S.B.I.R.T. for Mental Health and Substance Use

Screening, Brief Intervention & Referral to Treatment

Implementation Guide for HIV Care Services Programs

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About the Authors

The Center for Community Collaboration (CCC) is housed within the UMBC Psychology Department and was initially forged as a university-community collaborative through several Memoranda of Understanding with the Infectious Disease and Environmental Health Administration (IDEHA), formerly the Maryland AIDS Administration, beginning in 2004. Our mission has been to provide capacity building and training services for the implementation of evidence-based practices within direct care services agencies funded by Ryan White. We have served multiple community-based organizations throughout the State of Maryland with capacity building, trainings, direct services, workshops and surveys. Through a collaborative consultation process that emphasizes organizational stages of change and cultural competence, we treat key stakeholders and agency providers as the experts, helping them to identify programs' needs and providing them with relevant training to enhance quality of care. From 2008 to 2012, the CCC focused on dissemination of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for mental health and substance use for persons living with HIV/AIDS through a Continuous Quality Improvement (CQI) framework. The CCC is currently funded through the SAMHSA "No Wrong Door" project with IDEHA to expand our efforts into the development of integrated screening and referral networks and capacity building for mental health, substance use, sexual health, and infectious disease prevention and treatment with several collaborating partner agencies. As part of this movement toward integrated care, we continue to explore opportunities for better synergy and coordination of services.

The following current and former CCC staff, whose bios can be found at www.centerforcommunitycollaboration.org, contributed to the writing of this guide:

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Purpose of this Guide

SBIRT for Mental Health and Substance Use

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) model has emerged in response to primary and specialty health care services that were missing opportunities to intervene and effect change for patients in need of treatment for substance use disorders. The SBIRT model can be applied to a broader range of health-related concerns including mental health and other types of problems common among HIV+ populations. We have assisted agencies with the processes involved in tailoring SBIRT for their patients' needs and providers' goals, and through this work, we have learned valuable implementation lessons useful for HIV care agencies. SBIRT was largely thought of as an early intervention training model for clinicians and healthcare providers. However, our consultation work with local HIV care agencies indicates that the most effective and sustainable implementation of SBIRT takes the form of an integrated model throughout the agency, requiring involvement from multiple staff, with education and implementation at the provider, team, and system levels.

This guide is intended to assist agency directors and staff with understanding and incorporating an integrated SBIRT approach into their agencies, primarily focused on behavioral health (mental health and substance use) in the context of HIV care. Our semi-structured, manualized approach is designed to provide you with:

1. *A step-by-step guide for implementing SBIRT in your setting*
2. *Tips for how to assess and modify agency readiness to change*
3. *Exercises and activities to help you plan for and train SBIRT*
4. *Techniques for evaluating quality indicators and meeting goals*
5. *Tools for Continuous Quality Improvement (CQI)*
6. *Suggestions for successfully rolling out SBIRT in your organization*

Table of Contents

Helpful Tips Key

The following kinds of "Helpful Tips" appear throughout this guide with the goal of helping you to understand and share the language and terms associated with SBIRT, recognize the importance of considering readiness to change and solutions to perceived barriers at each step of SBIRT planning and implementation, to attend to issues of patient and organizational culture, and to emphasize quality standards of care in SBIRT implementation.

Common Language

Understanding and sharing SBIRT language and terms

Readiness Check

Tips for assessing readiness to change for each step in your SBIRT implementation process

Overcoming Obstacles

Commonly perceived barriers to SBIRT and suggested solutions

Culture

Tips for clinical and organizational cultural competence in SBIRT

Quality Improvement

Integrating best practices and Continuous Quality Improvement within SBIRT

Chapter 1

Introduction to SBIRT

Mental Health & Substance Use in HIV/AIDS Care

HIV can now be considered a manageable, chronic illness rather than a terminal disease. Healthcare providers are serving large numbers of patients who are living longer and facing multiple problems in addition to the management of their HIV positive status. Certainly, problems like homelessness, disease progression, mental illness, and drug abuse are still common among HIV patients, perhaps even on the rise in your area. Engagement, retention, and adherence among your HIV care patients continues to be a challenge complicated by the presence of these additional conditions and problems.

Co-occurrence of mental health problems and HIV

While the exact rates of multiple diagnoses among people living with HIV and AIDS is unknown, it is well documented that the rates of mental health and substance use problems are substantially higher than in the general population. Examining data from the HIV Cost and Services Utilization Study, a nationally representative study of people in the U.S. receiving HIV services, Bing and colleagues (2001) found that in a 12 month period:

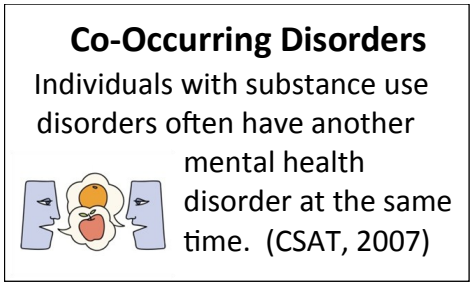
- *Nearly half of HIV care patients screened positive for a mental health problem.*
- *More than 40% used illicit drugs, excluding marijuana.*
- *19% reported problematic levels of alcohol use.*

These data are consistent with 2008 needs assessments obtained from local Maryland HIV care service agencies in Baltimore City and surrounding areas indicating that approximately 47% of patients had HIV/AIDS as well as a diagnosable mental health or substance use disorder (CCC survey data).

For many patients, infection with the HIV virus can be related to substance use or mental health problems. Substance use is a risk factor for HIV transmission. Similarly, mental health problems such as depression or severe mental illness (e.g., schizophrenia) are associated with risky sexual behaviors and negative health consequences before or after HIV infection (Antoni, 2003; Cournos, 2009; Grov, Golub, Parsons, Brennan, & Karpiak, 2010). Receiving the diagnosis may be experienced as a significant, potentially-life threatening stressor, contributing to depression and other stress responses, particularly in the context of poor social support, substance use problems, and limited access to health care often faced by individuals with HIV/AIDS (Antoni, 2003; Cournos, 2009).

Co-occurring disorders pose challenges for HIV care

The co-occurrence of mental health and substance use disorders is often referred to as "dual diagnosis." In reality, providers are often faced with patients who are multiply diagnosed – meeting criteria for two or more diagnoses — and who, in addition, are burdened by multiple social, physical, and environmental health problems. The co-occurrence of mental health and substance use disorders poses a major barrier to HIV care (Cook, Sereika, Hunt, Woodward, Erlen & Condigliaro, 2001; Tucker, Kanouse, Miu, Koegel, & Sullivan, 2003).



Risks associated with untreated mental health and substance use problems for persons living with HIV/AIDS:

- Poorer adherence to treatment and medication regimens
- Higher hospitalization rates for medical complications
- Greater likelihood of treatment drop-out or being lost to follow-up
- Greater risk of opportunistic infection (or re-infection)
- Greater risk of psychosocial problems (homelessness, legal problems, etc.)
- Greater risk of suicide or accidental death

Even for patients engaged in services, mental health and substance use problems can impact treatment adherence (e.g., session attendance, consistency of taking medications) and health-related outcomes if these problems are not properly understood, identified, and managed.

Rationale for SBIRT

Integrate mental health and substance abuse treatment into HIV care

Individuals living with HIV/AIDS experience a multitude of challenges - social, physical, financial, emotional, and spiritual. These individuals also bring experiences, personalities, and cultural influences that interact with the cultures of the agencies and the providers where they are seeking services. Sometimes, these interactions result in a struggle between the best interests of the patients, which are often viewed differently by providers and patients. Providers are asking patients to live full and meaningful lives, not just survive. In addition to medical treatment and medication adherence, they are expected to attain housing, income, social support and engage in mental health and substance abuse treatment. Hence, HIV care is more comprehensive than ever before. Agencies are often considered one-stop-shops for meeting patient goals and provide all these services. The best hope for positive patient outcomes is when mental health and/or substance use problems are identified early and addressed within an overall treatment plan. However, patients are not asked about mental health and substance use often enough, and problems that go un-identified allow patients to “fall through the cracks” of the healthcare system or be dismissed from care for failure to comply with treatment requirements. Providers often recognize the problems, but do not have the training, resources, or time to provide the type of care needed. Many of the patients with mental health and substance use problems are often shifted from provider to provider and eventually lost to follow-up.

Collaborate with patients on important treatment goals

Although HIV care providers may see the interconnectedness of mental and physical health, many patients do not, and they may prioritize one type of problem over others. At times, social, legal, and other personal concerns interfere with engagement in health care. The ideal role of *all* providers is to help identify important goals and elicit from patients the internal motivation, decision-making, and commitment needed to produce desired health behavior change. To do this, providers must meet patients where they are in the process of behavior change for each health-related behavioral goal.

The goal of the SBIRT model is to provide opportunities to identify earlier and to support important changes that would reduce the influence and impact of mental health and substance use problems. An integral part of the model involves using patient-centered communication to foster collaboration on identifying and reaching patient goals.

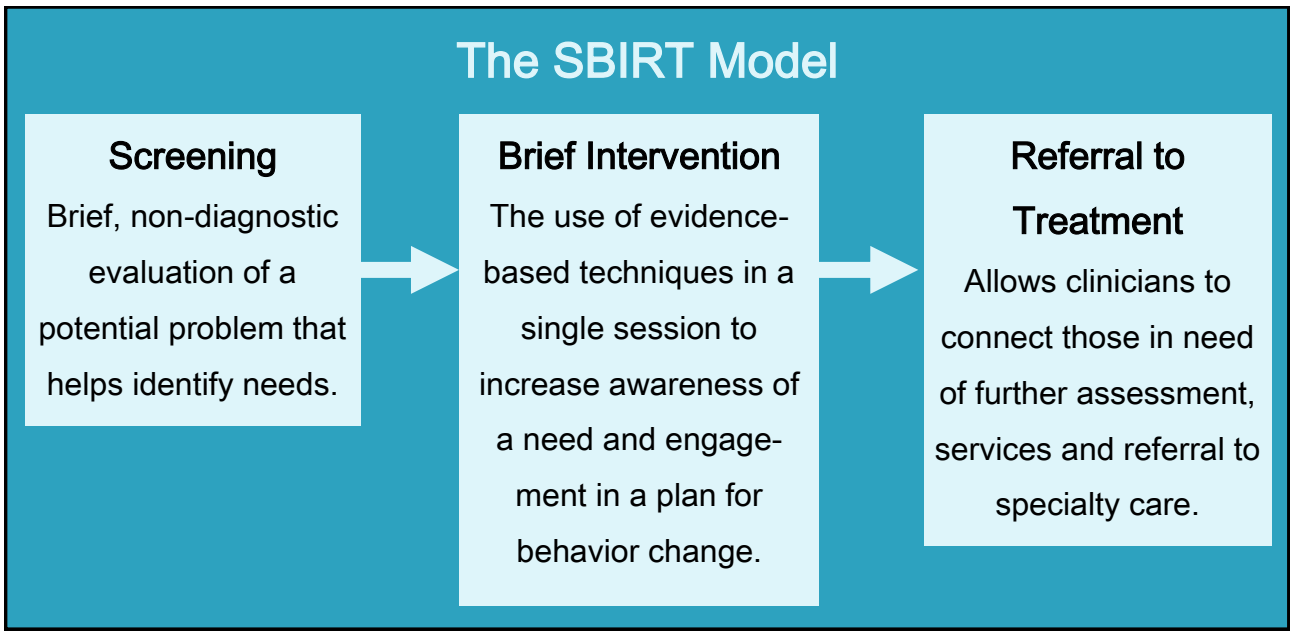
SBIRT: A simple solution to a complex problem

SBIRT is an integrated model containing several elements that together promote optimal patient care. These elements guide this integrated care approach. Since HIV care needs, mental health, and substance use often interact, an integrated care approach is needed.

The SBIRT Model *was developed as a way to engage people who are not seeking help for substance-related problems, but who have behaviors or symptoms that might indicate problem use* (SAMHSA, 2011). *It can also be applied successfully for other mental health problems.*

Implementation of a well-formulated SBIRT plan, including some form of **Screening** (either formal or informal) for all patients, strategic use of **Brief Intervention** skills, and effective **Referral to Treatment** can help prevent patients from falling through the cracks or being inadequately served by treatment programs.

Addressing the myriad of problems that patients with multiple diagnoses present can be very challenging, especially in the context of limited agency resources (staff, financial resources, ability to follow-up). While every agency may not be able to treat the most difficult and complex patients, they can effectively assess problems and help these patients receive appropriate care and support. In this manual, our focus is on SBIRT for mental health and substance use problems among persons living with HIV/AIDS, and we provide a step-by-step guide for implementing this model in your setting.



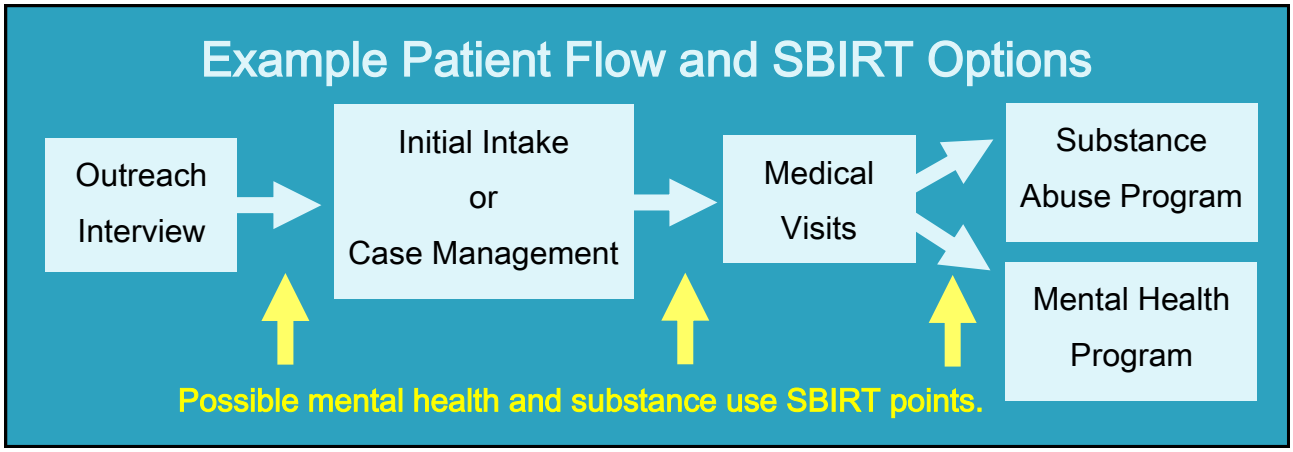
SBIRT Implementation: An Integrated Model

In general, Screening, Brief Intervention, and Referral to Treatment is a public health approach that assists with early identification and intervention with linkage to treatment services when needed. The original goal of the SBIRT model was to provide improved, or more efficient and reliable, identification of alcohol and substance use problems among medical patients, to provide evidence-based brief interventions for these problems, and, when needed, to provide enhanced and integrated substance abuse treatment. The SBIRT model can also be applied more broadly to a range of mental health and other problems that impact patient adherence to HIV care services. The goal of SBIRT is to move toward an integrated model of care that includes mental health and substance use problems in the context of primary or medical care settings, including HIV care settings.

Making Time to Help

By adhering to an SBIRT model, focused and directive interactions that are more likely to produce change across a variety of behaviors can be conducted with every patient within a short period of time.

The model below demonstrates a typical patient flow at HIV care services agencies. This intake and assessment process tends to be linear and similar for all patients entering treatment—they enter through various outreach doors, have an initial intake, receive case management for HIV care coordination, and then begin engaging in medical visits with HIV care providers. Sometimes, if providers detect a need for mental health or substance abuse treatment, patients may be referred to these programs. In yellow, we highlight the multiple points during patient intake during which patient-centered, tailored SBIRT options could be implemented for earlier intervention and improved linkages to integrated care.



A National Initiative

SBIRT for Behavioral Health

is now considered by many to be as important to health as regular flu shots or cancer screenings.

SBIRT is quickly becoming a gold-standard for integrated treatment services. Boards and federal agencies have taken a major interest in SBIRT, including the Substance Abuse and Mental Health Services Administration, the American College of Surgeons' Committee on Trauma, the Federation of State Medical Boards, the Accreditation Council for Continuing Medical Education, and the Joint Commission on Accreditation. While there is a growing body of literature and resources for SBIRT for substance use, few resources provide assistance with SBIRT implementation on an organizational level, and to our knowledge none have specifically addressed the importance of ongoing mental health and substance use screening and referral to treatment within HIV care settings. This guide seeks to meet this need through strategies, activities, and training similar to those we have used on-site with agencies, beginning with the "*Start to Consider*…" activity below.

Start to Consider...

1. What are some similarities between SBIRT and your current standards of practice? How do you currently screen and refer for mental health and substance use needs?

_____

_____

_____

2. What are some differences between SBIRT and your current standards of practice?

_____

_____

_____

3. In what ways can you see SBIRT helping to improve patient care in your agency?

_____

_____

_____

_____

Chapter 2

Working with Your Organization

Organizational Culture and Context

Changing individual behaviors or organizational practices happen in a context that can hinder or facilitate change. It is naïve to consider organizational change as a technical problem easily fixed by legislation, education, and training without considering and attending to important cultural and contextual components that can undermine or support successful SBIRT implementation. The culture of each organization and its staff members influences the readiness of that agency to implement an SBIRT model.

Organizational culture refers to the way things are typically done in an organization, or the norms for work and functioning (Glisson, 2007). Based on the CCC's experience in disseminating evidence-based practices, we treat culture as the context within which we engage individual and organizational level change; organizational culture is a broader contextual factor that influences dissemination and implementation of SBIRT.

Subcultures *within agencies are sometimes based on staff subgroup norms or characteristics (e.g., age and profession).*

Organizational climate refers to how staff perceive the organization and their views of, and emotional responses to, the characteristics of their work environment (Denison, 1996; Glisson, Dukes, & Green, 2006). As such, climate is a major determinant of an organization's ability to successfully accommodate change. When organizational climates are positive and functional workers tend to be achievement-motivated, flexible and open to innovations like SBIRT. Positive organizational climate is associated with better organizational process, work attitudes, and outcomes for mental health service (Aarons & Sawitzy, 2006). When organizational climates are negative or stressful, the attitudes of workers tend to be defensive and less open to change (Feldman, 1993; Glisson, 2007). It is difficult to successfully implement SBIRT, or any innovation, in an organizational climate undermined by negative emotions, poor relationships or conflicted priorities. These are important areas to address early in the process of organizational change.

Organizational Self-Assessment

Organizational Self-Assessment

helps you to understand how staff feel about the organization, duties, work environment and innovations like SBIRT.

An organizational self-assessment of culture and climate is an important first step before introducing a new agency process like SBIRT. This knowledge is critical to understanding staff motivation and commitment for SBIRT at your agency, which will subsequently affect implementation efforts. When perspectives are shared, heard, acknowledged, and responded to, the capacity of the organization to accommodate change is enhanced and the possibility of success increases (Gregory et al., 2012). There is little chance of sustained implementation without the buy-in of the staff responsible for implementation, and staff are more likely to buy in when they feel heard and perceive that their concerns and needs, in relation to the innovation, are being addressed (Fixsen, Naoom, Blase, Friedman & Wallace, 2005; Owczarzak & Dickson-Gomez, 2011). Comprehensive organizational assessments are qualitative as well as quantitative, and the most helpful input comes from all stakeholders involved, including administrators, staff, and patients. Subsequently, successful implementation of SBIRT is supported by the development of a detailed change plan that considers both the culture and climate specific to your organization.

Start to Consider...

1. Describe the culture in your agency in relation to mental health and substance use - How do you operate? What are the expectations for staff?

_____

_____

2. Describe the climate around these issues - Positive? Stressful? Communicative?

_____

_____

3. How might the culture and climate help or hinder SBIRT implementation - Is there buy-in for new procedures? Is there doubt about how it might work or be helpful?

_____

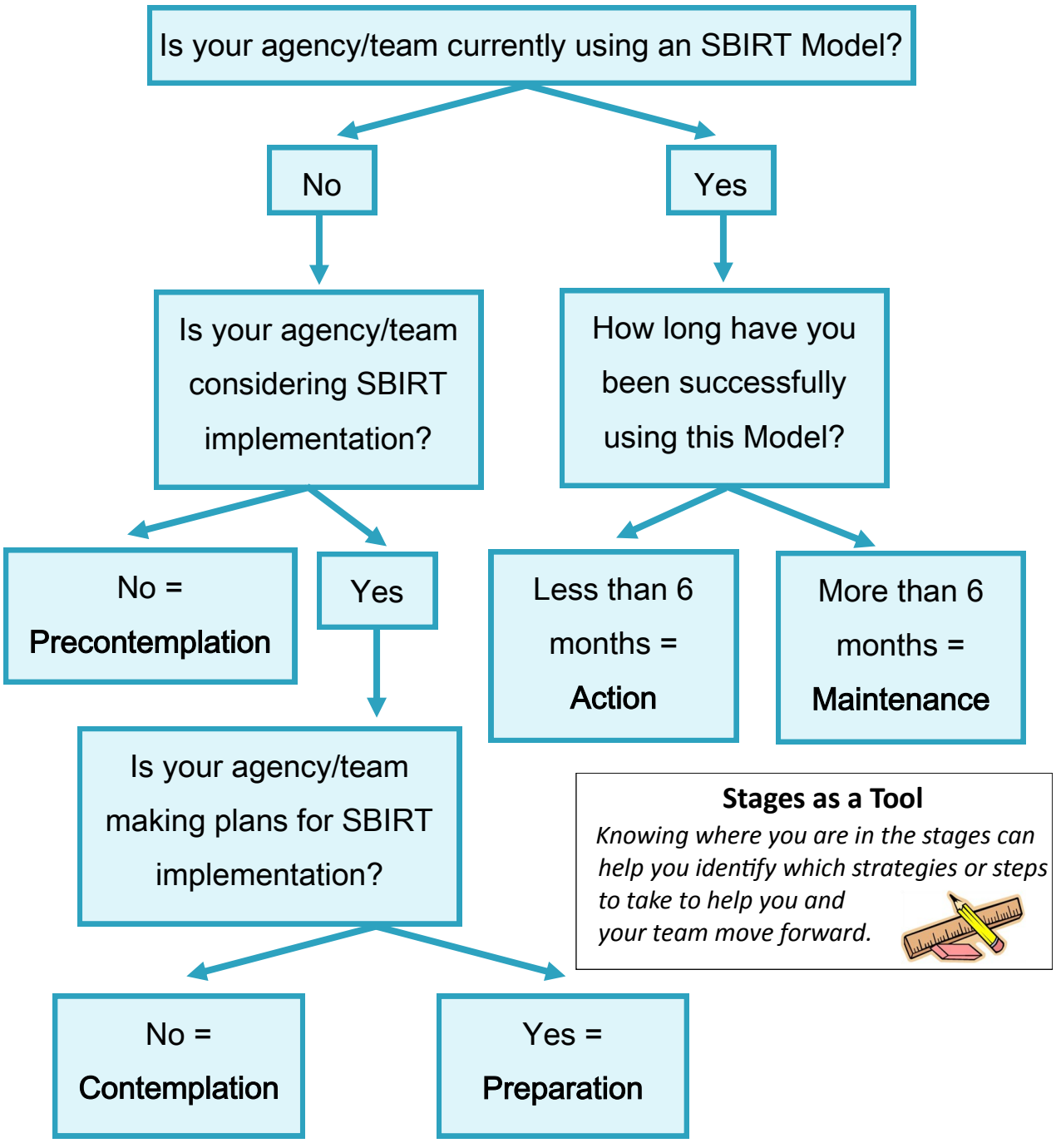
_____

_____

Organizational Stages of Change

The Stages of Change model (DiClemente, 2003; Prochaska & DiClemente, 1984), developed in the context of psychotherapy and addictions, is applicable to a variety of psychosocial issues and at many levels, including organizational change (Kruszynski, Kubek, & Boyle, 2006; Velasquez, 2004).

Use the **SBIRT Staging Algorithm** below to assess the current Stage of Change for SBIRT implementation at your agency, which can be done at individual and group or team levels. The following page provides details about each Stage of Change and how to support forward movement in the process of organizational change.



Stages as a Tool

Knowing where you are in the stages can help you identify which strategies or steps to take to help you and your team move forward.

Stage-Based SBIRT Implementation

Now that you have quickly assessed where your team or agency currently is in the Stages of Change with respect to the use of the SBIRT model, here we describe the characteristics of each stage of change as well as the tasks and strategies that will help your agency move forward in the process of organizational change for SBIRT:

Precontemplation: *Little or no interest in, or awareness of the need for, change.*

Organization Task: Increase awareness of the need and potential for improving mental health and substance use practices consistent with the SBIRT model.

Organization Strategies: Begin a dialog around the impact of mental health and substance use issues on HIV treatment processes and outcomes. Examine the effectiveness and quality of current practices for mental health and substance use problem identification and intervention. Educate the team on the value of SBIRT.

Contemplation: *Considering change; thinking about possible change.*

Organization Task: Weigh the pros and cons of SBIRT and make a decision.

Organization Strategies: Examine the rationale for current practices and the costs and benefits of SBIRT. Consider organizational culture and climate around SBIRT. Involve key stakeholders and promote decision-making toward SBIRT implementation.

Preparation: *Organizational and individual commitment to change and planning.*

Organization Task: Make a commitment to SBIRT and plan for implementation.

Organization Strategies: Enhance buy-in across the agency, identify resources, and form a team for SBIRT implementation. Create a change plan tailored to your agency and patient needs; get input into the plan from stakeholders.

Action: *Beginning to make a change and revising the plan as needed.*

Organization Task: Implementation of SBIRT and evaluation of effectiveness.

Organization Strategies: Train staff in SBIRT and pilot SBIRT on a small scale. Examine SBIRT quality indicators as well as staff and patient responses to the changes. Revise the plan as needed, addressing any barriers. Reinforce change with incentives and recognition for success.

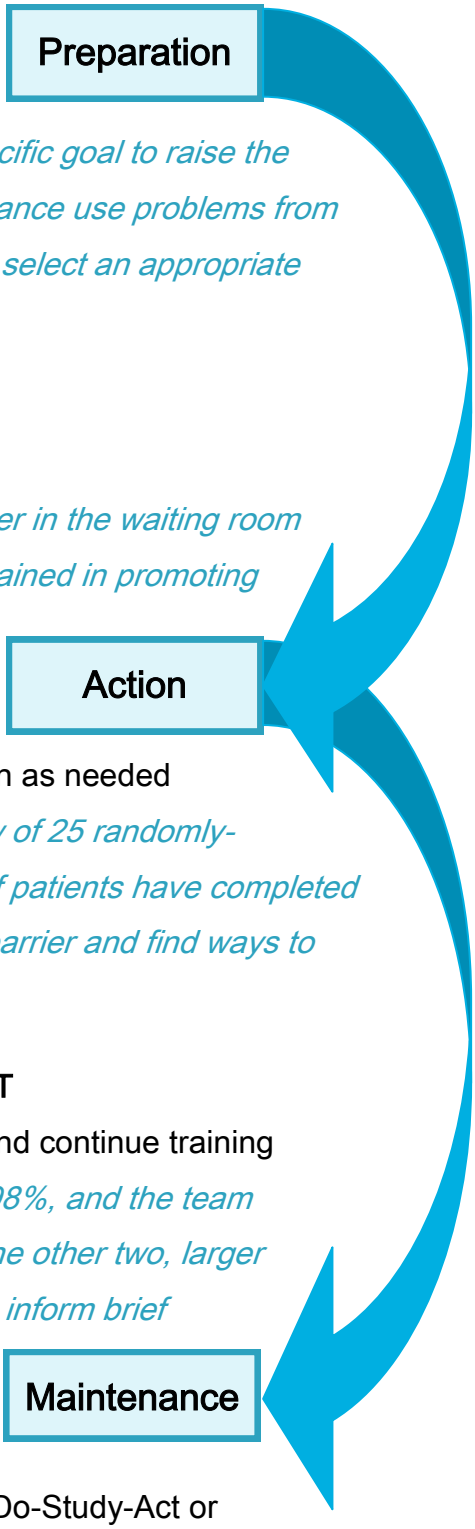
Maintenance: *The change is sustained and integrated into everyday practice.*

Organization Task: Integration of SBIRT into everyday practice with ongoing support.

Organization Strategies: Develop and engage in ongoing quality improvement processes for SBIRT. Provide ongoing training. Implement plans for SBIRT on a broader scale across the agency.

Stages of Change, *in reality, may be more like a cycle than a linear process; it is common to go through some stages multiple times before successfully reaching maintenance.*

As described in the Stages of Change tasks, moving from preparation to successful action and maintenance for SBIRT involves specific steps: planning, training, evaluation and adjustment of the plan, and implementation of SBIRT on a larger scale. Here is an example of an agency's application of these four steps for Screening:



Step 1: PLANNING

Develop a plan for SBIRT

Sample Agency: *The designated SBIRT team sets a specific goal to raise the percent of patients screened for mental health and substance use problems from 40% to 100% at intake. They involve the intake staff and select an appropriate screening tool that can be self-administered by patients.*

Step 2: TRAINING

Execute the plan; try it out on a smaller scale first

Sample Agency: *Screening tools are set up on a computer in the waiting room of the smallest of their three clinics and select staff are trained in promoting and documenting patient screening.*

Step 3: EVALUATION

Evaluate patient reports and feedback and adjust the plan as needed

Sample Agency: *SBIRT team members conduct a review of 25 randomly-selected charts after the first quarter and find that 80% of patients have completed screeners. They identify computer literacy as the major barrier and find ways to address the issue with staff and patient input.*

Step 4: IMPLEMENTATION & QUALITY IMPROVEMENT

Make the change systemic, conduct quality evaluation, and continue training

Sample Agency: *Screening documentation has risen to 98%, and the team begins to develop a plan for implementing screening in the other two, larger clinics and how the results can be used systematically to inform brief intervention and referral to treatment by medical staff.*

You may notice that these four steps are similar to a commonly used performance improvement model, Plan-Do-Study-Act or PDSA (New York State Department of Health AIDS Institute, 2006). We will refer to the steps above throughout this guide to help you with the process of SBIRT implementation.

Chapter 3

Screening

Introduction to Screening

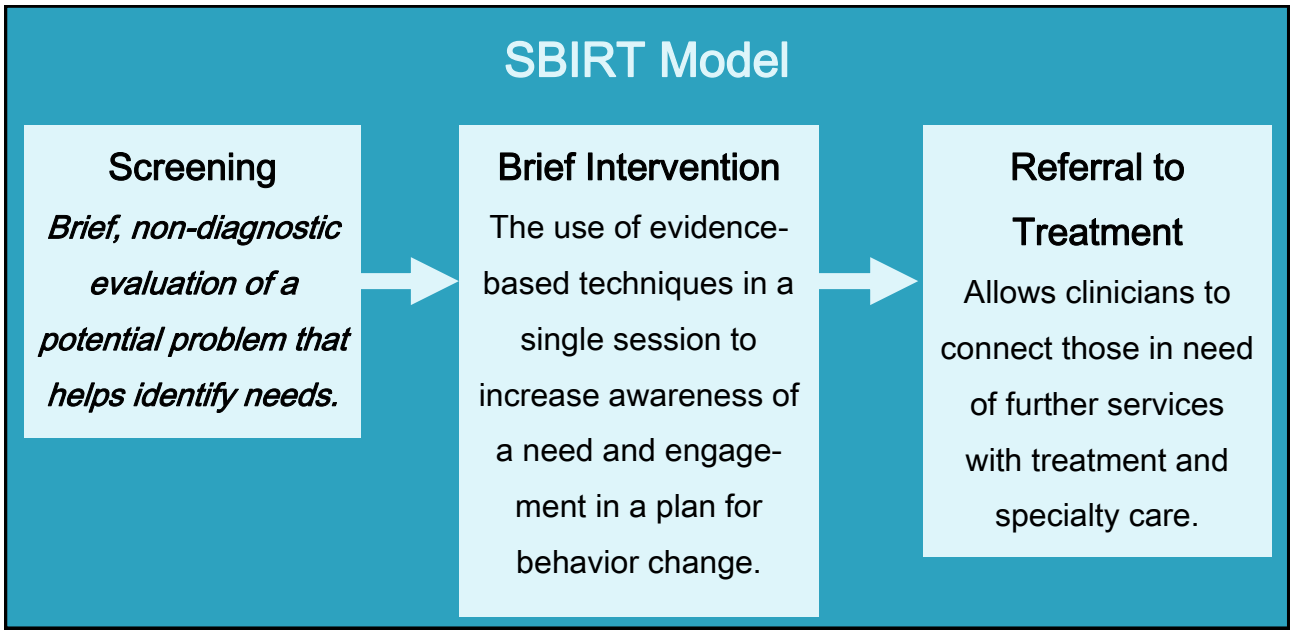
Screening is a brief evaluation to determine whether a patient does or does not warrant further attention at the present time in regard to a particular problem or disorder. To identify comorbid mental health and/or substance use problems, screening procedures should be integrated with HIV care processes and should have the ability to identify possible co-occurring disorders.

Screening helps HIV care agencies to understand and address:

- the high rates of mental health and substance use disorders among persons living with HIV/AIDS.
- the signs of diagnosable disorders and distinguish them from "acting out."
- the consequences of untreated mental health and substance use disorders.
- early intervention and referral needs for mental health and/or substance abuse treatment.

Screening:

The process of testing to determine whether a patient does or does not warrant further attention at the current time in regard to a particular disorder. (CSAT, 2007)



Red Flags versus Mental Disorders

There are important distinctions between maladaptive behaviors that might be seen as problematic in patients with HIV/AIDS and symptoms of mental health disorders (e.g., frequent crying or missed appointments). Intense, emotional responses to stressful experiences or ineffective coping strategies may be maladaptive and common among individuals recently diagnosed with HIV or struggling with life stressors, but they are not necessarily the result of a diagnosable mental disorder. However, if these responses occur over extended periods of time and result in impairment in functioning, they may reflect mental health disorders, and they may be considered "red flags" or signs that further mental health screening and/or assessment is needed.

Signs include what providers observe or notice about the patient that may reflect a mental health problem while **symptoms** involve what the patient is experiencing that reflects a diagnosable mental health problem. **Culture** influences mental health presentation, and what is considered "normal" or "healthy" varies widely cross-culturally.

Culturally competent providers

seek to understand what the patient considers "normal" based on his/her background and history.

Mental health and substance use disorders are characterized by:

- The nature and severity of sets of symptoms
- The duration of symptoms
- The extent to which symptoms interfere with one's ability to carry out daily routines, succeed at work or school, and form and keep meaningful interpersonal relationships

Screening vs. Assessment

Screening is not assessment as it does not typically involve gathering enough information to produce a clinical diagnosis.

Diagnostic assessment, typically conducted by a trained specialist in mental health, involves evaluating the necessary combination of symptoms, duration, and consequences of mental health problems, or criteria, to determine a clinical diagnosis. Screening typically does not involve gathering enough information to produce a clinical diagnosis, but it can help a variety of providers identify signs and symptoms that may reflect a mental health problem. The goal of screening in SBIRT is not to diagnose, but rather to determine if there is evidence of a need to provide a brief intervention and refer the patient for additional assessment and/or services for mental health and substance use disorders commonly experienced by persons living with HIV/AIDS.

Mental Health Disorders Common Among Persons with HIV/AIDS

The most common mental health disorder for individuals with HIV is depression, either major or mild depressive disorder, and thus, some settings choose to screen only for depression in HIV care settings. However, research demonstrates that several additional disorders are also more common among persons living with HIV/AIDS than the general population, as seen in the table below:

Mental Health Disorder (12-month period)	General Population	Persons living with HIV/AIDS
Any mental disorder	26.2%	48%
Major depressive disorder	6.7%	36%
Mild depressive disorder/Dysthymia	1.5%	27%
Generalized anxiety disorder	3.1%	16%
Substance use disorder	3.8%	12%
Panic disorder	2.7%	11%
Post-traumatic stress disorder (PTSD)	3.5%	10.4%
(Bing et al., 2001; Israelski et al., 2007; Kessler, Chiu, Demler, & Walters, 2005; SAMHSA, 2006)		

Depressive disorders involve prolonged feelings of sadness or emptiness and loss of interest in activities that an individual once enjoyed. Individuals with depression may experience feeling tired or "slowed down," problems concentrating, remembering, and making decisions, feeling restless or irritable, changes in eating, sleeping or other habits, and may be thinking of death or suicide frequently, or attempting suicide.

Anxiety disorders are marked by feelings of excessive worry or concern that may feel uncontrollable and interfere with functioning. There are several types of anxiety disorders, including panic disorder which is marked by moments of extreme physiological symptoms of anxiety, and post-traumatic stress disorder (PTSD) which is marked by a prolonged stress reaction to a shocking, life-threatening, or otherwise traumatic experience.

Substance use disorders involve use of one or more psychoactive substances (e.g., alcohol, cocaine, heroin and other opioids, amphetamines, and marijuana or cannabis) to an extent that causes harm, health or social consequences, and possibly forms of physiological and behavioral dependence.

It is beyond the scope of this guide to review each mental health and substance use disorder; see **Appendix** (p. 71-73) for recommended sources for mental health and substance use disorders education and training relevant to SBIRT implementation.

Designing Screening to Meet Patient Needs

Start to Consider...

How do the numbers presented in the table on page 23 compare to the problems presented by patients in your treatment setting? Knowledge of your patient population is an important part of planning for screening in an SBIRT process.

Consider the screening needs of your patients by completing the table below with your SBIRT team. Use a variety of data sources including patient charts, agency reports, and staff experience to answer the questions below and determine which problems you would like to identify earlier in the patient care process through screening implementation.

Comprehensive Screening

To better understand a patient's full range of treatment needs, screen for a variety of mental health and substance use problems.

Mental Health and Substance Use Problems	Common in our patient population?			Poses a barrier for HIV care/ engagement?			Would like to screen for this problem?		
Depression	Y	N	DK	Y	N	DK	Y	N	DK
Anxiety	Y	N	DK	Y	N	DK	Y	N	DK
Trauma and/or PTSD	Y	N	DK	Y	N	DK	Y	N	DK
Illicit drug use	Y	N	DK	Y	N	DK	Y	N	DK
Prescription drug misuse	Y	N	DK	Y	N	DK	Y	N	DK
Alcohol use problems	Y	N	DK	Y	N	DK	Y	N	DK
Panic disorder	Y	N	DK	Y	N	DK	Y	N	DK
Bipolar disorder	Y	N	DK	Y	N	DK	Y	N	DK
Thought/psychotic disorder	Y	N	DK	Y	N	DK	Y	N	DK
General health functioning (social health, physical health, mental health, etc.)	Y	N	DK	Y	N	DK	Y	N	DK
Other: _____ _____	Y	N	DK	Y	N	DK	Y	N	DK
Other: _____ _____	Y	N	DK	Y	N	DK	Y	N	DK

How to Screen

There are two styles of screening that can be used to help clinicians identify evidence of a substance use and/or mental health problem: *informal* and *formal*.

Informal Screening

Informal screening attempts to gather information about patients' mental health or substance use that is rather unstructured and may include questions about current or history of mental health problems and/or prior treatment. For example, if the question "Have you ever been diagnosed with a mental health problem?" receives an affirmative response from the patient, this may indicate a need for a brief intervention related to engaging in further mental health assessment and treatment. Some providers attend to the patient's behavior and body language as informal indicators of current problems (e.g., shaking hands may indicate anxiety or drug withdrawal symptoms). However, these signs could relate to a variety of other physical or acute conditions.

The most useful form of informal mental health and substance use screenings may be brief sets of validated questions that serve as *Primary Screening* to determine if additional screening is warranted. Informal screens are most effective when they begin with an open-ended question, as demonstrated in the alcohol screening example below (D'Onofrio, et al., 2008; Steinweg & Worth, 1993).

Example Primary Screening for Alcohol Misuse

1) *"I'd like to ask a few confidential question related to your health. Please start by telling me about your drinking."*

2) "*Each week, on how many days do you have a drink containing alcohol, including beer or wine?"* _____ **If more than "0 days" ask:**

3) *"How many drinks containing alcohol do you have on a typical day when you do drink? A standard drink is about 12 ounces of beer, 8 ounces of malt liquor, 5 ounces of wine, or 1.5 ounces, or a shot, of 80-proof liquor like vodka or whiskey."* _____

If more than 3 drinks for women/elderly and 4 drinks for men, POSITIVE screen.

Calculate # drinks per week (multiply Q2 and Q3 responses): _____

If more than 7 drinks for women/elderly and 14 drinks for men, POSITIVE screen.

4) *"How often in the past year did you have [3 for women or elderly and 4 for men] or more drinks on one occasion?"*_____ **If more than once, POSITIVE screen.**

IF POSITIVE, provide additional, formal screening such as the CAGE or AUDIT.

Based on NIAAA guidelines for low-risk drinking, useful for HIV+ populations.

Formal Screening

Formal screening typically involves the use of questionnaires administered in verbal, written, or electronic formats that have been *standardized and validated with clinical samples to establish their reliability to identify and predict a range of mental health problems or substance use*.

- Formal screening tools are used to detect the level of risk of the person's substance use or likelihood that responses reflect a mental health problem.
- Formal screening for substance use or mental health typically involve patients answering a set of structured questions that measure quantity and frequency of substance use, consequences of use, history, extent and severity of mental health symptoms, general functioning, and other behaviors.
- Formal screening tools for mental health and substance use problems differ in length, method of administration, and content.
- Formal screening tools typically are completed either by the patient him/herself prior to intake or as a part of an interview completed by an outreach worker, intake social worker, nurse, doctor, mental health staff, or substance abuse treatment staff.
- Formal screening can also be completed on a computer or paper in the waiting area by patients as part of any intake forms or paperwork prior to seeing a provider.

Formal Screening

is becoming the gold standard for early identification of mental health and substance use disorders.

You may notice that an informal initial screening tool like the one on the previous page, if used to make referrals directly for alcohol treatment, might capture many patients who do not actually need treatment (i.e., false positives). Formal screening tools are more sensitive for detecting current problem severity and often are used as secondary aids to determine the level of risk for problems with mental health or substances. Thus, formal screens can help identify those most in need of specialty care versus those who may benefit simply from a brief intervention and follow-up. If your agency is using specific questions on intake forms for assessments with new patients, check to see if these questions are based on validated sources. Using a series of questions that are not validated would still be considered *informal* screening. The table on the next page provides a list of validated screening tools we recommend.

Some screening tools are free and others require purchase. See Screening Tools Library in the Appendix (p.62).

CCC-Recommended Formal Screening Tools

Screening Tool Acronym:		ASI	ASSIST	AUDIT	CAGE-AID	CDQ	COJAC	GAIN-SS	DUKE	DUKE-AD	PHQ Full	PHQ Brief	SAMISS
		Addictions Severity Index	Alcohol, Smoking, and Substance Involvement Screening Test	Alcohol Use Disorders Identification Test	CAGE questions Adapted to Include Drugs	Client Diagnostic Questionnaire - Short Form	Co-Occurring Joint Action Council Screener	Global Appraisal of Individual Needs - Short Screener	The Duke Health Profile	DUKE Anxiety and Depression	Patient Health Questionnaire	Patient Health Questionnaire-Brief	Substance Abuse and Mental Illness Symptoms Screener
Problem Areas Screened	Depression and/or Bipolar disorder	X				X	X	X	X	X	X	X	X
	Anxiety	X				X		X	X	X	X	X	X
	Trauma and/or PTSD	X				X	X (and domestic violence)				X	X	X
	Drug Use	X	X		X	X	X	X					X
	Alcohol use	X	X	X	X	X	X	X					X
	Thought Disorder	X				X							
	Physical Health	X							X				
	General Functioning (disability, support)	X							X		X	X	
Method	Clinician-Administered	X	X	X		X	X						
	Patient Self-report			X	X			X	X	X	X	X	X
Length/Time	Brief (# of questions)			10 q	10 q		9 q	20 q	17 q	7 q	28 q	9 q	16 q
	Lengthy	60-90 min	71 q			15-20 min	*If positive complete GAIN-SS*				72 q		
Normed for HIV						X							X

Comparing Screening Methods

It is up to your agency to select efficient and effective screening methods. While *informal screening* may be convenient, *formal screening* tools can help providers to make more informed decisions about needs and options based on validated methods.

Start to Consider…

It is important to weigh the pros and cons of using formal versus informal screening tools at your specific agency when designing your screening process. Below is an activity intended to help you think through the pros and cons or not-so-positive aspects of using each type of screening.

Pros of Informal Screening

- Can be done by a variety of staff
- Flexibility of administration time, frequency, and staff able to screen
- Ability to tailor questions
- Part of intake so no additional paperwork
- _____
- _____

Cons of Informal Screening

- Lack of consistency in methods across staff, patients, and time points
- Lack of consistent documentation
- Open to false-positives and negatives
- Difficulty knowing when an informal indicator reflects a real problem
- _____
- _____

Pros of Formal Screening

- Tools already developed and validated
- Consistently screening all patients with the same method and timeframe
- Clear guidelines provided for scoring and cutoffs indicating problems
- Standard documentation built into tools
- _____
- _____

Cons of Formal Screening

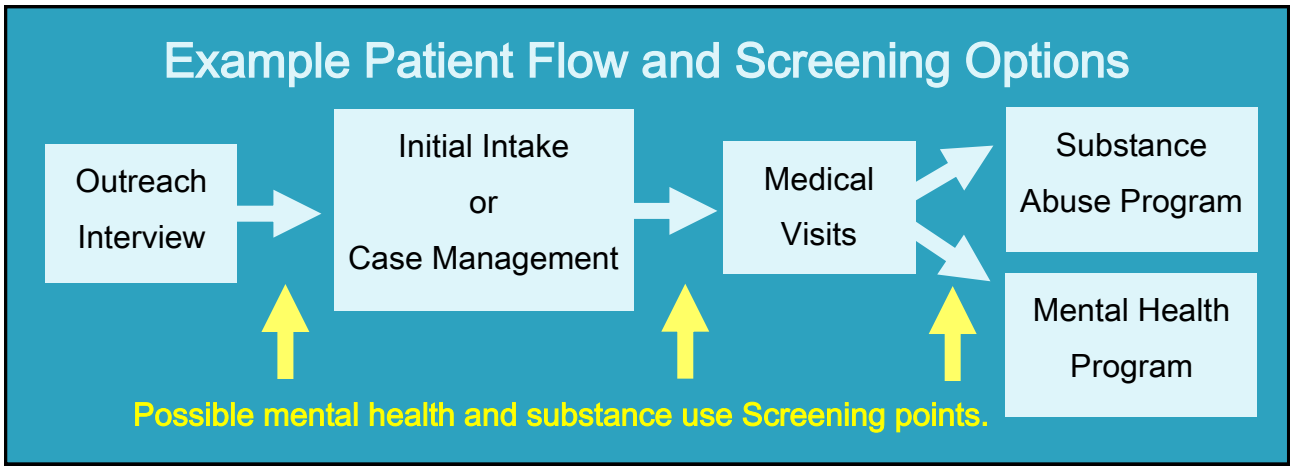
- May involve some additional time
- May produce additional paperwork
- Requires staff training to familiarize with forms and procedures
- _____
- _____

How important is each pro and con to your screening goals and patient population? Consider the value of each consideration in making screening decisions for your agency.

When to Screen

Agencies have options about when and how often to screen new and current patients. There are multiple potential screening opportunities during intake and treatment. Agencies screen during outreach, during intake, during the first medical appointment, and/or during the first substance abuse or mental health treatment session. Early and repeated screening is recommended for three reasons:

1) **Successful intervention is facilitated by early identification of problems.**
2) **Symptoms and readiness to seek treatment change over time.**
3) **Each screen offers a "teachable moment" for the patient.**



Start to Consider…

1. Thinking about patient flow in your agency, where would screening be most effective and sustainable? Could you screen at a single or multiple points of service?

_____

_____

2. For each potential screening point, what is the current practice? Do you already gather information about patient mental health and substance use? How is that working? Can you insert more efficient screening and documentation at that time?

_____

_____

3. For each potential screening opportunity at your agency, which providers or staff members could most accurately and efficiently conduct the screening and document the results: (Note that this process may work best with multiple staff involvement)

_____

_____

Screening Documentation

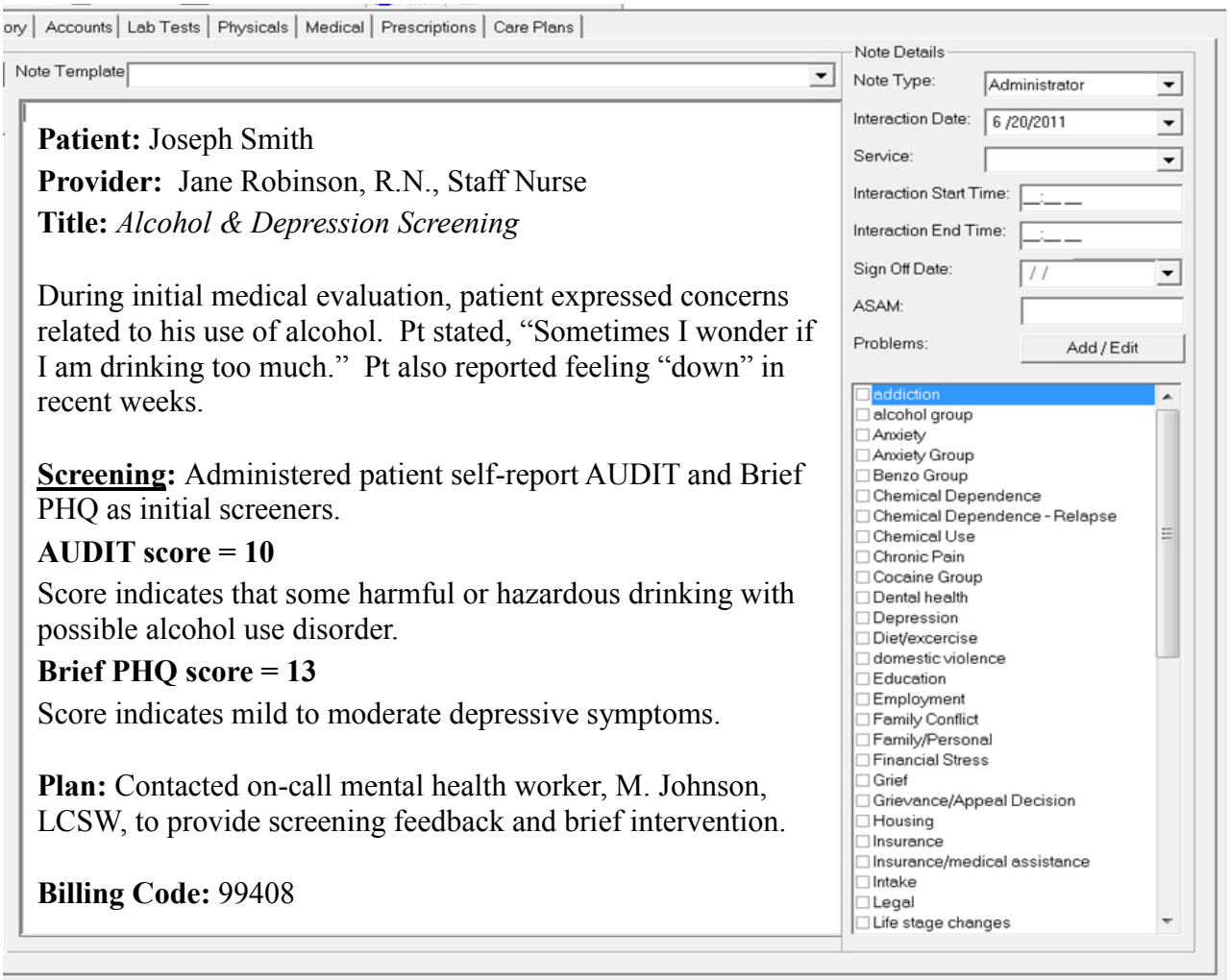
Documentation of screening is critical for a fully-integrated SBIRT system. Widespread screening documentation empowers the entire provider system to facilitate brief intervention and referral to treatment. Helpful documentation includes:

- Provider and patient information and date
- Any relevant statements from the patient
- Screening tools used, scoring results, and interpretation guidelines
- Plans for next steps or follow-up
- Relevant billing codes—note that SBIRT billing options and codes may vary and should be evaluated as part of your SBIRT plan development as well as your quality improvement process.

Screening Chart Notes

Note format will vary depending upon your settings' use of paper or electronic health records (EHR). EHR can facilitate the use of electronically scored screening tools as well as follow-up between providers.

The example screening note below demonstrates the use of formal alcohol and depression screening as part of a medical intake conducted by a nurse. We'll follow Joseph Smith's full SBIRT experience with documentation through the next two chapters.



Screening Training Objectives

You can train staff for screening implementation in a variety of ways. We recommend training a small group or team in screening, followed by additional trainings on brief interventions and referral to treatment leading up to full SBIRT implementation. The goal of screening training is to promote competence among staff about how to introduce the topic and assess signs of substance use and mental health problems in patients with HIV to facilitate engagement in behavioral health services.

Screening training objectives:

1. Understand the rationale for and importance of mental health and substance use screening among persons living with HIV/AIDS.
2. Understand the differences between informal and formal screening, the pros and cons of each, and collaborate with staff to develop an efficient and effective primary screening process that they can implement.
3. Understand the screening process, tool, scoring, interpretation, and documentation procedure to be implemented.

Screening Resources

See Appendix (p. 71) for resources to support your team's readiness to screen.

Screening Tips

For some staff and providers, asking patients about mental health and substance use will be new, and possibly uncomfortable. Here are tips for effective screening that promotes staff confidence and communicates respect and caring to patients:

- *Carefully follow screening administration and scoring instructions.*
- *Try to provide as much privacy as possible.*
- *Assure confidentiality (but be honest about the limits).*
- *Acknowledge that you recognize that some information may be difficult to discuss.*
- *Have a non-judgmental attitude.*
- *Be aware of, and seek assistance with, your pre-conceptions about mental health.*
- *Try to avoid using labels ("addict", "alcoholic") or diagnoses.*
- *Assure the patient that you are asking because of your concern for his/her health.*
- *Begin with open-ended questions initially and move to more directed questions.*
- *Ask "technical" terms first; use "slang" if patient doesn't seem to understand.*
- *Pay attention to the manner in which the patient responds as well as the content.*
- *Follow-up on answers that yield a "positive" screen for more details to document.*

Your Screening Plan

At this point, you may be able to develop a plan for screening implementation on a small scale or "pilot" at your agency that includes the following decisions:

What potential mental health or substance use problems will your screening identify?

Example: *Depression, anxiety, alcohol, and illicit substance use*

_____

_____

When in the patient care process will patients be screened and how often?

Example: *During initial HIV care medical intake and again at 3-month follow-up*

_____

_____

How will patients be screened? What format and tool?

Example: *DUKE-AD & CAGE-AID formal screening tools*

_____

_____

Who will ensure that screening is completed, documented, and followed-up for brief intervention and referral to treatment? Select staff who can dedicate time and capacity to screen and/or score self-reported screening tools. These may or may not be the same staff who will use the data for providing feedback, brief intervention, and referral to treatment. This may depend on the staff member time and roles with patients, skills, and training capacity. SBIRT can be facilitated by one person in a brief timeframe (1-5 minutes), or it can be shared among staff, integrated throughout the treatment process.

Example: *At initial medical appointment in HIV clinic, intake worker administers screening tools, scores, and documents. Then, intake nurse reviews, and if positive, provides brief intervention and referral to treatment, or handoff to on-call mental health staff.*

_____

_____

_____

_____

_____

Chapter 4

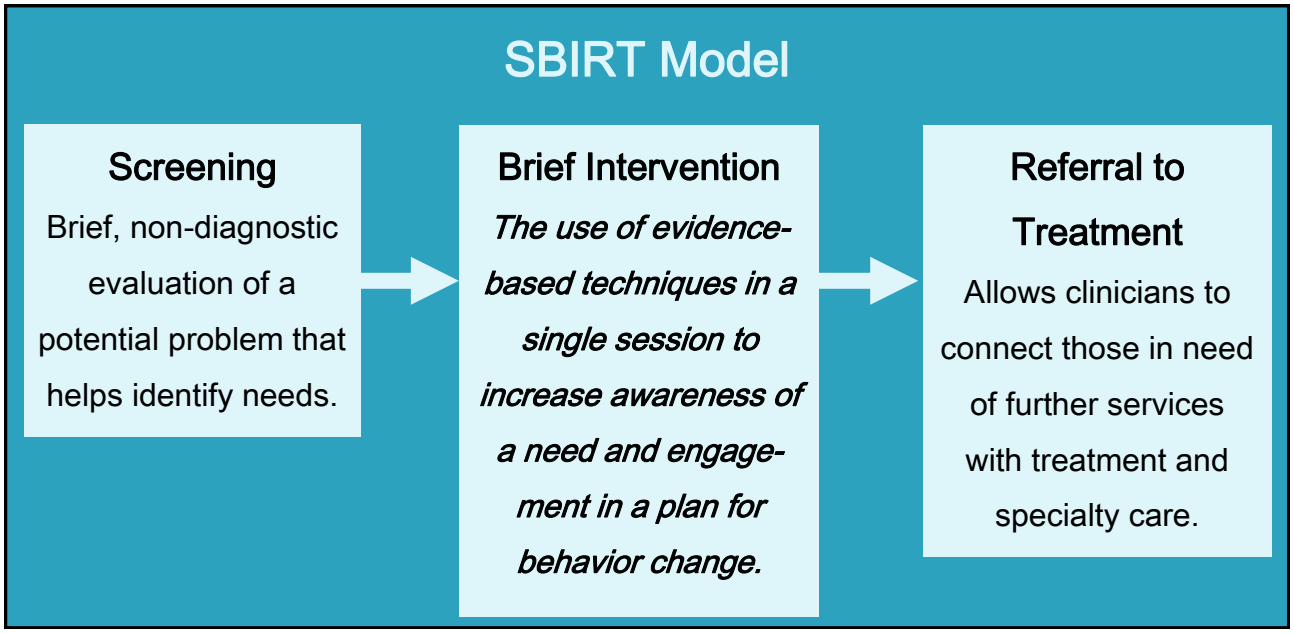
Brief Intervention

Introduction to Brief Intervention

Brief Interventions (BI) are intended to take advantage of a teachable moment, capture the attention of an individual who screens positive and motivate change. Providers sensitively and empathically explore potential mental health or substance use problems and enhance the motivation of the individual to do something about them, either using self-directed means or by seeking treatment (CSAT, 2007). Brief interventions emerged from findings that education or advice giving, while important coming from a health care provider, is not sufficient to motivate or support change (Babor, et al., 2007; SAMHSA, 2011). **Successful BI may be characterized by the following:**

- A brief encounter with a patient involving motivational enhancing strategies based on empirical research, including brief advice and more structured interviewing.
- Duration of 10-15 minutes on average, but may be as brief as 5 minutes or as long as 30 minutes with multiple patient encounters based on patient needs and provider style.
- Can be provided by many different staff at your agency who have confidential access to patients and good interpersonal skills.

This chapter provides information about BI style, skills, and options as well as exercises to aid in planning and training within the SBIRT model.



Enhancing Motivation to Change

There are different approaches to BI with some focusing mostly on advice giving and others on motivational enhancement. Almost all begin with three realizations: 1) positive screens often catch the patient off-guard; 2) patients can be in different Stages of Change or levels of readiness to address the screening issue; and 3) providers need to adapt approaches to BI based on patient readiness. One motivational intervention with significant research support has been effectively applied across a variety of health behaviors, settings, and professions.

Motivational Enhancement involves the use of strategies based in Motivational Interviewing (M.I.), a directive, patient-centered counseling style for eliciting behavior change by compassionately helping patients to explore and resolve ambivalence (Miller & Rollnick, 2002). Interacting with patients with the overall spirit of M.I., supported by four guiding principles, and the use of the core skills can help health care providers collaborate with patients and create opportunities for significant change in substance use and mental health problems (Miller & Rollnick, 2002; Rollnick, Miller & Butler, 2008).

Motivational Skills

require time and practice to develop. Several training resources can help (see p. 72).

Spirit of Motivational Interviewing and Motivational Enhancement

- **Autonomy** – Affirm the patient's rights and capacity for self-direction and change.
- **Collaboration** – Create a partnership that honors the patient's experience.
- **Evocation** – Draw on the patient's own perceptions, goals, and values that support change; in other words, elicit "change talk," the patient's own desires, abilities, reasons, and needs for change, and act as a guide.

R.U.L.E.: Guiding Principles for M.I. in Health Care Settings

- **Resist the Righting Reflex** of providing advice too soon, and allow the patient to be the one voicing the advantages of change.
- **Understand** your patient's motivations.
- **Listen** carefully, non-judgmentally, and empathically.
- **Empower** the patient by actively involving them in the interaction.

"It is the patient, rather than you, who should be voicing the arguments for behavior change." -Rollnick, Miller & Butler (2008, p. 9)

Core Skills: O.A.R.S.

- **Open-ended questions** – Use whenever possible to allow the patient to feel heard.
- **Affirmations** – Support past efforts and successes and current healthy behaviors.
- **Reflective listening** – Judiciously and simply state back what patient is saying that supports change or helps him/her to weigh the pros and cons of change.
- **Summarizing** – Communicates that you are listening and guides the conversation.

Tailoring Interventions to Patient's Readiness to Change

In Chapter 2 we introduced the concept of Stages of Change, originally developed to better understand the gradual steps involving multiple tasks and coping strategies that make up the process of change. Patients will be in different stages at different times for addressing their mental health and substance use (DiClemente, Carbonari, & Velasquez, 1992). Thus, an important goal of a brief, motivational intervention is to identify a patient's current readiness for change for each screening issue and to tailor the approach in ways that promote movement through the Stages of Change (DiClemente & Velasquez, 2002):

Stage of Change	Patient Task	Provider Strategies
Precontemplation	Become interested and concerned in need for change	Provide non-judgmental feedback and information
Contemplation	Risk-reward analysis and decision-making	Elicit pros and cons for change and reflect change-talk
Preparation	Commit and create a plan	Assist in developing an effective plan
Action	Implementation of change plan; revise as needed	Address barriers to change; support patient confidence
Maintenance	Consolidating change into lifestyle	Help patient prevent relapse; support patient coping skills

A Step-by-Step Approach to BI

Learning the skills and style of motivational enhancement and stage-based intervention is a great starting point for staff who will be implementing screening and brief intervention. In conjunction with these skills, the **Brief Negotiated Interview (BNI)** provides a four-step approach for addressing mental health and substance use with patients that is particularly useful when patient contact time is limited. We will introduce the BNI approach with examples and training tools in the pages that follow.

The Brief Negotiated Interview

The Brief Negotiated Interview (BNI) is a brief intervention approach that incorporates screening feedback and advice with motivational enhancement techniques to assist the patient in changing behaviors. The BNI procedure is laid out in a simple, four-step process that is patient-centered; the skills used are based in large part upon the patient's motivation and current readiness to change (D'Onofrio et al., 2008). We recommend the BNI approach for initial training and implementation of SBIRT within HIV care settings.

Brief Negotiated Interview in 4 Simple Steps:

Step 1 - Raise the Subject

Step 2 - Provide Feedback

Step 3 - Enhance Motivation

Step 4 - Negotiate and Advise

Step 1 - Raise the Subject: Rapport is established to engage the individual and ask permission to discuss mental health and substance use.

- Respectfully acknowledge that these areas may be difficult to discuss
- Carefully administer and/or interpret screening

Step 2 - Provide Feedback: Screening results are delivered back to the patient in a way that communicates the problem and connects it to his/her concerns.

- Review screening results and provide feedback on risk levels and possible problem areas
- Express genuine concern about the patient
- Provide guidelines/norms/handouts with information relevant to patient's situation

Step 3 - Enhance Motivation: Basic motivational skills that are consistent with the M.I. Spirit support effective interactions to help patients move forward with change.

- Expect ambivalence from the patient with respect to feedback
- Use reflective listening that enhances change talk
- Discuss pros & cons of current situation and of change
- Support self-efficacy by affirming efforts to change and improve functioning

Step 4 - Negotiate and Advise: Clear advice is given and a collaborative plan is made to secure an agreement regarding changes the patient is willing to make.

- Summarize by piecing together various patient pros and cons in a way that points toward change
- Provide clear, specific, patient-tailored advice
- Negotiate a goal for change or considering options to change; elicit patient input and decision-making
- Plan for follow-up (addressed further in the Referral to Treatment chapter)

BNI Tip

Avoid lecturing or threatening patients about what might happen if they don't change.

The Brief Negotiated Interview Examples

BNI Step	Example 1: Depression
1) Raise the Subject:	"Thanks for telling me how you have been feeling; it can be difficult. Would you mind if we talk for a moment about your current mood? I have a few questions that will help me understand better."
Administer and interpret screening:	**Primary Screen: Patient Health Questionnaire-2 (PHQ-2)** "Over the past two weeks, how often have you been bothered by any of the following problems?" (Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3) 1. Little interest or pleasure in doing things? ____ 2. Feeling down, depressed or hopeless? _____ *Score of 3 or above is a positive screen for depression. If positive, administer PHQ-9 or other formal screening tool.*
2) Provide Feedback Review screening information:	"The problems you have been having with feeling down and not being interested in things that were important to you before, including coming to your medical appointments, could be signs of depression. What do you make of that?"
Provide guidelines/ norms/handouts:	"I have some information, if you are willing to hear it. Depression is very common among people living with HIV and AIDS. It can interfere with health and wellbeing and can make sticking to HIV care difficult. The good news is, depression is treatable."
3) Enhance Motivation Discuss pros & cons:	"What could be some good things about seeking help for your mood?"
Affirm change efforts:	"You've been trying to feel better, which is important, and you're finding that it's tough to, 'pull yourself out of it,' as you say."
Reflective listening that enhances change talk:	**"**On the one hand, it can be difficult to be around people, and on the other hand you'd like to come to your medical appointments and get well."
4) Negotiate & Advise Summarize:	"This is what I've heard you say during our meeting [pull together reflective statements]"
Give clear advice:	"I recommend that you reach out for support. You could speak with one of our mental health workers. They are experienced and can talk more with you about what you're feeling and ways to help."
Negotiate goal:	"What's the next step? You have several options…"
Plan for follow-up and thank the patient:	"So you will attend the mental health walk-in clinic next week, and I'll call you to follow-up on that. Thank you for talking with me about this."

The Brief Negotiated Interview Examples

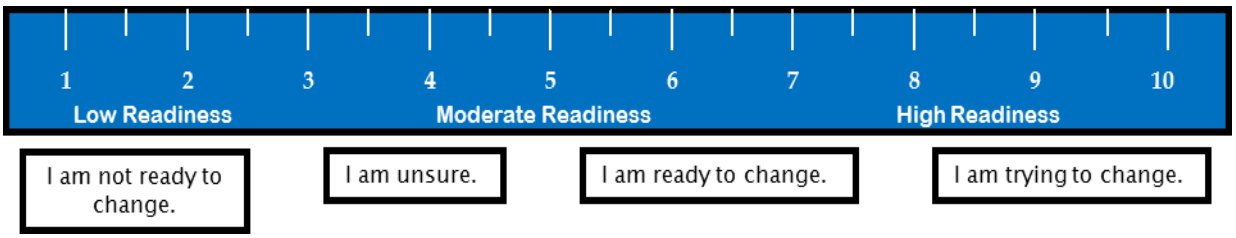
BNI Step	Example 2: Alcohol
1) Raise the Subject Administer and interpret screening:	"Would you mind taking a few minutes to talk with me about your alcohol use?" [e.g., administer Primary Alcohol Screen on page 32 followed by a formal screening tool such as AUDIT or CAGE-AID]
2) Provide Feedback Review screening information:	"From the information you provided, it seems you are drinking at higher levels than most people your age. Drinking above certain levels can cause some of the health problems you are describing, including difficulty sleeping and stomach problems, and it can also make sticking to HIV care very difficult. What do you make of that?"
Provide guidelines/ norms/handouts:	"I have some information, if you are willing to hear it...Reducing drinking to less than 3 drinks per day and fewer than 7 per week makes a person less likely to experience illness or problems as a result of drinking."
3) Enhance Motivation Reflect change talk and discuss pros & cons:	"What are some of the good things / not so good things about your current level of drinking?"… "What could be some good things about changing your drinking behavior?"
Assess and respond to Readiness to change:	"On a scale from 1-10, how ready are you to reduce the amount of drinks you have each day or week?" **(Readiness Ruler)**
Support self-efficacy:	**If >5:** "Great. What would help you move to a higher number?" **If <5:** "Why did you choose that number and not a lower one?"
Develop discrepancy:	**If <1 or unwilling, ask,** "Right now, changing your drinking is not something you really want to do...What would need to happen for this to become a concern for you?"
4) Negotiate & Advise Summarize: Give clear advice:	"This is what I've heard you say today…You are beginning to see some connection between your drinking and the difficulty you've had eating well and taking your medications. You feel that it might be tough to change, but you're willing to try something new to help you feel better."
Negotiate goal:	"If you can stay within the low-risk drinking limits, you will be less likely to experience illness or injury related to alcohol use." "What's the next step? You have several options…What might help you to achieve this goal of reduced drinking?..."
Plan for follow-up and thank patient:	"So you will work on reducing your drinking, and we will check in next month and consider those additional options for support and treatment. Thank you for taking the time to discuss this with me."

Enhancing Motivation: Working with Rulers

Simple 1 to 10 scales or rulers are useful ways for a provider to help a patient to identify her/his readiness to change. Determining **readiness** to change a behavior, the **importance** for this change in the patient's life, and the **confidence** the patient has to successfully make this change will aid in building rapport and collaboration and recognizing the patient's current priorities and perceived barriers to change (Miller & Rollnick, 2002). The objective for responding to the patient's ratings is to adhere to the motivational enhancement style and ask questions in ways that elicit change talk from the patient, rather than giving unhelpful advice or arguing for change (that elicits resistance).

Responding to Ratings

The response you provide after a patient rates a ruler is as important as the rating itself.



Using Brief Intervention Rulers

Readiness Ruler: *"On a scale of 1 to 10, how ready are you to _____?"*
Be specific and discuss only one change behavior at a time.

- **If >5, support self-efficacy and address barriers to change:** *"Great. What would help you move to a higher number?"*
- **If 2 to 5, elicit change talk by asking:** *"Good. Why that number and not a lower number?"*
- **If 1 or not ready, offer a double-sided reflection and listen empathically:** *"On the one hand changing [specific behavior] is not something you feel ready to do right now, and on the other hand you are noticing some problems it may be causing."*

Importance Ruler: *"On a scale of 1 to 10, where 1 is 'not as important as some other things in your life' and 10 is 'the most important thing,' how important is it to you to _____?"*

- **If 2-10, use the same approach as the Readiness Ruler above.**
- **If <1 or not important, offer a reflection and an open-ended question to develop discrepancy between the current status quo and the need for change:** "Right now, changing your drinking is not important to you...What would need to happen for this to become a concern for you?"

Confidence Ruler (use if Readiness and/or Importance are higher than 5): *"On a scale of 1 to 10, how confident are you that you could make this change?"*

- **If 2-10, use the same approach as the Readiness Ruler above.**
- **If <1 or not confident, offer a reflection and an open-ended question to support self-efficacy and affirm efforts to change:** "You have some doubts and at the same time this is something important to you. What has helped you make important changes in your life in the past?"

Practicing the Brief Negotiated Interview

One major benefit of the BNI approach is that *all* staff members at your agency can use it in their interaction with patients on a standard or "as-needed" basis. Use the space below to practice a motivational, brief interaction. Try it yourself or use it for training:

Sample Patient: *Imagine you are working with the primary care team. A patient arrives on the verge of tears and shares with you that it was a struggle to get to her appointment today; she has been feeling too sad and tired to get out of bed in the morning. She also reports losing interest in the things that she used to enjoy such as spending time with her son and going for walks with her dog. She is having trouble keeping up with her HIV medication regimen. You suspect she might be experiencing depression.*

Start to Consider…How would you use the steps of BNI with this patient?

- Step 1 - Raise the Subject:

_____

_____

_____

- Step 2 - Provide Feedback:

_____

_____

_____

_____

- Step 3 - Enhance Motivation:

_____

_____

_____

_____

- Step 4 - Negotiate and Advise:

_____

_____

_____

Brief Intervention Documentation

Your agency staff may have a variety of options when it comes to who will administer screening and brief intervention, and they may or may not be the same individual. Your specific process for screening and brief intervention will determine who has the responsibility for documenting each component of SBIRT. The following documentation example follows the patient we met in the Screening chapter, who received both alcohol and depression screening from an intake nurse followed by a brief intervention with a licensed social worker who has made herself available to see patients who screen positive during HIV care medical intakes. Note that an intake nurse, with BI training, could do the same.

BI Note Content

Identify issues and motivation.
Discuss advice.
Document plan.
Arrange follow-up.

ory | Accounts | Lab Tests | Physicals | Medical | Prescriptions | Care Plans

Note Template

Patient: Joseph Smith
Provider: M. Johnson, LCSW
Title: *Mental Health & Substance Use Screening & Brief Intervention*

Screening: During medical intake, pt completed AUDIT and Brief PHQ as initial screeners: **AUDIT score = 10 (**some harmful or hazardous drinking , possible alcohol use disorder) and **Brief PHQ score = 13** (mild to moderate depressive symptoms). Inquired about other drug use, and pt reported almost daily use of marijuana.

Brief Intervention: Provided patient with feedback from screening and informed him that his current level of drinking puts him at risk for a number of alcohol related consequences. Discussed with patient the pros and cons of reducing use of alcohol and marijuana and considering behavioral health treatment. Pt stated that he feels ready to make changes in substance use (readiness ruler response 8/10), but is not very confident in his ability to do so (4/10). Although J.S. acknowledged regular feelings of sadness and worthlessness, he denied suicidal ideation, and he rated working on the depressive symptoms as low importance (2/10) at this time. Discussed with pt recommendations and options for referrals to treatment.

Plan: Engage in referral to treatment and follow-up.

Billing Code: 99408, 99409

Note Details
Note Type: Administrator
Interaction Date: 6 /20/2011
Service:
Interaction Start Time: __:__
Interaction End Time: __:__
Sign Off Date: / /
ASAM:
Problems: Add / Edit

addiction
alcohol group
Anxiety
Anxiety Group
Benzo Group
Chemical Dependence
Chemical Dependence - Relapse
Chemical Use
Chronic Pain
Cocaine Group
Dental health
Depression
Diet/excercise
domestic violence
Education
Employment
Family Conflict
Family/Personal
Financial Stress
Grief
Grievance/Appeal Decision
Housing
Insurance
Insurance/medical assistance
Intake
Legal
Life stage changes

A Systems Approach to BI Training

A Motivational System of Care

For BI to become integrated into your agency's operations, it would be ideal to create and foster a "motivational system," in which each provider at every level of the agency possesses and routinely uses the skills associated with engaging in SBIRT with patients on an as-needed basis. It is important to consider who will be trained in BI at your agency. The length of the BI session and level of skill involved will be influenced by the individual's style, skills, and role at the agency. A motivationally enhancing system of care, however, tries to make all patient encounters positive and supportive of change. Although staff have a variety of different roles in patient services, all patient-staff interactions should reflect the spirit of collaboration. Whenever possible, patient encounters should be informed by the patient's screening results and tailored to the patient's readiness for change; thereby, staff concerned with mental health and substance use problems as they influence HIV care can be empathic and nonjudgmental with patients in ways that support motivation to change.

Support for All Staff

Provide support for ongoing staff BI skill-building at your agency. All staff should have accessible SBIRT guides, resources, and staff to turn to if they need assistance.

Think about Organizational Change for BI

Examine your agency's current organizational climate with respect to the use of motivational style and BI skills among staff members:

- Do staff buy in to the belief that patients are capable of change, a major element of the spirit of motivational enhancement?
- What skills do staff currently possess that will help them learn brief intervention approaches?
- How can staff procedures be modified to accommodate time for brief interventions with patients?

The activity on the next page will help you to assess your agency's current approach and make decisions about the most appropriate ways to support a motivational system and training for BI.

Your Brief Intervention Plan

Start to Consider…

1) What elements of brief, motivational interventions discussed here, if any, are currently being used by staff at your agency?

_____

_____

2) Which staff or teams at your agency have the skills to “raise the subject” of substance use or mental health problems with patients?

_____

_____

3) Which staff are/will be competent to “provide feedback” and “enhance motivation” for mental health and substance use change with patients?

_____

_____

4) Which staff are interested in training in brief, motivational intervention skills? How might these staff integrate SBI into their work with patients?

_____

_____

5) What kind of support is provided to staff with respect to training, utilization, and assistance associated with providing brief interventions?

_____

_____

6) What resources or technical support could you access to provide initial and ongoing training in brief, motivational interventions for your staff?

_____

_____

7) How might BI-skilled staff assist in training and supervision for others? Would outside consultation or training be helpful?

_____

_____

Chapter 5

Referral to Treatment

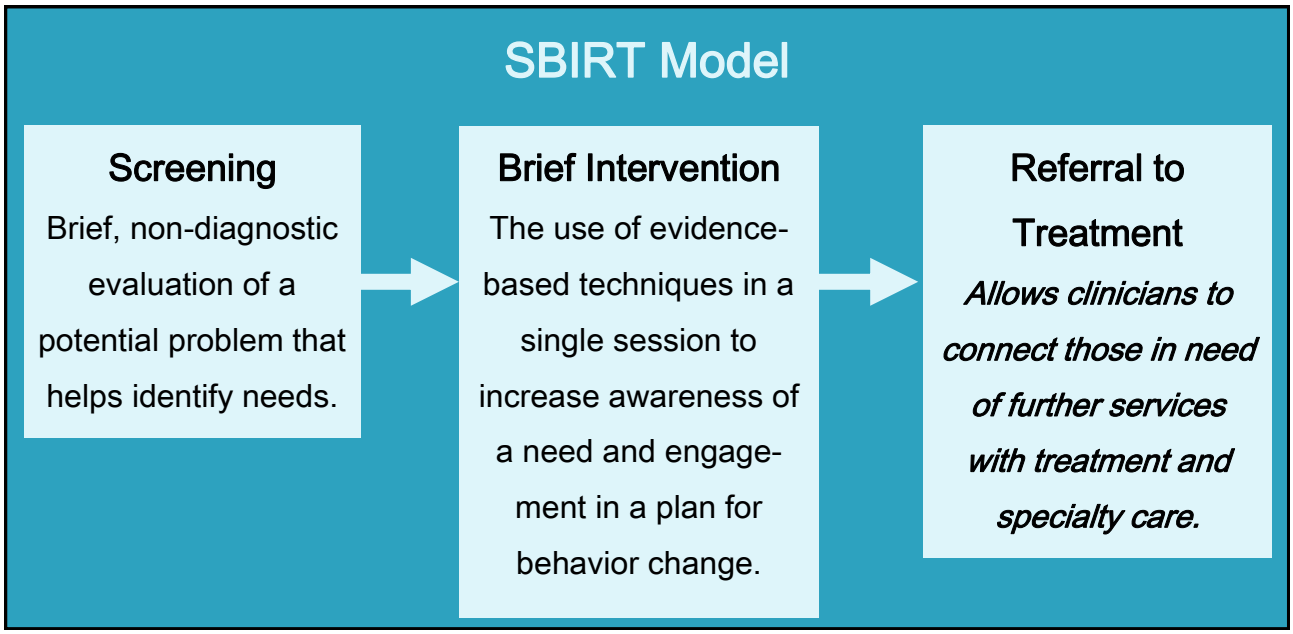
Introduction to Referral to Treatment in Four Steps

At this point in the SBIRT process, the provider has conducted the screening necessary to determine the patient's level of risk for substance use and mental health problems and has either themselves conducted a brief intervention or arranged for someone else to conduct a BI. The third step of the SBIRT process is referral to treatment (RT), a decision-making process incorporating the knowledge garnered about the patient from SBI. Referrals are better facilitated when the provider is informed about effective treatment options specific to care for HIV patients with varying characteristics and behaviors and when the patient is collaboratively involved in the process. We will discuss a 4-step referral to treatment process that can be applied effectively across services:

Referral to Treatment

involves arranging a follow-up plan, visit, and/or referral to a mental health or substance treatment provider.

1. **Determine the current Mental Health and/or Substance Abuse referral need.**
2. **Identify referral options with patient involvement.**
3. **Make an effective referral.**
4. **Document and follow-up with the referral source and patient.**



1. Determine the current referral need.

Depending on the level of severity of mental health and substance use problems for which the patient is screened, and the patient's response to brief intervention, SBIRT typically results in one of these three referrals (in addition to the usual HIV care-related services referrals including case management and primary care):

- **Self-Help, Mutual Help, and Group Support.** During SBI, patients who screen positive, particularly those with low levels of risk for mental health and substance use problems, often state that they will try to make changes on their own. For persons living with HIV/AIDS, social support is an important factor in promoting health, and community -based, mutual help groups can be very helpful. Although some patients may not be comfortable with group settings or abstinence-focused groups like Alcoholics Anonymous it is important to discuss these options with patients.

- **Initial Evaluation and Assessment in Mental Health and/or Substance Abuse Services.** During SBI, it may be apparent that a patient is struggling with mental health and/or substance use problems, and he or she may describe a history of treatment. Because SBI may not provide you with enough information to diagnose or determine level of treatment need, discuss with the patient your recommendation that he/she meet with a mental health or addictions provider for further evaluation which will help the patient to consider a range of treatment options.

Referral to Treatment

For HIV+ patients facing many challenges, SBI may not be enough to support self-change.

- **Emergent Care.** In some cases, mental health or substance use problems may be severe enough to warrant a same-day referral for emergency care services *including*:
  - When the patient reports severe depressive symptoms that have persisted for several weeks with possible suicidal ideation
  - When the patient is ready to abstain from daily substance use and may be at risk for dangerous withdrawal symptoms, such as those related to alcohol dependence
  - When the patient seems out of touch with reality (possibly related to psychosis or acutely induced by substance use)

  Discuss with the patient your concerns for his/her health and safety and your recommendation for an immediate referral to an emergency department, inpatient mental health, or detoxification services.

2. Identify referral options with patient collaboration.

During effective RT, as a provider discusses referral recommendations, he/she is negotiating a plan in a collaborative manner with the patient. In terms of the process of change, when the Stage of Change called Preparation is overlooked or underemphasized, successful and sustained change is less likely (DiClemente, 2003). For successful change, preparation involves developing a plan that is:

1. **Effective**—identify the appropriate options and the best referral source to meet the patient's current needs for substance use and/or mental health treatment based on the level of problem severity. A good, well-matched referral based on need and patient readiness can help motivate and engage the patient in treatment.
2. **Accessible**—ensure that the patient has financial support and/or insurance coverage for the referral, has transportation to reach the referral site, and has a plan to address any other barriers that might hinder access to following up on the referral.
3. **Acceptable**—discuss with the patient his/her experience with the referral source and if this referral is acceptable to him/her based on what has worked or not worked in the past. If it is unacceptable, negotiate where the patient is willing to go and if that meets your referral recommendations.

Referral Questions to Ask Yourself and Discuss with Patients

- Is the needed mental health or substance use service available at our agency?
- Does the patient prefer internal or external mental health and/or substance use services? (e.g., if patient has concerns about confidentiality or all-in-one services)
- Who is available externally to provide the service, and is the agency acceptable to the patient and his/her insurance?
- Does the agency have a good history of patient care and follow-up with our agency?

Linkages to Care: Internal vs. External Referral

Addressing these components in a referral plan with a patient can help you determine if your agency has the resources to meet the patients needs, or if an external referral is needed. Effective external referrals involve efforts to ensure patient engagement in services and a referral process that is timely, appropriate for each agency, and well-monitored.

Library of Referral Sources

Keep a well-maintained, up-to-date and shared listing of external referral sources for a variety of services on-hand.
See Appendix p. 73 for Referral to Treatment Resources.

3. Make an effective referral.

After negotiating a referral plan in collaboration with the patient, it is time to contact the referral source and facilitate an effective referral. Often providers simply provide the patient with a phone number or later schedule an appointment for the patient. Both of these methods would be considered a "**Cold Handoff**" in which the patient and referral provider are not adequately engaged in the process, and the patient is given the complete burden of self-activated follow-up. "**Warm**" or "**Hot**" communication styles and practices for referrals make it more likely that the patient will engage and that the referral source will provide follow-up:

- **Warm Handoff:** providing or assisting with indirect notification to the referral source that the patient is being connected to care, perhaps through a chart note or voicemail.
- **Hot Handoff:** this "gold-standard" for effective referral to treatment involves aiding in direct contact, perhaps by facilitating a meet-and-greet with the patient, yourself, and the referral source or through a phone call that involves all three parties.

Communication Style Check...

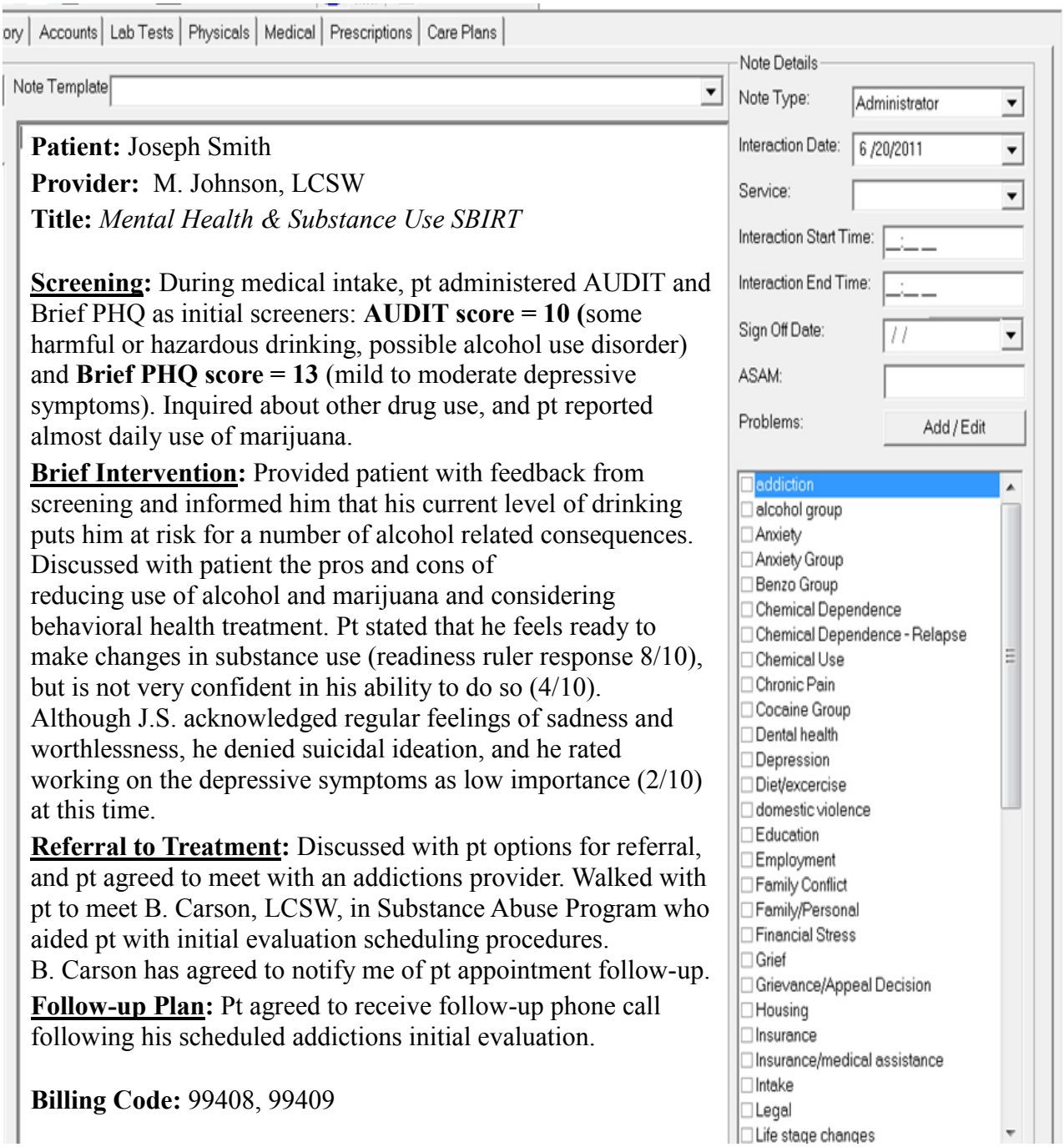
Take this quick quiz to test your knowledge of referral handoffs. Circle the H for Hot, W for Warm, or C for Cold next to each example and check the Answer Key below.

Referral Example	Circle Handoff Type		
1. Placing a "flag" in a patient's electronic medical record to inform a substance use counselor that a medical patient has screened positive for illicit substance use and has been recommended for treatment.	H	W	C
2. Walking a patient to meet the substance use counselor after patient screens positive for daily cocaine use and is motivated to seek substance use treatment.	H	W	C
3. Providing a patient with the name and number of a local mental health provider after patient expresses interest in couples' counseling.	H	W	C
4. Encouraging a patient with no reliable phone access to use your office phone to schedule her first mental health appointment.	H	W	C
5. Telling a patient that he needs to see a substance use counselor after urinalysis results indicate illicit drug use.	H	W	C
Answer key: 1. W 2. H 3. C 4. W 5. C			

Start to Consider ways in which your agency may begin to implement more **Hot Handoffs** into its SBIRT processes.

4. Document and follow-up with referral source and patient

Documentation and follow-up make up important components of what we call "closing the loop" in SBIRT. As demonstrated throughout this guide, the decision-making process for SBIRT will vary by your setting, screening methods, providers, and patient readiness. However, each patient interaction supported by well-planned SBIRT implementation and training can be clear, concise, and effective, as seen in the patient chart note below. In a matter of just a few minutes and one or two provider contacts, the patient has received clear feedback on his/her mental health and substance use risks, support to engage in change and linkages to appropriate care services that can provide feedback to medical providers.



Documentation and Follow-up: "Closing the Loop"

Particularly in the case of external referrals, documentation ensures that funding, regulatory, and legal requirements of collecting patient mental health and substance use information are met. Clinicians sometimes feel intimidated by legal constraints that they may see as barriers to communication and follow-up between referral sources and providers, which may even prevent them from making referrals to external services that may be better-equipped to meet the patient's treatment needs.

Primary legal issues to consider include HIPAA and 42 CFR. The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** and its regulations protect the privacy of an individual's health information and govern the way certain health care providers and benefits plans collect, maintain, use, and disclose protected health information. **Code of Federal Regulations, Title 42 (42 CFR)** is designed ensure that a patient seeking or using services for alcohol or drug use is not made more vulnerable due to the availability of his or her medical record. HIPAA allows, but does not require, programs to make disclosures to other healthcare providers without authorization, while 42 CFR prohibits disclosure unless there is authorization, court order, or the disclosure is done without revealing personal information. One method of addressing these regulations is the use of standard treatment consent forms and feedback form/service authorizations within your agency and between external referral sources. See Appendix for a sample Release of Information form (p. 75).

Closing the Loop

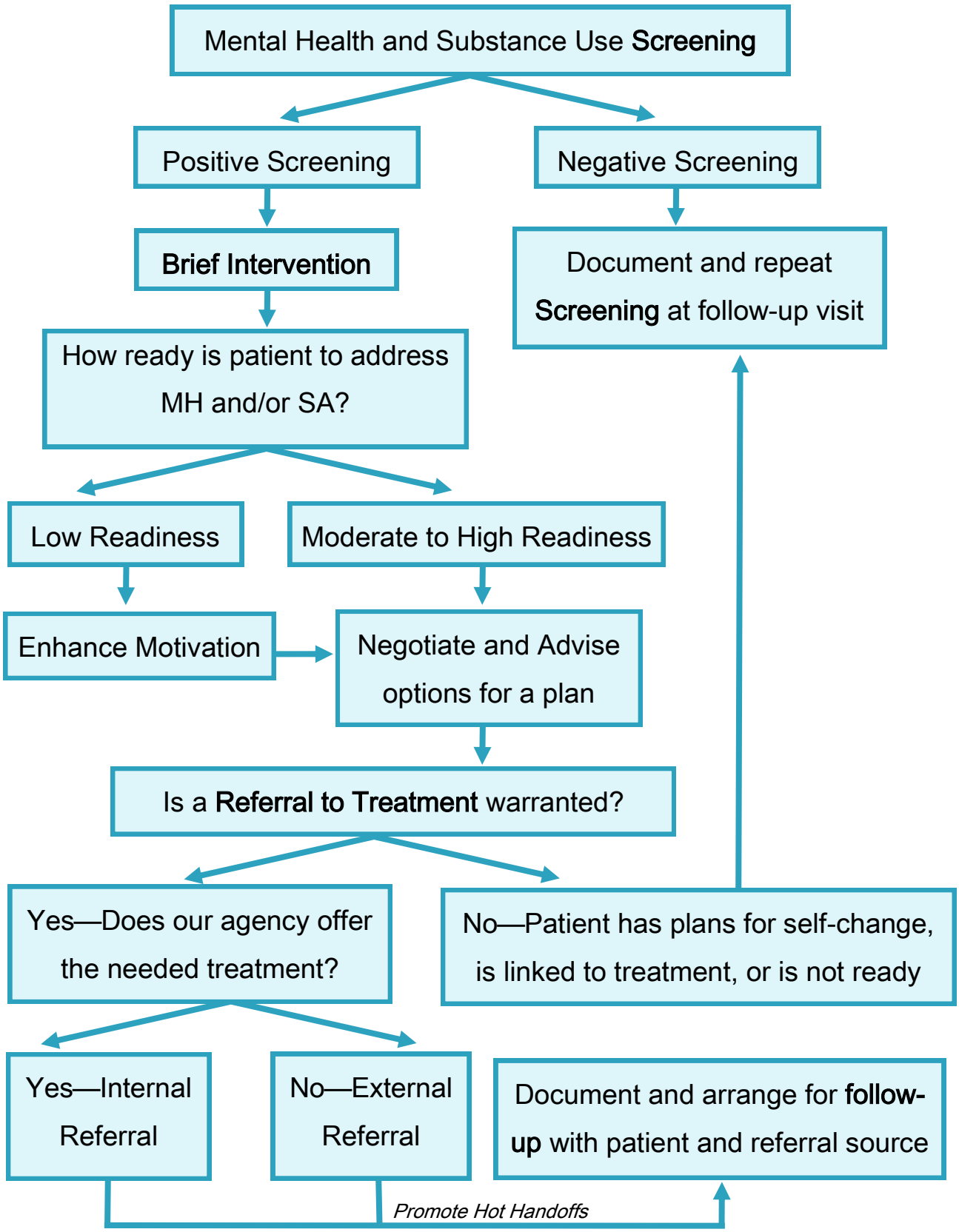
in SBIRT helps to ensure that patients with MH and SA needs and barriers to HIV care do not slip through cracks in the system.

Referral to Treatment Follow-Up Checklist

- Obtain Release of Information/Service Authorizations from the patient for the referral.
- Contact the referral source: elicit feedback that is both immediate and ongoing, from engagement to treatment process to discharge and/or loss of contact.
- Contact the patient and use motivational enhancement skills to promote patient engagement and to clarify health and behavior change goals and referral needs.
- Repeat SBIRT with the patient at his/her next in-person visit.

Pulling it All Together: An SBIRT Decision Tree

Decision trees offer a visual model to illuminate the entire SBIRT decision-making process and how each component of SBIRT is crucial in providing early identification and ongoing linkages to care for mental health and substance use in HIV care settings.



Ongoing SBIRT for Comprehensive and Integrated Care

We opened this guide by discussing co-occurring disorders and common psychosocial challenges for persons living with HIV/AIDS. A single SBIRT interaction between a patient and provider certainly will not solve the myriad of problems that persons living with HIV may face. When a patient is not willing to engage with a recommended referral to treatment due to low readiness to change or perhaps limited ability for staff to provide empathic, well-timed advice, another brief motivational intervention would be appropriate at follow-up contact or appointments. Inform the patient that you are concerned about him/her in relation to mental health or substance use risks you've discussed, and although he/she is not ready to address it at this time, you would like to follow-up with the patient soon or at the next visit. The patient now knows that you care and that his/her medical and HIV care providers value integrating mental health and substance use treatment into care. Ongoing SBIRT helps support this integration of services.

Readiness Changes Over Time

The next time you see the patient may be the opportune time to intervene again.

When SBIRT is successful at linking a patient to the care he/she needs, we are likely to see positive outcomes. Studies show that engagement in treatment for mental health problems, like depression, among patients with HIV is related to:

- ↑ **Adherence to prescribed antiretroviral therapy**
- ↑ **Improvements in CD4 count**
- ↑ **Stable housing**
- ↑ **Remaining abstinent from illicit drugs**
- ↑ **Higher self-efficacy, or confidence in personal abilities**

Effective treatments include psychosocial interventions with an emphasis on education, skills-building, and social support as well as linkages to a variety of other services that support independent functioning (Antoni, 2003; Springer, Chen, & Altice, 2009). Comprehensive treatment models move toward integrating mental health and substance use screening and treatment within primary care and HIV care settings and supplementing care with needed social services outside of these settings. These efforts can support these positive changes for patients living with HIV/AIDS as well as prevention for high-risk populations.

Chapter 6

Evaluation & Quality Improvement

Introduction to Quality Improvement

Moving from training and implementation of SBIRT on a small scale to a fully integrated SBIRT system does not happen overnight. It is a process of change after all, and evaluating how each SBIRT component worked in the initial implementation is a critical part of the action plan. This chapter discusses SBIRT quality evaluation. We believe that the secret to an effective SBIRT program is using a Continuous Quality Improvement process.

Quality is the degree to which a program or service meets or exceeds established professional standards and consumer expectations.
To improve systems of care, evaluation of the quality of care should consider:

1. Quality indicators of meeting standards
2. Quality of service delivery process
3. Quality of outcomes for patients and agency

Quality Indicators are Evidence *that defines, for your agency, what constitutes high-quality mental health and substance use SBIRT.*

Quality Assurance (QA) refers to a broad spectrum of evaluation activities aimed at ensuring compliance with *minimum* quality *standards*.

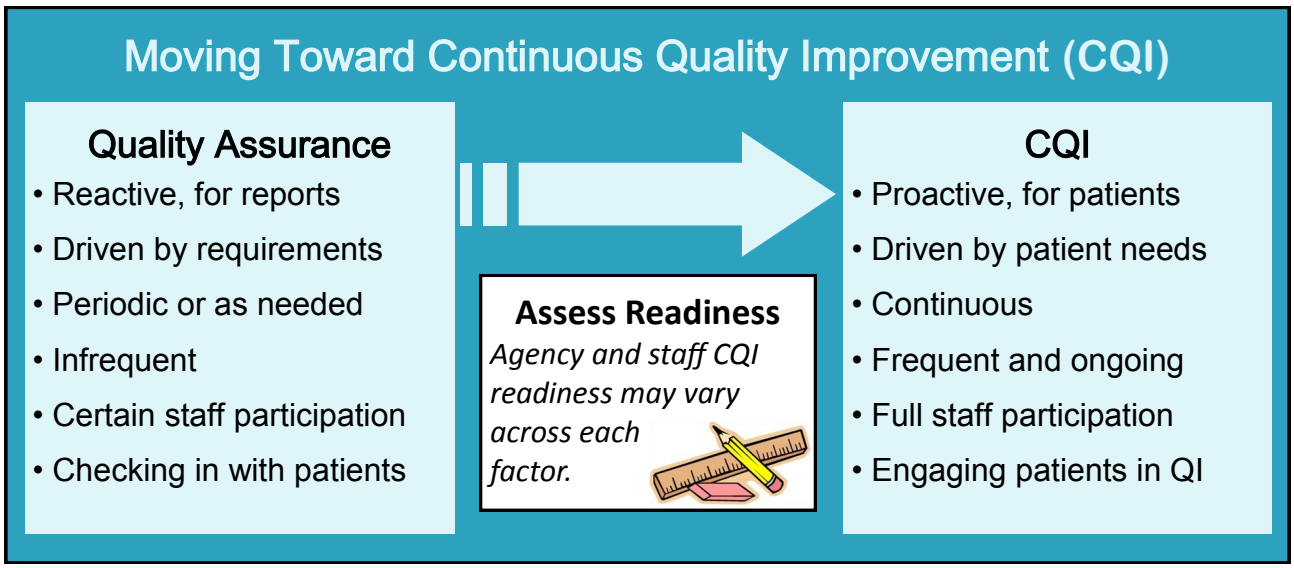
Quality Improvement (QI) refers to activities aimed at improving performance and evaluating the quality of service provision to meet patient needs.

Continuous Quality Improvement (CQI) is used to describe an *ongoing* monitoring, evaluation and improvement process. CQI uses a patient-driven philosophy, an inclusive staff involvement process and a focus on preventing problems and *maximizing* the quality of care.

Benefits of CQI: The CQI approach boasts many benefits for agency, patients and staff. CQI provides ongoing preparation for external evaluation, readily available agency-based data, shared responsibility through integration with agency operations, and it facilitates agency growth and provides direction for the future.

The Continuous Quality Improvement Approach

If you're reading this guide, quality of care is likely very important to you and your agency. You have probably discovered that Quality Assurance (QA) and Continuous Quality Improvement (CQI) differ. The CQI approach does not wait for external QA assessments to trigger self-assessment. Instead, it is a more proactive way to enable effective, sustainable enhancements to patient care. Here are some major differences between QA and CQI approaches to quality evaluation and organizational change:



Start to Consider...

1. What aspects of your agency's activities use a Quality Assurance (QA) approach for evaluation? Is this an internally-driven or externally-driven QA process?

_____

_____

2. What agency activities currently use a CQI approach, and how?

_____

_____

3. Are you interested in developing a CQI approach? What agency services could benefit from a CQI approach?

_____

_____

4. How confident are you that your agency could employ CQI? What might help?

_____

_____

Your Continuous Quality Improvement Team

A Quality Improvement Team involves representatives from various levels of staff from different disciplines or services, as well as ideally patient or peer/consumer representatives. This team meets regularly to review and improve quality of care through the ongoing assessment of quality indicators and then taking actions to problem-solve and improve services and policies.

Start to Consider...who could become a member of a CQI Team at your agency who may help to provide feedback on the SBIRT processes and aid in their implementation?

Organizational Self-assessment

should consider any barriers to CQI (e.g., staff time, resistance to change, and funding).

ROLE	NAME(S)
TEAM LEADERS	
Medical Director	
HIV Program Administrator	
Practitioners	
Nurses	
Case Managers	
Quality Improvement Staff	
Others	
KEY STAKEHOLDERS	
Patients/Peers/Consumers	
Board Member(s)	
Patient Advocate(s)	
Project Officer/Grant Representative	
Others	
MEETINGS (e.g., *Second Tuesday of the month in the Conference Room*)	
When:	Where:

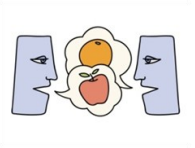
Adapted from *HIVQual Workbook* (New York State Department of Health AIDS Institute, 2006)

CQI Team SBIRT Evaluation

We recommend that your Quality Improvement Team meet regularly throughout SBIRT piloting, implementation, and evaluation to examine SBIRT quality indicators, engage in quality improvement planning, and address staff and patient issues. As part of the information-gathering process, feedback may be obtained from patients and staff using Quality Improvement surveys and forms (See Appendix p. 76 for a sample form).

When examining your SBIRT processes and outcomes, well-defined ***HIV Care Quality Indicators*** should meet these four main criteria (National Quality Center, 2008):

- **Relevance** – relates to a condition that occurs frequently or has an impact on patients
- **Measurability** – realistically and efficiently measured with finite resources
- **Accuracy** – based on accepted guidelines or developed through formal group-decision making methods
- **Improvability** – can be realistically improved given the limitations of the clinical service and patient population



Start to Consider…*the following questions may help guide your CQI Team Meetings*

1. What are the quality indicators for each component of your SBIRT implementation? Check all boxes on the next page that apply to denote areas in need of evaluation.

_____

_____

2. What accomplishments for SBIRT did the small-scale "pilot" experience?

_____

_____

3. What challenges did the small-scale SBIRT implementation experience?

_____

_____

4. How might the CQI Team address these challenges?

_____

_____

5. What kinds of consultation or training may help address these challenges?

_____

_____

Screening Quality Indicators

Type of screener?

- ☐ Mental health
- ☐ Substance use
- ☐ Informal
- ☐ Primary, general
- ☐ Primary, specific
- ☐ Formal, brief
- ☐ Formal, intensive

Screener validation?

- ☐ Validated with similar population to agency
- ☐ Validated with another population
- ☐ Validation work in progress
- ☐ Adapted from a validated measure

How is the screener used?

- ☐ Patient-administered
- ☐ Interviewer-administered
- ☐ Computer-based
- ☐ Observation
- ☐ One-time, initial
- ☐ Repeated regularly

How is screening documented/tracked?

- ☐ Intake documents
- ☐ Chart notes
- ☐ Screening outcomes in patient chart
- ☐ Regularly track number of patients screened

Brief Intervention Quality Indicators

BI Skills Training

- ☐ Screening-based feedback
- ☐ Patient-tailored information
- ☐ Reflective listening
- ☐ Resolve ambivalence—discuss pros and cons
- ☐ Assess readiness
- ☐ Respectful advice-giving
- ☐ Collaborative goal-setting

BI Documentation

- ☐ BI notes follow screening
- ☐ BI interaction and outcome documented
- ☐ BI notes in chart for other providers
- ☐ Negotiation and plan documented

BI System of Care

- ☐ Informal patient and staff feedback (e.g., comment cards, meetings)
- ☐ Formal patient and staff feedback (e.g., satisfaction surveys, patient outcome data)
- ☐ Patients asked how supported and understood they feel during brief interactions
- ☐ Staff asked how supportive setting is for motivational interactions with patients
- ☐ Staff provided BI training and resources

Referral to Treatment Quality Indicators

Determine Current Referral Need(s)

- ☐ Screening-based
- ☐ Discussed with patient via Brief Intervention
- ☐ Meets level of severity
- ☐ Addresses both mental health and substance use needs, if present
- ☐ Emergent care plans

Referral Options

- ☐ Effective, supported by evidence and current patient needs
- ☐ Accessible to patient
- ☐ Acceptable to patient at present time
- ☐ Internally available
- ☐ External referral

(See p. 47 checklist)

Effective Referrals

- ☐ Handoff communication style monitored
- ☐ Cold—patient and referral provider not actively engaged
- ☐ Warm—indirect notification to referral source
- ☐ Hot—all parties actively engaged in referral

Documentation & Follow-Up

- ☐ All SBIRT steps documented in chart
- ☐ Patient consent/release documented
- ☐ Closed the loop with all parties
- ☐ RT follow-up

(See p. 50 checklist)

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Velasquez, M.M. (2004). Strategies for affecting change at multiple levels of an organization*, In Addiction Technology Transfer Center. The Change Book. U.S. Department of Health and Human Services*, Rockville, MD, 2004.

Screening Tools Library

Addictions Severity Index (ASI)

- Website: www.tresearch.org/resources/instruments.htm
- Reference: Kosten, T. R., Rounsaville, B., & Kleber, H. D. (1983). Concurrent validity of the Addiction Severity Index. *Journal of Nervous and Mental Disorders, 171*, 606-610.

Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

- Website: www.who.int/substance_abuse/activities/assist/en/
- Reference: Humeniuk, R. E., et al. (2008). Validation of the Alcohol Smoking and Substance Involvement Screening Test (ASSIST). *Addiction, 103*(6), 1039-1047.

Alcohol Use Disorders Identification Test (AUDIT) — p. 64

- Website: http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf
- Reference: De Silva, P., Jayawardana, P., & Pathmeswaran, A. (2008). Concurrent validity of the Alcohol Use Disorders Identification Test (AUDIT). *Alcohol and Alcoholism, 43*(1), 49-50.

CAGE - Adapted to Include Drugs (CAGE-AID)

- Website: www.partnersagainstpain.com/hcp/pain-assessment/tools.aspx (listed under “Aberrant Drug-Related Behaviors”)
- Reference: Steinweg, D. L., & Worth, H. (1993). Alcoholism: The keys to the CAGE. *American Journal of Medicine, 94*, 520-523.

Patient Diagnostic Questionnaire - Short Form (CDQ)

- Website: www.hivguidelines.org/resource-materials/screening-tools/mental-health-screening-tools/
- Reference: Aidala, A., et al. (2004). Development and validation of the patient diagnostic questionnaire (CDQ): a mental health screening tool for use in HIV/ AIDS service settings. *Psychology, Health, and Medicine, 9*(3), 362-379.

Co-Occurring Joint Action Council Screener (COJAC) — p. 65

- Website: www.adp.state.ca.us/cojac/screening.shtml
- Reference: Currently undergoing 2-year validation study.

The Duke Health Profile (DUKE)

- Website: http://healthmeasures.mc.duke.edu/images/DukeForm.pdf
- Reference: Parkerson, G. R. Jr., Broadhead, W. E., & Tse, C. K. (1990). The Duke Health Profile: A 17-Item measure of health and dysfunction. *Medical Care, 28*(11):1056-1072.

DUKE Anxiety and Depression (DUKE-AD)

- Website: http://healthmeasures.mc.duke.edu/images/DukeAD.pdf
- Reference: Parkerson, G. R., Broadhead, W. E., & Tse, C. K. (1996). Anxiety and depressive symptom identification using the Duke Health Profile. *Journal of Clinical Epidemiology, 49*(1), 85-93.

Global Appraisal of Individual Needs—Short Screener (GAIN-SS)

- Website: www.chestnut.org/LI/gain/GAIN_SS/index.html
- Reference: Dennis, M. L., Chan, Y. F., & Funk, R. R. (2006). Development and validation of the GAIN Short Screener (GAIN-SS) for psychopathology and crime/violence among adolescents and adults. *The American Journal on Addictions, 15*(supplement 1), 80-91.

Patient Health Questionnaire (PHQ Full) — pp. 66-68

- Website: www.phqscreeners.com/
- Reference: Spitzer, R. L., Kroenke, K., & Williams J. B. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ Primary Care Study. *Journal of the American Medical Association, 282*, 1737-1744.

Patient Health Questionnaire-9 (PHQ-9) — p. 69

- Website: www.phqscreeners.com/
- Reference: Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 6*, 606-613.

Substance Abuse and Mental Illness Symptoms Screener (SAMISS) — p. 70

- Website: http://hiv.bvcog.org/2008/04/samiss.html
- Reference: Pence, B., Gaynes, B., Whetten, K., Eron, J., Ryder, R., & Miller, W. (2005). Validation of a brief screening instrument for substance use and mental illness in HIV-positive patients. *Journal of Acquired Immune Deficiency Syndromes, 40*(4), 434-444.

AUDIT

Date _____

Instructions: For each question, place a checkmark on the line next to the best answer.

1. How often do you have a drink containing alcohol?
   - Never ____
   - Monthly or less ____
   - Two to four times a month ____
   - Two to three times a week ____
   - Four or more times a week ____

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - 1 or 2 ____
   - 3 or 4 ____
   - 5 or 6 ____
   - 7 to 9 ____
   - 10 or more ____

3. How often do you have six or more drinks on one occasion?
   - 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 from you because of drinking?
   - 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 you had been drinking?
   - Never ____
   - Less than monthly ____
   - Monthly ____
   - Weekly ____
   - Daily or almost daily ____

9. Have you or someone else been injured as a result of your drinking?
   - No ____
   - Yes, but not in the last year ____
   - Yes, during the last year ____

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking, or suggested you cut down?
    - No ____
    - Yes, but not in the last year ____
    - Yes, during the last year ____

Retrieved from: www.projectcork.org/clinical_tools/html/AUDIT.html

COJAC SCREENING TOOL

#1 Just Ask The Primary Screening Questions . . .

3 Questions for Mental Health

- ❑ Have you ever been worried about how you are thinking, feeling or acting?
- ❑ Has anyone ever expressed concerns about how you were thinking, feeling, or acting?
- ❑ Have you ever harmed yourself or thought about harming yourself?

3 Questions for Alcohol & Drug Use (Health Canada Best Practice Report):

- ❑ Have you ever had any problem related to your use of alcohol or other drugs?
- ❑ Has a relative, friend, doctor, or other health worker been concerned about your drinking or other drug use or suggested cutting down?
- ❑ Have you ever said to another person, "No, I don't have an alcohol or drug problem," when around the same time you questioned yourself and felt, maybe I do have a problem?

3 Questions for Trauma/Domestic Violence:

- ❑ Have you ever been in a relationship where your partner has pushed or slapped you?
- ❑ Before you were 13, was there any time when you were punched, kicked, choked, or received a more serious physical punishment from a parent or other adult?
- ❑ Before you were 13, did anyone ever touch you in a sexual way or make you touch them when you did not want to?

#2 If index of suspicion is high for mental health, substance abuse, and/or trauma, then complete either:

- ❑ GAIN Short Screener (SS)

OR

- ❑ Modified MINI

Adapted from Collaborative Care Project, Canada and Co-Morbidity Screen, Boston Consortium.

Retrieved from: www.adp.state.ca.us/cojac/screening.shtml

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐
f. Headaches	☐	☐	☐
g. Chest pain	☐	☐	☐
h. Dizziness	☐	☐	☐
i. Fainting spells	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐
k. Shortness of breath	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. Questions about anxiety.		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question #5.			
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. Think about your last bad anxiety attack.		NO	YES
a.	Were you short of breath?	☐	☐
b.	Did your heart race, pound, or skip?	☐	☐
c.	Did you have chest pain or pressure?	☐	☐
d.	Did you sweat?	☐	☐
e.	Did you feel as if you were choking?	☐	☐
f.	Did you have hot flashes or chills?	☐	☐
g.	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h.	Did you feel dizzy, unsteady, or faint?	☐	☐
i.	Did you have tingling or numbness in parts of your body?...	☐	☐
j.	Did you tremble or shake?	☐	☐
k.	Were you afraid you were dying?	☐	☐

5. Over the last 4 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐
If you checked "Not at all", go to question #6.				
b.	Feeling restless so that it is hard to sit still.	☐	☐	☐
c.	Getting tired very easily.	☐	☐	☐
d.	Muscle tension, aches, or soreness.	☐	☐	☐
e.	Trouble falling asleep or staying asleep.	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐
g.	Becoming easily annoyed or irritable.	☐	☐	☐

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

	NO	YES
6. Questions about eating.		
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.		
c. Has this been as often, on average, as twice a week for the last 3 months?	☐	☐
7. In the last 3 months have you often done any of the following in order to avoid gaining weight?	**NO**	**YES**
a. Made yourself vomit?	☐	☐
b. Took more than twice the recommended dose of laxatives?	☐	☐
c. Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	**NO** ☐	**YES** ☐
9. Do you ever drink alcohol (including beer or wine)?	**NO** ☐	**YES** ☐
If you checked "NO" go to question #11.		
10. Have any of the following happened to you more than once in the last 6 months?	**NO**	**YES**
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c. You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d. You had a problem getting along with other people while you were drinking.	☐	☐
e. You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Retrieved from: www.phqscreeners.com

The Substance Abuse and Mental Illness Symptoms Screener (SAMISS)

Substance Abuse: Respondent screens positive if sum of responses to questions 1–3 is equal to or greater than 5, response to question 4 or 5 is equal to or greater than 3, or response to question 6 or 7 is equal to or greater than 1.	**Mental Illness:** Respondent screens positive if response to any question is "Yes."
1. How often do you have a drink containing alcohol? Never **0** Monthly or less **1** 2–4 times/mo **2** 2–3 times/wk **3** 4 or more times/wk **4**	8. In the past year, when not high or intoxicated, did you ever feel extremely energetic or irritable and more talkative than usual? Yes ☐ No ☐
2. How many drinks do you have on a typical day when you are drinking? None **0** 1 or 2 **1** 3 or 4 **2** 5 or 6 **3** 7–9 **4** 10 or more **5**	9. In the past year, were you ever on medication or antidepressants for depression or nerve problems? Yes ☐ No ☐
3. How often do you have 4 or more drinks on 1 occasion? Never **0** Less than monthly **1** Monthly **2** Weekly **3** Daily or almost daily **4**	10. In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row? Yes ☐ No ☐
4. In the past year, how often did you use nonprescription drugs to get high or to change the way you feel? Never **0** Less than monthly **1** Monthly **2** Weekly **3** Daily or almost daily **4**	11. In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure? Yes ☐ No ☐
5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel? Never **0** Less than monthly **1** Monthly **2** Weekly **3** Daily or almost daily **4**	12. In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious? Yes ☐ No ☐
6. In the past year, how often did you drink or use drugs more than you meant to? Never **0** Less than monthly **1** Monthly **2** Weekly **3** Daily or almost daily **4**	13. In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious? Yes ☐ No ☐
7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the past year, and were not able to? Never **0** Less than monthly **1** Monthly **2** Weekly **3** Daily or almost daily **4**	14. In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath? (If respondent volunteers, "Only when having a heart attack or due to physical causes," mark "No.") Yes ☐ No ☐
	15. During your lifetime, as a child or adult, have you experienced or witnessed traumatic event(s) that involved harm to yourself or to others? Yes ☐ No ☐ If yes: In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma? Yes ☐ No ☐
This questionnaire is based on the validated screening instrument developed by the University of North Carolina at Chapel Hill, Departments of Psychiatry, Medicine, Public Policy, and Community and Family Medicine; and the Health Inequities Program of Duke University.	16. In the past 3 months, have you experienced any event(s) or received information that was so upsetting it affected how you cope with everyday life? Yes ☐ No ☐

Retrieved from:http://hiv.bvcog.org/2008/04/samiss.html

Screening Resources

Alcohol & Drug Abuse Institute (ADAI) Library—University of Washington

- Substance Abuse Screening and Assessment Instruments Database http://lib.adai.washington.edu/instruments/

HIV Clinical Resource www.hivguidelines.org

Office of the Medical Director, New York State Department of Health AIDS Institute in collaboration with Johns Hopkins University Division of Infectious Diseases

- *Guidelines for Screening and Ongoing Assessment of Substance Use Among Individuals who are HIV positive*: www.hivguidelines.org/clinical-guidelines/hiv-and-substance-use/screening-and-ongoing-assessment-for-substance-use/
- Substance Use Screening Tools: www.hivguidelines.org/resource-materials/screening-tools/substance-use-screening-tools/

Mental Health First Aid www.mentalhealthfirstaid.org/cs/

A public education program that helps trainees identify, understand, and respond to signs of mental illnesses and substance use disorders.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) www.niaaa.nih.gov

- *Helping Patients Who Drink Too Much: A Clinician's Guide:* http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

National Institute on Drug Abuse (NIDA) www.nida.nih.gov

- *Alcohol Use among Older Adults: Pocket Screening Instruments for Health Care and Social Service Providers*: http://kap.samhsa.gov/products/brochures/pdfs/pocket_2.pdf

New York State Office of Mental Health (OMH)

- *Screening for Co-Occurring Disorders OMH and OASAS Guidance Document, July 31, 2008:* www.omh.ny.gov/omhweb/resources/providers/co_occurring/adult_services/screening.html

Substance Abuse and Mental Health Services Administration www.samhsa.gov

- *Co-Occurring Center for Excellence (COCE) Screening Review*: www.coce.samhsa.gov/cod_resources/PDF/ScreeningReportRevised9-12-07.pdf
- *Mental Health AIDS Newsletter*: www.samhsa.gov/hiv/mhaids.aspx

Brief Intervention Resources

American Psychological Association Office on AIDS: www.apa.org/pi/aids/

- HIV Office for Psychology Education (HOPE) Program: www.apa.org/pi/aids/programs/hope/
- HIV Integrated Care: Integrating Mental Health and Substance Abuse Assessment and Treatment Into HIV Prevention: www.apa.org/pi/aids/programs/bssv/integration.aspx

American Public Health Association—*Alcohol Screening and Brief Intervention: A guide for public health practitioners:* www.adp.cahwnet.gov/SBI/pdfs/Alcohol_SBI_Manual.pdf

Clinical Tools, Inc.—*SBIRT Training: Skills Training for Primary Care Providers:* www.sbirttraining.com/motivationalinterview

Health TeamWorks Online SBIRT and Tobacco Training Module: www.healthteamworks.biz/player.html

Motivational Interviewing: www.motivationalinterview.org

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change (2nd ed.)*. New York: Guilford Press.

Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational interviewing in health care: Helping patients change behavior*. New York: Guilford Press.

Rosengren, D. B. (2009). *Building Motivational Interviewing Skills: A Practitioner Workbook*. New York: Guilford Press.

National Association of State Alcohol and Drug Abuse Directors—*State Issue Brief: Current Research on Screening and Brief Intervention and Implications for State Alcohol and Other Drug (AOD) Systems* (2006): http://nasadad.org/resource.php?base_id=788

Pennsylvania SBIRT Project: www.ireta.org/sbirt/

Substance Abuse and Mental Health Services Administration

- *SAMHSA SBIRT Grantee Websites:* www.samhsa.gov/prevention/sbirt/grantees/orgs.aspx
- *White Paper: Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Healthcare*: www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf

University of Maryland Medical Doctors Making a Difference (MD3) SBIRT Training: www.sbirt.umaryland.edu

Referral to Treatment Resources

Maryland Referral Resources

- Baltimore Mental Health Systems Network of Care: http://baltimorecity.md.networkofcare.org/mh/index.aspx
- Baltimore Substance Abuse Systems: www.BSASinc.org/services/search.asp
- Maryland Community Services Locator: www.mdcsl.org

A search tool that locates health, social service, and criminal justice resources.

Mental Health Awareness, Screening, and Prevention

- American Foundation for Suicide Prevention: www.afsp.org
- Mental Health America: www.mentalhealthamerica.net
- National Council for Community Behavioral Healthcare: www.thenationalcouncil.org
- National Institute of Mental Health**:** www.nimh.nih.gov/index.shtml

SAMHSA Mental Health and Substance Abuse Treatment Locator:
www.SAMHSA.gov/treatment/index.aspx

Self-Help, Mutual Help, Support, and Advocacy

- Alcoholics Anonymous: www.aa.org
- Anxiety Disorders Association of America: www.adaa.org
- Anxiety Disorders Resource Center: www.anxietypanicattack.com
- Depression and Bipolar Support Alliance: www.dbsalliance.org
- National Alliance on Mental Illness: www.nami.org
- Narcotics Anonymous: www.na.org

Quality Improvement Resources

Agency for Healthcare Research and Quality www.ahrq.gov

A Department of Health and Human Services agency devoted to improving the quality and effectiveness of American health care.

- Up-to-date information on health care policies and access to quality diagnostic tools
- Healthcare Innovations Exchange: http://innovations.ahrq.gov/

HealthQual International www.healthqual.org

A public health initiative that looks to improve the quality of healthcare provided by national health care systems.

- HIV best practices and quality improvement measures, training, and resources

Health Resources and Services Administration (HRSA) HIV/AIDS Programs hab.hrsa.gov

Federal Ryan White HIV/AIDS Programs

- HIV/AIDS services resources
- Program data, funding, and management

HIV Clinical Resource www.hivguidelines.org

Office of the Medical Director, New York State Department of Health AIDS Institute in collaboration with Johns Hopkins University Division of Infectious Diseases

- Clinical guidelines and policy
- Clinical education and resource materials

Institute for Healthcare Improvement www.ihi.org

A non-profit organization that has dedicated itself to improving community health care through identifying effective care practices and aiding in their implementation.

- *HIVQual Workbook* including quality improvement materials
- Models of quality improvement and CQI planning resources

National Quality Center www.nationalqualitycenter.org

An HIV/AIDS quality care initiative committed to providing no-cost assistance in order to continually improve the level of HIV/AIDS care in the United States.

- HIV best practices and quality improvement measures, training, and resources

Release of Information Form

I, _____, hereby authorize
(*Patient's printed name)*

_____ to release
(Name/Agency to release information)

the following information regarding (check all that apply):

- ☐ services/treatment
- ☐ substance use history
- ☐ criminal record
- ☐ HIV/AIDS status
- ☐ attendance/participation records
- ☐ psychiatric history
- ☐ statement of charges
- ☐ other: _____

to:_____
(*Name/Agency to receive information)*

_____
(Address, telephone, fax number)

pertaining to _____
(*Patient's printed name)*

for the sole purpose of _____

_____
(*e.g., "referral follow-up", "treatment planning")*

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent at any time in writing except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.). This consent expires automatically **one year after treatment completion** or unless I revoke this privilege in writing.

_____ _____
Patient signature Date

_____ _____
Agency Staff Member signature Date

Quality Improvement Form

Staff and Patients: *Please use this form to communicate complaints, grievances, ideas, and suggestions related to our agency's service delivery and operations.*

Date Submitted: _____ (MM/DD/YYYY)

Submitted by: _____
(Leave blank if you wish to remain anonymous.)

Which are you? *Please circle one:* Staff Member Patient

Please fill out all relevant sections below:

Situation: *Describe the issue.*

Desired Change: *Describe the changes you would like to take place.*

Benefit: *Explain why this is important.*

Suggestions: *Provide specific activities that may contribute to the desired change.*

For CQI Team Use Only: Please Do Not Write Below This Line

Date Reviewed by CQI Team: **_____** (MM/DD/YYYY)

Action Taken: