (f = yes)/(e = positive)

  This metric should be ≥90%. When it falls below 90%, the implementation team should identify and address the barriers. For the recommended workflow, where Health Coaches deliver interventions immediately after completing brief assessments, this metric is usually close to 100%. It may fall below that when sessions are interrupted or when patients have positive assessments for multiple behavioral issues, receive an intervention for one or two issues at the first session, and do not return for a recommended follow-up visit when interventions for other behavioral issues were planned. For workflows without dedicated Health Coaches, the most common barrier is that the staff member who conducts interventions forgets or is too busy with other tasks.

- Follow-up visit rate: Of all recommended follow-up visits (g = yes), how many of those follow-up visits took place (h = yes)? (h = yes)/(g = yes)

  This metric should be ≥80%. For the recommended workflow, a low follow-up visit rate may stem from glitches in the visit scheduling system, patient inconvenience or transportation barriers (perhaps phone or telehealth follow-up visits would help), poor rapport between the patient and HC, or inadequate HC staffing.

- Positive screen rates for each behavioral issue: Of all patients who completed the HSF (b = yes), how many screened positive for each behavioral issue (c = positive)? (c = positive/(b = yes)

- Positive assessment rates for each behavioral issue: Of all patients who completed the HSF (b = yes), how many had a positive brief assessment for each behavioral issue (e = positive)? (e = positive/(b = yes)

  Positive screen and assessment rates can help document the need for the SBIRT/BSI program in your setting. If positive screening or assessment rates are lower than expected, consider whether those who are conducting screening and assessment are creating an environment in which patients feel sufficiently comfortable and safe to give accurate information on potentially sensitive and stigmatized issues.

  To more definitely assess patient comfort and satisfaction with SBIRT/BSI, consider asking them to complete brief, anonymous patient satisfaction surveys.

SBIRT/BSI Behavioral Outcomes

In addition, for each behavioral issue being addressed, an outcome measure should be tracked. Here are possible outcome measures:

Alcohol	Number of days in the previous 7 days in which men had 5 or more standard drinks or women had 4 or more standard drinks
Drugs	Number of days of drug use in the previous 7 days
Depression	PHQ-9 score
Anxiety	GAD-7 score
Smoking	Total number of cigarettes smoked in the previous 7 days

For each patient, outcome data on each behavioral issue being addressed should be collected at baseline and at each follow-up encounter.

Pharmacotherapy for Alcohol and Opioid Dependence

An important potential quality focus is pharmacotherapy for alcohol and opioid use disorder. All patients with moderate to severe alcohol or opioid use disorder should be offered FDA-approved pharmacotherapy – acamprosate, disulfiram, or naltrexone for alcohol, and buprenorphine, naltrexone, or methadone for opioids. Ideally, most patients would agree to pharmacotherapy and take it. Clinics can maximize patient receipt of pharmacotherapy by proactively identifying patients with alcohol and opioid use disorders through SBIRT, educating patients about pharmacotherapy, using a motivational interviewing approach to helping patients consider pharmacotherapy, and offering it in-house.

To assess the quality of SBIRT regarding pharmacotherapy, the following data should be collected:

i. Patients whose brief assessment suggests alcohol dependence
j. Patients who receive education on pharmacotherapy
k. Patients who received a prescription and reported taking at least one dose

Pharmacotherapy education rate: Of all patients with likely alcohol dependence (i), how many received recommended education (j)? Rate = j/i.

Pharmacotherapy receipt rate: Of all patients with likely alcohol dependence (i), how many received a prescription and reported taking at least one dose (k)? Rate = k/i.

Similar data can be collected and similar rates can be calculated for patients with opioid disorder. A minor difference is that patients who take methadone for opioid use disorder would not receive a prescription. They would receive methadone at a federally licensed methadone clinic.

What data will you collect? _____

_____

_____

_____

_____

_____

_____

_____

Who will collect the various pieces of data and how? _____

_____

_____

Who will enter the data, how often, and where will the data be entered? _____

_____

_____

Who will analyze the data and create reports, how, and how often? _____

_____

_____

Who will review the data, identify opportunities for improvement, and decide how to respond to those opportunities? Ideally, the SBIRT Implementation Team would be involved.

_____

_____

9. Plan for (or revisit) billing and reimbursement

   Ample preparation is needed to begin billing for SBIRT/BSI.

   Who are your patients' most common payers? _____

   _____

   For each of those payers:

   • What diagnostic and procedural codes are required for billing? _____

   _____

   • Who can perform reimbursable services? _____

   _____

   • What are the documentation requirements? _____

   _____

   • Where in the EHR will services be documented? _____

   _____

   • If SBIRT/BSI services are to be delivered by staff other than licensed providers:

     - How will you ensure that providers are kept up to date on their patients? _____

     _____

     - What expectations will you set for providers about reviewing and co-signing non-providers' documentation? _____

     _____

     - Under what circumstances should non-providers who deliver SBIRT/BSI immediately alert providers about patients rather than assuming that providers will review non-providers' documentation at some point? Consider new possible diagnoses of addiction/dependence, recent overdose, recent serious healthcare conditions, suicidal thoughts, homicidal thoughts, and possible child or elder abuse. _____

     _____

What will be your workflow for billing? _____

_____

10. Establish (or revisit) treatment and recovery referral resources

Before you start SBIRT/BSI, it is helpful to gather information on potential referral resources, so that individuals who offer referrals have that information available without delay.

For each specialty behavioral service (including pharmacotherapy for alcohol dependence and opioid dependence; and residential programs, day programs, and outpatient programs for alcohol/drug treatment, collect information on:

- Name of the organization

- Contact information

- Location

- Public transportation options

- Availability of child care

- Preferred ways of making a referral

- Helpful individuals and their contact information

- Insurance plans accepted and other information regarding payment

- Special populations served and unique services offered

For mutual support groups, such as Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, She Recovers, list webpages on meeting schedules and locations. If possible, identify recovering patients or others in your community who will meet with patients and accompany them to their first meeting.

- Where will you keep this information so providers and staff can access it as they are seeing patients? _____

- How will this information be updated and by whom as providers and staff become aware of new information? _____

11. Consider (or revisit) electronic health record (EHR) modification

EHRs can help improve efficiency of service delivery, documentation, and billing.

EHRs can be helpful by:
- Prompting screening for patients who are due
- Helping administer screens and assessments to patients
- Recording patients' responses to screens and assessments
- Scoring screens and assessments
- Guiding interventions, referrals, and follow-up sessions
- Offering templates to facilitate documentation of each service
- Alerting primary care providers to their patients' progress
- Collecting and reporting data necessary for reimbursement claim submission
- Tracking key behavioral outcomes for each patient over time
- Generating reports on service delivery and outcomes for all patients and various demographic and clinical subgroups of patients, which would guide quality improvement efforts and performance reporting

• In terms of dollars or staff time, what is your budget for EHR modifications? _____

_____

• In order of priority, what EHR modifications do you plan, and which must be completed before program launch?

_____

_____

_____

_____

_____

_____

_____

_____

_____

12. Conduct a Practice "Walk Through"

A "walk through" is a process improvement technique to test your program to see what the patient experience is like, in order to make changes before launching with patients. The University of Wisconsin Network for Improvement of Addiction Treatment (NIATx) has put together instructions for this found at: https://www.niatx.net/download/walk-through-instructions/.

Their description of a walkthrough includes: "Taking this perspective of services – from the first step, through the final step – is the most useful way to understand how the customer feels. It helps identify improvements that will serve the customer better." For SBIRT, the most important customer is the patient. However, it is also important to consider SBIRT from the point of view of various staff, so that their work can be optimized.

Detailed instructions on walkthroughs[6] can be found at https://www.niatx.net/walkthrough. A brief description of those steps is as follows:

1. Select a process to walk-through
It can be any process. NOTE: If you find a physical walk-through is not practical, consider doing a ***talk-through*** of the process with staff and/or other stakeholders.

2. Let staff know in advance that you will be doing the walk-through exercise.
A walk-through is not a secret shopper exercise. It is better to inform and include staff than to surprise them. As you role play the customer, ask staff to treat you as they would any other customer. Make clear to staff this exercise is not punitive – rather, it is to discover opportunities for improvement, together.

3. Walk-through your chosen process.
Experience the entire process just as your customer would. Take notes at each step.

4. Try to think and feel as a customer would.
Look around as they might. What are they thinking? How do they feel at any given moment? Remember, you are role playing that person and their life situation. Note your observations and feelings.

5. At each step, ask the staff what they think.
Ask staff/stakeholders to tell you what changes would make it better for the *customer* and what changes would make it better for the *staff*. Write down their ideas as well as your own.

6. Summarize what you learned.
Finally, write down a list of the needs you found and any improvements that could be made to address these needs. Be sure to address what the needs are from both the *customer* and *staff/stakeholder* perspectives.

[6]

13. Start small, assess, and expand

When rolling out new clinical programs or improvements, it's often best to start small, so any problems that surface can be addressed before larger numbers of patients are served.

How will you start small? What patients will be eligible? _____

_____

_____

As glitches are addressed, what steps will you take to expand patient participation, and what criteria will trigger each step? _____

_____

_____

14. Launch SBIRT (or SBIRT improvements)

A clinic-wide meeting immediately before launching services can help generate excitement and cooperation.

Items to consider including in a launch meeting are:

- Explanation of the rationale for initiating SBIRT/BSI, anticipated benefits, and its compatibility with your mission

- Supportive and inspiring statements from your Champion and other influential individuals

- Explanation of the SBIRT/BSI process

- Emphasis on the quality improvement process and your openness to concerns and suggestions from all providers and staff

- Highlighting of your team approach and expectations of each provider and staff member

Offering breakfast, lunch, or refreshments during the launch meeting can enhance excitement and participation.

What will be your plan for a launch meeting? _____

APPENDIX 1 – SBIRT/BSI Brief Assessment Questionnaires

The Alcohol Use Disorders Identification Test (AUDIT)

In the past 12 months…	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
3. How often do you have 3 or more drinks on one occasion? *Skip to Questions 9 and 10 if the Total Score for Questions 2 and 3 = 0*	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Scoring: Each AUDIT question is a multiple-choice question with 3 or 5 possible responses. For each possible response, the number at the top of the column shows how many points to add to the total score.

A total score of 0 to 7 suggests low-risk drinking. A score of 8 to 15 suggests hazardous drinking and should prompt a brief intervention. A score of 16 to 19 suggests harmful or problem drinking and should prompt a brief intervention. A score of 20 or more suggests dependence and should prompt a referral to an expert for a comprehensive alcohol assessment.

The Drug Abuse Screening Test

In the past 12 months…

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to?
4. Have you ever had blackouts or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Do people in your life ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?

Scoring: Each question is answered "Yes" or "No. For a "No" response to item 3, add 1 point. For each "Yes" response to other items, add 1 point.

A score of 0 suggests no drug-related problems in patients' lives. A score of 1 to 5 suggests a low to moderate level of drug-related problems and should prompt a brief intervention. A score of 6 or more suggests a substantial to severe level of drug-related problems in patients' lives and should prompt a referral to an expert for a comprehensive drug assessment.

Modifications to consider:

- In Item 3, "abuse" is pejorative and may discourage positive responses. Consider changing "abuse" to "use."
- Some patients get confused by Item 8. They say that all drug users should answer yes, because drug possession is illegal, but the intent of this question is to determine whether patients engaged in other illegal activities, such as selling drugs, stealing, or selling or exchanging sex. Therefore, consider adding "other than possession" after "illegal."

A potential disadvantage to making the above modifications is that the effect of those modifications on DAST reliability and validity is unknown.

The Short Index of Problems for Alcohol and Drugs (SIP-AD)

Over the last twelve months, how often …	Never	Once or a few times	Once or twice a week	Daily or almost daily
1. have you been unhappy because of your drinking/drug use?				
2. lost weight or not eaten properly because of your drinking/drug use?				
3. failed to do what was expected because of drinking/drug use?				
4. has your personality changed for the worse when drinking or using drugs?				
5. have you taken foolish risks when drinking or using drugs?				
6. you said harsh or cruel things to someone when drinking or using drugs?				
7. have you done impulsive things you regretted when drinking or using drugs?				
8. have you had money problems because of drinking/drug use?				
9. has your physical appearance been harmed by drinking/using drugs?				
10. has your family been hurt by your drinking or drug use?				
11. has a friendship or close relationship been damaged by your drinking or drug use?				
12. have you lost interest in activities or hobbies because of your drinking/drug use?				
13. has your drinking/drug use gotten in the way of your personal growth?				
14. has your drinking or drug use damaged your social life, popularity, or reputation?				
15. have you spent too much money or lost money because of your drinking or drug use?				

Scoring: For each response of "never" add 0 points; "once or a few times", 1 point; "once or twice a week, " 2 points; and "daily or almost daily," 3 points.

A score of 0 suggests no alcohol- or drug-related consequences. A score of 1 or more suggests alcohol- or drug-related consequences and places the patient in the category of problem use or dependence, depending on the result of a questionnaire on dependence symptoms.

The Severity of Dependence Scale (SDS)

During the past twelve months …	Never	Once or a few times	Once or twice a week	Daily or almost daily
1. do you think your use of [substance] was out of control?	✓			
2. has the prospect of missing a drink/fix/dose made you anxious or worried?	✓			
3. have you worried about your drinking/use of [substance]?	✓			
4. have you wished you could stop drinking/using [substance]?	✓			
	Not difficult	Quite difficult	Very difficult	Impos-sible
5. how difficult to you find it to go without [substance]	✓			

The 5 questions of the SDS should be asked for each substance that patients use. If the patient uses more than 3 substances, patients should be asked to complete the SDS for the 3 substances that they believe has the most impact on their lives.

Scoring: For each response of "never" or "not difficult" add 0 points; "once or a few times" or "quite difficult," 1 point; "once or twice a week" or "very difficult," 2 points; and "daily or almost daily" or "impossible," 3 points.

A score of 3 or more suggests dependence for adults. A score of 4 or more suggests dependence for adolescents.

The Patient Health Questionnaire-9 (PHQ-9)

1. Over the last 2 weeks, how often have you been bothered by little interest or pleasure in doing things?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
2. Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
3. Over the last 2 weeks, how often have you been bothered by trouble falling or staying asleep, or? sleeping too much?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
4. Over the last 2 weeks, how often have you been bothered by feeling tired or having little energy?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
5. Over the last 2 weeks, how often have you been bothered by poor appetite or overeating?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
6. Over the last 2 weeks, how often have you been bothered by feeling bad about yourself – or that? you are a failure or have let yourself or your family down?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
7. Over the last 2 weeks, how often have you been bothered by trouble concentrating on things, such as reading the newspaper or watching TV?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
8. Over the last 2 weeks, how often have you been bothered by moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
9. Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?*	__ Not at all __ Several days	__ More than half the days __ Nearly every day

* Patients who respond “several days,” “ more than half the days,” or “nearly every day” to Question 9 should be assessed for suicide risk by a qualified professional to determine whether they need inpatient psychiatric care.

The Generalized Anxiety Disorder-7 (GAD-7)

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
Over the last 2 weeks, how often have you been bothered by worrying too much about different things?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
Over the last 2 weeks, how often have you been bothered by trouble relaxing?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
Over the last 2 weeks, how often have you been bothered by being so restless that it is hard to sit still?	__ Not at all __ Several days	__ More than half the days __ Nearly every day?
Over the last 2 weeks, how often have you been bothered by becoming easily annoyed or irritable?	__ Not at all __ Several days	__ More than half the days __ Nearly every day
Over the last 2 weeks, how often have you been bothered by feeling afraid as if something awful might happen?	__ Not at all __ Several days	__ More than half the days __ Nearly every day